NOTICES OF EXEMPT RULEMAKING

The Administrative Procedure Act requires the *Register* publication of the rules adopted by the state's agencies under an exemption from all or part of the Administrative Procedure Act. Some of these rules are exempted by A.R.S. §§ 41-1005 or 41-1057; other rules are exempted by other statutes; rules of the Corporation Commission are exempt from Attorney General review pursuant to a court decision as determined by the Corporation Commission.

NOTICE OF EXEMPT RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

[R06-389]

PREAMBLE

1. Sections Affected — **Rulemaking Action**

R9-22-1601	New Section
R9-22-1602	New Section
R9-22-1603	New Section
R9-22-1604	New Section
R9-22-1605	New Section
R9-22-1606	New Section
R9-22-1607	New Section
R9-22-1608	New Section
R9-22-1609	New Section
R9-22-1610	New Section
R9-22-1611	New Section
R9-22-1612	New Section
R9-22-1614	New Section
R9-22-1615	New Section
R9-22-1616	New Section
R9-22-1618	New Section
R9-22-1619	New Section

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

Authorizing statute: A.R.S. § 36-2930

Implementing statute: A.R.S. § 36-2930

3. The effective date of the rules:

October 1, 2006

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

Not applicable

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

Name: Linda Barry

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

Telephone: (602) 417-4484

Fax: (602) 253-9115

E-mail: AHCCCSRules@azahcccs.gov

6. An explanation of the rule, including the agency's reasons for initiating the rule, including the statutory citation to the exemption from the regular rulemaking procedures:

The Arizona Health Care Cost Containment System (AHCCCS) has established the Social Security Disability Insurance Temporary Medical Coverage Program as specified in A.R.S. § 36-2930. AHCCCS was required to promulgate rules to implement this program. The program authorizes the AHCCCS Administration to provide healthcare coverage to any uninsured individual who receives Social Security Disability Insurance (SSDI) payments, who is not eligible for Medicare, and who does not meet the eligibility requirements for AHCCCS benefits, but is eligible for this state funded Social Security Disability Insurance Temporary Medical Coverage Program as specified in A.R.S. § 36-2930. The specific requirements of this program are specified in A.R.S. § 36-2930 and have been clarified in rule.

This rulemaking is exempt from the provisions of Title 41, Chapter 6 under Laws 2006, Ch. 373, §3.

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

The Administration did not review any study relevant to this rule.

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

Not applicable

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

Not applicable

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

Not applicable

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

COMMENTS	AHCCCS RESPONSE TO THE COMMENTS
Participants expressed concern about the exclusion of behavioral health services.	Due to the limited funding provided for the SSDI Temporary Medical Coverage Program, the AHCCCS Administration proposed to exclude behavioral health services in order to provide health coverage to the greatest number of individuals. Behavioral health services were excluded because the Arizona Department of Health Services receives funding to provide general behavioral health services as well as behavioral health services for the seriously mentally ill. In light of public comments and the possibility that members may have difficulties in receiving state funded behavioral health services, the AHCCCS Administration amended the SSDI Temporary Medical Coverage rules to include coverage of behavioral health services. The costs for the SSDI Temporary Medical Coverage Program, including the potential number of eligible persons, will be reviewed as part of the budget development process in FY 2008.
Participants inquired about the $1.00 co-payment amount.	The AHCCCS Administration selected co-payment amounts that are consistent with other AHCCCS programs.
Participants inquired about the premium calculation.	The tiered premiums are calculated based on gross household income as specified in statute.
Participants questioned the time-frame needed to complete the rulemaking process and the timing of the public hearing.	AHCCCS staff began preparing for implementation of the SSDI Temporary Medical Coverage Program prior to passage of the bill, and meetings commenced in early July to begin drafting proposed rules. Because these rules are exempt from the formal rulemaking process, AHCCCS was not required to hold a public hearing. However, a public hearing was scheduled to provide the public an opportunity to comment on the proposed rules. The SSDI Temporary Medical Coverage Program will become effective on 10/1/06, and the rules will be filed with the Secretary of State prior to the effective date. The 9/15/06 public hearing provided the AHCCCS Administration adequate time to consider and address the comments that were presented.

