NOTICES OF PROPOSED RULEMAKING

Unless exempted by A.R.S. § 41-1005, each agency shall begin the rulemaking process by first submitting to the Secretary of State's Office a Notice of Rulemaking Docket Opening followed by a Notice of Proposed Rulemaking that contains the preamble and the full text of the rules. The Secretary of State's Office publishes each Notice in the next available issue of the *Register* according to the schedule of deadlines for *Register* publication. Due to time restraints, the Secretary of State's Office will no longer edit the text of proposed rules. We will continue to make numbering and labeling changes as necessary.

Under the Administrative Procedure Act (A.R.S. § 41-1001 et seq.), an agency must allow at least 30 days to elapse after the publication of the Notice of Proposed Rulemaking in the *Register* before beginning any proceedings for adoption, amendment, or repeal of any rule. A.R.S. §§ 41-1013 and 41-1022.

NOTICE OF PROPOSED RULEMAKING

TITLE 9. HEALTH SERVICES

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

PREAMBLE

1. Sections Affected	Rulemaking Action
R9-27-101	Amend
R9-27-201	Amend
R9-27-202	Amend
R9-27-203	Amend
R9-27-204	Amend
R9-27-205	Amend
R9-27-206	Amend
R9-27-207	Amend
R9-27-208	Amend
R9-27-209	Amend
R9-27-210	Amend
R9-27-301	Amend
R9-27-302	Amend
R9-27-303	Amend
R9-27-304	Repeal
R9-27-305	Amend
R9-27-306	Amend
R9-27-307	Amend
R9-27-308	Amend
R9-27-309	Amend
R9-27-310	Amend
R9-27-401	Amend
R9-27-402	Amend
R9-27-403	Amend
R9-27-404	Amend
R9-27-405	Amend
R9-27-406	Amend
R9-27-407	Amend
R9-27-501	Amend
R9-27-502	Amend
R9-27-503	Amend
R9-27-504	Amend

R9-27-505	Amend
R9-27-506	Amend
R9-27-507	Amend
R9-27-509	Amend
R9-27-510	Amend
R9-27-511	Amend
R9-27-512	Amend
R9-27-513	Amend
R9-27-514	Amend
R9-27-515	Amend
R9-27-516	Amend
R9-27-701	Amend
R9-27-702	Amend
R9-27-703	Amend
R9-27-704	Amend
R9-27-705	Amend
R9-27-801	Amend

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

Authorizing statute: A.R.S. § 36-2912(A)

Implementing statute: A.R.S. § 36-2912(E) and (F)(6)

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

Notice of Rulemaking Docket Opening: 5 A.A.R. 3230, September 17, 1999

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

Name: Cheri Tomlinson, Federal & State Policy Administrator

Address: AHCCCS
Office of Policy Analysis and Coordination
801 East Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone Number: (602) 417-4198

Fax Number: (602) 256-6756

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

Seven Articles in 9 A.A.C. 27 have been opened for the following reasons:

To make the language conform with federal and state statutory changes and current agency practice that include:

Changing definition of full-time employee to be consistent with A.R.S. § 36-2912.04,

Changing definition of preexisting condition to be consistent with A.R.S. § 36-2912.04,

Changing definition of pre-existing condition exclusion to be consistent with A.R.S. § 36-2912(Q),

Changing timeframe of portability of prior coverage in order to be consistent with A.R.S. § 20-2308,

Striking exclusion that does not cover inpatient costs for the delivery of a child for 10 months after the effective date of coverage in order to be consistent with 42 U.S.C. 300gg(d),

Changing size of employer group in order to be consistent with A.R.S. § 36-2912(B)(3), and

Changing percentage of employees in an employer group who need to participate in HCG in order to be consistent with A.R.S. § 36-2912.

To make the language comply with the Secretary of State's requirements;

To make the language clearer, more concise, and understandable.

6. Reference to any study that the agency proposes to rely on and its evaluation of or justification for proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:

Not applicable

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

Not applicable

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

The following entities will be impacted by the proposed changes:

The Healthcare Group Administration (HCGA) and its health plans may be moderately impacted by proposed changes to rule. These costs are primarily associated with changes that ultimately clarify and simplify processes in the HCGA. Other changes were made to comply with federal law and state statute.

Employer groups and their employees may be minimally to significantly impacted by changes made to clarify covered services. They may also be impacted by proposed changes made to comply with state statute.

Health care delivery providers may be minimally to moderately impacted by changes made to clarify rule and conform to changes in statute.

All parties should benefit from making proposed rules more clear, concise, and understandable. The following parties will benefit from these proposed changes:

HCGA,

Health plans,

Health care providers, and

Employer groups and their employees.

The following groups were considered but will not be affected by proposed changes:

Taxpayers;

The larger business community, except for AHCCCS health plans and providers that are businesses; and

Political subdivisions, such as cities and counties.

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

Name:	Cheri Tomlinson, Federal & State Policy Administrator
Address:	AHCCCSA, Office of Policy Analysis and Coordination
	801 East Jefferson, Mail Drop 4200
	Phoenix, AZ 85034
Telephone Number:	(602) 417-4198
Fax Number:	(602) 256-6756

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

Date:	Monday, April 17, 2000
Time:	10:00 a.m.
Location:	AHCCCS 701 East Jefferson Phoenix, AZ 85034 Gold Room
Location:	ALTCS: Arizona Long-Term Care System 110 South Church, Suite 3250 Tucson, AZ 85701

Location: Arizona Long-Term Care System
3480 East Route 66
Flagstaff, AZ 86004

Nature: Videoconference Oral Proceeding

The Administration will accept written comments until 5:00 p.m., April 17, 2000. Please submit comments to the following person:

Name: Cheri Tomlinson, Federal and State Policy Administrator

Address: AHCCCSA, Office of Policy Analysis and Coordination
801 East Jefferson, Mail Drop 4200
Phoenix, AZ 85034

Telephone Number: (602) 417-4198

Fax Number: (602) 256-6756

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

Not applicable

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

42 U.S.C. 1396u-2, August 5, 1997, incorporated in R9-27-209

29 U.S.C. 1161 et seq., December 19, 1989, incorporated in R9-27-406

13. Was this rule previously adopted as an emergency rule?

Not applicable

14. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

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

ARTICLE 1. DEFINITIONS

Section
R9-27-101. Definitions

ARTICLE 2. SCOPE OF SERVICES

Section
R9-27-201. Scope of Services
R9-27-202. Covered Services
R9-27-203. Excluded Services
R9-27-204. Out-of-Service Area Coverage
R9-27-205. Outpatient Health Services
R9-27-206. Laboratory, Radiology, and Medical Imaging Services
R9-27-207. Pharmaceutical Services
R9-27-208. Inpatient Hospital Services
R9-27-209. Emergency Medical Services
R9-27-210. Pre-existing Conditions

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

Section
R9-27-301. Eligibility Criteria for Employer Groups
R9-27-302. Eligibility Criteria for Employee Members
R9-27-303. Eligibility Criteria for Dependents
R9-27-304. ~~Employer Group Member Eligibility Verification~~ Repealed
R9-27-305. Health History Form

ARTICLE 4. CONTRACTS, ADMINISTRATION, AND STANDARDS

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

ARTICLE 7. STANDARD FOR PAYMENTS

ARTICLE 8. COORDINATION OF BENEFITS

ARTICLE 1. DEFINITIONS

R9-27-101. Definitions

Definitions. In addition to the definitions contained in A.R.S. Title 36, Chapter 29, unless the context explicitly requires another meaning:

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

~~1.~~ "AHCCCS" means the Arizona Health Care Cost Containment System, which is composed of the Administration, contractors, and other arrangements through which health care services are provided to an eligible member.

~~2.~~ "Ambulance" means any vehicle defined in A.R.S. § 36-2201~~(2)~~.

"Certification" specified in 29 U.S.C. 1181.

~~3.~~ "Clean claim" means ~~1~~ a claim that can be processed without obtaining additional information from the provider of the service or from a 3rd party. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

~~4.~~ "Coinsurance" means a ~~predetermined~~ pre-determined amount a member agrees to pay to a provider for covered services. A coinsurance payment is a percentage of the fee schedule rate for the services.

~~5.~~ "Copayment" means a monetary amount specified by the ~~Healthcare Group Administration~~ HCGA which a member or dependent pays directly to a provider at the time a covered ~~services~~ service ~~are~~ is rendered.

~~6.~~ "Covered services" means the health and medical services described in ~~R9-27-202~~ 9 A.A.C. 27, Article 2.

"Creditable coverage" defined in A.R.S. § 36-2912.04

~~7.~~ "Day" means a calendar day unless otherwise specified in the text.

~~8.~~ "Deductible" means a fixed annual dollar amount a member agrees to pay for certain covered services before the ~~Healthcare Group~~ HCG Plan agrees to pay.

~~9.~~ "Dependent" means the eligible spouse and children of an employee member under ~~R9-27-303~~ 9 A.A.C. 27, Article 3.

~~10.~~ "Eligible employee" means an employee who is eligible for ~~Healthcare Group~~ HCG coverage ~~under R9-27-302~~ according to 9 A.A.C. 27, Article 3.

~~11~~. "Emergency ambulance service" means:

Transportation by an ambulance or air ambulance company for a ~~persons~~ member requiring emergency medical services.

Emergency medical services that are provided by a person certified by the ~~Arizona Department of Health Services~~ ADHS to provide the services before, during, or after a member is transported by an ambulance or air ambulance company.

~~12~~. "Emergency medical services" means medical services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in:

Placing ~~the~~ a patient's health in serious jeopardy~~;~~,

Serious impairment to bodily functions~~;~~, or

Serious dysfunction of any bodily organ.

~~13~~. "Employer group" means the aggregate enrollment of an employed group or business that is contracting with a ~~Healthcare Group~~ HCG Plan for covered services.

~~14~~. "Employee member" means an enrolled employee of an employer group.

~~15~~. "Enrollment" means the process by which an employer group or a member applies for coverage and contracts with a ~~Healthcare Group~~ HCG Plan.

~~16~~. "Full-time employee" means an employee who works at least ~~20~~ 32 hours per week and expects to continue employment for at least 5 months following enrollment.

~~17~~. "Grievance" means a complaint arising from an adverse action, a decision, or a policy by a ~~Healthcare Group~~ HCG Plan, a subcontractor, a noncontracting provider, or the ~~Healthcare Group Administration~~ HCGA, presented by ~~an individual~~ a member or an entity specified in ~~R9-27-601~~ 9 A.A.C. 27, Article 6.

