

NOTICE OF FINAL RULEMAKING

TITLE 9. HEALTH SERVICES

CHAPTER 27. ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

HEALTH CARE GROUP COVERAGE

PREAMBLE

<u>1. Article, Part, or Section Affected (as applicable)</u>	<u>Rulemaking Action:</u>
CHAPTER 27	Repeal
ARTICLE 1	Repeal
R9-27-101	Repeal
ARTICLE 2	Repeal
R9-27-202	Repeal
R9-27-203	Repeal
R9-27-204	Repeal
R9-27-210	Repeal
ARTICLE 3	Repeal
R9-27-301	Repeal
R9-27-302	Repeal
R9-27-303	Repeal
R9-27-307	Repeal
R9-27-310	Repeal
R9-27-311	Repeal
R9-27-312	Repeal
ARTICLE 5	Repeal
R9-27-509	Repeal
ARTICLE 7	Repeal
R9-27-702	Repeal
R9-27-703	Repeal

2. Citations to the agency’s statutory rulemaking authority to include both the authorizing statute (general) and the implementing statute (specific):

Authorizing statute: A.R.S. § 36-29~~03.0142~~

Implementing statute: A.R.S. § 36-2912.01 and Laws 2013, First Special Session, Chapter 10, §§ 8 and 42

3. The effective date of the rule:

The agency selected an effective date of 60 days from the date of filing with the Secretary of State as specified in A.R.S. § 41-1032(A).

4. Citations to all related notices published in the Register to include the Register as specified in R1-1-409(A) that pertain to the record of the final rulemaking package:

Notice of Rulemaking Docket Opening: 19 A.A.R. 3582, November 15, 2013

Notice of Proposed Rulemaking: 19 A.A.R. 3561, November 15, 2013

5. The agency’s contact person who can answer questions about the rulemaking:

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6. An agency’s justification and reason why a rule should be made, amended, repealed or renumbered, to include an explanation about the rulemaking:

The Administration is proposing repealing the HCG program rules since the program ceased to operate as of December 31, 2013. The HCG program has been impacted by the changes made from the Affordable Care Act: both the increase in the percentage of the federal poverty level that qualifies individuals for Medicaid (AHCCCS) and the availability of

individual and small group health care coverage through the Exchange operated by the federal government make health insurance more available to persons who would have been covered under the HCG program.

Laws 2013, First Special Session, Ch. 10 § 42, prohibited the Administration from enrolling any new businesses or new employees to an existing Geographical Service Area (GSA) into the Healthcare Group program. Laws 2013, First Special Session, Ch. 10 § 8 repealed the HCG program (by repealing A.R.S. §§ 36-2912, 36-2912.02, 36-2912.03, and 36-2912.04) effective from and after December 31, 2013 which requires this rulemaking to repeal the rules that implemented the HCG program.

This provision is necessary to comply with state requirements that contain dates certain for compliance (that is, the December 31, 2013 repeal of the program). The HCG program as described under A.R.S. § 36-2912 and ceased to exist January 1, 2014. New enrollment into HCG program ceased August 1, 2013.

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

A study was not referenced or relied upon when repealing the HCG coverage rules.

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

Not applicable.

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

The HCG program has been repealed from and after December 31, 2013. The HCG program was self-sustained through the premiums collected from participating employers. Individuals and small employer-based groups who were covered under the HCG program will be able to obtain health insurance on a guaranteed, community rated basis through the Exchange operated by the federal government and may qualify for advanced premium tax credits

through the Exchange. There were 1787 employer groups covering 5203 members (counting dependents) enrolled as of December, 2013.

The Administration believes most of these groups/members will qualify for health care coverage through the Health Care Exchange and benefit from the tax subsidies. And as a result, little to no impact is expected on small business and consumers; they will pay premiums (and in some cases subsidized premiums) to private insurers through the federally-operated Exchange rather than to the Healthcare Group program.

10. A description of any changes between the proposed rulemaking, to include supplemental notices, and the final rulemaking:

No **significant** changes were made between the proposed rulemaking and the final rulemaking.

11. An agency's summary of the public or stakeholder comments made about the rulemaking and the agency response to the comments:

No comments were received as of the close of the comment period of December 30, 2013.

12. All agencies shall list other matters prescribed by statute applicable to the specific agency or to any specific rule or class of rules. Additionally, an agency subject to Council review under A.R.S. §§ 41-1052 and 41-1055 shall respond to the following questions:

No other matters are applicable.

a. Whether the rule requires a permit, whether a general permit is used and if not, the reasons why a general permit is not used:

Not applicable.

b. Whether a federal law is applicable to the subject of the rule, whether the rule is more stringent than federal law and if so, citation to the statutory authority to exceed the requirements of federal law:

Not applicable.

c. Whether a person submitted an analysis to the agency that compares the rule's impact of the competitiveness of business in this state to the impact on business in other states:

No analysis was submitted.