A participant shared experiences of individuals losing AHCCCS coverage during medical treatments and thanked the Agency for working together to implement the SSDI Temporary Medical Coverage Program. Other participants thanked the Agency for implementing the program to assist individuals who lost their healthcare coverage due to their SSDI payments.	The AHCCCS Administration thanked the participants for their support of the SSDI Temporary Medical Coverage Program and the efforts of the AHCCCS Administration.

12. Any other matters prescribed by statute that are applicable to the specific agency or to any specific rule or class of rules:
Not applicable

13. Incorporations by reference and their location in the rules:
No incorporations by reference

14. Was this rule previously adopted as an emergency rule?
No

15. The full text of the rules follows:

TITLE 9. HEALTH SERVICES

CHAPTER 22. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION

ARTICLE 16. ~~REPEALED~~ SOCIAL SECURITY DISABILITY INSURANCE - TEMPORARY MEDICAL COVERAGE

Section
R9-22-1601. ~~Repealed~~ General Information
R9-22-1602. ~~Repealed~~ Ineligible Person
R9-22-1603. ~~Repealed~~ Definitions
R9-22-1604. ~~Repealed~~ Effective Date of Eligibility for Services
R9-22-1605. ~~Repealed~~ Services
R9-22-1606. ~~Repealed~~ Application Process
R9-22-1607. ~~Repealed~~ Withdrawal
R9-22-1608. ~~Repealed~~ Assignment of Rights Under Operation of Law
R9-22-1609. ~~Repealed~~ General Eligibility Criteria
R9-22-1610. ~~Repealed~~ Changes/Redetermination
R9-22-1611. ~~Repealed~~ Copayments
R9-22-1612. ~~Repealed~~ Resources
R9-22-1614. ~~Repealed~~ Confidentiality and Safeguarding of Information
R9-22-1615. ~~Repealed~~ Notice Requirements
R9-22-1616. ~~Repealed~~ Calculating the Monthly Income for Determining the Premium Amount
R9-22-1618. ~~Repealed~~ General Provisions related to Premiums
R9-22-1619. ~~Repealed~~ Request for Hearing Process

ARTICLE 16. ~~REPEALED~~ SOCIAL SECURITY DISABILITY INSURANCE - TEMPORARY MEDICAL COVERAGE

R9-22-1601. ~~Repealed~~ General Information

A. The Administration shall administer the program as specified in A.R.S. § 36-2930.

B. Operational Authority. The Director has full operational authority to adopt rules or to use the appropriate rules for the development and management of an eligibility and enrollment system as specified in A.R.S. § 36-2930.

C. Expenditure limit and enrollment

1. All applicants must enroll in a capitated health plan as specified in A.R.S. § 36-2930 (C).
2. The Administration will accept enrollees subject to the availability of funds. If the Director determines that monies may be insufficient for the program, the Administration shall stop processing applications for the program as specified in A.R.S. § 36-2930.

3. If the Administration stops processing an application because the monies are insufficient as specified in this Section, the Administration shall place an applicant on a waiting list and notify the applicant.
4. After the Administration has verified that funding is sufficient, it will resume processing applications as specified in A.R.S. § 36-2930.

R9-22-1602. ~~Repealed~~ Ineligible Person

A person is not eligible for coverage under this Article if the person is an inmate of a public institution.

R9-22-1603. ~~Repealed~~ Definitions

In addition to the definitions contained in this Chapter, the words and phrases in this Article have the following meaning unless the context explicitly requires another meaning:

"Child" means a person less than 18 years old or an unborn child.

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

"Income" means the total gross amount of all money received by or directly deposited into a financial account of a member of the household income group as specified in R9-22-1616.

"Monthly equivalent" means a monthly income amount established by averaging, prorating, or converting a person's income.

"Monthly income" means the gross income received or projected to be received during the month or the monthly equivalent.

"Parent" means a biological, adoptive, or step-parent.

"Premium" means a monthly payment that an enrolled member pays to the Administration to remain eligible.