~~18~~. ~~"Group Service Agreement (GSA)" means~~ "GSA" means Group Service Agreement, a contract between an employer group and a ~~Healthcare Group~~ HCG Plan.

~~19~~. ~~"Healthcare Group of Arizona (HCG)"~~ "HCl" means ~~the~~ Healthcare Group of Arizona which is the registered name of the Healthcare Group Program, which is a prepaid medical coverage product marketed by the Healthcare Group Plans to small uninsured businesses and political subdivisions within the state.

~~20~~. ~~"Healthcare Group Administration (HCGA)"~~ "HCGA" means ~~the section~~ Healthcare Group Administration which is the organization within AHCCCS that directs and regulates the continuous development and operation of the HCG Program.

~~21~~. ~~"Healthcare Group Plan (HCG Plan or Plan)"~~ "HCG Plan" means a Healthcare Group prepaid health plan that is currently under contract with the HCGA to provide covered services.

~~22~~. "Hospital" means a health care institution licensed as a hospital by the ~~Department of Health Services~~ ADHS under A.R.S. Title 36, Chapter 4, Article 2, and certified as a provider under Title XVIII of the Social Security Act, as amended, or is determined by AHCCCS to meet the requirements for certification under Title XVIII of the Social Security Act, as amended.

~~23~~. "Inpatient hospital services" means medically necessary services that require an inpatient stay in an acute care hospital. Inpatient hospital services are provided by or under the direction of a physician or other health care practitioner upon referral from a member's primary care provider.

"Late enrollee" specified in A.R.S. § 36-2912.04.

~~24~~. "Life threatening" means any condition for which a delay in obtaining pre-authorization or traveling to an approved medical facility would have a severe adverse effect on ~~the~~ a patient's condition.

~~25~~. "Medical record" means a single, complete record kept at the site of a member's primary care provider which documents the medical services received by ~~the~~ a member, including inpatient discharge summary, outpatient care, and emergency care.

~~26~~. "Medical services" means ~~services pertaining to medical care that are performed at the direction of a physician, on behalf of members by physicians, nurses, or other health care practitioners and technical personnel~~ health care services provided or prescribed to a member by a physician, a nurse or other health care practitioner and technical personnel at the direction of a physician.

~~27~~. "Medically necessary" means covered services provided by a physician or other health care practitioner within the scope of the physician or other health care practitioner's practice under state law to:

Prevent disease, disability, and other adverse health conditions or their progression; or

Prolong life.

~~28~~. "Member" means an employee or a dependent who is enrolled with a HCG Plan.

~~29~~. "Noncontracting provider" means a provider who renders covered services to a member but who does not have a subcontract with the member's HCG Plan.

~~30~~. ~~"Other health~~ "Health care practitioner" means a person other than a physician who is licensed or certified under Arizona law to deliver health care services.

~~31~~. "Outpatient services" means medically necessary services that may be provided in any setting on an outpatient basis ~~(~~which does not require an overnight stay in an inpatient hospital~~)~~. Outpatient services are provided by or under the direction of a physician or other health care practitioner, upon referral from a member's primary care provider.

~~32~~. "Pharmaceutical services" means medically necessary ~~drugs~~ medication prescribed by a physician, a practitioner, or a dentist upon referral by a primary care provider and dispensed ~~in accordance with~~ according to ~~R9-27-207~~ 9 A.A.C. 27, Article 2.

~~33~~. "Physician services" means services provided within the scope of practice of medicine or osteopathy as defined by state law, ~~or by or under the personal supervision of~~ by, or under the direction of an individual licensed under state law to practice medicine or osteopathy.

~~34~~. "Political subdivision" means the state of Arizona, ~~or~~ a county, a city, a town, or a school district within the state.

~~36~~. "Pre-existing condition" ~~means an illness or injury that is diagnosed or treated within the 12~~ 6 ~~-month period preceding the effective date of coverage~~ specified in A.R.S. § 36-2912.04.

"Pre-existing condition exclusion" specified in A.R.S. § 36-2912.04.

~~37.~~ "Premium" means the monthly ~~prepayment~~ pre-payment submitted to HCGA by the employer group.

~~38.~~ "Pre-payment" means submission of the employer group's premium payment 30 days in advance of the effective date of coverage ~~in accordance with~~ according to ~~R9-27-306~~ 9 A.A.C. 27, Article 3.

~~39.~~ "Prescription" means an order ~~to a provider~~ for covered services for a member, which is signed or transmitted by a provider licensed under applicable state law to prescribe or order the services.

~~35.~~ "Primary care practitioner" means a ~~physician's~~ physician assistant or a registered nurse practitioner who is certified and practicing in an appropriate affiliation with a physician, as authorized by law.

~~40.~~ "Primary care provider" means a ~~patient's~~ member's primary care physician or a primary care practitioner.

~~41.~~ "Prior authorization" means the process by which the HCG Plan authorizes, in advance, the delivery of covered services.

~~42.~~ "Quality management" means a methodology used by professional health personnel to assess the degree of conformance to desired medical standards and practices and to implement activities designed to continuously improve and maintain quality service and care, and which is performed through a formal program with involvement of multiple organizational components and committees.

~~43.~~ "Referral" means the process by which a primary care provider directs a member to another appropriate provider or resource for diagnosis or treatment.

~~44.~~ "Rider" or "contract rider" means an amendment to the ~~group service agreement~~ GSA between an employer group and a HCG Plan.

~~45.~~ "Scope of services" means the covered, limited, and excluded services listed in ~~R9-27-201 through R9-27-210~~ 9 A.A.C. 27, Article 2.

~~46.~~ "Service area" means the geographic area designated by HCGA where each HCG Plan shall provide covered health care benefits to members directly or through subcontracts.

~~47.~~ "Spouse" means ~~the~~ a husband or a wife of a HCG member who has entered into a marriage recognized as valid by Arizona.

~~48.~~ "Subcontract" means an agreement entered into by a HCG Plan with any of the following:

A provider of health care services who agrees to furnish covered services to members~~;~~,

A marketing organization~~;~~, or

Any other organization to serve the needs of the HCG Plan.

~~49.~~ "Subscriber" means an enrolled employee of an employer group.

~~50.~~ "Subscriber agreement" means a contract between an employee member and a HCG Plan.

~~51.~~ "Utilization control" means an overall accountability program encompassing quality management and utilization review.

~~52.~~ "Utilization review" means a methodology used by professional health personnel to assess the medical indications, appropriateness, and efficiency of care provided.

"Waiting period" specified in A.R.S. § 36-2912.04.

ARTICLE 2. SCOPE OF SERVICES

R9-27-201. Scope of Services

A. HCG Plan to provide lists of covered services. Each HCG Plan shall provide, either directly or through subcontracts, the covered services specified in this Article.

B. Provision of covered services. The HCG Plans shall ensure that covered services are provided by, or under the direction of, a primary care provider.

C. Scope of covered services. ~~The scope of covered services and excluded services may be further delineated or limited in the Group Service Agreement.~~ A HCG Plan may further delineate, expand, or limit the scope of covered services through a rider in the GSA with prior written approval from the HCGA.

R9-27-202. Covered Services

~~**A.**~~ Covered services. Subject to the exclusions and limitations specified in these rules, the following services shall be covered by the HCG Plans:

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

~~**B.** The scope of covered services may be expanded or reduced through a rider to the group service agreement with the prior written consent of the HCGA.~~

~~**C.** Any medical service not specifically provided for in this Article or in a rider is not a covered service.~~

R9-27-203. Excluded Services

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

B. Excluded services. The following services shall not be covered:

1. Services or items furnished solely for cosmetic purposes;
2. Services or items requiring prior authorization for which prior authorization has not been obtained;
3. Services or items furnished gratuitously or for which charges are not usually made;
4. Hearing aids, eye examinations for prescriptive lenses, and prescriptive lenses;
5. Long-term care services, including nursing services;

6. Private or special duty nursing services, provided in a hospital unless medically necessary and prior authorized by the HCG Plan Medical Director.
7. Care for health conditions that are required by state or local law to be treated in a public facility;
8. Care for military service disabilities treatable through governmental facilities if the member is legally entitled to treatment and the facilities are reasonably available;
9. Gastric stapling or diversion for weight loss;
10. Reports, evaluations, or physical examinations not required for health reasons including, but not limited to, employment, insurance, or governmental licenses, sports and court-ordered forensic or custodial evaluations;
11. Treatment of temporomandibular joint dysfunction, unless treatment is prior authorized and determined by the HCG Plan Medical Director or designee to be medically necessary;
12. Elective abortions;
13. Medical and hospital care and costs for the child of a dependent, unless the child is otherwise eligible under the GSA;
14. Nonmedical ancillary services including vocational rehabilitation, employment counseling, psychological counseling and training, and physical therapy for learning disabilities;
15. Sex change operations and reversal of voluntarily induced infertility (sterilization);
16. Services not deemed medically necessary by the HCG Plan Medical Director, or the responsible primary care provider;
17. Routine foot care;
18. ~~Blood, blood products;~~ Charges for administrative costs separately billed for blood and blood products;
19. ~~Human organ~~ Organ transplants ~~except for cornea and kidney transplants~~ except as specified in R9-27-202.
20. Bone marrow transplants including autologous, auto-related and auto-unrelated;
~~20.~~ 21. Mental health services;
~~21.~~ 22. Durable medical equipment;
~~22.~~ 23. Artificial implants;
~~23.~~ 24. Dental services;
~~24.~~ 25. Transportation other than emergency ambulance services;
~~25.~~ 26. Psychotherapeutic drugs;
~~26.~~ 27. Charges for injuries incurred as the result of participating in a riot, or committing, or attempting to commit a felony or assault, or by suicide attempt;
~~27.~~ 28. Early and periodic screening, diagnosis and treatment services (EPSDT); ~~and~~
~~28.~~ 29. In vitro fertilization and all other fertilization treatments ~~.~~;
30. Allergy testing and hyposensitization treatment; and
31. Experimental services as determined by the HCGA, or services provided primarily for the purpose of research, shall not be covered.

R9-27-204. Out-of-Service Area Coverage

Out of area coverage. ~~In accordance with~~ As specified in R9-27-209, a ~~member's out-of-area care~~ member is ~~limited~~ entitled to ~~emergencies~~ only emergency services when ~~the member is traveling or temporarily~~ outside ~~of~~ the member's HCG ~~Plan's~~ Plan service area.

