

Senate Engrossed House Bill

FILED

**JANICE K. BREWER
SECRETARY OF STATE**

State of Arizona
House of Representatives
Forty-eighth Legislature
First Regular Session
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CHAPTER 263

HOUSE BILL 2789

AN ACT

CHANGING THE DESIGNATION OF TITLE 20, CHAPTER 13, ARIZONA REVISED STATUTES, TO "ACCOUNTABLE HEALTH PLANS"; CHANGING THE DESIGNATION OF TITLE 20, CHAPTER 13, ARTICLE 2, ARIZONA REVISED STATUTES, TO "UNINSURED SMALL BUSINESS HEALTH INSURANCE PLANS"; AMENDING SECTIONS 20-2341, 36-545.08, 36-574, 36-672, 36-2901, 36-2901.03, 36-2903.01 AND 36-2912.01, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 29, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-2923; AMENDING SECTIONS 36-2930, 36-2988 AND 36-3410, ARIZONA REVISED STATUTES; REPEALING SECTION 36-3415, ARIZONA REVISED STATUTES; AMENDING SECTIONS 38-654 AND 43-210, ARIZONA REVISED STATUTES; AMENDING TITLE 46, CHAPTER 1, ARIZONA REVISED STATUTES, BY ADDING ARTICLE 6; MAKING APPROPRIATIONS; RELATING TO HEALTH AND WELFARE BUDGET RECONCILIATION.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Heading change

3 The chapter heading of title 20, chapter 13, Arizona Revised Statutes,
4 is changed from "SPECIAL HEALTH INSURANCE PLANS" to "ACCOUNTABLE HEALTH
5 PLANS".

6 Sec. 2. Heading change

7 The article heading of title 20, chapter 13, article 2, Arizona Revised
8 Statutes, is changed from "SMALL BUSINESS HEALTH INSURANCE PLANS" to
9 "UNINSURED SMALL BUSINESS HEALTH INSURANCE PLANS".

10 Sec. 3. Section 20-2341, Arizona Revised Statutes, is amended to read:
11 20-2341. Uninsured small business health insurance plans;

12 mandatory coverage exemption; definitions

13 A. A policy, subscription contract, contract, plan or evidence of
14 coverage issued to a- AN UNINSURED small business by a health care insurer is
15 not subject to the requirements of any of the following:

- 16 1. Section 20-461, subsection A, paragraph 17 and subsection B.
- 17 2. Section 20-826, subsection C, paragraph 1.
- 18 3. Section 20-826, subsections F, J, K, U, V, W, X and Y.
- 19 4. Sections 20-841, 20-841.01, 20-841.02, 20-841.03, 20-841.04,
20 20-841.06, 20-841.07 and 20-841.08.
- 21 5. Section 20-841.05, subsections B and E.
- 22 6. Section 20-1057, subsections C, K, L, Y, Z, AA and BB.
- 23 7. Sections 20-1057.01, 20-1057.03, 20-1057.04, 20-1057.05 and
24 20-1057.08.
- 25 8. Section 20-1057.02, subsection B.
- 26 9. Section 20-1342, subsection A, paragraph 8, subdivision (a).
- 27 10. Section 20-1342, subsection A, paragraphs 11 and 12.
- 28 11. Section 20-1342, subsections H, I, J and K.
- 29 12. Section 20-1342.01.
- 30 13. Sections 20-1376, 20-1376.01, 20-1376.02, 20-1376.03 and
31 20-1376.04.
- 32 14. Section 20-1402, subsection A, paragraph 4, subdivision (a).
- 33 15. Section 20-1402, subsection A, paragraphs 7 and 8.
- 34 16. Section 20-1402, subsections H, I, J, K and L.
- 35 17. Section 20-1404, subsection F, paragraph 1.
- 36 18. Section 20-1404, subsections I, Q, R, S, T and U.
- 37 19. Section 20-1406.
- 38 20. Sections 20-1406.01, 20-1406.02, 20-1406.03 and 20-1406.04.
- 39 21. Section 20-1407.
- 40 22. Section 20-2321.
- 41 23. Section 20-2327.
- 42 24. Section 20-2329.

43 B. Section 20-2304, subsection B does not apply to a policy,
44 subscription contract, contract, plan or evidence of coverage issued to a- AN
45 UNINSURED small business pursuant to subsection A of this section.

1 C. In this article, unless the context otherwise requires:

2 1. "Health care insurer" means a disability insurer, group disability
3 insurer, blanket disability insurer, health care services organization,
4 hospital service corporation, medical service corporation or hospital and
5 medical service corporation.

6 ~~2. "Small business" means a business that employed at least two but
7 not more than twenty five persons at any time during the most recent calendar
8 year and that has been uninsured for at least six months.~~

9 2. "UNINSURED SMALL BUSINESS" MEANS A SMALL EMPLOYER THAT DID NOT
10 PROVIDE A HEALTH BENEFITS PLAN FOR AT LEAST SIX CONSECUTIVE MONTHS
11 IMMEDIATELY BEFORE THE EFFECTIVE DATE OF COVERAGE PROVIDED PURSUANT TO THIS
12 SECTION, EXCEPT THAT THIS REQUIREMENT DOES NOT APPLY AT THE RENEWAL OF
13 COVERAGE PURSUANT TO THIS SECTION.

14 Sec. 4. Section 36-545.08, Arizona Revised Statutes, is amended to
15 read:

16 36-545.08. Arizona state hospital fund; purpose

17 A. The Arizona state hospital fund is established for the purposes
18 prescribed in section 36-545.01, subsection I. The department of health
19 services shall administer the fund. The fund consists of the following:

20 ~~1. Monies appropriated by the legislature and matching federal monies
21 paid to the department for disproportionate share payments to the state
22 hospital.~~

23 ~~2.~~ 1. Monies reimbursed by the federal government under title XIX of
24 the social security act for services provided at the state hospital.

25 ~~3.~~ 2. Monies collected pursuant to section 36-3410 for services to
26 clients at the state hospital.

27 ~~4.~~ 3. Monies collected from counties for the cost of a defendant's
28 inpatient competency restoration treatment.

29 B. The department shall deposit monies collected pursuant to
30 subsection A of this section into three separate accounts.

31 C. Monies in the fund deposited under subsection A, paragraphs 1,~~2~~
32 and ~~4~~ 3 of this section are subject to legislative appropriation and are
33 designated for state hospital operations. Monies in the fund deposited under
34 subsection A, paragraph ~~3~~ 2 of this section are a continuing appropriation
35 and are exempt from the provisions of section 35-190 relating to lapsing of
36 appropriations. Monies in the fund deposited under subsection A, ~~paragraphs~~
37 ~~1 and 4~~ PARAGRAPH 3 of this section remaining unexpended and unencumbered at
38 the end of the fiscal year revert to the state general fund. Monies in the
39 fund deposited under subsection A, paragraph ~~2~~ 1 of this section are exempt
40 from the provisions of section 35-190 relating to lapsing of appropriations.

41 Sec. 5. Section 36-574, Arizona Revised Statutes, is amended to read:

42 36-574. Children's autism services; contract

43 A. Subject to legislative appropriation, in addition to any existing
44 autism services, the department may provide children's autism services
45 through the division of developmental disabilities to serve children who

1 have, or who are at risk of having, autism by entering into a contract with
2 any organization for training and oversight of habilitation workers to
3 utilize intensive behavioral treatment through applied behavioral analysis.

4 B. SUBJECT TO LEGISLATIVE APPROPRIATION, IN ADDITION TO ANY EXISTING
5 AUTISM SERVICES, THE DEPARTMENT MAY PROVIDE CHILDREN'S AUTISM SERVICES TO
6 SERVE CHILDREN WHO HAVE, OR WHO ARE AT RISK OF HAVING, AUTISM BY ENTERING
7 INTO CONTRACTS WITH THE FOLLOWING PROVIDERS FOR THE FOLLOWING SERVICES:

8 1. AN ESTABLISHED FIRM THAT SPECIALIZES IN AUTISM SERVICES AND RELATED
9 DISORDERS AND THAT EMPLOYS AT LEAST FIVE NATIONALLY BOARD CERTIFIED BEHAVIOR
10 ANALYSTS, ONE OF WHOM IS A STATE-LICENSED PSYCHOLOGIST. THE CONTRACT SHALL
11 BE FOR SERVICES THAT ARE FOR CHILDREN WHO BEGIN TREATMENT BEFORE THEY REACH
12 FIVE YEARS OF AGE AND THAT UTILIZE TECHNIQUES OF DISCRETE TRIAL AND NATURAL
13 ENVIRONMENT INTENSIVE BEHAVIORAL TREATMENT THROUGH APPLIED BEHAVIORAL
14 ANALYSIS.

15 2. AN AUTISM AND RESEARCH FIRM THAT IS BASED IN THIS STATE AND THAT
16 HAS RAISED AT LEAST FIFTEEN MILLION DOLLARS OF PRIVATE SECTOR MONIES. THE
17 CONTRACT SHALL BE FOR PROVIDING TODDLERS WITH AUTISM SERVICES THAT UTILIZE
18 INTENSIVE EARLY INTERVENTION.

19 Sec. 6. Section 36-672, Arizona Revised Statutes, is amended to read:

20 36-672. Immunizations; department rules

21 A. Consistent with section 15-873, the director shall adopt rules
22 prescribing required immunizations for school attendance, the approved means
23 of immunization and indicated reinforcing immunizations for diseases, and
24 identifying types of health agencies and health care providers which may sign
25 a laboratory evidence of immunity. The rules shall include the required
26 doses, recommended optimum ages for administration of the immunizations,
27 persons who are authorized representatives to sign on behalf of a health
28 agency and other provisions necessary to implement this article.

29 B. The director, in consultation with the superintendent of public
30 instruction, shall develop by rule standards for documentary proof.

31 C. IMMUNIZATION AGAINST THE HUMAN PAPILLOMAVIRUS IS NOT REQUIRED FOR
32 SCHOOL ATTENDANCE.

33 Sec. 7. Section 36-2901, Arizona Revised Statutes, is amended to read:

34 36-2901. Definitions

35 In this article, unless the context otherwise requires:

36 1. "Administration" means the Arizona health care cost containment
37 system administration.

38 2. "Administrator" means the administrator of the Arizona health care
39 cost containment system.

40 3. "Contractor" means a person or entity that has a prepaid capitated
41 contract with the administration pursuant to section 36-2904 to provide
42 health care to members under this article either directly or through
43 subcontracts with providers.

44 4. "Department" means the department of economic security.

1 5. "Director" means the director of the Arizona health care cost
2 containment system administration.

3 6. "Eligible person" means any person who is:

4 (a) Any of the following:

5 (i) Defined as mandatorily or optionally eligible pursuant to title
6 XIX of the social security act as authorized by the state plan.

7 (ii) ~~Effective on October 1, 2002,~~ Defined in title XIX of the social
8 security act as an eligible pregnant woman WITH A FAMILY INCOME THAT DOES NOT
9 EXCEED ONE HUNDRED FIFTY PER CENT OF THE FEDERAL POVERTY GUIDELINES, as a
10 child under the age of six years and whose family income does not exceed one
11 hundred thirty-three per cent of the federal poverty guidelines or as
12 children who have not attained nineteen years of age and whose family income
13 does not exceed one hundred per cent of the federal poverty guidelines.

14 (iii) Under twenty-one years of age and who was in the custody of the
15 department of economic security pursuant to title 8, chapter 5 or 10 when the
16 person became eighteen years of age.

17 (iv) Defined as eligible pursuant to section 36-2901.01.

18 (v) Defined as eligible pursuant to section 36-2901.04.

19 (b) A full-time officer or employee of this state or of a city, town
20 or school district of this state or other person who is eligible for
21 hospitalization and medical care under title 38, chapter 4, article 4.

22 (c) A full-time officer or employee of any county in this state or
23 other persons authorized by the county to participate in county medical care
24 and hospitalization programs if the county in which such officer or employee
25 is employed has authorized participation in the system by resolution of the
26 county board of supervisors.

27 (d) An employee of a business within this state.

28 (e) A dependent of an officer or employee who is participating in the
29 system.

30 (f) Not enrolled in the Arizona long-term care system pursuant to
31 article 2 of this chapter.

32 (g) Defined as eligible pursuant to section 1902(a)(10)(A)(ii)(XV) and
33 (XVI) of title XIX of the social security act and who meets the income
34 requirements of section 36-2929.

35 7. "Malice" means evil intent and outrageous, oppressive or
36 intolerable conduct that creates a substantial risk of tremendous harm to
37 others.

38 8. "Member" means an eligible person who enrolls in the system.

39 9. "Noncontracting provider" means a person who provides health care
40 to members pursuant to this article but not pursuant to a subcontract with a
41 contractor.

42 10. "Physician" means a person licensed pursuant to title 32, chapter
43 13 or 17.

44 11. "Prepaid capitated" means a mode of payment by which a health care
45 contractor directly delivers health care services for the duration of a

1 contract to a maximum specified number of members based on a fixed rate per
2 member notwithstanding:

3 (a) The actual number of members who receive care from the contractor.

4 (b) The amount of health care services provided to any member.

5 12. "Primary care physician" means a physician who is a family
6 practitioner, general practitioner, pediatrician, general internist, or
7 obstetrician or gynecologist.