"SSDI Temporary Medical Coverage" means Social Security Disability Insurance Temporary Medical Coverage

R9-22-1604. ~~Repealed~~ Effective Date of Eligibility for Services

Effective date of initial enrollment:

1. For an eligibility determination completed by the 25th day of the month, enrollment shall begin on the first day of the month following the determination of eligibility.
2. For an eligibility determination completed after the 25th day of the month, enrollment shall begin on the first day of the second month following the determination of eligibility.

R9-22-1605. ~~Repealed~~ Services

The Administration shall cover medically necessary services under 9 A.A.C. 22, Article 2, for a member, subject to the limitations and exclusions specified in Article 2, unless otherwise specified in this Chapter.

R9-22-1606. ~~Repealed~~ Application Process

A. Availability. The Administration shall make available program applications. Any person may request a program application.

B. Who may apply for a person. The provisions in R9-22-1406 (B) apply to this Article.

C. An application is completed and submitted to the Administration:
1. In person,
2. By mail,
3. By fax, or
4. By other form approved by the Administration

D. Date of application. The date of application is the date the Administration receives an application that:
1. Is signed and dated by the person making the application,
2. Includes the legible name of the person for whom assistance is requested, and
3. Includes the address or location of the person submitting the application.

E. Completed Application.
1. The provisions in R9-22-1406(E) apply to this Section.
2. The Administration shall consider an application complete when:
   a. All questions are answered,
   b. An enrollment choice is included, and
   c. All necessary verification is provided by an applicant or an applicant's representative.
3. If the application is incomplete, the Administration shall do one or both of the following:
   a. Contact an applicant or an applicant's representative by telephone to obtain the missing information required for an eligibility determination;
   b. Mail a request for additional information to an applicant or an applicant's representative, allowing 10 days from the date of the request to provide the required additional information;
   c. An applicant shall provide the Administration with all requested information within 10 days from the date of the written request for the information. If an applicant fails to provide the requested information and fails to request an extension of the 10 day period or the request for extension is denied, the Administration shall deny eligibility.

F. Eligibility determination. When an application is complete, the Administration shall mail notification to the applicant regarding the eligibility determination.

R9-22-1607. ~~Repealed~~ Withdrawal

A. An applicant or member may withdraw from AHCCCS medical coverage at any time by giving oral or written notice of withdrawal to the Administration. The applicant, member, applicant's legal or authorized representative, or member's legal or authorized representative shall provide the Administration with:
1. The reason for the withdrawal,
2. The date the notice is effective, and
3. The name of the applicant or member for whom AHCCCS medical coverage is being withdrawn.

B. The Administration shall notify the applicant or member of the discontinuance as required by R9-22-1615.

R9-22-1608. ~~Repealed~~ Assignment of Rights Under Operation of Law

A person shall assign rights to the system of all types of medical benefits to which the person is entitled.

R9-22-1609. ~~Repealed~~ General Eligibility Criteria

A. To be eligible for this program:
1. An applicant must have received Medicaid coverage, pursuant to A.R.S. §§ 36-2901 paragraph 6 and 36-2931 paragraph 5, within the 24-month period prior to application for this program.
2. The applicant is not receiving healthcare coverage from Health Care Group pursuant to A.R.S. § 36-2912.
3. The applicant or member must apply for and comply with the Title TXIX or Title TXXI programs if an applicant or member screens potentially eligible for any Title TXIX or Title TXXI programs.
4. An applicant or member is eligible for SSDI under 42 U.S.C. 423 and is not eligible for Medicare benefits under 42 U.S.C. 426 (b) or 426-1.
5. An applicant or member shall not have creditable coverage as specified in 42 USC 300gg(c).

B. Social Security Number. An applicant applying under this Article shall furnish a SSN or apply for one.

C. State residency. An applicant or member is not eligible unless the person is a resident of Arizona as specified under A.R.S. § 36-2930.

D. Citizenship and immigrant status. An applicant or a member is not eligible for coverage under this Article unless the applicant or member is a citizen of the United States or is a qualified alien under A.R.S. § 36-2903.03(B).