R9-27-205. Outpatient Health Services

Outpatient services. The HCG Plans shall provide the following outpatient services:
1. Ambulatory surgery and anesthesiology services not specifically excluded;
2. Physician's services;
3. Pharmaceutical services and prescribed drugs to the extent authorized ~~by these rules~~ in this Article, and applicable provider contracts;
4. Laboratory services;
5. Radiology and medical imaging services;
6. Services of other health care practitioners when supervised by a physician;
7. Nursing services provided in an outpatient health care facility;
8. The use of emergency, examining, or treatment rooms when required for the provision of physician's services;
9. Home physician visits, as medically necessary;
10. Specialty care physician services referred by a primary care provider;
11. Physical examinations, periodic health examinations, health assessments, physical evaluations, or diagnostic workups that include tasks or procedures to:
    a. Determine risk of disease~~;~~,
    b. Provide early detection of disease~~;~~,
    c. Detect the presence of injury or disease at any stage~~;~~,
    d. Establish a treatment plan for injury or disease at any stage~~;~~,

e. Evaluate the results or progress of a treatment plan or treatment decision~~;~~, or
f. Establish the presence and characteristics of a physical disability that may be the result of disease or injury.

12. Short-term rehabilitation and physical therapy may be provided for a 60-day period, if in the judgment of the HCG Plan Medical Director or designee, the treatment can be expected to result in the significant improvement of a member's condition.

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

A. Coverage of laboratory, radiology and medical imaging services. If medically necessary, ~~The~~ the HCG Plans shall provide laboratory, radiology, and medical imaging services, prescribed by ~~the~~ a member's primary care provider, which are ~~ordinarily~~ provided in a ~~hospitals~~ hospital, a ~~clinics~~ clinic, a ~~physicians' offices~~ physician's office, and other health facilities by a licensed or a certified health care ~~providers,~~ provider. ~~if medically necessary.~~

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

R9-27-207. Pharmaceutical Services

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

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

1. Drugs personally dispensed by a physician or a dentist are not covered, except in geographically remote areas where there is no participating pharmacy or when accessible pharmacies are closed.
2. Prescription drugs are prescribed up to a 30-day supply unless the HCG Plan determines a longer supply is more cost effective.
3. ~~Immunosuppressant (anti-rejection) drugs are covered except when prescribed as part of the post-operative treatment for noncovered organ transplants. However, if a member is taking immunosuppressant drugs at the time of enrollment as part of the post-operative treatment for any organ transplant, the drugs are not covered.~~ Members are eligible for immunosuppressant drugs only as part of the post operative treatment for a covered kidney and cornea transplant as specified in R9-27-202 performed by a HCG Plan.
4. ~~Only drugs that are not available over the counter~~ Over-the-counter drugs are not covered.

R9-27-208. Inpatient Hospital Services

A. Inpatient hospital services. The HCG Plans shall provide the following inpatient hospital services:

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

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

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

R9-27-209. Emergency Medical Services

A. Emergency medical services provided within the HCG Plan's service area.
1. Emergency medical services shall be ~~available~~ provided to a ~~members~~ member 24 hours-a-day, 7 days-a-week based on the prudent layperson standard specified in 42 U.S.C. 1396u-2, August 5, 1997, which is incorporated by reference and on file with the HCGA and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments.
2. The member or provider shall notify the HCG Plan within 24 hours after the initiation of treatment.
3. If a member is incapacitated, the provider is responsible for notifying the HCG Plan. Failure to provide timely notice constitutes cause for denial of payment.

B. Emergency medical services provided outside the HCG Plan's service area.
1. Emergency medical services provided outside the HCG Plan's service area which cannot be postponed until the member is able to return to the service area are covered.
2. The member or provider shall notify the HCG Plan within 48 hours after the initiation of treatment.
3. If a member is incapacitated, the provider is responsible for notifying the HCG Plan. Failure to provide timely notice constitutes cause for denial of payment.

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

R9-27-210. Pre-existing Conditions

A. Pre-existing condition exclusions. Subject to subsection ~~(C)~~(B), a HCG Plan shall not cover ~~inpatient~~ any services related to a pre-existing condition as specified in A.R.S. § 36-2912(Q) ~~for 12 months from the effective date of coverage~~.

~~**B.** A HCG Plan shall not cover inpatient costs for the delivery of a child for 10 months from the effective date of coverage.~~

~~**C**~~**B.** Failure to impose a pre-existing condition exclusion. A HCG Plan shall not impose a pre-existing condition exclusion against an eligible employee who meets the following standards:
1. Newborns from the time of ~~their~~ birth;
2. Eligible employees who meet the portability requirements of A.R.S. § 20-2308:
   a. A person who had continuous coverage for a 1-year period and during that year had no breaks in coverage totaling more than 31 days; and
   b. ~~The~~ A person's prior coverage ended within ~~60~~ 63 days before the date of application for enrollment.

~~**D**~~**C.** Credit for prior health coverage. A HCG Plan shall apply a credit toward meeting the 12 month pre-existing condition exclusion of 1 month for each month of continuous coverage that an eligible employee had under another HCG Plan or accountable health plan ~~in accordance with~~ according to A.R.S. § 36-2912. Upon request, a contracted health plan or an accountable health plan which provided continuous coverage to an individual shall promptly disclose the coverage provided.-

R9-27-211. Repealed

ARTICLE 3. ELIGIBILITY AND ENROLLMENT

R9-27-301. Eligibility Criteria for Employer Groups

A. Criteria for employer groups. An employer group shall conduct business within Arizona for at least 60 days before making application to be an employer group eligible for HCG coverage. ~~This shall be determined by 1 or more of the following:~~ The HCG Plan shall determine eligibility for employer groups and their employees by using, but not limited to, 1 or more of the following documents:
1. Participation in state unemployment insurance~~;~~,
2. Participation in state worker's compensation~~;~~,
3. Possession of a state tax identification number~~;~~, ~~and~~ or
4. Other verifiable proof that the applicant is conducting a business in Arizona.

B. Amount of full time employees and enrollment. ~~An employer group other~~ Other than the state of Arizona and political subdivisions of the state, an employer group shall have a minimum of 1 and a maximum of ~~40~~ 50 full-time employees at the effective date of ~~it's~~ the 1st contract with a HCG Plan. Acceptable proof of the number of full-time employees may include canceled checks, bookkeeping records, and personnel ledgers.

C. Required enrollment of a particular number of employees. Other than state employees and employees of political subdivisions of the state, ~~50% of the eligible employees in a group must enroll in order for the employer group to contract with a~~

~~HCG Plan. Employees with proof of other medical coverage who do not wish to participate in the HCG shall not be considered in determining the percentage~~. employers with 1 to 50 eligible employees may contract with a health care group plan if the employer:

1. Has 5 or fewer full time employees and enrolls 100% of these employees into a HCG plan, or
2. Has 6 or more full time employees and enrolls 80% of these employees into a HCG plan.

D. Employees with proof of other insurance. Employees with proof of existing health care coverage who elect not to participate in HCG shall not be considered when determining the percentage of the required number of enrollees if the health care coverage is:

1. Group coverage offered through a spouse, a parent or a legal guardian; or
2. Coverage available from a government subsidized health care program.

~~**D.**~~**E.** Post enrollment changes in group size. Changes in group size that occur during the term of the ~~Group Service Agreement~~ GSA shall not affect eligibility.

F. Review and verification of eligibility determinations.

1. HCG Plans may at any time conduct random reviews of eligibility determinations of employer groups and their members.
2. HCGA may at any time conduct random reviews of eligibility determinations completed by the HCG Plans.

R9-27-302. Eligibility Criteria for Employee Members

A. Residence. Employee members shall reside, work, or reside and work in Arizona.

B. Eligible employer group. Employee members shall be employed by an eligible employer group specified in R9-27-301.

C. Days of consecutive employment. Employee members shall have been employed at least 60 consecutive days before the effective date of coverage.

D. Hours of employment per week. Employee members or self-employed persons shall work for the employer group at least ~~20~~ 32 hours per week, with anticipated employment of at least 5 months following enrollment.

R9-27-303. Eligibility Criteria for Dependents

A. Eligible dependents. Eligible dependents of employee members shall reside in Arizona and include:

1. A legal spouse;
2. Unmarried children less than the age of 19 or less than the age of 24 if the child is a full-time student and is a:
   a. Natural child~~;~~,
   b. Adopted child~~;~~,
   c. Step-child~~;~~, or
   ~~d. Child supported by the employee member under a valid court order; and~~
   ~~e~~d. Child for whom the employee member is a legal guardian~~; and .~~
3. A child incapable of self-sustaining support by reason of mental or physical disability existing before the child's 19th birthday, as determined by the HCG Plan Medical Director or designee.

B. Limitations. A grandchild of an employee member shall be eligible to receive covered services only if the grandchild meets the eligibility requirements of R9-27-303(A)(2) ~~and~~ or (3).

R9-27-304. ~~Employer Group Member Eligibility Verification~~ Repealed

~~**A.** The HCG Plan shall determine the eligibility status of the employer group and members.~~

~~**B.** Eligibility verification may be conducted at random or for cause by the HCGA or HCG Plan.~~

R9-27-305. Health History Form

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

R9-27-306. Effective Date of Coverage

Payment in advance of effective date. Employer groups shall submit payment 30 days in advance of the effective date of coverage; the effective date of coverage shall be the 1st day of the month for which the premium has been pre-paid.

R9-27-307. Open Enrollment of Employee Members

A. Open enrollment. Enrollment of employee members shall occur only during 1 of the following open enrollment periods:

1. Thirty days following the effective date of the ~~Group Service Agreement~~ GSA for newly enrolled employer groups;
2. A 30-day period to start 60 days from the date of employment for a new employee in an enrolled employer group, or a 30-day period after the completion of an employer's waiting period on eligibility for health care coverage, whichever period is greater; ~~and~~ or

3. A 30-day period to begin 105 days and conclude at least 75 days before the employer group's renewal date, as determined by the HCGA.

B. New dependent enrollment. Enrollment of new dependents shall occur: ~~within the 30-day period following the acquisition of a new dependent and in accordance with R9-27-308 if the dependent is a newborn.~~
1. Within the 30-day period following the addition of a new dependent defined in R9-27-303(A), or
2. According to R9-27-308 if the new dependent is a newborn.