8 13. "Primary care practitioner" means a nurse practitioner certified
9 pursuant to title 32, chapter 15 or a physician assistant certified pursuant
10 to title 32, chapter 25. This paragraph does not expand the scope of
11 practice for nurse practitioners as defined pursuant to title 32, chapter 15,
12 or for physician assistants as defined pursuant to title 32, chapter 25.

13 14. "Section 1115 waiver" means the research and demonstration waiver
14 granted by the United States department of health and human services.

15 15. "Special health care district" means a special health care district
16 organized pursuant to title 48, chapter 31.

17 16. "State plan" has the same meaning prescribed in section 36-2931.

18 17. "System" means the Arizona health care cost containment system
19 established by this article.

20 Sec. 8. Section 36-2901.03, Arizona Revised Statutes, is amended to
21 read:

22 36-2901.03. Federal poverty program; eligibility

23 A. The administration shall adopt rules for a streamlined eligibility
24 determination process for any person who applies to be an eligible person as
25 defined in section 36-2901, paragraph 6, subdivision (a), item (iv). The
26 administration shall adopt these rules in accordance with state and federal
27 requirements and the section 1115 waiver.

28 B. The administration must base eligibility on an adjusted gross
29 income that does not exceed one hundred per cent of the federal poverty
30 guidelines.

31 C. For persons who the administration determines are eligible pursuant
32 to this section, the date of eligibility is the first day of the month of
33 application.

34 D. EXCEPT AS PROVIDED IN SUBSECTION E OF THIS SECTION, the
35 administration shall determine an eligible person's continued eligibility on
36 an annual basis.

37 E. EVERY SIX MONTHS THE ADMINISTRATION SHALL DETERMINE THE CONTINUED
38 ELIGIBILITY OF ANY ADULT WHO IS AT LEAST TWENTY-ONE YEARS OF AGE AND WHO IS
39 SUBJECT TO REDETERMINATION OF ELIGIBILITY FOR TEMPORARY ASSISTANCE FOR NEEDY
40 FAMILIES CASH BENEFITS BY THE DEPARTMENT. ACUTE CARE REDETERMINATIONS
41 PURSUANT TO THIS SUBSECTION SHALL BEGIN ON THE EFFECTIVE DATE OF THIS
42 AMENDMENT TO THIS SECTION AND SHALL OCCUR SIMULTANEOUSLY WITH
43 REDETERMINATIONS OF ELIGIBILITY FOR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES
44 CASH BENEFITS.

1 Sec. 9. Section 36-2903.01, Arizona Revised Statutes, is amended to
2 read:

3 36-2903.01. Additional powers and duties; report

4 A. The director of the Arizona health care cost containment system
5 administration may adopt rules that provide that the system may withhold or
6 forfeit payments to be made to a noncontracting provider by the system if the
7 noncontracting provider fails to comply with this article, the provider
8 agreement or rules that are adopted pursuant to this article and that relate
9 to the specific services rendered for which a claim for payment is made.

10 B. The director shall:

11 1. Prescribe uniform forms to be used by all contractors. The rules
12 shall require a written and signed application by the applicant or an
13 applicant's authorized representative, or, if the person is incompetent or
14 incapacitated, a family member or a person acting responsibly for the
15 applicant may obtain a signature or a reasonable facsimile and file the
16 application as prescribed by the administration.

17 2. Enter into an interagency agreement with the department to
18 establish a streamlined eligibility process to determine the eligibility of
19 all persons defined pursuant to section 36-2901, paragraph 6,
20 subdivision (a). At the administration's option, the interagency agreement
21 may allow the administration to determine the eligibility of certain persons
22 including those defined pursuant to section 36-2901, paragraph 6,
23 subdivision (a).

24 3. Enter into an intergovernmental agreement with the department to:

25 (a) Establish an expedited eligibility and enrollment process for all
26 persons who are hospitalized at the time of application.

27 (b) Establish performance measures and incentives for the department.

28 (c) Establish the process for management evaluation reviews that the
29 administration shall perform to evaluate the eligibility determination
30 functions performed by the department.

31 (d) Establish eligibility quality control reviews by the
32 administration.

33 (e) Require the department to adopt rules, consistent with the rules
34 adopted by the administration for a hearing process, that applicants or
35 members may use for appeals of eligibility determinations or
36 redeterminations.

37 (f) Establish the department's responsibility to place sufficient
38 eligibility workers at federally qualified health centers to screen for
39 eligibility and at hospital sites and level one trauma centers to ensure that
40 persons seeking hospital services are screened on a timely basis for
41 eligibility for the system, including a process to ensure that applications
42 for the system can be accepted on a twenty-four hour basis, seven days a
43 week.

1 (g) Withhold payments based on the allowable sanctions for errors in
2 eligibility determinations or redeterminations or failure to meet performance
3 measures required by the intergovernmental agreement.

4 (h) Recoup from the department all federal fiscal sanctions that
5 result from the department's inaccurate eligibility determinations. The
6 director may offset all or part of a sanction if the department submits a
7 corrective action plan and a strategy to remedy the error.

8 4. By rule establish a procedure and time frames for the intake of
9 grievances and requests for hearings, for the continuation of benefits and
10 services during the appeal process and for a grievance process at the
11 contractor level. Notwithstanding sections 41-1092.02, 41-1092.03 and
12 41-1092.05, the administration shall develop rules to establish the procedure
13 and time frame for the informal resolution of grievances and appeals. A
14 grievance that is not related to a claim for payment of system covered
15 services shall be filed in writing with and received by the administration or
16 the prepaid capitated provider or program contractor not later than sixty
17 days after the date of the adverse action, decision or policy implementation
18 being grieved. A grievance that is related to a claim for payment of system
19 covered services must be filed in writing and received by the administration
20 or the prepaid capitated provider or program contractor within twelve months
21 after the date of service, within twelve months after the date that
22 eligibility is posted or within sixty days after the date of the denial of a
23 timely claim submission, whichever is later. A grievance for the denial of a
24 claim for reimbursement of services may contest the validity of any adverse
25 action, decision, policy implementation or rule that related to or resulted
26 in the full or partial denial of the claim. A policy implementation may be
27 subject to a grievance procedure, but it may not be appealed for a hearing.
28 The administration is not required to participate in a mandatory settlement
29 conference if it is not a real party in interest. In any proceeding before
30 the administration, including a grievance or hearing, persons may represent
31 themselves or be represented by a duly authorized agent who is not charging a
32 fee. A legal entity may be represented by an officer, partner or employee
33 who is specifically authorized by the legal entity to represent it in the
34 particular proceeding.

35 5. Apply for and accept federal funds available under title XIX of the
36 social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section
37 1396 (1980)) in support of the system. The application made by the director
38 pursuant to this paragraph shall be designed to qualify for federal funding
39 primarily on a prepaid capitated basis. Such funds may be used only for the
40 support of persons defined as eligible pursuant to title XIX of the social
41 security act or the approved section 1115 waiver.

42 6. At least thirty days before the implementation of a policy or a
43 change to an existing policy relating to reimbursement, provide notice to
44 interested parties. Parties interested in receiving notification of policy

1 changes shall submit a written request for notification to the
2 administration.

3 C. The director is authorized to apply for any federal funds available
4 for the support of programs to investigate and prosecute violations arising
5 from the administration and operation of the system. Available state funds
6 appropriated for the administration and operation of the system may be used
7 as matching funds to secure federal funds pursuant to this subsection.

8 D. The director may adopt rules or procedures to do the following:

9 1. Authorize advance payments based on estimated liability to a
10 contractor or a noncontracting provider after the contractor or
11 noncontracting provider has submitted a claim for services and before the
12 claim is ultimately resolved. The rules shall specify that any advance
13 payment shall be conditioned on the execution before payment of a contract
14 with the contractor or noncontracting provider that requires the
15 administration to retain a specified percentage, which shall be at least
16 twenty per cent, of the claimed amount as security and that requires
17 repayment to the administration if the administration makes any overpayment.

18 2. Defer liability, in whole or in part, of contractors for care
19 provided to members who are hospitalized on the date of enrollment or under
20 other circumstances. Payment shall be on a capped fee-for-service basis for
21 services other than hospital services and at the rate established pursuant to
22 subsection G or H of this section for hospital services or at the rate paid
23 by the health plan, whichever is less.

24 3. Deputize, in writing, any qualified officer or employee in the
25 administration to perform any act that the director by law is empowered to do
26 or charged with the responsibility of doing, including the authority to issue
27 final administrative decisions pursuant to section 41-1092.08.

28 4. Notwithstanding any other law, require persons eligible pursuant to
29 section 36-2901, paragraph 6, subdivision (a), section 36-2931, paragraph 5
30 and section 36-2981, paragraph 6 to be financially responsible for any cost
31 sharing requirements established in a state plan or a section 1115 waiver and
32 approved by the centers for medicare and medicaid services. Cost sharing
33 requirements may include copayments, coinsurance, deductibles, enrollment
34 fees and monthly premiums for enrolled members, including households with
35 children enrolled in the Arizona long-term care system.

36 E. The director shall adopt rules which further specify the medical
37 care and hospital services which are covered by the system pursuant to
38 section 36-2907.

39 F. In addition to the rules otherwise specified in this article, the
40 director may adopt necessary rules pursuant to title 41, chapter 6 to carry
41 out this article. Rules adopted by the director pursuant to this subsection
42 shall consider the differences between rural and urban conditions on the
43 delivery of hospitalization and medical care.

1 G. For inpatient hospital admissions and all outpatient hospital
2 services before March 1, 1993, the administration shall reimburse a
3 hospital's adjusted billed charges according to the following procedures:

4 1. The director shall adopt rules that, for services rendered from and
5 after September 30, 1985 until October 1, 1986, define "adjusted billed
6 charges" as that reimbursement level that has the effect of holding constant
7 whichever of the following is applicable:

8 (a) The schedule of rates and charges for a hospital in effect on
9 April 1, 1984 as filed pursuant to chapter 4, article 3 of this title.

10 (b) The schedule of rates and charges for a hospital that became
11 effective after May 31, 1984 but before July 2, 1984, if the hospital's
12 previous rate schedule became effective before April 30, 1983.

13 (c) The schedule of rates and charges for a hospital that became
14 effective after May 31, 1984 but before July 2, 1984, limited to five per
15 cent over the hospital's previous rate schedule, and if the hospital's
16 previous rate schedule became effective on or after April 30, 1983 but before
17 October 1, 1983. For the purposes of this paragraph, "constant" means equal
18 to or lower than.

19 2. The director shall adopt rules that, for services rendered from and
20 after September 30, 1986, define "adjusted billed charges" as that
21 reimbursement level that has the effect of increasing by four per cent a
22 hospital's reimbursement level in effect on October 1, 1985 as prescribed in
23 paragraph 1 of this subsection. Beginning January 1, 1991, the Arizona
24 health care cost containment system administration shall define "adjusted
25 billed charges" as the reimbursement level determined pursuant to this
26 section, increased by two and one-half per cent.

27 3. In no event shall a hospital's adjusted billed charges exceed the
28 hospital's schedule of rates and charges filed with the department of health
29 services and in effect pursuant to chapter 4, article 3 of this title.

30 4. For services rendered the administration shall not pay a hospital's
31 adjusted billed charges in excess of the following:

32 (a) If the hospital's bill is paid within thirty days of the date the
33 bill was received, eighty-five per cent of the adjusted billed charges.

34 (b) If the hospital's bill is paid any time after thirty days but
35 within sixty days of the date the bill was received, ninety-five per cent of
36 the adjusted billed charges.

37 (c) If the hospital's bill is paid any time after sixty days of the
38 date the bill was received, one hundred per cent of the adjusted billed
39 charges.

40 5. The director shall define by rule the method of determining when a
41 hospital bill will be considered received and when a hospital's billed
42 charges will be considered paid. Payment received by a hospital from the
43 administration pursuant to this subsection or from a contractor either by
44 contract or pursuant to section 36-2904, subsection I shall be considered
45 payment of the hospital bill in full, except that a hospital may collect any

1 unpaid portion of its bill from other third party payors or in situations
2 covered by title 33, chapter 7, article 3.

3 H. For inpatient hospital admissions and outpatient hospital services
4 on and after March 1, 1993 the administration shall adopt rules for the
5 reimbursement of hospitals according to the following procedures:

6 1. For inpatient hospital stays, the administration shall use a
7 prospective tiered per diem methodology, using hospital peer groups if
8 analysis shows that cost differences can be attributed to independently
9 definable features that hospitals within a peer group share. In peer
10 grouping the administration may consider such factors as length of stay
11 differences and labor market variations. If there are no cost differences,
12 the administration shall implement a stop loss-stop gain or similar
13 mechanism. Any stop loss-stop gain or similar mechanism shall ensure that
14 the tiered per diem rates assigned to a hospital do not represent less than
15 ninety per cent of its 1990 base year costs or more than one hundred ten per
16 cent of its 1990 base year costs, adjusted by an audit factor, during the
17 period of March 1, 1993 through September 30, 1994. The tiered per diem
18 rates set for hospitals shall represent no less than eighty-seven and
19 one-half per cent or more than one hundred twelve and one-half per cent of
20 its 1990 base year costs, adjusted by an audit factor, from October 1, 1994
21 through September 30, 1995 and no less than eighty-five per cent or more than
22 one hundred fifteen per cent of its 1990 base year costs, adjusted by an
23 audit factor, from October 1, 1995 through September 30, 1996. For the
24 periods after September 30, 1996 no stop loss-stop gain or similar mechanisms
25 shall be in effect. An adjustment in the stop loss-stop gain percentage may
26 be made to ensure that total payments do not increase as a result of this
27 provision. If peer groups are used the administration shall establish
28 initial peer group designations for each hospital before implementation of
29 the per diem system. The administration may also use a negotiated rate
30 methodology. The tiered per diem methodology may include separate
31 consideration for specialty hospitals that limit their provision of services
32 to specific patient populations, such as rehabilitative patients or children.
33 The initial per diem rates shall be based on hospital claims and encounter
34 data for dates of service November 1, 1990 through October 31, 1991 and
35 processed through May of 1992.