E. Applicant and member responsibility. As a condition of eligibility, an applicant and a member shall:
1. Authorize the Administration to obtain verification of information for initial or continued eligibility;
2. Give the Administration complete and truthful information. The Administration may deny an application or discontinue eligibility if:
   a. The applicant or member fails to provide information necessary for initial or continuing eligibility;
   b. The applicant or member fails to provide the Administration with written authorization to permit the Administration to obtain necessary verification;
   c. The applicant or member fails to provide verification after the Administration had made an effort to obtain the necessary verification but has not obtained the necessary information; or
   d. The applicant or member does not assist the Administration in resolving incomplete, inconsistent, or unclear information that is necessary for initial or continuing eligibility; and
3. Provide information concerning third-party coverage for medical care.
4. A member must notify the Administration when the member becomes eligible for Medicare benefits under 42 U.S.C. 426 (b) or 426-1. When the member becomes eligible for Medicare benefits, the member is ineligible for coverage under this Article.

F. Verification of eligibility information.
1. The applicant or member has the primary responsibility to provide the Administration with verification of all information necessary to complete the determination of eligibility.
2. The Administration shall provide an applicant or a member no less than 10 days following the date of written request for the information to provide required verification. If an applicant or member does not provide the required information timely, the Administration may deny the application or discontinue eligibility.

R9-22-1610. ~~Repealed~~ Changes/Redetermination

A. Reporting Changes. A member or a member's representative shall report the following changes within 10 days to the Administration:
1. Any change in income that will begin or continue into the following month,
2. Any change of address,
3. The addition or departure of a household member,
4. Creditable health coverage under private or group health insurance,
5. Receipt of Medicare Benefits, and
6. Incarceration of a member or placement in a public institution.

B. Verification. If required verification is needed and requested as a result of a change specified in subsection (A) of this Section to determine the impact on eligibility and is not received within 10 days, the Administration shall discontinue eligibility and send a notice of adverse action to the member.
C. Redetermination. If no change is reported, the Administration shall initiate an annual redetermination.
D. Termination. If the Administration determines that a member no longer meets the eligibility or premium criteria, the Administration shall terminate coverage.

R9-22-1611. ~~Repealed~~ Copayments
A. Except for a member receiving behavioral health services or a Native American, a member is subject to the copayments as specified in R9-22-711(D).
B. The provider shall not deny a service because of the member's inability to pay a copayment.

R9-22-1612. ~~Repealed~~ Resources
There is no resource test for coverage under this Article.

R9-22-1614. ~~Repealed~~ Confidentiality and Safeguarding of Information
The Administration shall maintain the confidentiality of an applicant's or member's records and limit the release of information as specified under R9-22-512.

R9-22-1615. ~~Repealed~~ Notice Requirements
A. Upon completion of a determination or redetermination of eligibility for an applicant or member, the Administration shall issue a written notice to an individual who initiated the application. This notice shall include a statement of the intended action, an explanation of a person's hearing rights as specified in 9 A.A.C. 34, Article 1, and:
1. If approved, the notice shall contain the name and effective date of eligibility for the approved applicant;
2. If denied, the notice shall contain:
   a. The name of the ineligible applicant,
   b. The effective date of the denial,
   c. The reasons for ineligibility,
   d. The legal authority supporting the reason for ineligibility, and
   e. The resource or reference materials where the legal authority citations are found.

B. Discontinuance.
1. When the Administration discontinues a member's eligibility, the Administration shall provide a member with:
   a. Advance notice at least 10 days before the effective date of the adverse action except as provided in subsection (B)(1)(b).
   b. Adequate notice no later than the date of adverse action when a member:
      i. Voluntarily withdraws and indicates an understanding of the results of the action,
      ii. Becomes an inmate of a public institution as specified in R9-22-1606 (F),
      iii. Dies and the Administration has verification of the death,
      iv. Has whereabouts that are unknown and the Administration's loss of contact is confirmed by returned mail from the post office with no forwarding address,
      v. Is approved for Title XIX, Title XXI, or HCG.
      vi. Becomes eligible for Medicare benefits.
2. In addition to the requirements listed in subsection (A)(2), the termination notice shall include an explanation of a member's right to continued coverage pending a request for hearing as provided in 9 A.A.C. 34, Article 1.