R9-27-308. Enrollment of Newborns

Newborn enrollment. All newborns shall be enrolled within 30 days of birth to be eligible for coverage. Upon enrollment, the newborn's premium is due to the HCGA within 30 days of birth for coverage retroactive to the 1st day of the month in which the birth occurred.

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

A. Enrollment of newly ~~Eligible~~ eligible employee due to loss of own coverage. An eligible employee who had health care through a spouse, shall be eligible to enroll as a member within 30 days of the loss of coverage, if that loss of separate coverage was due to:
1. Death of the eligible employee's spouse~~;~~,
2. Divorce~~;~~, ~~or~~
3. Termination of employment of the eligible employee's spouse ~~.~~,
4. Legal separation, or
5. Loss due to reduction in hours of employment.

B. Enrollment of newly ~~Eligible~~ eligible dependent due to loss of own coverage. An eligible dependent, who had individual or family coverage separate from the member's coverage ~~and who loses that coverage due to termination of employment or retirement~~, shall be eligible to enroll as a dependent member within 30 days of the loss of coverage~~.~~, if that loss of separate coverage was due to:
1. Death,
2. Divorce,
3. Termination of employment,
4. Legal separation,
5. Loss due to reduction in hours of employment, or
6. Retirement.

R9-27-310. Denial and Termination of Enrollment

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

B. Termination of enrollment. Termination of enrollment and coverage for an employer group, an employee member, or a dependent shall occur on the last day of the month in which:
1. The employer group loses eligibility~~;~~,
2. The employee member loses eligibility~~;~~, or
3. The dependent loses eligibility.

C. Exclusion from enrollment. The HCG Plan may exclude employer groups or employee members from enrollment who have committed fraud or misrepresentation while enrolled with another HCG Plan or health benefits carrier.

ARTICLE 4. CONTRACTS, ADMINISTRATION, AND STANDARDS

R9-27-401. General

A. Contracts to provide services. ~~Contracts to provide services under the HCG program shall be established between the HCGA and qualified HCG Plans in accordance with~~ The HCGA shall establish contracts with qualified HCG Plans as specified in ~~the applicable provisions in~~ this Article and A.R.S. Title 36 to provide services under the HCG program.

B. Contracts and subcontracts. Contracts and subcontracts entered into under this Article shall become public records on file with the HCGA unless otherwise made confidential by law.

R9-27-402. Contracts

A. Requirements. ~~To contract with the HCGA, a~~ A health plan must meet the requirements of A.R.S. § 36-2912 to contract with the HCGA.

B. Contract requirements. Each contract shall be in writing and ~~contain, at a minimum,~~ include but not be limited to the following information:
1. The method and amount of compensation or other consideration to be received by the HCG Plan;
2. ~~The name and address of the HCG Plan;~~ The HCG Plan's name and address;
3. The population and geographic service area ~~to be covered by~~ the contract will cover;
4. The amount, duration, and scope of medical services to be provided, or for which compensation will be paid;

5. The term of the contract, including the beginning and ending dates, as well as methods of extension, re-negotiation, and termination;
6. A provision that the HCG Plan arrange for the collection of any required copayment, coinsurance, deductible, and 3rd-party insurance;
7. A provision that the HCG Plan will not bill or attempt to collect from a member for any covered service except as may be authorized by statute, these rules, or contract riders that have been approved by the HCGA;
8. A provision that the contract will not be assigned or transferred without the prior written approval of the HCGA;
9. Procedures for the covered population's enrollment ~~of the covered population~~;
10. Procedures and criteria for terminating or suspending the contract; ~~and~~
11. A provision that the HCG Plan will hold harmless and indemnify the state, AHCCCS, HCGA, and members against claims, liabilities, judgments, costs, and expenses with respect to 3rd parties, which may accrue against the state, AHCCCS, HCGA, or members, through the negligence or other action of the HCG Plan~~.~~; and
12. A provision that HCG Plans demonstrate they have an adequate network of providers as specified in contract.

R9-27-403. Subcontracts

A. Approval. Any subcontract entered into by a HCG Plan to provide covered services to HCG members is subject to review and approval of the HCGA. No subcontract alters the legal responsibility of the HCG Plan to the HCGA to ensure that all activities under the contract are carried out.

B. ~~Subcontracts~~ Subcontract requirements. Each subcontract shall be in writing and include:
1. A specification that the subcontract will be governed by and construed under all laws, rules, and contractual obligations of the HCG Plan~~.~~;
2. A provision that the HCG Plan will notify the HCGA in the event ~~the~~ a subcontract with ~~the~~ a HCG Plan is amended or terminated~~.~~;
3. A provision that assignment or delegation of ~~the~~ a subcontract is void unless the HCGA gives prior written approval ~~is obtained from the HCGA.~~;
4. An agreement to hold ~~harmless~~ the state, AHCCCS, the HCGA, and members harmless in the event the HCG Plan is unable to or does not pay for covered services performed by ~~the~~ a subcontractor~~.~~;
5. A provision that the HCGA may review and give prior written approval for a subcontract and a subcontract ~~amendments~~ amendment ~~are subject to review and prior written approval by the HCGA~~ and that the HCGA may terminate, rescind, or cancel a subcontract or a contract amendment ~~a subcontract or subcontract amendment may be terminated, rescinded, or canceled by the HCGA~~ for violation of a provision of these rules~~.~~;
6. An agreement to hold harmless and indemnify the state, AHCCCS, the HCGA, and members against claims, liabilities, judgments, costs, and expenses with respect to 3rd parties, which may accrue against the state, AHCCCS, the HCGA, or members, through the negligence or other action of ~~the~~ a subcontractor~~.~~;
7. The method and amount of compensation or other consideration ~~to be received by the subcontractor.~~ a subcontractor will receive; and
8. The amount, duration, and scope of medical services a subcontractor will provide ~~to be provided by the subcontractor,~~ and for which compensation will be paid.

C. Waiver of requirement to contract with hospitals. A HCG Plan may submit a written request to the HCGA requesting a waiver of the requirement that the HCG Plan subcontract with a hospital in the HCG Plan's service area as specified in R9-27-402(12). The request shall state the reasons for requesting a waiver and all efforts that have been made to secure a subcontract with a hospital within the HCG Plan's service area. For good cause shown, the HCGA may waive the hospital subcontract requirement. The HCGA shall consider the following criteria in deciding whether to waive the hospital subcontract requirement:
1. The number of hospitals in the service area;
2. The extent to which the HCG Plan's primary care providers have staff privileges at noncontracting hospitals in the service area;
3. The size and population of, and the demographic distribution within, the service area;
4. The patterns of medical practice and care within the service area;
5. Whether the HCG Plan has diligently attempted to negotiate a hospital subcontract in the service area;
6. Whether the HCG Plan has any subcontracts in adjoining areas with hospitals that are reasonably accessible to the HCG Plan's members in the service area; and
7. Whether the HCG Plan's members can reasonably be expected to receive all covered services in the absence of a hospital subcontract.

R9-27-404. Contract Amendments

A. Merger, reorganization, change of ownership. Any merger, reorganization, or change in ownership of a HCG Plan or a subcontractor affiliated with the HCG Plan shall constitute a contract amendment.

B. Written approval necessary. The HCG Plan shall obtain written approval from the HCGA, before any merger, reorganization, or change in ownership of ~~the~~ a HCG Plan or a subcontractor that is related to or affiliated with the HCG Plan.

C. Contract amendment requirements. To be effective, contract amendments shall be submitted in writing to the HCGA and executed by both parties.

R9-27-405. Contract Termination

A. Contract between the HCGA and HCG Plan. The HCGA may suspend, deny, refuse, fail to renew, or terminate a contract or require the HCG Plan to terminate a subcontract for good cause which may include the following reasons:
1. Submission of any misleading, false, or fraudulent information;
2. Provision of any services in violation of or not authorized by licensure, certification, or other law;
3. A material breach of contract;
4. Failure to provide and maintain quality health care services to members, as determined by standards established by the state; and
5. Failure to reimburse a medical provider within 60 days of receipt of a clean claim unless a different period is specified by contract.

B. ~~Group Service Agreement~~ GSA between HCG Plan and an employer group.
1. The GSA may be terminated with written notice from either the HCG Plan or an employer to the other party ~~no more than 60~~ at least 90 days before the expiration date of the plan, and at least 45 days before the anniversary date of the GSA.
2. The GSA may be terminated by the HCG Plan for cause with 10 ~~days'~~ days written notice for the following:
   a. Material misrepresentation of information furnished by ~~the~~ an employer to the HCG Plan, or
   b. Employer's default in payment of premiums time being of the essence.
3. The GSA may be terminated by ~~the~~ an employer group or the HCG Plan with 45 ~~days'~~ days written notice for a material breach of the contract.

C. Termination of an employee member by the HCGA or HCG Plan.
1. Cause for immediate termination of coverage. The HCGA or HCG Plan may terminate an employee member's coverage for the following:
   a. Fraud or misrepresentation when applying for coverage or obtaining services; or
   b. Violence, ~~or threatening~~ threats or other substantially abusive behavior toward the HCGA or the HCG Plan employees or agents, ~~or~~ contracting or noncontracting providers or their employees or agents.
2. Cause for termination with 30 days written notice. The HCGA or the HCG Plan may terminate coverage of an employee member for the following reasons:
   a. Repeated and unreasonable demands for unnecessary medical services;
   b. Failure to pay any copayment, coinsurance, deductible, or required financial obligation; and
   c. Material violation of any provision of the ~~Group Service Agreement~~ GSA.
3. ~~Termination~~ Cause for termination by reason of ineligibility.
   a. ~~Termination of employment;~~ Coverage of a ~~dependent~~ member or a member's dependent shall automatically cease on the last day of the month in which the member or member's dependent ~~member~~ loses coverage~~.~~; ~~for any reason described in R9-27-406 and R9-27-407.~~
   b. Failure of employer or employee to pay premium. Termination shall be effective the 1st day of the month for which the premium has not been paid;
   ~~c. Coverage of a dependent member shall automatically cease on the last day of the month in which the dependent member loses coverage, for any reason described in R9-27-406 and R9-27-407.~~
   ~~d~~c. Subject to continuation coverage and conversion coverage, as described in R9-27-406 and R9-27-407, on the effective date of termination of coverage, the HCG Plan shall have no further obligation to provide services and benefits to a member whose coverage has been terminated; except that a member confined to a hospital at the effective date of termination shall continue to receive coverage until there has been a determination by the HCG Plan Medical Director or designee that care in the hospital is no longer medically necessary for the condition for which the member was admitted to the hospital; and
   ~~e~~d. An employee member whose coverage terminates according to this subsection shall not be eligible for re-enrollment until the employer group's next open enrollment period. The employee shall meet all the eligibility criteria prescribed ~~by these rules~~ in this Article before re-enrollment.