36 2. For rates effective on October 1, 1994, and annually thereafter,
37 the administration shall adjust tiered per diem payments for inpatient
38 hospital care by the data resources incorporated market basket index for
39 prospective payment system hospitals. For rates effective beginning on
40 October 1, 1999, the administration shall adjust payments to reflect changes
41 in length of stay for the maternity and nursery tiers.

42 3. Through June 30, 2004, for outpatient hospital services, the
43 administration shall reimburse a hospital by applying a hospital specific
44 outpatient cost-to-charge ratio to the covered charges. Beginning on July 1,
45 2004 through June 30, 2005, the administration shall reimburse a hospital by

1 applying a hospital specific outpatient cost-to-charge ratio to covered
2 charges. If the hospital increases its charges for outpatient services filed
3 with the Arizona department of health services pursuant to chapter 4, article
4 3 of this title, by more than 4.7 per cent for dates of service effective on
5 or after July 1, 2004, the hospital specific cost-to-charge ratio will be
6 reduced by the amount that it exceeds 4.7 per cent. If charges exceed 4.7
7 per cent, the effective date of the increased charges will be the effective
8 date of the adjusted Arizona health care cost containment system
9 cost-to-charge ratio. The administration shall develop the methodology for a
10 capped fee-for-service schedule and a statewide cost-to-charge ratio. Any
11 covered outpatient service not included in the capped fee-for-service
12 schedule shall be reimbursed by applying the statewide cost-to-charge ratio
13 that is based on the services not included in the capped fee-for-service
14 schedule. Beginning on July 1, 2005, the administration shall reimburse
15 clean claims with dates of service on or after July 1, 2005, based on the
16 capped fee-for-service schedule or the statewide cost-to-charge ratio
17 established pursuant to this paragraph. The administration may make
18 additional adjustments to the outpatient hospital rates established pursuant
19 to this section based on other factors, including the number of beds in the
20 hospital, specialty services available to patients and the geographic
21 location of the hospital.

22 4. Except if submitted under an electronic claims submission system, a
23 hospital bill is considered received for purposes of this paragraph on
24 initial receipt of the legible, error-free claim form by the administration
25 if the claim includes the following error-free documentation in legible form:

- 26 (a) An admission face sheet.
- 27 (b) An itemized statement.
- 28 (c) An admission history and physical.
- 29 (d) A discharge summary or an interim summary if the claim is split.
- 30 (e) An emergency record, if admission was through the emergency room.
- 31 (f) Operative reports, if applicable.
- 32 (g) A labor and delivery room report, if applicable.

33 Payment received by a hospital from the administration pursuant to this
34 subsection or from a contractor either by contract or pursuant to section
35 36-2904, subsection I is considered payment by the administration or the
36 contractor of the administration's or contractor's liability for the hospital
37 bill. A hospital may collect any unpaid portion of its bill from other third
38 party payors or in situations covered by title 33, chapter 7, article 3.

39 5. For services rendered on and after October 1, 1997, the
40 administration shall pay a hospital's rate established according to this
41 section subject to the following:

- 42 (a) If the hospital's bill is paid within thirty days of the date the
43 bill was received, the administration shall pay ninety-nine per cent of the
44 rate.

1 (b) If the hospital's bill is paid after thirty days but within sixty
2 days of the date the bill was received, the administration shall pay one
3 hundred per cent of the rate.

4 (c) If the hospital's bill is paid any time after sixty days of the
5 date the bill was received, the administration shall pay one hundred per cent
6 of the rate plus a fee of one per cent per month for each month or portion of
7 a month following the sixtieth day of receipt of the bill until the date of
8 payment.

9 6. In developing the reimbursement methodology, if a review of the
10 reports filed by a hospital pursuant to section 36-125.04 indicates that
11 further investigation is considered necessary to verify the accuracy of the
12 information in the reports, the administration may examine the hospital's
13 records and accounts related to the reporting requirements of section
14 36-125.04. The administration shall bear the cost incurred in connection
15 with this examination unless the administration finds that the records
16 examined are significantly deficient or incorrect, in which case the
17 administration may charge the cost of the investigation to the hospital
18 examined.

19 7. Except for privileged medical information, the administration shall
20 make available for public inspection the cost and charge data and the
21 calculations used by the administration to determine payments under the
22 tiered per diem system, provided that individual hospitals are not identified
23 by name. The administration shall make the data and calculations available
24 for public inspection during regular business hours and shall provide copies
25 of the data and calculations to individuals requesting such copies within
26 thirty days of receipt of a written request. The administration may charge a
27 reasonable fee for the provision of the data or information.

28 8. The prospective tiered per diem payment methodology for inpatient
29 hospital services shall include a mechanism for the prospective payment of
30 inpatient hospital capital related costs. The capital payment shall include
31 hospital specific and statewide average amounts. For tiered per diem rates
32 beginning on October 1, 1999, the capital related cost component is frozen at
33 the blended rate of forty per cent of the hospital specific capital cost and
34 sixty per cent of the statewide average capital cost in effect as of
35 January 1, 1999 and as further adjusted by the calculation of tier rates for
36 maternity and nursery as prescribed by law. The administration shall adjust
37 the capital related cost component by the data resources incorporated market
38 basket index for prospective payment system hospitals.

39 9. For graduate medical education programs:

40 (a) Beginning September 30, 1997, the administration shall establish a
41 separate graduate medical education program to reimburse hospitals that had
42 graduate medical education programs that were approved by the administration
43 as of October 1, 1999. The administration shall separately account for
44 monies for the graduate medical education program based on the total
45 reimbursement for graduate medical education reimbursed to hospitals by the

1 system in federal fiscal year 1995-1996 pursuant to the tiered per diem
2 methodology specified in this section. The graduate medical education
3 program reimbursement shall be adjusted annually by the increase or decrease
4 in the index published by the global insight hospital market basket index for
5 prospective hospital reimbursement. Subject to legislative appropriation, on
6 an annual basis, each qualified hospital shall receive a single payment from
7 the graduate medical education program that is equal to the same percentage
8 of graduate medical education reimbursement that was paid by the system in
9 federal fiscal year 1995-1996. Any reimbursement for graduate medical
10 education made by the administration shall not be subject to future
11 settlements or appeals by the hospitals to the administration. The monies
12 available under this subdivision shall not exceed the fiscal year 2005-2006
13 appropriation adjusted annually by the increase or decrease in the index
14 published by the global insight hospital market basket index for prospective
15 hospital reimbursement, except for monies distributed for expansions pursuant
16 to subdivision (b) of this paragraph.

17 (b) THE MONIES AVAILABLE FOR GRADUATE MEDICAL EDUCATION PROGRAMS
18 PURSUANT TO THIS SUBDIVISION SHALL NOT EXCEED THE FISCAL YEAR 2006-2007
19 APPROPRIATION ADJUSTED ANNUALLY BY THE INCREASE OR DECREASE IN THE INDEX
20 PUBLISHED BY THE GLOBAL INSIGHT HOSPITAL MARKET BASKET INDEX FOR PROSPECTIVE
21 HOSPITAL REIMBURSEMENT. GRADUATE MEDICAL EDUCATION PROGRAMS ELIGIBLE FOR
22 SUCH REIMBURSEMENT ARE NOT PRECLUDED FROM RECEIVING REIMBURSEMENT FOR FUNDING
23 UNDER SUBDIVISION (c) OF THIS PARAGRAPH. Beginning July 1, 2006, the
24 administration shall distribute any monies appropriated for graduate medical
25 education above the amount prescribed in subdivision (a) of this paragraph in
26 the following order or priority:

27 (i) For the direct costs to support the expansion of graduate medical
28 education programs established before July 1, 2006 at hospitals that do not
29 receive payments pursuant to subdivision (a) of this paragraph. These
30 programs must be approved by the administration.

31 (ii) For the direct costs to support the expansion of graduate medical
32 education programs established on or before October 1, 1999. These programs
33 must be approved by the administration.

34 ~~(iii) For the direct costs of graduate medical education programs~~
35 ~~established on or after July 1, 2006. These programs must be approved by the~~
36 ~~administration.~~

37 (c) THE ADMINISTRATION SHALL DISTRIBUTE TO HOSPITALS ANY MONIES
38 APPROPRIATED FOR GRADUATE MEDICAL EDUCATION ABOVE THE AMOUNT PRESCRIBED IN
39 SUBDIVISIONS (a) AND (b) OF THIS PARAGRAPH FOR THE FOLLOWING PURPOSES:

40 (i) FOR THE DIRECT COSTS OF GRADUATE MEDICAL EDUCATION PROGRAMS
41 ESTABLISHED OR EXPANDED ON OR AFTER JULY 1, 2006. THESE PROGRAMS MUST BE
42 APPROVED BY THE ADMINISTRATION.

43 (ii) FOR A PORTION OF ADDITIONAL INDIRECT GRADUATE MEDICAL EDUCATION
44 COSTS FOR PROGRAMS THAT ARE LOCATED IN A COUNTY WITH A POPULATION OF LESS
45 THAN FIVE HUNDRED THOUSAND PERSONS AT THE TIME THE RESIDENCY POSITION WAS

1 CREATED OR FOR A RESIDENCY POSITION THAT INCLUDES A ROTATION IN A COUNTY WITH
2 A POPULATION OF LESS THAN FIVE HUNDRED THOUSAND PERSONS AT THE TIME THE
3 RESIDENCY POSITION WAS ESTABLISHED. THESE PROGRAMS MUST BE APPROVED BY THE
4 ADMINISTRATION.

5 ~~(e)~~ (d) The administration shall develop, by rule, the formula by
6 which the monies are distributed.

7 ~~(d)~~ (e) Each graduate medical education program that receives funding
8 pursuant to subdivision (b) OR (c) of this paragraph shall identify and
9 report to the administration the number of new residency positions created by
10 the funding provided in this paragraph, including positions in rural areas.
11 THE PROGRAM SHALL ALSO REPORT INFORMATION RELATED TO THE NUMBER OF FUNDED
12 RESIDENCY POSITIONS THAT RESULTED IN PHYSICIANS LOCATING THEIR PRACTICE IN
13 THIS STATE. The administration shall report to the joint legislative budget
14 committee by February 1 of each year on the number of new residency positions
15 as reported by the graduate medical education programs.

16 (f) BEGINNING JULY 1, 2007, LOCAL, COUNTY AND TRIBAL GOVERNMENTS MAY
17 PROVIDE MONIES IN ADDITION TO ANY STATE GENERAL FUND MONIES APPROPRIATED FOR
18 GRADUATE MEDICAL EDUCATION IN ORDER TO QUALIFY FOR ADDITIONAL MATCHING
19 FEDERAL MONIES FOR PROGRAMS OR POSITIONS IN A SPECIFIC LOCALITY OR AT A
20 SPECIFIC INSTITUTION. THESE PROGRAMS AND POSITIONS MUST BE APPROVED BY THE
21 ADMINISTRATION. THE ADMINISTRATION SHALL REPORT TO THE PRESIDENT OF THE
22 SENATE, THE SPEAKER OF THE HOUSE OF REPRESENTATIVES AND THE DIRECTOR OF THE
23 JOINT LEGISLATIVE BUDGET COMMITTEE ON OR BEFORE JULY 1 OF EACH YEAR ON THE
24 AMOUNT OF MONEY CONTRIBUTED AND NUMBER OF RESIDENCY POSITIONS FUNDED BY
25 LOCAL, TRIBAL AND COUNTY GOVERNMENTS, INCLUDING THE AMOUNT OF FEDERAL
26 MATCHING MONIES USED.

27 ~~(e)~~ (g) For the purposes of this paragraph, "graduate medical
28 education program" means a program, including an approved fellowship, that
29 prepares a physician for the independent practice of medicine by providing
30 didactic and clinical education in a medical discipline to a medical student
31 who has completed a recognized undergraduate medical education program.

32 (h) ANY FUNDS APPROPRIATED BUT NOT ALLOCATED BY THE ADMINISTRATION FOR
33 SUBDIVISION (b) OR SUBDIVISION (c) OF THIS PARAGRAPH MAY BE REALLOCATED IF
34 FUNDING FOR EITHER SUBDIVISION IS INSUFFICIENT TO COVER APPROPRIATE GRADUATE
35 MEDICAL EDUCATION COSTS.