13. A list of any incorporated by reference material as specified in A.R.S. § 41-1028 and its location in the rule:

None

14. Whether the rule was previously made, amended or repealed as an emergency rule. If so, cite the notice published in the Register as specified in R1-1-409(A). Also, the agency shall state where the text was changed between the emergency and the final rulemaking packages:

Not applicable.

15. The full text of the rules follows:

NOTICE OF FINAL RULEMAKING
TITLE 9. HEALTH SERVICES
CHAPTER 27. ~~ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM~~
~~HEALTHCARE GROUP COVERAGE~~ Repeal

ARTICLE 1. ~~DEFINITIONS~~ Repeal

Section

R9-27-101. ~~Location of Definitions~~ Repeal

ARTICLE 2. ~~SCOPE OF SERVICES~~ Repeal

Section

R9-27-202. ~~Covered Services~~ Repeal

R9-27-203. ~~Exclusions and Limitations~~ Repeal

R9-27-204. ~~Emergency Medical Services~~ Repeal

R9-27-210. ~~Pre-existing Conditions~~ Repeal

ARTICLE 3. ~~ELIGIBILITY AND ENROLLMENT~~ Repeal

Section

R9-27-301. ~~Eligibility Criteria for Employers~~ Repeal

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

R9-27-303. ~~Dependent Eligibility Criteria~~ Repeal

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

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

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

R9-27-312. ~~Continuation Coverage~~ Repeal

ARTICLE 5. ~~GENERAL PROVISIONS AND STANDARDS~~ Repeal

Section

R9-27-509. ~~Information to Subscribers~~ Repeal

~~ARTICLE 7. STANDARDS FOR PAYMENTS~~ Repeal

Section

R9-27-702. ~~Charges to Members~~ Repeal

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

R9-27-704. ~~Liability of an HCG Plan to a Noncontracting Hospital for the Provision of
Emergency and Post-stabilization Services to Members~~ Repeal

ARTICLE 1. DEFINITIONS Repeal

R9-27-101. Location of Definitions Repeal

A. ~~Location of definitions. Definitions applicable to this Chapter are found in the following:~~

~~Definition Section or Citation~~

~~"Accountable health plan" A.R.S. § 20-2301~~

~~"ADHS" R9-27-101~~

~~"AHCCCS" R9-27-101~~

~~"Ambulance" A.R.S. § 36-2201~~

~~"Certification" 29 U.S.C. 1181~~

~~"Clean claim" A.R.S. § 36-2904~~

~~"COBRA continuation provisions" A.R.S. § 36-2912~~

~~"Coinsurance" R9-27-101~~

~~"Copayment" R9-27-101~~

~~"Covered services" R9-27-101~~

~~"Creditable coverage" A.R.S. § 36-2912~~

~~"Day" R9-27-101~~

~~"Deductible" R9-27-101~~

~~"Dependent" R9-27-101~~

~~"Disability" R9-27-303~~

~~"Effective date of coverage" R9-27-101~~

~~"Eligible employee" A.R.S. § 36-2912~~

~~"Emergency ambulance service" R9-27-101~~

~~"Emergency medical services" R9-27-101~~

~~"Employee" R9-27-101~~

~~"Employer" R9-27-101~~

~~"Employer group" R9-27-101~~

~~"Enrollment" R9-27-101~~

~~"Experimental services" R9-27-101~~

~~"Full-time employee" R9-27-101~~

~~"GSA" R9-27-101~~

~~"HCG" R9-27-101~~
~~"HCGA" R9-27-101~~
~~"HCG plan" R9-27-101~~
~~"Health care coverage" R9-27-101~~
~~"Health care practitioner" R9-27-101~~
~~"Hospital" R9-27-101~~
~~"Inpatient hospital services" R9-27-101~~
~~"Late enrollee" R9-27-101~~
~~"Medical services" A.R.S. § 36-401~~
~~"Medically necessary" R9-27-101~~
~~"Member" R9-27-101~~
~~"Member handbook and evidence of coverage" R9-27-101~~
~~or "member handbook"~~
~~"Network" R9-27-101~~
~~"Network provider" R9-27-101~~
~~"Political subdivision" R9-27-101~~
~~"Post-stabilization services" R9-27-101~~
~~"Pre-existing condition" A.R.S. § 36-2912~~
~~"Pre-existing condition exclusion" A.R.S. § 36-2912~~
~~"Premium" R9-27-101~~
~~"Pre-payment" R9-27-101~~
~~"Prior authorization" R9-27-101~~
~~"Qualifying event" R9-27-101~~
~~"Scope of services" R9-27-101~~
~~"Spouse" R9-27-101~~
~~"Subcontract" R9-27-101~~
~~"Subscriber" R9-27-101~~
~~"Subscriber enrollment form" R9-27-101~~
~~"Substantial gainful activity" R9-27-303~~
~~"United States" R9-27-101~~
~~"Waiting period" A.R.S. § 36-2912~~

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

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

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

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

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

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

"Day" means a calendar day unless otherwise specified.