D. Exclusion for fraud. The HCG Plan may exclude employer groups or employee members from enrollment who have committed fraud or misrepresentation while enrolled with another HCG Plan or health benefits carrier.

R9-27-406. Continuation Coverage

Continuation coverage. Employer groups with at least 20 employees on a typical business day during the preceding calendar year shall provide continuation coverage as required by 29 U.S.C. 1161 et seq., December 19, 1989, incorporated by reference

and on file with the HCGA and the Office of the Secretary of State. This incorporation by reference contains no future editions or amendments. The employer group shall collect the premium from the employee and pay the premium to HCGA.

R9-27-407. Conversion Coverage

Conversion coverage. ~~This Section~~ Conversion coverage applies only to employee members and dependents of employer groups with fewer than 20 employees.

1. An employee member, a dependent, or a qualified beneficiary who loses eligibility for a qualifying event, as defined in 29 U.S.C. 1163, and who has been covered for at least 3 months under the GSA may convert the policy to an individual policy for a period of 180 days.
2. A member shall have 30 days after the date of termination of group coverage to convert the coverage and pay the initial premium. Any services used within the 30-day conversion period before payment of the initial premium shall not be covered unless the care was provided or authorized by the member's primary care provider or the HCG Plan.
3. A member shall pay the premium for the converted coverage directly to the HCGA. Converted coverage shall be retroactive to the date of termination of group coverage.

ARTICLE 5. GENERAL PROVISIONS AND STANDARDS

R9-27-501. Availability and Accessibility of Services

~~A.~~ Availability and accessibility of services. HCG Plans shall ensure that, within each service area, an adequate number of hospitals, medical care facilities, and service providers are available and reasonably accessible to provide covered services~~,~~ to members. At a minimum, a HCG Plan shall~~:~~ have:

1. ~~Have a~~ A designated emergency medical ~~services~~ service facility, providing care 24 hours-a-day, 7 days-a-week. Emergency medical ~~services~~ service facilities shall be accessible to members in each service area with at least 1 physician and nurse on call or on duty at the facility at all times.
2. ~~Have a~~ An emergency medical ~~services~~ service system employing at least 1 physician, a registered nurse, a ~~physician's~~ physician assistant, or a nurse practitioner, accessible by telephone 24 hours-a-day, 7 days-a-week, to provide information to providers who need verification of patient membership and treatment authorization; and in the case of an emergency as defined under emergency medical services in R9-27-101.
3. ~~Maintain an~~ An emergency medical services call log that contains the following information:
   a. Member's name,
   b. Member's address,
   c. Member's telephone number,
   d. Date of call,
   e. Time of call, and
   f. Instructions given to each member.
4. A written procedure plan for the communication of emergency medical ~~services~~ service information to the member's primary care provider and other appropriate organizational units.
5. An appointment system for each of the HCG Plan's service locations. The appointment system shall ensure that:
   a. Members with acute or urgent problems are triaged and provided same-day service when necessary;
   b. Time-specific appointments for routine medically necessary care from the primary care provider are available within 3 weeks of a member's request and on the same day for emergency care; and
   c. Referral appointments to specialists are in the same day for emergency care, within 3 days for urgent care, and within 30 days for routine care.
6. ~~One primary~~ Primary care ~~provider~~ providers that ~~an~~ enrolled ~~member~~ members may select or to whom the member may be assigned. HCG Plans whose organization does not ordinarily include primary care providers shall enter into affiliation or subcontract with an organization or individuals to provide primary care. The HCG Plans shall agree to provide services under the primary care provider's guidance and direction. The primary care provider is responsible for:
   a. Supervising, coordinating, and providing initial and primary care to patients;
   b. Initiating referrals for specialty care; and
   c. Maintaining continuity of patient care.
7. Primary care physicians and specialists providing inpatient services to members ~~must~~ shall have staff privileges in a minimum of 1 general acute care hospital under subcontract with the contracting health plan, within or near the service area of the HCG Plan.

R9-27-502. Reinsurance

A. Provision of reinsurance. ~~Reinsurance may be provided by the~~ The HCGA may elect to provide reinsurance through private reinsurers.

B. Insured entities. For purposes of the HCGA's reinsurance program, the insured entities shall be the HCG Plans with which the HCGA contracts.

1. A specified amount per member, per month, shall be deducted by the HCGA from the HCG Plan's monthly premium to cover the cost of the reinsurance contract.
2. The HCG Plan shall comply with the reimbursement requirements of the reinsurance agreement between the reinsurer and the HCGA.

R9-27-503. Marketing, Prohibition Against Inducements, Misrepresentation, Discrimination, Sanctions

A. Marketing representatives shall not:

1. ~~misrepresent~~ Misrepresent themselves, the HCG Plan or the HCG program through false advertising, false statements, or in any other manner in order to induce members of other contracting entities to enroll in a particular HCG Plan.;

~~**B.**~~2. ~~Marketing representatives shall not claim~~ Claim, infer, or falsely represent themselves to be employees of the state or representatives of the HCGA, a county, or a HCG ~~plan~~ Plan other than the HCG Plan with whom they are employed or by whom they are reimbursed.; or

~~**C.**~~3. ~~Marketing representatives shall not engage~~ Engage in any marketing or other pre-enrollment practices that discriminate against an ~~eligible person~~ applicant or a member because of race, creed, age, color, sex, religion, national origin, ancestry, marital status, sexual preference, physical or mental disability, or health status.

~~**D.**~~ **B.** HCG plans to bear responsibility. HCG Plans shall bear responsibility for the performance of any marketing representative, subcontractor or agent, program, or process under their employ or direction.

R9-27-504. Approval of Advertisements and Marketing Material

A. Submission of marketing materials. The HCG Plans shall submit ~~to the HCGA for review and approval~~ proposed marketing strategies and marketing materials in writing to the HCGA for review and approval before distributing the marketing materials or implementing any activities. ~~The proposed marketing strategies and materials shall be submitted in writing to the HCGA.~~

B. Review of marketing materials. The HCGA shall review and approve or disapprove all proposed marketing materials and strategies. The HCGA shall notify the HCG Plan in writing of the approval or disapproval of the proposed marketing materials and marketing strategies. The notification shall include a statement of objections and recommendations.

C. Drafts. To minimize the expense of revising marketing materials or other copy, a HCG Plan may submit the material in draft form subject to final approval and filing of a proof or final copy.

D. Submission and maintenance of final copies. HCG Plans shall submit 2 copies of the proof or final approved copy of materials to the HCGA, which shall maintain the proof or copy for 5 years.

R9-27-505. Member Records and Systems

Member record. Each HCG Plan shall maintain a member service record for each member that contains encounter data, grievances, complaints, and service information ~~for each member~~.

R9-27-506. Fraud or Abuse

Suspected fraud or abuse. All HCG Plans, providers, and nonproviders shall advise the HCGA immediately in writing of suspected fraud or abuse.

R9-27-507. Release of Safeguarded Information

A. Safeguarded information. ~~Information to be safeguarded concerning an applicant or member of a HCG Plan includes~~ A HCG Plan shall safeguard an applicant's or a member's information. Safeguarded information includes:

1. Name, address, and social security number;
2. Evaluation of personal information; and
3. Medical data and services including diagnosis and history of disease or disability.

B. Unrestricted information. The restrictions upon disclosure of information shall not apply to summary data, utilization data, and other information that does not identify an individual applicant or member.

C. Disclosure of safeguarded information. Safeguarded information concerning a member or an applicant ~~shall be disclosed only to:~~ may be released to the following only under the conditions specified in subsections (D), (E), and (F).

1. The member or applicant, or, in the case of a minor, the parent, custodial relative, or guardian;
2. Individuals authorized by the member or applicant; and
3. A ~~Persons~~ person or an ~~agencies~~ agency for official purposes.
4. ~~Safeguarded information may be released to these parties only under the conditions specified in subsections (D), (E), and (F).~~

D. Review of medical records. A member or an authorized representative may view the member's medical record after written notification to the provider and at a reasonable time and place.

E. Release to individuals authorized by the individual concerned. A HCG Plan shall release medical records and any other HCG-related confidential information of a member or an applicant to individuals authorized ~~by the member or applicant~~ only under the following conditions:

1. Authorization for release of information ~~must~~ shall be obtained from the member, applicant, or authorized representative. In the case of a minor, the member's or applicant's parent, custodial relative, or guardian shall submit an authorization for release of information.
2. Authorization used for release of information must be, submitted in writing separate from any other document, and ~~must~~ shall specify the following:
   a. Information or records, in whole or in part, which are authorized for release;
   b. To whom the release shall be made;
   c. The period of time for which the authorization is valid, if limited; and
   d. The dated signature of the member, applicant, or authorized representative. In the case of a minor member or applicant, signature of a parent, custodial relative, or guardian is required unless the minor is able to understand the consequences of authorizing and not authorizing.
3. If a grievance or appeal has been filed, the grievant, appellant, or designated representative shall be permitted to review, obtain, or copy any nonprivileged record necessary for the proper presentation of the case. The grievant or appellant also may authorize release of safeguarded information deemed necessary to the contested issue, to any opposing party in the case.

F. Release to persons or agencies for official purposes.
1. Safeguarded information, case records, and medical services information ~~may be disclosed~~ is disclosable without the consent of the member, to agents or employees of a review committee.
2. For purposes of this Section, "review committee" means an organizational structure within the HCG Plan whose primary purpose is to:
   a. Evaluate and improve the quality of health care~~;~~,
   b. Review and investigate the conduct of licensed health care providers to determine whether disciplinary action should be imposed~~;~~, and
   c. Encourage proper and efficient utilization of health care services and facilities.
3. Any member, agent, or employee of a review committee, who in good faith and without malice, furnishes records, information, or assistance related to the duties of the review committee; or, who takes an action or makes a decision or recommendation related to the duties or functions of the review committee shall not be subject to liability for civil damages as a consequence of the action. This does not relieve a person of liability that arises from that person's medical treatment of a patient.
4. Information considered by a review committee related to the duties or functions of the committee, including records of their actions and proceedings, ~~are~~ is confidential and ~~are~~ is not subject to subpoena or order to produce except:
   a. When otherwise subject to discovery as a patient's medical records~~.~~; and
   b. In proceedings before an appropriate state licensing or certifying agency. If the information is transferred to an appropriate state licensing or certifying agency, the information shall be kept confidential and shall be subject to the same provisions concerning discovery and use in legal actions.
5. A member of a review committee or staff engaged in work for the committee or any other person assisting or furnishing information to the review committee shall not be subpoenaed to testify in a judicial or quasi-judicial proceeding if the subpoena is based solely on review committee activities.