36 10. The prospective tiered per diem payment methodology for inpatient
37 hospital services ~~may~~ SHALL include a mechanism for the payment of claims
38 with extraordinary operating costs per day. For tiered per diem rates
39 effective beginning on October 1, 1999, outlier cost thresholds are frozen at
40 the levels in effect on January 1, 1999 and adjusted annually by the
41 administration by the ~~data resources incorporated~~ GLOBAL INSIGHT HOSPITAL
42 market basket index for prospective payment system hospitals. BEGINNING WITH
43 DATES OF SERVICE ON OR AFTER OCTOBER 1, 2007, THE ADMINISTRATION SHALL PHASE
44 IN THE USE OF THE MOST RECENT STATEWIDE URBAN AND STATEWIDE RURAL AVERAGE
45 MEDICARE COST-TO-CHARGE RATIOS OR CENTERS FOR MEDICARE AND MEDICAID SERVICES

1 APPROVED COST-TO-CHARGE RATIOS TO QUALIFY AND PAY EXTRAORDINARY OPERATING
2 COSTS. COST-TO-CHARGE RATIOS SHALL BE UPDATED ANNUALLY. ROUTINE MATERNITY
3 CHARGES ARE NOT ELIGIBLE FOR OUTLIER REIMBURSEMENT. THE ADMINISTRATION SHALL
4 COMPLETE FULL IMPLEMENTATION OF THE PHASE-IN ON OR BEFORE OCTOBER 1, 2009.

5 11. Notwithstanding section 41-1005, subsection A, paragraph 9, the
6 administration shall adopt rules pursuant to title 41, chapter 6 establishing
7 the methodology for determining the prospective tiered per diem payments.

8 I. The director may adopt rules that specify enrollment procedures
9 including notice to contractors of enrollment. The rules may provide for
10 varying time limits for enrollment in different situations. The
11 administration shall specify in contract when a person who has been
12 determined eligible will be enrolled with that contractor and the date on
13 which the contractor will be financially responsible for health and medical
14 services to the person.

15 J. The administration may make direct payments to hospitals for
16 hospitalization and medical care provided to a member in accordance with this
17 article and rules. The director may adopt rules to establish the procedures
18 by which the administration shall pay hospitals pursuant to this subsection
19 if a contractor fails to make timely payment to a hospital. Such payment
20 shall be at a level determined pursuant to section 36-2904, subsection H
21 or I. The director may withhold payment due to a contractor in the amount of
22 any payment made directly to a hospital by the administration on behalf of a
23 contractor pursuant to this subsection.

24 K. The director shall establish a special unit within the
25 administration for the purpose of monitoring the third party payment
26 collections required by contractors and noncontracting providers pursuant to
27 section 36-2903, subsection B, paragraph 10 and subsection F and section
28 36-2915, subsection E. The director shall determine by rule:

29 1. The type of third party payments to be monitored pursuant to this
30 subsection.

31 2. The percentage of third party payments that is collected by a
32 contractor or noncontracting provider and that the contractor or
33 noncontracting provider may keep and the percentage of such payments that the
34 contractor or noncontracting provider may be required to pay to the
35 administration. Contractors and noncontracting providers must pay to the
36 administration one hundred per cent of all third party payments that are
37 collected and that duplicate administration fee-for-service payments. A
38 contractor that contracts with the administration pursuant to section
39 36-2904, subsection A may be entitled to retain a percentage of third party
40 payments if the payments collected and retained by a contractor are reflected
41 in reduced capitation rates. A contractor may be required to pay the
42 administration a percentage of third party payments that are collected by a
43 contractor and that are not reflected in reduced capitation rates.

1 L. The administration shall establish procedures to apply to the
2 following if a provider that has a contract with a contractor or
3 noncontracting provider seeks to collect from an individual or financially
4 responsible relative or representative a claim that exceeds the amount that
5 is reimbursed or should be reimbursed by the system:

6 1. On written notice from the administration or oral or written notice
7 from a member that a claim for covered services may be in violation of this
8 section, the provider that has a contract with a contractor or noncontracting
9 provider shall investigate the inquiry and verify whether the person was
10 eligible for services at the time that covered services were provided. If
11 the claim was paid or should have been paid by the system, the provider that
12 has a contract with a contractor or noncontracting provider shall not
13 continue billing the member.

14 2. If the claim was paid or should have been paid by the system and
15 the disputed claim has been referred for collection to a collection agency or
16 referred to a credit reporting bureau, the provider that has a contract with
17 a contractor or noncontracting provider shall:

18 (a) Notify the collection agency and request that all attempts to
19 collect this specific charge be terminated immediately.

20 (b) Advise all credit reporting bureaus that the reported delinquency
21 was in error and request that the affected credit report be corrected to
22 remove any notation about this specific delinquency.

23 (c) Notify the administration and the member that the request for
24 payment was in error and that the collection agency and credit reporting
25 bureaus have been notified.

26 3. If the administration determines that a provider that has a
27 contract with a contractor or noncontracting provider has billed a member for
28 charges that were paid or should have been paid by the administration, the
29 administration shall send written notification by certified mail or other
30 service with proof of delivery to the provider that has a contract with a
31 contractor or noncontracting provider stating that this billing is in
32 violation of federal and state law. If, twenty-one days or more after
33 receiving the notification, a provider that has a contract with a contractor
34 or noncontracting provider knowingly continues billing a member for charges
35 that were paid or should have been paid by the system, the administration may
36 assess a civil penalty in an amount equal to three times the amount of the
37 billing and reduce payment to the provider that has a contract with a
38 contractor or noncontracting provider accordingly. Receipt of delivery
39 signed by the addressee or the addressee's employee is prima facie evidence
40 of knowledge. Civil penalties collected pursuant to this subsection shall be
41 deposited in the state general fund. Section 36-2918, subsections C, D and
42 F, relating to the imposition, collection and enforcement of civil penalties,
43 apply to civil penalties imposed pursuant to this paragraph.

1 M. The administration may conduct postpayment review of all claims
2 paid by the administration and may recoup any monies erroneously paid. The
3 director may adopt rules that specify procedures for conducting postpayment
4 review. A contractor may conduct a postpayment review of all claims paid by
5 the contractor and may recoup monies that are erroneously paid.

6 N. The director or the director's designee may employ and supervise
7 personnel necessary to assist the director in performing the functions of the
8 administration.

9 O. The administration may contract with contractors for obstetrical
10 care who are eligible to provide services under title XIX of the social
11 security act.

12 P. Notwithstanding any OTHER law ~~to the contrary~~, on federal approval
13 the administration may make disproportionate share payments to private
14 hospitals, county operated hospitals, including hospitals owned or leased by
15 a special health care district, and state operated institutions for mental
16 disease beginning October 1, 1991 in accordance with federal law and subject
17 to legislative appropriation. If at any time the administration receives
18 written notification from federal authorities of any change or difference in
19 the actual or estimated amount of federal funds available for
20 disproportionate share payments from the amount reflected in the legislative
21 appropriation for such purposes, the administration shall provide written
22 notification of such change or difference to the president and the minority
23 leader of the senate, the speaker and the minority leader of the house of
24 representatives, the director of the joint legislative budget committee, the
25 legislative committee of reference and any hospital trade association within
26 this state, within three working days not including weekends after receipt of
27 the notice of the change or difference. In calculating disproportionate
28 share payments as prescribed in this section, the administration may use
29 either a methodology based on claims and encounter data that is submitted to
30 the administration from contractors or a methodology based on data that is
31 reported to the administration by private hospitals and state operated
32 institutions for mental disease. The selected methodology applies to all
33 private hospitals and state operated institutions for mental disease
34 qualifying for disproportionate share payments.

35 Q. Notwithstanding any law to the contrary, the administration may
36 receive confidential adoption information to determine whether an adopted
37 child should be terminated from the system.

38 R. The adoption agency or the adoption attorney shall notify the
39 administration within thirty days after an eligible person receiving services
40 has placed that person's child for adoption.

41 S. If the administration implements an electronic claims submission
42 system it may adopt procedures pursuant to subsection H of this section
43 requiring documentation different than prescribed under subsection H,
44 paragraph 4 of this section.

1 Sec. 10. Section 36-2912.01, Arizona Revised Statutes, is amended to
2 read:

3 36-2912.01. Healthcare group fund; nonlapsing

4 A. The healthcare group fund is established consisting of:

5 1. Premiums paid by small employers and eligible employees, including
6 employee contributions, for the cost of providing hospitalization and medical
7 care under the system.

8 2. Gifts, grants and donations.

9 3. Legislative appropriations.

10 B. The administration shall administer the fund.

11 C. Monies in the fund are continuously appropriated and are exempt
12 from the provisions of section 35-190 relating to the lapsing of
13 appropriations. Administrative costs to operate the program are subject to
14 legislative appropriation.

15 D. On notice from the administration, the state treasurer shall invest
16 and divest monies in the fund as provided by section 35-313, and monies
17 earned from investment shall be credited to the fund.

18 E. The administration shall use fund monies to pay the administrative
19 costs and the cost of providing hospitalization and medical care for small
20 employers and eligible employees as defined in section 36-2912.

21 F. Subject to legislative appropriation, the administration may use
22 fund monies from premiums to pay the administrative costs for the
23 administration to operate the healthcare group program. FOR THE PURPOSES OF
24 THIS SUBSECTION, "administrative costs":

25 1. INCLUDES ALL COSTS TO SUPERVISE THE WORK DONE BY PRIVATE HEALTH
26 PLANS AND FEE-FOR-SERVICE NETWORK PROVIDERS.

27 2. ~~DOES~~ DOES not include commissions or fees paid by the healthcare
28 program to insurance producers.

29 Sec. 11. Title 36, chapter 29, article 1, Arizona Revised Statutes, is
30 amended by adding section 36-2923, to read:

31 36-2923. Insurer claims data reporting requirements;
32 administration as payor of last resort; report;
33 definition

34 A. A HEALTH CARE INSURER SHALL:

35 1. PROVIDE ALL ENROLLMENT INFORMATION NECESSARY TO DETERMINE THE TIME
36 PERIOD IN WHICH A PERSON WHO IS DEFINED AS AN ELIGIBLE PERSON PURSUANT TO
37 SECTION 36-2901, PARAGRAPH 6, SUBDIVISION (a) OR THAT PERSON'S SPOUSE OR
38 DEPENDENTS MAY BE OR MAY HAVE BEEN COVERED BY THE HEALTH CARE INSURER AND THE
39 NATURE OF THAT COVERAGE. THE INFORMATION SHALL BE PROVIDED TO THE
40 ADMINISTRATION IN THE MANNER PRESCRIBED BY THE SECRETARY OF THE UNITED STATES
41 DEPARTMENT OF HEALTH AND HUMAN SERVICES OR IN A MANNER AGREED TO BETWEEN THE
42 HEALTH CARE INSURER AND THE ADMINISTRATION.

43 2. ACCEPT THE STATE'S RIGHT OF RECOVERY FROM A THIRD PARTY PAYOR
44 PURSUANT TO SECTION 36-2903 AND THE ASSIGNMENT TO THIS STATE OF ANY RIGHT OF
45 AN INDIVIDUAL OR OTHER ENTITY TO PAYMENT FROM THE THIRD PARTY PAYOR FOR AN

1 ITEM OR SERVICE FOR WHICH PAYMENT HAS BEEN MADE PURSUANT TO THIS CHAPTER.
2 THIS PARAGRAPH DOES NOT EXPAND THE SCOPE OF COVERAGE, BENEFITS OR RIGHTS
3 UNDER THE POLICY ISSUED BY THE HEALTH CARE INSURER.

4 3. RESPOND TO ANY INQUIRY MADE BY THE DIRECTOR REGARDING A CLAIM FOR
5 PAYMENT FOR ANY HEALTH CARE ITEM OR SERVICE THAT IS SUBMITTED NOT LATER THAN
6 THREE YEARS AFTER THE DATE OF THE PROVISION OF THE HEALTH CARE ITEM OR
7 SERVICE. THIS PARAGRAPH APPLIES TO A CLAIM IN WHICH THE ADMINISTRATION
8 DETERMINES THERE IS A REASONABLE BELIEF THAT THE INDIVIDUAL WAS INSURED BY
9 THE HEALTH CARE INSURER ON THE DATE OF SERVICE REFERENCED BY THE CLAIM.

10 4. NOT DENY A CLAIM SUBMITTED BY THIS STATE SOLELY ON THE BASIS OF THE
11 DATE OF THE SUBMISSION OF THE CLAIM, THE TYPE OR FORMAT OF THE CLAIM FORM OR
12 THE FAILURE TO PRESENT PROPER DOCUMENTATION AT THE POINT OF SALE THAT IS THE
13 BASIS OF THE CLAIM IF THE FOLLOWING CONDITIONS HAVE BEEN MET:

14 (a) THE CLAIM IS SUBMITTED BY THIS STATE IN THE THREE-YEAR PERIOD
15 BEGINNING ON THE DATE ON WHICH THE ITEM OR SERVICE WAS FURNISHED.

16 (b) AN ACTION BY THIS STATE TO ENFORCE ITS RIGHTS WITH RESPECT TO THE
17 CLAIM IS COMMENCED WITHIN SIX YEARS AFTER THE STATE SUBMITTED THE CLAIM. THE
18 HEALTH CARE INSURER MAY DENY THE CLAIM SUBMITTED BY THE STATE IF THE HEALTH
19 CARE INSURER HAS ALREADY PAID THE CLAIM IN ACCORDANCE WITH THE BENEFIT PLAN
20 UNDER WHICH THE MEMBER WAS COVERED BY THE HEALTH CARE INSURER ON THE DATE OF
21 SERVICE.