C. Premium Change.
1. When the Administration receives information that increases a member's premium amount, the Administration shall provide the member with:
   a. Advance notice at least 10 days before the effective date of the adverse action.
   b. The reason for the increase in premium including appropriate income calculations and income standard, and
   c. An explanation of the member's hearing rights as specified in 9 A.A.C. 34, Article 1.
2. When the Administration receives information that decreases a member's premium amount, the Administration shall provide the member with notice of the decrease.

R9-22-1616. ~~Repealed~~ Calculating the Monthly Income for Determining the Premium Amount
A. The Administration shall count gross household income.
B. The person(s) whose income is counted. The following persons, when residing together, constitute a household income group whose income is counted:
1. The applicant;
2. A child of the applicant;
3. A stepchild of the applicant;
4. The spouse of the applicant; and
5. The other parent of any of the applicant's children.

C. The Administration shall consider the following factors when determining the income period to use to determine monthly income:
1. Type of income,
2. Frequency of income,
3. If source of income is new or terminated, or
4. Income fluctuation.

D. Methods for Calculating the Monthly Income
1. Projecting income.
   a. Description. Projecting income is a method of determining the amount of income that a person will receive.
   b. Calculation. The Administration shall project income by:
      i. Converting income to a monthly equivalent,
      ii. Using unconverted income, or
      iii. Prorating income to determine a monthly equivalent.
   c. Exclusion. When calculating projected monthly income, the Administration shall exclude an unusual variation in income under subsection (F)(5), except for a month in which the variation is anticipated to occur.
2. Averaged income.
   a. Description. Averaging income proportionally distributes the person's income received on a regular basis.
   b. Calculation. To average income, the Administration shall add the amount of the income and divide by the total number of pay periods. If the amount of income received per pay period fluctuates, and the fluctuation is expected to continue, the Administration shall:
      i. Use the averaged weekly or bi-weekly amounts to convert weekly or bi-weekly income to a monthly equivalent;
      ii. Use the averaged monthly or semi-monthly amounts to project monthly income; and
      iii. Use the averaged hours worked and multiply the average by the current rate of pay. If there is a change in the rate of pay, use the new rate of pay when calculating projected income under subsection (D)(1).
3. Prorated income.
   a. Description. Prorated income evenly distributes a person's income over the period the income is intended to cover to calculate a monthly equivalent.
   b. Calculation. To prorate income, the Administration shall divide the total amount of the person's income received during the period by the number of months that the income is intended to cover.
4. Converted income.
   a. Description. Converted income is income received weekly or biweekly that is changed to a monthly equivalent.
   b. Calculation.
      i. The Administration shall average the weekly or bi-weekly income amounts before converting to the monthly equivalent if the person's past income fluctuates and the fluctuation is expected to recur.
      ii. To convert income paid weekly to a monthly equivalent, the Administration shall multiply the weekly average by 4.3 weeks.
      iii. To convert income paid bi-weekly to a monthly equivalent, the Administration shall multiply the bi-weekly average by 2.15 weeks.
5. Unconverted income.
   a. Description. Unconverted income is the actual amount of income received or projected to be received during a month.
   b. Calculation. The Administration shall sum the actual amount of income received or projected to be received during a month.

E. Calculations and Use of Methods Listed in subsection (D) Based on Frequency of Income
1. Monthly income. If income is received monthly or in a lump sum, the Administration shall use the unconverted method for calculating monthly income.
   a. Lump sum means a nonrecurring payment that serves as a complete payment.
   b. Lump sum payments include but are not limited to: rebates or credits; inheritances; insurance settlements; and payments for prior months from such sources as Social Security, Veterans Administration, Railroad Retirement, child support arrearages, or other benefits.
   c. A lump sum payment may include a portion intended for the current month.
2. Weekly income. If income is received weekly, the Administration shall convert the income to a monthly equivalent under subsection (D)(4).
3. Bi-weekly income. If income is received bi-weekly, the Administration shall convert the income to a monthly equivalent under subsection (D)(4).
4. Semi-monthly or daily income. If income is received semi-monthly or daily, the Administration shall use the unconverted method for calculating monthly income under subsection (D)(5).
5. Bimonthly, quarterly, semi-annual, or annual income. If income is received bimonthly, quarterly, semi-annually, or

annually, the Administration shall prorate the income received or projected to be received under subsection (D)(3).