G. Transmission of medical records by providers. Subcontracting providers shall not be required to obtain written approval from the member before transmitting member medical records to physicians:
1. Providing services to members under subcontract with the HCG Plan; or
2. Retained by the subcontractor to provide services that are infrequently used or are of an unusual nature.

R9-27-509. Information to Enrolled Members

A. Member handbook. Each HCG Plan shall produce and distribute a printed member handbook to each enrolled member by the effective date of coverage. The member handbook shall include the following:
1. A description of all available services and an explanation of any service limitation, and exclusions from coverage or charges for services, when applicable;
2. An explanation of the procedure for obtaining covered services, including a notice stating the HCG Plan shall only be liable for services authorized by a member's primary care provider or the HCG Plan;
3. A list of the names, telephone numbers, and business addresses of primary care providers available for selection by the member, and a description of the selection process, including a statement that informs members they may request another primary care provider, if they are dissatisfied with their selection;
4. Locations, telephone numbers, and procedures for obtaining emergency health services;
5. Explanation of the procedure for obtaining emergency health services outside the HCG Plan's service area;
6. ~~The causes~~ Causes for which a member may lose coverage;
7. A description of the grievance procedures;
8. Copayment, coinsurance, and deductible schedules;
9. Information on the appropriate use of health services and on the maintenance of personal and family health;

10. Information regarding emergency and medically necessary transportation offered by the HCG Plan; and
11. Other information necessary to use the program.

B. Notification of changes in services. Each HCG Plan shall prepare and distribute to members a printed member handbook insert describing any changes that the HCG Plan proposes to make in services provided within the HCG Plan's service areas. The insert shall be distributed to all affected members or family units at least 14 days before a planned change. Notification shall be provided as soon as possible when unforeseen circumstances require an immediate change in services or service locations.

R9-27-510. Discrimination Prohibition

A. Discrimination. ~~A~~ HCG ~~Plan~~ Plans shall not discriminate against an applicant or a member because of race, color, creed, religion, ancestry, marital status, sexual preference, national origin, age, sex or physical or mental disability in accordance with Title VII of the U.S. Civil Rights Act of 1964, 42 U.S.C., Section 2000 D, regulations promulgated under the Act, or as otherwise provided by law or regulation. For the purpose of providing covered services under contract ~~under~~ according to A.R.S. Title 36, Chapter 29, discrimination on the grounds of race, creed, color, religion, ancestry, marital status, age, sex, national origin, sexual preference, or physical or mental disability includes, but is not limited to, the following:

1. Denying a member any covered service or availability of a facility for any reason except as defined in a rider provided under R9-27-202 or for a pre-existing condition as described in R9-27-210;
2. Providing ~~to~~ a member any covered service that is different, or is provided in a different manner or at a different time from that provided to other HCG members under contract, except where medically indicated;
3. Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service, or restricting a ~~member in any way in the~~ member's enjoyment of any advantage or privilege enjoyed by others receiving any covered service; and
4. Assigning times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual preference, or physical or mental disability of the ~~participants~~ members to be served.

B. Provision of covered services. ~~A~~ HCG ~~Plan~~ Plans shall take affirmative action to ensure that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, or physical or mental disability, except where medically indicated.

R9-27-511. Equal Opportunity

~~A.~~ Equal opportunity requirements. HCG ~~Plan~~ Plans shall comply with the following equal opportunity employment requirements:

1. ~~State in all solicitations or advertisements for employees placed by or on behalf of the~~ All solicitations or advertisements placed by or on behalf of a HCG Plan~~,~~ shall state that it is an equal opportunity employer~~; and~~ .
2. ~~Send a notice provided by the HCGA,~~ HCG Plans shall send a notice prepared by the HCGA to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding. The notice shall advise the labor union or workers' representative of the HCG Plan's commitment as an equal opportunity employer and shall be posted in conspicuous places available to employees and applicants for employment.

R9-27-512. Periodic Reports and Information

A. Contract performance. Upon request by the HCGA, each HCG Plan shall furnish to the HCGA information from its records relating to contract performance.

B. Separation of records. Each HCG Plan shall maintain separate records to identify ~~separately~~ all HCG-related transactions.

R9-27-513. Medical Audits

A. Conducting of medical audits. HCGA shall conduct a medical audit of each HCG Plan at least once every 12 months. Unless HCGA determines that advance notice will render a medical review less useful, the HCGA shall notify the HCG Plan approximately 3 weeks in advance of the date of an on-site medical review. HCGA may conduct, without prior notice, inspections of the HCG Plan facilities or perform other elements of a medical review, either in conjunction with the ~~medial~~ medical audit or as part of an unannounced inspection program.

B. Procedure for medical audits. As part of the medical audit, the HCGA may perform any or all of the following procedures:

1. Conduct private interviews and group conferences with:
   a. Members;
   b. Physicians and other health care practitioners;
   c. Members of the HCG Plan's administrative staff including, but not limited to, its principal management persons; and
2. Examine records, books, reports, and papers of the HCG Plan, any management company of the HCG Plan, and all providers or subcontractors providing health care and other services to the HCG Plan. The examination may include, but is not limited to:
   a. ~~The minutes~~ Minutes of medical staff meetings~~;~~,

b. Peer review and quality of care review records~~;~~,
c. Duty rosters of medical personnel~~;~~,
d. Appointment records~~;~~,
e. Written procedures for the internal operation of the HCG Plan~~;~~,
f. Contracts~~;~~,
g. Correspondence with members and ~~with~~ providers of health care services and other services to the HCG Plan~~;~~, and
h. Additional documentation deemed necessary by the HCGA to review the quality of medical care.

R9-27-514. HCG Plan's Internal Quality Management and Utilization Review System

A. Quality management and utilization review. ~~The~~ HCG Plans shall comply with the following quality management and utilization review requirements:
1. ~~Prepare~~ Annually prepare and submit a written quality management plan which includes utilization review to HCGA for review and approval ~~annually a written quality management plan which includes utilization review~~. The quality management plan must be designed and implemented with actions to promote the provision of quality health care services.
2. Design and implement procedures for continuously reviewing the performance of health care personnel and the utilization of facilities, services, and costs.
3. Medical records and systems~~.~~:
   a. Ensure that member's medical records are maintained by the primary care provider, and include a record of all medical services received by the member from the HCG Plan and its subcontracting and noncontracting providers.
   b. Ensure that medical records are maintained in a manner that:
      i. Conforms to professional medical standards and practices~~;~~,
      ii. Permits professional medical review and medical audit processes~~;~~, and
      iii. Facilitates a system for follow-up treatment.
4. Develop and implement a program of utilization review methods for hospitals that, at a minimum, includes:
   a. Prior authorization of nonemergency hospital admissions~~;~~,
   b. Concurrent review of inpatient stays~~;~~, and
   c. Retrospective review of hospital claims to ensure that covered hospital services are not used unnecessarily or unreasonably.

B. Evaluation of utilization control system. The HCG Plan's utilization control system is subject to evaluation by the HCGA to determine cost effectiveness, and to measure whether quality management and utilization review methods are reducing, controlling, or eliminating unnecessary or unreasonable utilization. ~~The~~ HCG ~~Plan~~ Plans may subcontract with an organization or entity designed to conduct activities regarding prior authorization, concurrent review, retrospective review, or any combination of these activities. A subcontract to conduct quality management or utilization review activities is subject to prior approval by the HCGA.

R9-27-515. Continuity of Care

A. Requirements for continuity of care. HCG ~~Plan~~ Plans shall establish and maintain a system to ensure continuity of care which includes:
1. Referral of members needing specialty health care services~~;~~,
2. Monitoring of members with chronic medical conditions~~;~~,
3. Providing hospital discharge planning and coordination including post-discharge care~~;~~, and
4. Monitoring the operation of the system through professional review activities.

R9-27-516. Financial Resources

A. Adequate reserves. ~~A~~ HCG ~~Plan~~ Plans shall demonstrate to the HCGA that it has adequate financial reserves, administrative abilities, and soundness of program design to carry out its contractual obligations.

B. Contract provisions. Contract provisions required by the HCGA may include, but are not limited to:
1. ~~The maintenance~~ Maintenance of deposits,
2. Performance bonds,
3. Financial reserves, or
4. Other financial security.

ARTICLE 7. STANDARD FOR PAYMENTS

R9-27-701. Scope of the HCGA's Liability; Payments to HCG Plans

A. Scope of liability for covered services. The HCGA shall bear no liability for the provision of covered services or the completion of a plan of treatment ~~to~~ for any member.

~~**B.** All payments to HCG Plans shall be made under the terms and conditions of contracts executed between the HCG Plan and HCGA in accordance with these rules.~~

~~**C.**~~**B.** Scope of liability for subcontracts. ~~The HCGA shall bear no liability for subcontracts that the HCG Plan executes with other parties for the provision of either administrative or management services, medical services, covered health care services, or for any other purpose. The HCG Plan shall indemnify and hold the HCGA harmless from any and all liability arising from the HCG Plan's subcontracts. The HCG Plan shall bear all costs of defense of any litigation over liability and shall satisfy in full any judgment entered against the HCGA arising from a HCG Plan subcontract. All deposits, bonds, reserves, and security posted under R9-27-516 shall be held by the HCGA to satisfy the obligations of this Section.~~

1. The HCGA shall bear no liability for subcontracts that the HCG Plan executes with other parties for the provision of:
   a. Administrative or management services,
   b. Medical services,
   c. Covered health care services, or
   d. For any other purpose.
2. The HCG Plan shall indemnify and hold the HCGA harmless from any and all liability arising from the HCG Plan's subcontracts.
3. The HCG Plan shall bear all costs of defense of any litigation over liability and shall satisfy in full any judgment entered against the HCGA arising from a HCG Plan subcontract.
4. The HCGA shall hold all deposits, bonds, reserves, and security posted under R9-27-516 to satisfy the obligations of this Section.