22 B. ON OR BEFORE JANUARY 1 OF EACH YEAR, THE DIRECTOR SHALL PUBLISH A
23 REPORT ON HEALTH CARE INSURER COMPLIANCE WITH THE CLAIMS DATA REPORTING
24 REQUIREMENTS OF THIS SECTION. THE REPORT SHALL INCLUDE THE FOLLOWING:

25 1. A LIST OF EACH HEALTH CARE INSURER THAT HAS NOT MATERIALLY COMPLIED
26 WITH THE REQUIREMENTS OF THIS SECTION.

27 2. CORRECTIVE ACTIONS, IF ANY, THAT HEALTH CARE INSURERS HAVE TAKEN TO
28 COMPLY WITH THE REQUIREMENTS OF THIS SECTION.

29 C. THE DIRECTOR SHALL SUBMIT A COPY OF EACH REPORT TO THE GOVERNOR,
30 THE PRESIDENT OF THE SENATE AND THE SPEAKER OF THE HOUSE OF REPRESENTATIVES
31 AND SHALL PROVIDE A COPY OF EACH REPORT TO THE SECRETARY OF STATE AND THE
32 DIRECTOR OF THE ARIZONA STATE LIBRARY, ARCHIVES AND PUBLIC RECORDS.

33 D. ANY INFORMATION OBTAINED BY THE DIRECTOR OR THE ADMINISTRATION
34 UNDER THIS SECTION SHALL BE MAINTAINED AS CONFIDENTIAL AS REQUIRED BY THE
35 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (P.L. 104-191;
36 110 STAT. 1936) AND OTHER APPLICABLE LAW AND SHALL BE USED SOLELY FOR THE
37 PURPOSE OF DETERMINING WHETHER A HEALTH CARE INSURER WAS ALSO PROVIDING
38 COVERAGE TO AN INDIVIDUAL DURING THE PERIOD THAT THE INDIVIDUAL WAS AN
39 ELIGIBLE MEMBER, FOR THE PURPOSES OF AVOIDING PAYMENTS BY THE SYSTEM FOR
40 SERVICES COVERED THROUGH OTHER INSURANCE AND FOR ENFORCING THE
41 ADMINISTRATION'S RIGHT TO ASSIGNMENT UNDER SUBSECTION A OF THIS SECTION.

42 E. FOR THE PURPOSES OF THIS SECTION, "HEALTH CARE INSURER" MEANS A
43 SELF-INSURED HEALTH BENEFIT PLAN, A GROUP HEALTH PLAN AS DEFINED IN SECTION
44 507(1) OF THE EMPLOYMENT RETIREMENT INCOME SECURITY ACT OF 1974, A PHARMACY
45 BENEFIT MANAGER OR ANY OTHER PARTY THAT BY STATUTE, CONTRACT OR AGREEMENT IS

1 RESPONSIBLE FOR PAYING FOR ITEMS OR SERVICES PROVIDED TO AN ELIGIBLE PERSON
2 UNDER THIS CHAPTER, INCLUDING:

3 1. AN ENTITY TRANSACTING DISABILITY INSURANCE AS DEFINED IN SECTION
4 20-253.

5 2. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, DENTAL
6 SERVICE CORPORATIONS, OPTOMETRIC SERVICE CORPORATIONS AND HOSPITAL, MEDICAL,
7 DENTAL AND OPTOMETRIC SERVICE CORPORATIONS AS DEFINED IN SECTION 20-822.

8 3. A PREPAID DENTAL PLAN ORGANIZATION AS DEFINED IN SECTION 20-1001.

9 4. A HEALTH CARE SERVICES ORGANIZATION AS DEFINED IN SECTION 20-1051.

10 5. AN ENTITY TRANSACTING GROUP DISABILITY INSURANCE PURSUANT TO
11 SECTION 20-1401.

12 6. AN ENTITY TRANSACTING BLANKET DISABILITY INSURANCE PURSUANT TO
13 SECTION 20-1404.

14 Sec. 12. Section 36-2930, Arizona Revised Statutes, is amended to
15 read:

16 36-2930. Temporary medical coverage program; qualifications;
17 fund; program termination

18 A. The temporary medical coverage program is established. Beginning
19 October 1, 2006, the administration shall establish eligibility for the
20 program for any uninsured person who meets the following requirements:

21 1. Is a resident of this state.

22 2. Is a citizen of the United States or a legal resident that meets
23 the requirements of section 36-2903, subsection B or C.

24 3. Submits an application as prescribed by the administration.

25 4. Has been eligible for services pursuant to section 36-2901,
26 paragraph 6 or section 36-2931, paragraph 5 and enrolled in the system,
27 excluding persons who are receiving services pursuant to section 36-2912, at
28 any time within twenty-four months before the person submits an application
29 pursuant to paragraph 3 of this subsection.

30 5. Is receiving benefits pursuant to 42 United States Code section
31 423.

32 6. Is not eligible for medicare benefits pursuant to 42 United States
33 Code section 426(b) or section 426-1.

34 B. The director may adopt rules to implement the program and the
35 requirements of this section and to prescribe the following:

36 1. The application process.

37 2. Actuarially sound capitation rates.

38 3. The collection of monthly premiums from program enrollees. Monthly
39 premiums shall not exceed the capitation rate paid to health plans for the
40 enrollee and shall be based on the enrollee's gross household income with
41 tiered premiums for any enrollee whose income is:

42 (a) More than one hundred but not more than one hundred fifty per cent
43 of the federal poverty guidelines.

44 (b) More than one hundred fifty but not more than two hundred per cent
45 of the federal poverty guidelines.

1 (c) More than two hundred but not more than two hundred fifty per cent
2 of the federal poverty guidelines.

3 (d) More than two hundred fifty but not more than three hundred per
4 cent of the federal poverty guidelines.

5 (e) More than three hundred per cent of the federal poverty
6 guidelines.

7 C. All covered services shall be provided by health plans that have
8 contracts with the administration pursuant to section 36-2906.

9 D. Unless otherwise required by the administration, the health plans
10 shall provide medically necessary health and medical services as required by
11 section 36-2907.

12 E. A person who is enrolled in the program must notify the
13 administration when the person becomes eligible for medicare benefits through
14 42 United States Code section 426(b) or section 426-1. A person who is
15 enrolled in the program and who becomes eligible for medicare benefits is
16 ineligible for the program.

17 F. If the director determines that monies may be insufficient for the
18 program, the administration may stop processing applications until the
19 administration is able to verify that funding is sufficient to fund the
20 program.

21 G. The temporary medical coverage fund is established consisting of
22 premiums collected from enrollees pursuant to subsection B of this section,
23 ~~legislative appropriations~~, gifts, grants and donations received by the
24 administration to operate the program. The administration shall use fund
25 monies to pay for the services and costs associated with persons who are
26 eligible pursuant to this section. On notice from the administration, the
27 state treasurer shall invest and divest monies in the fund as provided by
28 section 35-313, and monies earned from investment shall be credited to the
29 fund. Monies in the fund are subject to legislative appropriation.

30 H. The program established by this section ends on July 1, 2016
31 pursuant to section 41-3102.

32 Sec. 13. Section 36-2988, Arizona Revised Statutes, is amended to
33 read:

34 36-2988. Delivery of services; health plans; requirements

35 A. To the extent possible, the administration shall use contractors
36 that have a contract with the administration pursuant to article 1 of this
37 chapter or qualifying plans to provide services to members who qualify for
38 the program.

39 B. The administration has full authority to amend existing contracts
40 awarded pursuant to article 1 of this chapter.

41 C. As determined by the director, reinsurance may be provided against
42 expenses in excess of a specified amount on behalf of any member for covered
43 emergency services, inpatient services or outpatient services in the same
44 manner as reinsurance provided under article 1 of this chapter. Subject to

1 the approval of the director, reinsurance may be obtained against expenses in
2 excess of a specified amount on behalf of any member.

3 D. Notwithstanding any other law, the administration may procure,
4 provide or coordinate covered services by interagency agreement with
5 authorized agencies of this state for distinct groups of members, including
6 persons eligible for children's rehabilitative services through the
7 department of health services and members eligible for comprehensive medical
8 and dental benefits through the department of economic security.

9 E. After contracts are awarded pursuant to this section, the director
10 may negotiate with any successful bidder for the expansion or contraction of
11 services or service areas.

12 F. Payments to contractors shall be made monthly and may be subject to
13 contract provisions requiring the retention of a specified percentage of the
14 payment by the director, a reserve fund or any other contract provisions by
15 which adjustments to the payments are made based on utilization efficiency,
16 including incentives for maintaining quality care and minimizing unnecessary
17 inpatient services. Reserve monies withheld from contractors shall be
18 distributed to providers who meet performance standards established by the
19 director. Any reserve fund established pursuant to this subsection shall be
20 established as a separate account within the Arizona health care cost
21 containment system.

22 G. The director may negotiate at any time with a hospital on behalf of
23 a contractor for inpatient hospital services and outpatient hospital services
24 provided pursuant to the requirements specified in section 36-2904.

25 H. A contractor may require that subcontracting providers or
26 noncontracting providers be paid for covered services, other than hospital
27 services, according to the capped fee-for-service schedule adopted by the
28 administration or at lower rates as may be negotiated by the contractor.

29 I. ~~The administration and contractors shall not contract for any~~
30 ~~services or functions related to this article with a school district~~
31 ~~including contracting for the delivery of services, screening, outreach or~~
32 ~~information that involves the use of school staff and facilities.~~ A school
33 district may perform outreach and information activities that relate to this
34 article, WITH PERMISSION OF THE SCHOOL PRINCIPAL AND SCHOOL DISTRICT. THE
35 ADMINISTRATION AND CONTRACTORS MAY COLLABORATE WITH ENTITIES SUCH AS
36 COMMUNITY BASED ORGANIZATIONS, FAITH BASED ORGANIZATIONS, SCHOOLS AND SCHOOL
37 DISTRICTS FOR OUTREACH AND INFORMATION ACTIVITIES RELATED TO THIS ARTICLE.
38 OUTREACH AND INFORMATION ACTIVITIES SHALL NOT INCLUDE DELIVERY OF SERVICES,
39 SCREENING ACTIVITIES, ELIGIBILITY DETERMINATION OR ENROLLMENT RELATED TO THIS
40 ARTICLE. OUTREACH AND INFORMATION ACTIVITIES INCLUDE PROMOTION OF HEALTH
41 CARE COVERAGE, PARTICIPATION IN SCHOOL EVENTS AND DISTRIBUTION OF
42 APPLICATIONS AND MATERIALS TO PUPILS AND THEIR FAMILIES. Outreach and
43 information activities performed by THE ADMINISTRATION, CONTRACTORS OR a
44 school district shall not reduce or interfere with classroom instruction
45 time.

1 J. The administration is exempt from the procurement code pursuant to
2 section 41-2501.

3 Sec. 14. Section 36-3410, Arizona Revised Statutes, is amended to
4 read:

5 36-3410. Regional behavioral health authorities; contracts;
6 monthly summaries; inspection; copying fee;
7 children's behavioral health services; transfers;
8 prohibition

9 A. If the department contracts with behavioral health contractors
10 which would act as regional behavioral health authorities or directly with a
11 service provider for behavioral health services, the department and each
12 behavioral health contractor or service provider shall prepare and make
13 available monthly summary statements, in a format prescribed by the
14 department, that separately detail by title XIX and nontitle XIX and by
15 service category and service type, as defined by contract with the
16 department, the number of clients served, the units of service provided and
17 the state and federal monies distributed through the department to each
18 regional behavioral health authority or direct contract service provider and
19 the amounts distributed by each regional behavioral health authority or
20 direct contract service provider to their subcontractors. The director may
21 require additional information in the monthly statement which the director
22 determines to be critical for proper regulation and oversight of the regional
23 behavioral health authority or the direct contract service provider.

24 B. FOR SERVICES PROVIDED DIRECTLY BY A REGIONAL BEHAVIORAL HEALTH
25 AUTHORITY, THE MAXIMUM REIMBURSEMENT TO THAT REGIONAL BEHAVIORAL HEALTH
26 AUTHORITY SHALL BE THIRTY PER CENT ABOVE THE ARIZONA HEALTH CARE COST
27 CONTAINMENT SYSTEM FEE FOR SERVICE RATE FOR THE PARTICULAR SERVICE RENDERED.

28 C. EXCEPT AS PROVIDED IN SUBSECTIONS D AND E OF THIS SECTION,
29 BEHAVIORAL HEALTH CONTRACTORS UNDER CONTRACT WITH THE DEPARTMENT TO ACT AS
30 REGIONAL BEHAVIORAL HEALTH AUTHORITIES MAY PERFORM ONLY MANAGED CARE
31 FUNCTIONS. REGIONAL BEHAVIORAL HEALTH AUTHORITIES AND THEIR SUBSIDIARIES
32 SHALL NOT DELIVER BEHAVIORAL HEALTH SERVICES DIRECTLY TO CLIENTS. THE
33 PROHIBITION ON REGIONAL BEHAVIORAL HEALTH AUTHORITIES AND THEIR SUBSIDIARIES
34 DELIVERING BEHAVIORAL HEALTH SERVICES DIRECTLY TO CLIENTS SHALL BE FULLY
35 IMPLEMENTED BY SEPTEMBER 1, 2009.