F. Use of Methods Listed in subsection (E) Based on Type of Income

1. New income.
   a. Description. New income is income received from a new source during the first calendar month that the income is received from the source.
   b. Calculating monthly income.
      i. If a full month's income is received, the Administration shall use the appropriate method described in subsection (E) to calculate the monthly income.
      ii. If less than a full month's income is received, the Administration shall use the unconverted method to calculate the monthly income.
2. Terminated income.
   a. Description. Terminated income is income received during the last calendar month that income is received from a source when no more income is expected to be received from the source.
   b. Calculating monthly income.
      i. If a full month's income is received, the Administration shall use the appropriate method described in subsection (E) to calculate the monthly income.
      ii. If less than a full month's income is received, the Administration shall use the unconverted method to calculate the monthly income.
3. Break in income.
   a. Description. A break in income is a break in established frequency of income of one calendar month or more.
   b. Calculating monthly income.
      i. If a full month's income is received, the Administration shall use the appropriate method described in subsection (E) to calculate the monthly income.
      ii. If less than a full month's income is received, the Administration shall use the unconverted method to calculate the monthly income.
4. Contract income.
   a. Description. Contract income is income a person earns under a contract or other legal document that specifies a length of time the contract or legal document covers, the amount of income to be paid, and the frequency of payment.
   b. Calculating monthly income.
      i. The Administration shall calculate the monthly income based on the frequency of payment if income is paid more frequently than monthly.
      ii. The Administration shall prorate over the period of time specified by the contract if income is paid monthly or less frequently.
5. Unusual variation in the amount of income.
   a. Description. Unusual variation is an amount of income that is different from the established amount received and is not projected to continue or recur.
   b. Calculating monthly income.
      i. When calculating income for the month in which an unusual variation in income occurs, the Administration shall include the unusual variation in the income calculation.
      ii. When an unusual variation in income occurs during the month, the Administration shall use the converted method for calculating monthly income if income is received weekly or bi-weekly.
      iii. When projecting income for the months following the month in which the unusual variation occurs, the Administration shall exclude the unusual variation in income from the income calculation.
6. Self-employment income.
   a. Description. Self-employment income is income a person earns from the person's own trade or business less allowable expenses.
   b. Calculating monthly income. The Administration shall use the following methods in the following order:
      i. When the self-employed person filed a tax return for the prior year and the person states that the current income is the same, the Administration shall prorate the income under subsection (D).
      ii. When the self-employed person did not file a tax return for the prior year or states that the current income is not the same, the Administration shall use the person's business ledger or other records to verify the current income received, less allowable expenses and use the appropriate method described in subsection (E) to calculate the monthly income.
      iii. When the self-employed person did not file a tax return or keep business records of the income received and expense incurred during the income period, the Administration shall use the person's written statement to verify income received, shall not deduct incurred expenses from the income without hard-copy verification of the expense, and shall use the appropriate method described in subsection (E) to calculate the monthly income.

R9-22-1618. ~~Repealed~~ General Provisions related to Premiums

A. For the purpose of this Section:
1. To remain eligible, all members shall pay the premium amounts specified in this Section.
2. Failure to pay two months' premiums by the last working day of the second month of non-payment shall result in discontinuance of benefits under this Article.

B. Premiums
1. When household income is 100 percent and less than or equal to 150 percent of the FPL, the monthly premium for each eligible member is $60 per month.
2. When household income is greater than 150 percent of the FPL and less than or equal to 200 percent of the FPL, the monthly premium for each eligible member is $120 per month.
3. When household income is greater than 200 percent of the FPL and less than or equal to 250 percent of the FPL, the monthly premium for each eligible member is $180 per month.
4. When household income is greater than 250 percent of the FPL and less than or equal to 300 percent of the FPL, the monthly premium for each eligible member is $240 per month.
5. When household income is greater than 300 percent of the FPL, the monthly premium for each eligible member is $300 per month.