C. Payments. All payments to HCG Plans shall be made under the terms and conditions of contracts executed between the HCG Plan and HCGA as specified in this Article.

D. Premiums. Premium payments, less HCGA administrative charges and reinsurance fees, shall be paid monthly to those HCG Plans that have either posted required performance bonds or have otherwise provided sufficient security to the HCGA.

R9-27-702. Prohibition Against Charges to Members

Prohibition against charges to members. No HCG Plan, subcontractor, noncontracting provider, or nonprovider reimbursed by a HCG Plan shall charge, submit a claim, demand, or otherwise collect payment from a member or person acting on behalf of a member for any covered service except to collect an authorized copayment, coinsurance, and deductible. This prohibition shall not apply if the HCGA determines that ~~the~~ a member willfully withheld information pertaining to the member's enrollment in a HCG Plan. HCG Plans shall have the right to recover from a member that portion of payment made by a 3rd-party to ~~the~~ a member when the payment duplicates HCG benefits and has not been assigned to the HCG Plan.

R9-27-703. Payments by HCG Plans

A. Payment for covered services. A HCG Plan shall pay for all covered services rendered to the HCG Plan's members if the services were arranged by the HCG Plan's agents or the HCG Plan's employees, subcontracting providers, or other individuals acting on behalf of the HCG Plan and if necessary authorization was obtained.

B. Payment for medically necessary outpatient services. A HCG Plan shall reimburse subcontracting providers and noncontracting providers for covered health care services provided to the HCG Plan's members. Reimbursement shall be made within the time period specified by contract between a HCG Plan and a subcontracting entity or within 60 days of receipt of a clean claim, if a time period is not specified.

C. Payment for instate inpatient and outpatient hospital services including emergency services.

1. HCG Plans shall reimburse instate subcontracting providers for the provision of inpatient and outpatient hospital services, including emergency services~~,~~ specified in R9-27-209 at the subcontracted rate.
2. HCG Plans shall reimburse instate noncontracting providers for the provision of inpatient and outpatient hospital services, including emergency services specified in R9-27-209, ~~in accordance with~~ according to the reimbursement methodology ~~stipulated~~ stated in A.R.S. § 36-2903.01(J).

D. ~~1.~~ Payment for emergency services. HCG Plans shall pay for all emergency care services rendered ~~their~~ to the HCG Plan's members by noncontracting providers if the services:

~~a.~~1. Conform to the definition of emergency medical services in Article 1 and Article 2 of these rules; and

~~b.~~2. Conform to the notification requirements in Article 2 of these rules.

~~2. HCG Plans shall provide written notice to providers whose claims are denied or reduced by the HCG Plan within 30 days of adjudication of the claims. This notice shall include a statement describing the provider's right to:~~

~~a. Grieve the HCG Plan's rejection or reduction of the claim; and~~

~~b. Submit a grievance to the HCGA, or its designee under Article 6 of these rules.~~

~~**D.**~~**E.** Payment for out-of-state inpatient and outpatient hospital services. The HCG Plans shall reimburse out-of-state subcontracting providers at the subcontracted rate. The HCG Plans shall reimburse out-of-state noncontracting providers for the provision of inpatient and outpatient hospital services at the lower of negotiated discounted rates or 80% of billed charges.

~~E.~~**F.** Payment for emergency ambulance services. The HCG Plans shall reimburse out-of-state subcontracting providers at the subcontracted rate. The HCG Plans shall reimburse noncontracting providers for emergency ambulance services at the lower of negotiated discounted rates or 80% of the billed charges.

G. Nonpayment of a claim. In the absence of a contract, a HCG Plan is not required to pay a claim for a covered service that is submitted more than 6 months after the date of the service or that is submitted as a clean claim more than 12 months after the date of service.

H. Notice of denied claims. HCG Plans shall provide written notice to providers whose claims are denied or reduced by the HCG Plan within 30 days of adjudication of the claims. This notice shall include a statement describing the provider's right to:

1. Grieve the HCG Plan's rejection or reduction of the claim; and
2. Submit a grievance to the HCGA, or its designee under Article 6 of these rules.

R9-27-704. HCG Plan's Liability to Noncontracting and Nonprovider Hospitals for the Provision of Emergency and Subsequent Care to Enrolled Members

A. Liability to noncontracting and nonprovider hospitals. For purposes of HCG Plan liability, an emergency medical condition shall be ~~subject to reimbursement only~~ reimbursable: ~~until the time the member's condition is stabilized and the member is transferable to a subcontractor, or until the member is discharged following stabilization, subject to the requirements of A.R.S. § 36-2909(E) and Article 2 of these rules.~~

1. Until the time the member's condition is stabilized and the member is transferable to a subcontractor; or
2. Until the member is discharged following stabilization, subject to the requirements of A.R.S. § 36-2909(E) and Article 2 of these rules.

B. Liability when transfer of member is not possible. Subject to subsection (A), if a member cannot be transferred following stabilization to a facility that has a subcontract with the HCG Plan of record, the HCG Plan shall pay for all appropriately documented medically necessary treatment provided the member before the date of discharge or transfer at the lower of a negotiated discounted rate or prospective tiered-per-diem rate.

C. Member refusal of transfer. If a member refuses transfer from a nonprovider or noncontracting hospital to a hospital affiliated with the member's HCG Plan, neither the HCGA nor the HCG Plan shall be liable for any costs incurred subsequent to the date of refusal if:

1. Subsequent to consultation with the member's HCG Plan, the member continues to refuse the transfer; and
2. The member has been provided and signs a written statement of liability, before the date of transfer informing the member of the medical and financial consequences of refusing to transfer. If the member refuses to sign a written statement, a statement signed by 2 witnesses indicating that the member was informed may be substituted.

R9-27-705. Copayments

A. Payment of copayment. A member shall be required to pay a copayment directly to a provider at the time covered services are rendered.

B. Determination of copayment. The HCGA shall establish the amount of copayment a member shall be charged. The HCGA shall consider the following in determining the amount of copayment:

1. The impact the amount of the copayment will have on the population served~~;~~, and
2. The copayment amount charged by other group health plans or health insurance carriers for particular services.

C. Copayment provisions. The HCGA shall include the copayment provisions in ~~it's~~ the contract with a HCG Plan.

D. Schedule of copayments. The HCG Plans shall provide a schedule of the copayments to members at the time of enrollment.

ARTICLE 8. COORDINATION OF BENEFITS

R9-27-801. Priority of Benefit Payment

A. HCG Plans shall coordinate all 3rd-party benefits. Services provided under the HCG Plan are not intended to duplicate other services and benefits available to an employee member.

B. Order of payment for members with other insurance. If a member has other coverage, payment for services shall occur in the following order:

1. A policy, plan, or program that has no coordination of benefits provision or nonduplication provision shall make payment 1st.
2. If a member is covered by another plan or policy which has coordination of benefits:
   a. The plan that provided or authorized the service shall make payment 1st.
   b. A plan~~,~~ ~~that is not~~ other than a prepaid plan~~,~~ that covers a person as an employee shall make payment before a plan that covers the person as a dependent.
3. If coverage is provided to a dependent child and both parents have family coverage:
   a. The plan of the employee whose birthday occurs 1st in the calendar year shall be primary, and the plan of the employee whose birthday occurs last in the calendar year shall be secondary.

b. If both employees have the same birthday, the plan of the employee, that has been in force longer shall pay 1st.
c. If 1 of the plans determines the order of benefits based upon the gender of an employee, and the plans do not agree on the order of benefits, the plan with the gender rule shall determine the order of benefits.

4. If coverage is provided to a dependent child of divorced employees, the order of benefit shall be:
a. The plan of the employee with custody of the child shall pay 1st;
b. The plan of the spouse of the employee with custody of the child shall pay 2nd; and
c. The plan of the employee not having custody of the child shall pay last.

C. Primary payors. HCG Plans shall not be primary payers for claims involving workers' compensation, automobile insurance, or homeowner's insurance.

D. Lien and subrogation rights. HCG Plans shall not have lien or subrogation rights beyond those held by health care services organizations licensed under A.R.S. ~~§~~ Title 20, Chapter 4, Article 9.

NOTICE OF PROPOSED RULEMAKING

TITLE 15. REVENUE

CHAPTER 5. DEPARTMENT OF REVENUE
TRANSACTION PRIVILEGE AND USE TAX SECTION

PREAMBLE

1. Sections Affected — **Rulemaking Action**

Article 22	Amend
R15-5-2220	Amend
R15-5-2221	Amend
R15-5-2302	Repeal
R15-5-2305	Amend
R15-5-2306	Amend
R15-5-2307	Repeal
R15-5-2308	Repeal
R15-5-2310	Amend
R15-5-2321	Repeal

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

Authorizing statute: A.R.S. §§ 42-1005

Implementing statute: A.R.S. §§ 52-5008, 42-5009, 42-5151, 42-5152, 42-5154, 42-5155, 42-5159 through 42-5163

3. List of all previous notices appearing in the Register addressing the proposed rules:

Notice of Rulemaking Docket Opening: 5 A.A.R. 3236, September 17, 1999

Notice of Rulemaking Docket Opening: 6 A.A.R., March 10, 2000

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

Name: Ernest Powell, Supervisor

Address: Tax Research & Analysis Section
Arizona Department of Revenue
1600 W. Monroe
Phoenix, AZ 85007

Telephone Number: (602) 542-4672

Fax Number: (602) 542-4680

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

The rules provide guidance in the application of use tax to purchases of tangible personal property which is stored, used, or consumed in Arizona. As a result of the Department's 5-year review of Articles 22 and 23, the Department is proposing to amend or repeal the rules to conform to current statutes and case law, remove repetitive language, and conform to current rulemaking guidelines.

6. Reference to any study that the agency proposes to rely on and its evaluation of or justification for proposed rule and where the public may obtain or review the study, all data underlying each study, any analysis of the study and other supporting material:

None

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

Not applicable

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

It is expected that the benefits of the rules will be greater than the costs. The amendment of these rules will benefit the public by making the rules conform to current statute, case law, and rulemaking guidelines, which will make the rules more accurate as well as clearer and easier to understand. These rules only provide guidance in the application of the statute; the statute imposes the tax and establishes any deductions. The Department will incur the costs associated with the rulemaking process. Taxpayers are not expected to incur any expense in the amendment of these rules.