36 D. IF A DIRECT SERVICES BEHAVIORAL HEALTH PROVIDER EXPERIENCES
37 CONTRACT PERFORMANCE FAILURE, THE REGIONAL BEHAVIORAL HEALTH AUTHORITY MAY,
38 AFTER RECEIVING APPROVAL FROM THE DEPARTMENT, PROVIDE DIRECT CARE SERVICES
39 FOR ONLY AS LONG AS NECESSARY TO ASSURE DELIVERY OF UNINTERRUPTED CARE TO
40 CLIENTS AND EITHER:

41 1. ACCOMPLISH THE ORDERLY TRANSITION OF THOSE MEMBERS TO A NEW
42 PROVIDER OR OTHER EXISTING PROVIDERS.

43 2. UNTIL THE PROVIDER IN QUESTION REORGANIZES OR OTHERWISE CORRECTS
44 THE CONTRACT PERFORMANCE FAILURE.

1 E. SUBSECTION C OF THIS SECTION DOES NOT APPLY TO A REGIONAL
2 BEHAVIORAL HEALTH AUTHORITY OPERATED BY A FEDERALLY RECOGNIZED INDIAN TRIBE.

3 ~~B-~~ F. In the contracts specified under subsection A of this section,
4 the department may include a provision to charge for services provided at the
5 state hospital. The charges are only for clients on whose behalf the
6 contractor has been paid by the department.

7 ~~G-~~ G. The summaries and the contracts on which they are based are
8 open to public inspection. The department and each regional behavioral
9 health authority or direct contract service provider shall make the summaries
10 available for inspection and copying at the office of each regional
11 behavioral health authority or direct contract service provider and at the
12 department.

13 ~~D-~~ H. The department and a regional behavioral health authority or
14 direct contract service provider shall charge a copying fee which is not in
15 excess of the actual cost of reproduction or the amount charged by the
16 secretary of state pursuant to section 41-126, whichever is less.

17 ~~E-~~ I. Copying fees received by the department, pursuant to subsection
18 ~~D-~~ H of this section, shall be placed in the state general fund.

19 ~~F-~~ J. Monies appropriated for fiscal year 2001-2002 and each fiscal
20 year thereafter for children's behavioral health services shall be spent on
21 services only as prescribed by the appropriation and may not be used for any
22 other purpose.

23 K. MONIES APPROPRIATED FOR FISCAL YEAR 2007-2008 AND EACH FISCAL YEAR
24 THEREAFTER FOR SERIOUSLY MENTALLY ILL SERVICES SHALL BE SPENT ON SERVICES
25 ONLY AS PRESCRIBED BY THE APPROPRIATION AND SHALL NOT BE USED FOR ANY OTHER
26 PURPOSE.

27 Sec. 15. Repeal

28 Section 36-3415, Arizona Revised Statutes, is repealed.

29 Sec. 16. Section 38-654, Arizona Revised Statutes, is amended to read:

30 38-654. Special employee health insurance trust fund; purpose;
31 investment of monies; use of monies; exemption from
32 lapsing; annual report

33 A. There is established a special employee health insurance trust fund
34 for the purpose of administering the state employee health insurance benefit
35 plans. The fund shall consist of legislative appropriations, monies
36 collected from the employer and employees for the health insurance benefit
37 plans and investment earnings on monies collected from employees. The fund
38 shall be administered by the director of the department of administration.
39 Monies in the fund that are determined by the legislature to be for
40 administrative expenses of the department of administration, including monies
41 authorized by subsection D, paragraph 4 of this section, are subject to
42 legislative appropriation.

43 B. On notice from the department of administration, the state
44 treasurer shall invest and divest monies in the fund as provided by section
45 35-313, and monies earned from investment shall be credited to the fund.

1 There shall be a separate accounting of monies contributed by the employer,
2 monies collected from state employees and investment earnings on monies
3 collected from employees. Monies collected from state employees for health
4 insurance benefit plans shall be expended prior to expenditure of monies
5 contributed by the employer.

6 C. The director of the department of administration may authorize the
7 employer health insurance contributions by fund to be payable in advance
8 whether the budget unit is funded in whole or in part by state monies. By
9 July 15 each year, the joint legislative budget committee staff shall
10 determine the amount appropriated for employer health insurance
11 contributions. The department of administration may transfer to the special
12 employee health insurance trust fund in whole or in part the amount
13 appropriated to budget units for employer health insurance contributions as
14 deemed necessary.

15 D. Monies in the fund shall be used by the department of
16 administration for the following purposes for the benefit of officers and
17 employees who participate in a health insurance benefit plan pursuant to this
18 article:

19 1. To administer a health insurance benefit program for state officers
20 and employees.

21 2. To pay health insurance premiums, claims costs and related
22 administrative expenses.

23 3. To apply against future premiums, claims costs and related
24 administrative expenses.

25 4. To apply the equivalent of not more than one dollar fifty cents for
26 each employee for each month to administer applicable federal and state laws
27 relating to health insurance benefit programs and to design, implement and
28 administer improvements to the employee health insurance or benefit program.

29 E. Subsection D of this section shall not be construed to require that
30 all monies in the special employee health insurance trust fund shall be used
31 within any one or more fiscal years. Any person who is no longer a state
32 employee or an employee who is no longer a participant in a health insurance
33 plan under contract with the department of administration shall have no claim
34 upon monies in the fund.

35 F. Monies deposited in or credited to the fund are exempt from the
36 provisions of section 35-190 relating to lapsing of appropriations.

37 G. Claims for services rendered prior to July 1, 1989 shall not be
38 paid from the special employee health insurance trust fund.

39 H. The department of administration shall submit an annual report on
40 the financial status of the special employee insurance trust fund to the
41 governor, the president of the senate, the speaker of the house of
42 representatives, the chairpersons of the house and senate appropriations
43 committees and the joint legislative budget committee staff by March 1 of
44 each year. The report shall include:

1 1. The actuarial assumptions and a description of the methodology used
2 to set premiums and reserve balance targets for the health insurance benefit
3 program for the current plan year.

4 2. An analysis of the actuarial soundness of the health insurance
5 benefit program for the previous plan year.

6 3. An analysis of the actuarial soundness of the health insurance
7 benefit program for the current plan year, based on both year-to-date
8 experience and total expected experience.

9 4. A preliminary estimate of the premiums and reserve balance targets
10 for the next plan year, including the actuarial assumptions and a description
11 of the methodology used.

12 I. THE DEPARTMENT SHALL SUBMIT A REPORT TO THE JOINT LEGISLATIVE
13 BUDGET COMMITTEE DETAILING ANY CHANGES TO THE TYPE OF BENEFITS OFFERED UNDER
14 THE PLAN AND ASSOCIATED COSTS AT LEAST FORTY-FIVE DAYS BEFORE MAKING THE
15 CHANGE. THE REPORT SHALL INCLUDE:

16 1. AN ESTIMATE OF THE COST OR SAVING ASSOCIATED WITH THE CHANGE.

17 2. AN EXPLANATION OF WHY THE CHANGE WAS IMPLEMENTED BEFORE THE NEXT
18 PLAN YEAR.

19 Sec. 17. Section 43-210, Arizona Revised Statutes, is amended to read:

20 43-210. Premium tax credit; health insurance; certification of
21 qualified persons; violation; classification;
22 definitions

23 A. The department shall issue a certificate of eligibility to a person
24 who files an application with the department in the form and manner
25 prescribed by the department on a first come, first served basis, subject to
26 subsection E. AN APPLICATION SUBMITTED TO THE DEPARTMENT UNDER THIS SECTION
27 SHALL CONTAIN OR BE VERIFIED BY A WRITTEN DECLARATION THAT IT IS MADE UNDER
28 PENALTY OF PERJURY. A person is entitled to receive a certificate if the
29 department determines monies are available for this program pursuant to
30 subsection E, the person has never before received a certificate and the
31 person is either:

32 1. A small business.

33 2. An individual who satisfies all of the following:

34 (a) Earns less than two hundred fifty per cent of the federal poverty
35 level.

36 (b) Is a legal resident of this state and a citizen of the United
37 States or a legal resident alien.

38 (c) Has not been covered under a health insurance policy for at least
39 six consecutive months before the application.

40 (d) Is not enrolled in the Arizona health HEALTH care cost containment
41 system, medicare or any other state or federal government health insurance
42 program.

43 B. A health care insurer that enrolls an individual or small business
44 certified pursuant to this section shall deduct the amount of the certificate
45 from the premium.

- 1 C. For an individual, the amount of the certificate is the lesser of:
2 1. One thousand dollars for coverage on a single person, five hundred
3 dollars for coverage on a child or three thousand dollars for family
4 coverage.
5 2. Fifty per cent of the health insurance premium.
6 D. For a small business, the amount of the certificate is the lesser
7 of:
8 1. One thousand dollars for coverage on each single employee or three
9 thousand dollars for each employee who elects family coverage.
10 2. Fifty per cent of the health insurance premium.
11 E. A health care insurer that enrolls an individual or small business
12 certified pursuant to this section shall notify the department of the
13 enrollment and the amount of premium tax credit ~~they intend~~ IT INTENDS to
14 claim for the current calendar year no later than the fifteenth day of the
15 month following commencement of coverage. The department shall not issue any
16 certificates under this section that exceed in the aggregate a combined total
17 of five million dollars in any calendar year.
18 F. The initial certificate is valid for a period of ~~thirty~~ NINETY days
19 after the date the department issues the certificate. If the individual or
20 small business ~~applies for~~ OBTAINS health care insurance within this period
21 of time the certificate is valid for one year from commencement of coverage.
22 G. Sixty days before the expiration of the certificate the department
23 shall review the status of the individual or small business. If the
24 individual or small business continues to meet the qualifications pursuant to
25 subsection A, paragraph 1 or paragraph 2, subdivisions (a), (b) and (d) ~~of~~
26 ~~this section~~, the department shall reissue the certificate of eligibility.
27 H. Individuals and small businesses are eligible for a maximum of two
28 reissued certificates of eligibility.
29 I. This section does not guarantee health insurance coverage to an
30 individual or small business pursuant to this section.
31 J. The department shall issue the certificate of eligibility in the
32 name of a specific individual and the certificate is nontransferable. A
33 person who sells, conveys, transfers or assigns the certificate to another
34 person or attempts to sell, convey, transfer or assign the certificate to
35 another person is guilty of a class 2 misdemeanor.
36 K. For the purposes of this section:
37 1. "Family" means any of the following:
38 (a) An adult and the adult's spouse.
39 (b) An adult, the adult's spouse and all unmarried dependent children
40 under nineteen years of age or under twenty-five years of age if a full-time
41 student.
42 (c) An adult and the adult's unmarried dependent children under
43 nineteen years of age or under twenty-five years of age if a full-time
44 student.

1 2. "Federal poverty level" means the federal poverty level guidelines
2 published annually by the United States department of health and human
3 services.

4 3. "Health care insurer" means a disability insurer, group disability
5 insurer, blanket disability insurer, health care services organization,
6 hospital service corporation, medical service corporation or hospital and
7 medical service corporation that provides health insurance in this state.

8 4. "Health insurance" means a licensed health care plan or arrangement
9 that pays for or furnishes medical or health care services and that is
10 issued by a health care insurer.

11 5. "Small business" means a business that has been in existence for at
12 least one calendar year in this state, that had not provided health insurance
13 to its employees for at least six consecutive months before the application
14 and THAT had at least two and no more than twenty-five employees during the
15 most recent calendar year.

16 Sec. 18. Title 46, chapter 1, Arizona Revised Statutes, is amended by
17 adding article 6, to read:

18 ARTICLE 6. LIFESPAN RESPITE CARE PROGRAM

19 46-171. Definitions

20 IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

21 1. "LIFESPAN RESPITE CARE" MEANS A COORDINATED SYSTEM OF ACCESSIBLE,
22 COMMUNITY-BASED RESPITE CARE SERVICES FOR FAMILY CAREGIVERS OF CHILDREN OR
23 ADULTS WITH SPECIAL NEEDS.

24 2. "RESPITE CARE" MEANS SHORT-TERM CARE AND SUPERVISION SERVICES THAT
25 ARE PROVIDED TO AN INDIVIDUAL TO RELIEVE THE INDIVIDUAL'S CAREGIVER.

26 46-172. Lifespan respite care program; program termination

27 A. THE DEPARTMENT SHALL ESTABLISH A LIFESPAN RESPITE CARE PROGRAM.

28 B. THE LIFESPAN RESPITE CARE PROGRAM SHALL:

29 1. ESTABLISH A RESPITE PROGRAM FOR PRIMARY CAREGIVERS OF INDIVIDUALS
30 WHO DO NOT CURRENTLY QUALIFY FOR OTHER PUBLICLY FUNDED RESPITE SERVICES.

31 2. COORDINATE WITH OTHER RESPITE SERVICES, INCLUDING SERVICES THAT ARE
32 PROVIDED PURSUANT TO TITLE 36, CHAPTER 5.1 AND SECTIONS 36-2939, 36-3407 AND
33 46-193.

34 3. SUPPORT THE GROWTH AND MAINTENANCE OF A STATEWIDE RESPITE
35 COALITION.

36 4. CONDUCT A STUDY ON THE NEED FOR RESPITE CARE THROUGHOUT THE
37 LIFESPAN OF INDIVIDUALS.