C. Payment Due Date for Current Month. The monthly premium payment is due on the 15th day of the month for coverage of that month. This would be considered a current payment.

D. Payment Received Date. A payment is considered received on the date that the Administration receives and credits the payment to the member's account.

E. Past Due Payment
1. Past due payment date. A payment is considered past due if the Administration does not receive the full payment by the 15th day of the month in which the payment is due.
2. Payment not received. If payment for a month is not received in full by the last working day of the month in which the payment is due, the Administration shall include the past and current due amounts in the next billing statement.

F. Payment Type. A premium shall be paid to the Administration by a:
1. Cashier's check,
2. Personal check,
3. Money order,
4. Electronic debit, or
5. Other form approved by the Administration.

G. Insufficient Funds. The Administration shall not accept a personal check or electronic debit when the premium has been previously paid with a personal check or electronic debit that was returned to the Administration because of insufficient funds.

H. Payment In Advance. A premium may be paid in advance.

I. Reimbursement of a Premium
1. A premium paid in advance is nonrefundable, unless the member is disenrolled at least 15 days prior to the month of coverage.
2. A premium paid during an appeal and request for hearing process is applied as specified in R9-22-1619.

J. Change in Premium Amount.
1. When there is a decrease in the amount of the member's premium the decrease is effective the month following receipt of verification of the income decrease.
2. When there is an increase in the amount of the member's premium, the member receives advance notice. The premium increase is effective the first month following the month in which 10 day advance notice is issued.

K. Payment of Outstanding Premium and Enrollment Fee owed to the Administration.
1. As a condition of eligibility, an applicant or member shall pay any unpaid premiums and enrollment fees owed to the Administration that were previously incurred. The unpaid premiums and enrollment fees consist of:
   a. All unpaid premiums and enrollment fees for any AHCCCS program that the applicant incurred prior to becoming eligible, and
   b. All unpaid premiums for the applicant's children.
2. Allocation of Outstanding Payments. All payments received for eligible members shall first be applied to any past due amounts for prior months owed to the Administration. Any remaining amounts shall first be applied to the amount due for the current month for a person, eligible under this Article.

R9-22-1619. ~~Repealed~~ Request for Hearing Process

A. Denial. If the Administration denies a member under R9-22-1615, a request for hearing process shall be conducted under 9 A.A.C. 34.

B. Discontinuance. If the Administration discontinues a member under R9-22-1615, the request for hearing process shall be conducted under 9 A.A.C. 34.

C. Discontinuance for Non-Payment of Premiums. Except as provided in this Section, the Administration shall discontinue

eligibility on the effective date of the discontinuance if the past due amount for at least one prior month is not received by the Administration in full before the effective date of the discontinuance.

D. Reinstatement of Coverage. The Administration shall rescind the discontinuance and continue eligibility if the past due amount for at least one prior month is received by the Administration in full before the effective date of the discontinuance.

E. Continuation of Coverage during the request for hearing process. To receive coverage from the time a Director's decision is issued, except as specified in subsection (E)(3).

1. A member shall:
   a. File a request for hearing prior to the effective date of the discontinuance.
   b. Submit the full monthly premium amount to the Administration prior to the date of the discontinuance, and
   c. Continue to timely pay the full monthly premium amount each month during the hearing process.
2. If the decision is upheld, the Administration shall not refund any premium amounts that have been paid during the hearing process.
3. A member must notify the Administration when the member becomes eligible for Medicare benefits under 42 U.S.C. 426 (b) or 426-1. When the member becomes eligible for Medicare benefits, the member is ineligible for continuation of coverage.

F. Increase in premium amount. To stop the Administration from increasing the premium amount from the time request for hearing is filed until a Director's decision is issued:

1. A member shall file a request for hearing prior to the effective date of the action as specified in 9 A.A.C. 34.
2. If the decision to increase the premium is upheld, the member shall be responsible for paying the higher premium retroactively from the proposed effective date of the increase in the premium amount that is being appealed.

G. Method of payment during the hearing process. To continue coverage a member shall pay the premium by:

1. Cashier's check,
2. Money order, or
3. Other form approved by the Administration.