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

Name: Ernest Powell, Supervisor

Address: Tax Research & Analysis Section
Arizona Department of Revenue
1600 W. Monroe
Phoenix, AZ 85007

Telephone Number: (602) 542-4672

Fax Number: (602) 542-4680

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

Oral proceedings at which members of the public may appear and make comments regarding the rules or the economic, small business, and consumer impact statement will occur as follows:

Date: April 17, 2000

Time: 9:00 a.m.

Location: Department of Revenue Building
1600 W. Monroe, Small Conference Room, B1 Floor
Phoenix, AZ 85007

Nature: Public hearing

A person may submit written comments regarding the proposed rule by submitting the comments no later than 5:00 p.m., April 17, 2000, to the person above.

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

Not applicable

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

None

13. The full text of the rules follows:

TITLE 15. REVENUE

CHAPTER 5. DEPARTMENT OF REVENUE
TRANSACTION PRIVILEGE AND USE TAX SECTION

ARTICLE 22. ~~SALES TAX –~~ ADMINISTRATION

Section
R15-5-2220. Registration for the Collection of Use Tax ~~and Licensing~~

R15-5-2221. Remittal of Use Tax on Purchases from Unregistered ~~Unlicensed~~ Retailers

ARTICLE 23. USE TAX

Section
R15-5-2302. ~~General~~ Repealed
R15-5-2305. Credit for Excise ~~Sales~~ Tax Paid in State of Purchase
R15-5-2306. Distinction Between Transaction Privilege ~~Sales~~ Tax and Use Tax
R15-5-2307. ~~When a Transaction is Subject to the Sales Tax~~ Repealed
R15-5-2308. ~~When a Transaction is Subject to the Use Tax~~ Repealed
R15-5-2310. Collection ~~Payment~~ of Use Tax from a Purchaser by a Registered Retailer ~~Purchaser~~
R15-5-2321. ~~Exemptions -- Articles to be Incorporated into a Manufactured Product~~ Repealed

ARTICLE 22. ~~SALES TAX –~~ ADMINISTRATION

R15-5-2220. Registration for the Collection of Use Tax ~~and Licensing~~

A. A retailer that makes ~~Out-of-state vendors making~~ sales to Arizona purchasers and is not required to have an Arizona transaction privilege tax license shall register with the Department for the collection of use tax ~~obtain a use tax license from the Department~~, unless the retailer cannot be required to collect use tax under the United States Constitution.

B. A retailer may voluntarily register with the Department to collect use tax ~~Use Tax collected on an isolated sale to an Arizona customer may be remitted under a cover letter rather than on a standard report form~~. A retailer that voluntarily registers for the collection of use tax shall be subject to the same requirements as a retailer that is required to register. The retailer shall collect the use tax from all of its Arizona purchasers and shall remit the use tax to the Department.

C. An out-of-state retailer that makes an isolated sale to an Arizona customer is not required to register for the collection of use tax solely for the purpose of collecting and remitting tax on the transaction from the purchaser. If the retailer collects use tax from the purchaser on such an isolated sale, the retailer may remit the tax to the Department under a cover letter rather than on a standard report form. The cover letter shall identify the purchaser and the items purchased.

R15-5-2221. Remittal of Use Tax on Purchases from Unregistered ~~Unlicensed~~ Retailers

A. Arizona purchasers that ~~regularly~~ make ~~making~~ purchases subject to use tax from unregistered retailers during more than 3 different months within a calendar year ~~unlicensed vendors, where the purchases are subject to use tax,~~ shall register for the payment of ~~obtain a~~ use tax ~~license~~ and remit payments directly to the Department. A purchaser that has an Arizona transaction privilege tax license is not required to separately register for payment of use tax.

B. An Arizona purchaser ~~who~~ that purchases ~~is licensed in Arizona shall remit the use tax to the Department on the purchaser's Sales, Use, and Severance Tax Return (ST-1) if~~ tangible personal property ~~is purchased~~ from a ~~an out-of-state~~ retailer that is not subject to transaction privilege tax and the retailer ~~who~~ is not registered ~~licensed~~ to collect the use tax~~.~~ shall remit the use tax to the Department using the following:

1. The purchaser's Transaction Privilege, Use, and Severance Tax Return (TPT-1) if the purchaser has a transaction privilege tax license or the purchaser is registered, or required to register, for payment of use tax; or
2. ~~C.~~ A ~~An Arizona purchaser who is not licensed in Arizona shall remit the use tax to the Department under a~~ cover letter if the purchaser does not have a transaction privilege tax license, and the purchaser is not registered or required to register for the payment of use tax ~~tangible personal property is purchased from an out-of-state retailer who is not licensed to collect the use tax~~.

ARTICLE 23. USE TAX

R15-5-2302. ~~General~~ Repealed

~~**A.** The Use Tax Act imposes upon the buyer a tax on the purchase of tangible personal property from an out-of-state vendor.~~

~~**B.** The tax applies to the use, storage, or consumption of items purchased from out-of-state suppliers.~~

~~**C.** In cases where the buyer has paid Sales Tax to an out-of-state seller, the amount paid may be applied against his Arizona Use Tax liability.~~

R15-5-2305. Credit for Excise ~~Sales~~ Tax Paid in State of Purchase

A. If ~~When~~ the sale or use of tangible personal property has already been subjected to an excise tax under the laws of another state of the United States, the Arizona use tax is reduced by the lesser of:

1. The amount of excise tax already imposed under the laws of the other state on the sale or use of the tangible personal property, or
2. The total Arizona use tax ~~a Sales Tax has been paid in the state of purchase equal to or greater than the Arizona Use Tax, the purchaser has no further liability.~~

B. To qualify for the reduction in subsection (A), the excise tax imposed under the laws of the other state shall be imposed:

1. Directly on each sale or purchase of tangible personal property at retail, such as a sales tax; or

2 On the business of selling tangible personal property at retail, such as Arizona's transaction privilege tax. ~~In cases where the amount of Sales Tax paid in the state of purchase is less than the Arizona Use Tax, the purchaser has an additional liability to the state of Arizona. For example, if the amount of tax paid in another state is 3% of the purchase price and the Arizona Use Tax rate is 4%, the purchaser is required to pay an additional 1%.~~

C. The amount in subsection (A)(1) includes taxes imposed by counties, cities, or other political subdivisions of the other state.

R15-5-2306. Distinction Between Transaction Privilege ~~Sales~~ Tax and Use Tax

A. Generally, sales of tangible personal property by a retailer maintaining a place of business within Arizona are subject to transaction privilege tax. However, the retailer will instead be liable for use tax collection if:
1. The sale is made from an out-of-state location of the retailer;
2. The sale is dissociated from the local business; and
3. The tangible personal property is delivered by the out-of-state business unit directly to an Arizona address that is not connected with the retailer. ~~The Sales Tax is imposed on sales made by vendors located within Arizona, while the Use Tax is levied on purchases from out-of-state vendors.~~

B. Use tax applies to the storage, use, or consumption in Arizona of tangible personal property not included in the measure of the transaction privilege tax and purchased from a retailer or utility business, unless an exemption applies. A purchase from an out-of-state retailer or any other retailer not subject to transaction privilege tax is subject to use tax. Purchases from the United States Government are not subject to use tax because the United States Government is not a retailer. ~~Since the Sales Tax and Use Tax are complementary taxes, only one of the taxes can be applied to a given transaction.~~

C. Use tax also applies to tangible personal property that was purchased for resale but was subsequently used or consumed by the purchaser.

D. If a retailer claims a deduction from transaction privilege tax based on factual representation provided by the purchaser and the purchaser cannot establish the accuracy and completeness of the factual representation, the purchaser is liable in an amount equal to any tax, penalty, and interest the retailer would have been required to pay. Payment of the amount equal to what the retailer would have been required to pay exempts the purchaser from use tax on the transaction.

E. Transaction privilege tax and use tax are complementary taxes. Therefore, only 1 of the taxes can be applied to a given transaction. If both may apply, transaction privilege tax is the applicable tax.

R15-5-2307. ~~When a Transaction is Subject to the Sales Tax~~ Repealed

~~Sales made by vendors maintaining a place of business within Arizona are subject to the Sales Tax. Sellers operating from a commercial location or point of distribution, soliciting from a public place of business, or buying and selling articles on their own account within the state are deemed to be in business in Arizona. For example, an office equipment dealer maintains a sales office in Arizona, solicits business from customers in Arizona, and orders the equipment from its home office out of state. Although the seller maintains no stock of inventory in Arizona and the products are shipped directly to the purchaser, he is nevertheless considered to be engaging in business within the state for purposes of this regulation. Such sales are taxable under the Sales Tax statutes.~~

R15-5-2308. ~~When a Transaction is Subject to the Use Tax~~ Repealed

~~Purchases made from vendors not maintaining a place of business in this state to Arizona customers are subject to the Use Tax. For example, purchases from an out-of-state vendor selling by mail order to Arizona residents are subject to the Use Tax.~~

R15-5-2310. Collection ~~Payment~~ of Use Tax from a Purchaser by a Registered Retailer ~~Purchaser~~

A. A retailer or utility business that is registered for the collection of use tax shall collect the use tax from the purchaser and shall pay the use tax to the Department of Revenue. A retailer or utility business cannot be relieved of the requirement to collect the use tax from the purchaser, unless the purchase is exempt from use tax. ~~The Use Tax must be paid to:~~
1. ~~An out-of-state vendor holding a certificate of authority for the collection of Use Tax, or~~
2. ~~The Arizona Department of Revenue in cases where the vendor is not registered for the collection of the tax.~~

~~**B.** Arizona purchasers making recurring purchases from out of state may apply to the Department for a registration certificate and remit payment directly to the state on a monthly report form in lieu of making payment to the vendor.~~

B~~C~~. The purchaser will be relieved of the use tax ~~his~~ liability ~~for the tax~~ when the purchaser obtains a receipt from a qualified retailer or utility business that itemizes the use tax that was paid by the purchaser. For purposes of this section, a qualified retailer or utility business either maintains a place of business in Arizona or is registered with the Department for the collection of use tax ~~payment is made directly to the out-of-state vendor registered and a receipt of the tax paid is obtained by him~~.

C. If the Department audits a retailer that has not collected the use tax, the Department shall give the retailer credit for any use tax, interest and penalty paid to the Department by the purchaser subject to the provisions in A.R.S. 42-1118(D).

R15-5-2321. ~~Exemptions—Articles to be Incorporated into a Manufactured Product~~ Repealed

~~Purchases of articles which become an integral part of a manufactured product are not subject to the Use Tax. They are considered purchases for resale.~~