38 5. IDENTIFY LOCAL TRAINING RESOURCES FOR RESPITE CARE PROVIDERS.

39 6. LINK FAMILIES WITH RESPITE CARE PROVIDERS AND OTHER TYPES OF
40 RESPITE CAREGIVER CONSULTANTS.

41 7. CREATE AN EVALUATION TOOL FOR RECIPIENTS OF RESPITE CARE TO ASSURE
42 QUALITY OF CARE.

43 C. THE PROGRAM ESTABLISHED BY THIS SECTION ENDS ON JULY 1, 2017
44 PURSUANT TO SECTION 41-3102.

1 46-173. Lifespan respite care advisory committee

2 THE DEPARTMENT SHALL ESTABLISH A LIFESPAN RESPITE CARE ADVISORY
3 COMMITTEE THAT INCLUDES FAMILY CAREGIVERS AND RESPITE CARE PROVIDERS TO
4 ADVISE THE LIFESPAN RESPITE CARE PROGRAM ON RESPITE CARE MATTERS.

5 Sec. 19. AHCCCS; disproportionate share payments

6 Disproportionate share payments for fiscal year 2007-2008 made pursuant
7 to section 36-2903.01, subsection P, Arizona Revised Statutes, as amended by
8 this act, include:

9 1. \$89,439,900 for a qualifying nonstate operated public hospital.
10 The Maricopa county special health care district shall provide a certified
11 public expense form for the amount of qualifying disproportionate share
12 hospital expenditures made on behalf of this state to the administration on
13 or before June 1, 2008. The administration shall assist the district in
14 determining the amount of qualifying disproportionate share hospital
15 expenditures. Once the administration files a claim with the federal
16 government and receives federal funds participation based on the amount
17 certified by the Maricopa county special health care district, if the
18 certification is equal to or greater than \$89,439,900, the administration
19 shall distribute \$4,202,300 to the Maricopa county special health care
20 district and deposit the balance of the federal funds participation in the
21 state general fund. If the certification provided is for an amount less than
22 \$89,439,900, and the administration determines that the revised amount is
23 correct pursuant to the methodology used by the administration pursuant to
24 section 36-2903.01, Arizona Revised Statutes, as amended by this act, the
25 administration shall notify the governor, the president of the senate and the
26 speaker of the house of representatives, shall distribute \$4,202,300 to the
27 Maricopa county special health care district and shall deposit the balance of
28 the federal funds participation in the state general fund. If the
29 certification provided is for an amount less than \$89,439,900 and the
30 administration determines that the revised amount is not correct pursuant to
31 the methodology used by the administration pursuant to section 36-2903.01,
32 Arizona Revised Statutes, as amended by this act, the administration shall
33 notify the governor, the president of the senate and the speaker of the house
34 of representatives and shall deposit the total amount of the federal funds
35 participation in the state general fund.

36 2. \$28,474,900 for the Arizona state hospital. The Arizona state
37 hospital shall provide a certified public expense form for the amount of
38 qualifying disproportionate share hospital expenditures made on behalf of the
39 state to the administration on or before March 31, 2008. The administration
40 shall assist the Arizona state hospital in determining the amount of
41 qualifying disproportionate share hospital expenditures. Once the
42 administration files a claim with the federal government and receives federal
43 funds participation based on the amount certified by the Arizona state
44 hospital, the administration shall distribute the entire amount of federal
45 financial participation to the state general fund. If the certification

1 provided is for an amount less than \$28,474,900, the administration shall
2 notify the governor, the president of the senate and the speaker of the house
3 of representatives and shall distribute the entire amount of federal
4 financial participation to the state general fund. The certified public
5 expense form provided by the Arizona state hospital shall contain both the
6 total amount of qualifying disproportionate share hospital expenditures and
7 the amount limited by section 1923(g) of the social security act.

8 3. \$26,147,700 for private qualifying disproportionate share
9 hospitals.

10 Sec. 20. AHCCCS; acute care redeterminations; report

11 The Arizona health care cost containment system administration shall
12 report to the president of the senate, the speaker of the house of
13 representatives and the joint legislative budget committee on or before
14 February 10, 2008 on the effects through January 2008 of changing the
15 redetermination period for the population described in section 36-2901.03,
16 subsection E, Arizona Revised Statutes, as amended by this act. The report
17 shall include the number of redetermination letters sent out, the number of
18 redetermination interviews conducted and the number of redetermination
19 interviews resulting in continued acute care benefits.

20 Sec. 21. County acute care contribution; fiscal year 2007-2008

21 A. Notwithstanding section 11-292, Arizona Revised Statutes, for
22 fiscal year 2007-2008 for the provision of hospitalization and medical care,
23 the counties shall contribute the following amounts:

24	1. Apache	\$ 268,800
25	2. Cochise	\$ 2,214,800
26	3. Coconino	\$ 742,900
27	4. Gila	\$ 1,413,200
28	5. Graham	\$ 536,200
29	6. Greenlee	\$ 190,700
30	7. La Paz	\$ 212,100
31	8. Maricopa	\$23,067,900
32	9. Mohave	\$ 1,237,700
33	10. Navajo	\$ 310,800
34	11. Pima	\$14,951,800
35	12. Pinal	\$ 2,715,600
36	13. Santa Cruz	\$ 482,800
37	14. Yavapai	\$ 1,427,800
38	15. Yuma	\$ 1,325,100

39 B. If a county does not provide funding as specified in subsection A
40 of this section, the state treasurer shall subtract the amount owed by the
41 county to the Arizona health care cost containment system fund and the
42 long-term care system fund established by section 36-2913, Arizona Revised
43 Statutes, from any payments required to be made by the state treasurer to
44 that county pursuant to section 42-5029, subsection D, paragraph 2, Arizona
45 Revised Statutes, plus interest on that amount pursuant to section 44-1201,

1 Arizona Revised Statutes, retroactive to the first day the funding was due.
2 If the monies the state treasurer withholds are insufficient to meet that
3 county's funding requirements as specified in subsection A of this section,
4 the state treasurer shall withhold from any other monies payable to that
5 county from whatever state funding source is available an amount necessary to
6 fulfill that county's requirement. The state treasurer shall not withhold
7 distributions from the highway user revenue fund pursuant to title 28,
8 chapter 18, article 2, Arizona Revised Statutes.

9 C. Payment of an amount equal to one-twelfth of the total amount
10 determined pursuant to subsection A of this section shall be made to the
11 state treasurer on or before the fifth day of each month. On request from
12 the director of the Arizona health care cost containment system
13 administration, the state treasurer shall require that up to three months'
14 payments be made in advance, if necessary.

15 D. The state treasurer shall deposit the amounts paid pursuant to
16 subsection C of this section and amounts withheld pursuant to subsection B of
17 this section in the Arizona health care cost containment system fund and the
18 long-term care system fund established by section 36-2913, Arizona Revised
19 Statutes.

20 E. If payments made pursuant to subsection C of this section exceed
21 the amount required to meet the costs incurred by the Arizona health care
22 cost containment system for the hospitalization and medical care of those
23 persons defined as an eligible person pursuant to section 36-2901, paragraph
24 6, subdivisions (a), (b) and (c), Arizona Revised Statutes, the director of
25 the Arizona health care cost containment system administration may instruct
26 the state treasurer either to reduce remaining payments to be paid pursuant
27 to this section by a specified amount or to provide to the counties specified
28 amounts from the Arizona health care cost containment system fund and the
29 long-term care system fund.

30 F. It is the intent of the legislature that the Maricopa county
31 contribution pursuant to subsection A of this section be reduced in each
32 subsequent year according to the changes in the GDP price deflator. For the
33 purposes of this subsection, "GDP price deflator" has the same meaning
34 prescribed in section 41-563, Arizona Revised Statutes.

35 Sec. 22. ALTCS; county contributions

36 Notwithstanding section 11-292, Arizona Revised Statutes, county
37 contributions for the Arizona long-term care system for fiscal year 2007-2008
38 are as follows:

39	1. Apache	\$ 594,500
40	2. Cochise	\$ 5,444,200
41	3. Coconino	\$ 1,783,800
42	4. Gila	\$ 2,288,100
43	5. Graham	\$ 1,042,800
44	6. Greenlee	\$ 132,300
45	7. La Paz	\$ 856,200

1	8. Maricopa	\$152,779,700
2	9. Mohave	\$ 7,988,900
3	10. Navajo	\$ 2,459,300
4	11. Pima	\$ 39,528,700
5	12. Pinal	\$ 10,974,800
6	13. Santa Cruz	\$ 1,822,600
7	14. Yavapai	\$ 8,591,700
8	15. Yuma	\$ 6,456,900
9	Sec. 23. <u>Hospitalization and medical care contribution; fiscal</u>	
10	<u>year 2006-2007</u>	

11 A. Notwithstanding any other law, for fiscal year 2007-2008, beginning
 12 with the second monthly distribution of transaction privilege tax revenues,
 13 the state treasurer shall withhold the following amounts from state
 14 transaction privilege tax revenues otherwise distributable, after any amounts
 15 withheld for the county long-term care contribution or the county
 16 administration contribution pursuant to section 11-292, subsection P, Arizona
 17 Revised Statutes, for deposit in the Arizona health care cost containment
 18 system fund established by section 36-2913, Arizona Revised Statutes, for the
 19 provision of hospitalization and medical care:

20	1. Apache	\$ 87,300
21	2. Cochise	\$ 162,700
22	3. Coconino	\$ 160,500
23	4. Gila	\$ 65,900
24	5. Graham	\$ 46,800
25	6. Greenlee	\$ 12,000
26	7. La Paz	\$ 24,900
27	8. Mohave	\$ 187,400
28	9. Navajo	\$ 122,800
29	10. Pima	\$1,115,900
30	11. Pinal	\$ 218,300
31	12. Santa Cruz	\$ 51,600
32	13. Yavapai	\$ 206,200
33	14. Yuma	\$ 183,900

34 B. If a county does not provide funding as specified in subsection A
 35 of this section, the state treasurer shall subtract the amount owed by the
 36 county to the Arizona health care cost containment system fund from any
 37 payments required to be made by the state treasurer to that county pursuant
 38 to section 42-5029, subsection D, paragraph 2, Arizona Revised Statutes, plus
 39 interest on that amount pursuant to section 44-1201, Arizona Revised
 40 Statutes, retroactive to the first day the funding was due. If the monies
 41 the state treasurer withholds are insufficient to meet that county's funding
 42 requirement as specified in subsection A of this section, the state treasurer
 43 shall withhold from any other monies payable to that county from whatever
 44 state funding source is available an amount necessary to fulfill that
 45 county's requirement. The state treasurer shall not withhold distributions

1 from the highway user revenue fund pursuant to title 28, chapter 18, article
2 2, Arizona Revised Statutes.

3 C. Payment of an amount equal to one-twelfth of the total monies
4 prescribed pursuant to subsection A of this section shall be made to the
5 state treasurer on or before the fifth day of each month. On request from
6 the director of the Arizona health care cost containment system
7 administration, the state treasurer shall require that up to three months'
8 payments be made in advance, if necessary.

9 D. The state treasurer shall deposit the monies paid pursuant to
10 subsection C of this section in the Arizona health care cost containment
11 system fund established by section 36-2913, Arizona Revised Statutes.

12 E. In fiscal year 2007-2008, the sum of \$2,646,200 withheld pursuant
13 to subsection A or B of this section, as applicable, is allocated for the
14 county acute care contribution for the provision of hospitalization and
15 medical care services administered by the Arizona health care cost
16 containment system administration.

17 F. County contributions made pursuant to subsection A of this section
18 are excluded from the county expenditure limitations.

19 Sec. 24. Child care eligibility levels; report

20 Notwithstanding section 46-803, Arizona Revised Statutes, for fiscal
21 year 2007-2008, the department of economic security may reduce maximum income
22 eligibility levels for child care assistance in order to manage within
23 appropriated and available monies. The department shall notify the joint
24 legislative budget committee of any change in maximum income eligibility
25 levels for child care within fifteen days after implementing that change.

26 Sec. 25. Competency restoration treatment; county and city
27 reimbursement; fiscal year 2007-2008; deposit; tax
28 withholding

29 A. Notwithstanding section 13-4512, Arizona Revised Statutes, if the
30 state pays the costs of a defendant's inpatient competency restoration
31 treatment pursuant to section 13-4512, Arizona Revised Statutes, for counties
32 with a population of eight hundred thousand or more persons and for all
33 cities, the city or county shall reimburse the department of health services
34 for eighty-six per cent of these costs for fiscal year 2007-2008.

35 B. The department shall deposit the reimbursements, pursuant to
36 sections 35-146 and 35-147, Arizona Revised Statutes, in the Arizona state
37 hospital fund established by section 36-545.08, Arizona Revised Statutes.

38 C. Each city and county shall make the reimbursements for these costs
39 as specified in subsection A of this section within thirty days after a
40 request by the department. If the city or county does not make the
41 reimbursement, the superintendent of the Arizona state hospital shall notify
42 the state treasurer of the amount owed and the treasurer shall withhold the
43 amount, including any additional interest as provided in section 42-1123,
44 Arizona Revised Statutes, from any transaction privilege tax distributions to
45 the city or county. The treasurer shall deposit the withholdings, pursuant

1 to sections 35-146 and 35-147, Arizona Revised Statutes, in the Arizona state
2 hospital fund established by section 36-545.08, Arizona Revised Statutes.

3 Sec. 26. Health insurance premiums; department of
4 administration

5 For fiscal year 2007-2008, the department of administration shall not
6 implement a differentiated health insurance premium based on the integrated
7 or nonintegrated status of a health insurance provider available through the
8 state employee health insurance program beginning October 1, 2007.

9 Sec. 27. Children's health insurance program; parent
10 eligibility; fiscal year 2007-2008

11 A. Notwithstanding any other law, for fiscal year 2007-2008, a parent
12 of a child who is eligible for or enrolled in the children's health insurance
13 program or a parent who has a child enrolled under title 36, chapter 29,
14 article 1, Arizona Revised Statutes, but who would be eligible for the
15 children's health insurance program, is eligible for the children's health
16 insurance program prescribed in title 36, chapter 29, article 4, Arizona
17 Revised Statutes, and may apply for eligibility based on an income that does
18 not exceed two hundred per cent of the federal poverty level.

19 B. Eligibility and program continuation is dependent on the
20 continuation of an enhanced federal matching rate for state monies. The
21 program ends on expiration of the enhanced federal matching rate.

22 C. In determining eligibility pursuant to subsection A of this
23 section, the Arizona health care cost containment system administration shall
24 apply other eligibility requirements pursuant to sections 36-2981 and
25 36-2983, Arizona Revised Statutes, and rules adopted by the administration.
26 If the parent is determined eligible pursuant to this section, except as
27 provided in subsection D of this section, all other requirements established
28 by the administration by rule, including available services, pursuant to
29 title 36, chapter 29, article 4, Arizona Revised Statutes, apply.

30 D. Persons receiving services under this section shall make premium
31 payments on a monthly basis. The director of the Arizona health care cost
32 containment system administration shall adopt rules to prescribe tiered
33 premiums based on the following:

34 1. For households with incomes of more than one hundred per cent but
35 less than one hundred fifty per cent of the federal poverty guidelines, the
36 premium is equal to three per cent of the household's net income.

37 2. For households with incomes of at least one hundred fifty per cent
38 but less than one hundred seventy-five per cent of the federal poverty
39 guidelines, the premium is equal to four per cent of the household's net
40 income.

41 3. For households with incomes of at least one hundred seventy-five
42 per cent but not more than two hundred per cent of the federal poverty
43 guidelines, the premium is equal to five per cent of the household's net
44 income.

1 E. Premiums paid pursuant to subsection D of this section apply to the
2 entire household unit, regardless of the number of parents or children
3 participating.

4 Sec. 28. AHCCCS; exclusions from outlier payment report

5 The Arizona health care cost containment system administration shall
6 work with impacted stakeholders, including hospitals and health plans, to
7 evaluate whether certain types of procedures or services, including implants,
8 medications and operating room charges, should be excluded from outlier
9 payments or paid under a different methodology and shall report its findings
10 to the joint legislative budget committee on or before December 31, 2007.
11 The report shall include a fiscal impact analysis and a review of statutory
12 changes required to implement the recommendations.

13 Sec. 29. AHCCCS; exemption from rule making

14 The Arizona health care cost containment system administration is
15 exempt from rule making requirements of title 41, chapter 6, Arizona Revised
16 Statutes, until December 31, 2008 in order to implement a revised outlier
17 reimbursement methodology and a graduate medical education methodology
18 pursuant to this act. The administration shall hold at least one public
19 hearing to receive public comments before implementing rules pursuant to this
20 section.

21 Sec. 30. Healthcare group; temporary enrollment limit

22 Notwithstanding section 36-2912, Arizona Revised Statutes, beginning on
23 July 1, 2007 and ending on the effective date of this act, healthcare group
24 shall not enroll more than nine thousand eight hundred employer groups
25 defined as eligible pursuant to section 36-2901, paragraph 6, subdivisions
26 (b), (c), (d) and (e), Arizona Revised Statutes.

27 Sec. 31. Healthcare group; enrollment freeze

28 Notwithstanding section 36-2912, Arizona Revised Statutes, beginning on
29 the effective date of this act, healthcare group shall not enroll any
30 additional employer groups defined as eligible pursuant to section 36-2901,
31 paragraph 6, subdivisions (b), (c), (d) and (e), Arizona Revised Statutes.

32 Sec. 32. Healthcare group; financial examination

33 A. The director of the department of insurance shall conduct a
34 statutory financial examination of healthcare group as if healthcare group
35 were a health care insurer, as defined in section 20-3101, Arizona Revised
36 Statutes.

37 B. The director shall submit the report of examination to the
38 governor, the president of the senate, the speaker of the house of
39 representatives, the auditor general, the joint legislative budget committee
40 and the Arizona health care cost containment system administration on or
41 before February 15, 2008.

42 Sec. 33. Healthcare group study committee; report

43 A. The healthcare group study committee is established, consisting of
44 the following members:

- 1 1. Five members of the senate who are appointed by the president of
2 the senate and not more than three of whom are members of the same political
3 party.
- 4 2. Five members of the house of representatives who are appointed by
5 the speaker of the house of representatives and not more than three of whom
6 are members of the same political party.
- 7 3. One representative of a health care insurance company who is
8 appointed by the president of the senate.
- 9 4. One representative of a health care insurance company who is
10 appointed by the speaker of the house of representatives.
- 11 5. One actuary with experience in health care rating who is appointed
12 by the president of the senate.
- 13 6. One representative of the small business community who is appointed
14 by the speaker of the house of representatives.
- 15 7. The designee of the director of the Arizona health care cost
16 containment system administration.
- 17 8. The director of the department of insurance or the director's
18 designee.
- 19 B. The committee shall:
 - 20 1. Identify and examine the current financial and operational issues
21 of healthcare group and identify changes required to ensure financial
22 stability.
 - 23 2. Examine the feasibility of continuing healthcare group or
24 establishing a high risk pool for uninsurable or other individuals, or both,
25 including the potential fiscal impact to the state and the impact on existing
26 healthcare group members for each option.
 - 27 3. Recommend, based on that examination, whether to continue
28 healthcare group or establish a state funded high risk pool, or both.
 - 29 4. Recommend programmatic and operational changes designed to ensure
30 financial stability of healthcare group, if continuing healthcare group is
31 recommended.
 - 32 5. Develop a proposed high risk pool plan pursuant to subsection C, if
33 establishing a high risk pool is recommended.
- 34 C. If the committee recommends establishing a high risk pool, the
35 committee shall develop a plan for the high risk pool. The plan shall
36 include an operations plan, including technical functions, and shall
37 recommend:
 - 38 1. An administrative structure for the high risk pool.
 - 39 2. Eligibility for the high risk pool, including whether individuals
40 eligible for portability coverage under the health insurance portability and
41 accountability act of 1996 (P.L. 104-191; 110 Stat. 19367) and existing
42 healthcare group members should be eligible.
 - 43 3. A rating strategy based on a percentage of standard individual
44 market rates.
 - 45 4. Options for benefits offered under the high risk pool.

1 5. Estimated funding needs and sources.

2 D. The committee shall submit a report of its findings and
3 recommendations to the governor, the president of the senate, the speaker of
4 the house of representatives and the joint legislative budget committee on or
5 before December 15, 2007 and submit a copy of its report to the secretary of
6 state and the director of the Arizona state library, archives and public
7 records.

8 Sec. 34. Healthcare group; AHCCCS rates

9 Notwithstanding section 36-2912, subsection I, paragraph 2, Arizona
10 Revised Statutes, if a contract does not exist between a healthcare group
11 contractor and a provider, the default reimbursement rate shall be one
12 hundred fourteen per cent of Arizona health care cost containment system
13 administration reimbursement rates established pursuant to section
14 36-2903.01, subsection H, Arizona Revised Statutes, as amended by this act.

15 Sec. 35. Delayed repeal

16 Sections 31, 32, 33 and 34 of this act, relating to healthcare group,
17 are repealed from and after July 31, 2008.

18 Sec. 36. Health savings account and health reimbursement
19 account programs; review

20 A. The department of administration shall design for state employees
21 both of the following:

22 1. A program for the use of health savings accounts with a qualifying
23 state-sponsored high deductible health plan, as defined in Public Law
24 108-173.

25 2. A program for the use of health reimbursement accounts with a
26 state-sponsored high deductible health plan, which may be the same as the
27 qualifying high deductible health plan designed for use with a health savings
28 account pursuant to paragraph 1 of this subsection.

29 B. On or before December 1, 2007, the department shall submit the
30 program designs to the joint legislative budget committee for review. The
31 report on program designs may include multiple options for final
32 implementation, which may include various levels of state participation or
33 benefit design. The program designs shall include:

34 1. Benefit design, including deductible amounts, for the high
35 deductible health plans.

36 2. Premium amounts for the high deductible health plans.

37 3. Employee and employer contribution strategy for the high deductible
38 health plan premiums.

39 4. Employer and employee contribution strategy for health savings
40 account deposits and the employer contribution strategy for health
41 reimbursement account deposits along with any expected employee cost sharing.

42 5. The ability for employees to make pre-tax contributions through a
43 salary reduction arrangement, for health savings accounts only.

44 6. Options for custodial or trustee arrangement of the health savings
45 account.

1 7. Investment options for account holders.

2 8. Administrative and claim costs.

3 9. Actuarial assumptions, including demographic, participation and
4 utilization assumptions, used in program design.

5 10. An analysis of the impact on existing health plans of offering the
6 option of an account paired with a high deductible health plan.

7 B. The average per person employer cost of the programs, including the
8 contributions for the health savings account and high deductible health plan
9 or the health reimbursement account and high deductible health plan, shall
10 not exceed the average per person employer cost of the self-insured state
11 employee health benefits program for the same fiscal year.

12 Sec. 37. AHCCCS; nonemergency transportation report

13 The Arizona health care cost containment system administration shall
14 report to the joint legislative budget committee on or before December 15,
15 2007 on nonemergency transportation usage. The report shall include, at a
16 minimum, the estimated costs of emergency and nonemergency transportation and
17 potential cost-saving modifications to nonemergency transportation
18 utilization.

19 Sec. 38. Vital records; fund balances; appropriation;
20 retroactivity

21 A. In addition to any other appropriation, any amount remaining of the
22 fiscal year 2005-2006 balance in the vital records electronic systems fund
23 established by section 36-341.01, Arizona Revised Statutes, is appropriated
24 to the department of health services in fiscal year 2007-2008.

25 B. This section applies retroactively to from and after June 30, 2007.

26 Sec. 39. Proposition 204 administration; county expenditure
27 limitation

28 County contributions for the administrative costs of implementing
29 sections 36-2901.01 and 36-2901.04, Arizona Revised Statutes, that are made
30 pursuant to section 11-292, subsection P, Arizona Revised Statutes, are
31 excluded from the county expenditure limitations.

32 Sec. 40. Appropriations; AHCCCS; pregnant women

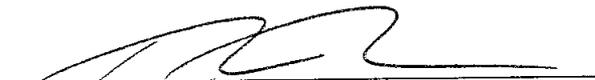
33 A. The sum of \$1,800,000 from the state general fund is appropriated
34 in fiscal year 2007-2008 to the Arizona health care cost containment system
35 administration for the increase in the income eligibility limit for pregnant
36 women pursuant to section 36-2901, Arizona Revised Statutes, as amended by
37 this act.

38 B. The sum of \$3,536,500 in expenditure authority of federal monies is
39 appropriated in fiscal year 2007-2008 to the Arizona health care cost
40 containment system administration for the increase in the income eligibility
41 limit for pregnant women pursuant to section 36-2901, Arizona Revised
42 Statutes, as amended by this act.

Passed the House May 23, 2007

by the following vote: 31 Ayes,

28 Nays, 1 Not Voting



Speaker of the House
Pro Tempore



Chief Clerk of the House

Passed the Senate June 18, 2007

by the following vote: 22 Ayes,

6 Nays, 2 Not Voting



President of the Senate



Secretary of the Senate

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF GOVERNOR

This Bill received by the Governor this

_____ day of _____, 20____

at _____ o'clock _____ M.

Secretary to the Governor

Approved this _____ day of

at _____ o'clock _____ M.

Governor of Arizona

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF SECRETARY OF STATE

This Bill received by the Secretary of State

this _____ day of _____, 20____

at _____ o'clock _____ M.

Secretary of State

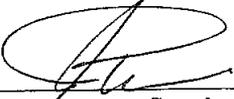
H.B. 2789

HOUSE CONCURS IN SENATE
AMENDMENTS AND FINAL PASSAGE

June 19, 2007,

by the following vote: 41 Ayes,

18 Nays, 1 Not Voting



Speaker of the House


Chief Clerk of the House

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF GOVERNOR

This Bill was received by the Governor this

19th day of June, 2007

at 4:56 o'clock p. M.



Secretary to the Governor

Approved this 25 day of

June, 2007,

at 10¹⁰ o'clock A. M.



Governor of Arizona

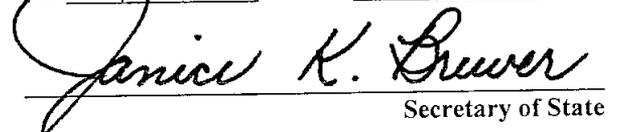
H.B. 2789

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF SECRETARY OF STATE

This Bill was received by the Secretary of State

this 25 day of June, 2007,

at 11:25 o'clock A. M.



Secretary of State