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

"Dependent" means the eligible child and spouse of a subscriber under Article 3 of this Chapter.

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

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

"Emergency medical services" means covered medical services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of

~~health and medicine, may reasonably expect the absence of immediate medical attention to result in:~~

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

~~Serious impairment to bodily functions, or~~

~~Serious dysfunction of any bodily organ.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~Coverage that is issued as a supplement to liability insurance;~~

~~Medicare supplemental insurance;~~

~~Workers' compensation insurance; or~~

~~Automobile medical payment insurance.~~

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

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

~~"Inpatient hospital services" means services provided to a member who is admitted to a hospital for medical care and treatment. An inpatient hospital service is provided by or~~

~~under the direction of a physician or other health care practitioner upon referral from a member's primary care provider.~~

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

~~"Medically necessary" means a covered service is determined by the HCG Plan or HCGA Medical Director, and a physician or other licensed health care practitioner within the scope of the physician's or other health care practitioner's practice under state law to: Prevent disease, disability, or other adverse health condition or its progression; or Prolong life.~~

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

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

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

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

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

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

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

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

~~"Prior authorization" means the process by which the HCGA or the HCG Plan informs a provider that it has made a preliminary determination that a requested service is~~

~~medically necessary, appropriate, and is a covered service. Prior authorization is not a guarantee of payment.~~

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

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

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

~~"Subcontract" means an agreement entered into by HCGA or an HCG Plan with any of the following:~~

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

~~A marketing organization, or~~

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

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

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

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

ARTICLE 2. SCOPE OF SERVICES Repeal

R9-27-202. Covered Services Repeal

~~Covered services. HCGA or an HCG Plan shall provide covered services to members as specified in the GSA.~~

R9-27-203. Exclusions and Limitations Repeal

A. ~~Excluded services. An HCG Plan shall not cover the following:~~

- ~~1. Excluded services as specified in the GSA and the member handbook;~~
- ~~2. Services not covered in the member's choice of HCG benefit options;~~
- ~~3. Services that require prior authorization for which the member does not obtain prior authorization;~~
- ~~4. Care for a health condition for which a state or local law requires the member to be treated in a public facility;~~
- ~~5. Care for military service disabilities treatable through governmental facilities if the member is legally entitled to treatment and the facilities are available;~~
- ~~6. Pregnancy termination, except when required by law to be covered;~~
- ~~7. Treatment of gender dysphoria including gender reassignment surgeries and reversal of voluntarily induced infertility (sterilization);~~
- ~~8. Services that HCGA, through its Medical Director, deems not to be medically necessary;~~
- ~~9. Charges for injuries incurred as the result of:
 - ~~a. Participating in a riot,~~
 - ~~b. Committing or attempting to commit a felony or assault,~~
 - ~~c. Committing intentional acts of self-inflicted injury, or~~
 - ~~d. Attempting suicide.~~~~
- ~~10. Infertility testing, in vitro fertilization, and all other fertilization treatments;~~
- ~~11. Experimental services; and~~
- ~~12. Medications not approved by the FDA.~~

B. ~~Limitations. When providing covered services, the HCG Plan shall adhere to the coverage limitations in this Article and the following:~~

- ~~1. Inpatient hospital accommodations are covered as specified in the GSA and the member handbook.~~
- ~~2. Alternative levels of care instead of hospitalization are covered if cost-effective and medically necessary.~~
- ~~3. Dialysis is limited to services not covered by Title XVIII, of the Social Security Act, as amended.~~

R9-27-204. Emergency Medical Services Repeal

- ~~A. Emergency medical services provided at a medical facility in the United States are covered when a member presents for emergency medical services regardless of whether the services are provided within or outside the network if the member or provider notifies the selected HCG Plan no later than 48 hours from the day that the member presents for the emergency service. Failure to provide timely notice constitutes cause for denial of payment unless the member or provider shows good cause. All emergency medical services are subject to review after services are received to ensure that the services are emergent and are covered, medically necessary services.~~
- ~~B. Emergency medical services provided outside the United States are not covered.~~

R9-27-210. Pre-existing Conditions Repeal

- ~~A. Pre-existing conditions exclusions. Except as provided in subsection (B), any health and medical services related to a pre-existing condition are not covered as specified in A.R.S. § 36-2912 and the GSA.~~
- ~~B. Pre-existing conditions coverage. Health and medical services relating to pre-existing conditions for the following individuals are covered:
 - 1. Newborns from the time of birth, adopted children, and children placed for adoption, if enrolled within the time frames set forth in the GSA;
 - 2. A subscriber eligible under R9-27-302 who meets the aggregate periods of creditable coverage as calculated under A.R.S. § 36-2912 of 12 months or 18 months in the case of a late enrollee.~~
- ~~C. Credit for prior health coverage. A member shall receive a credit toward meeting the 12-month or 18-month pre-existing condition exclusion period of one month for each month of continuous coverage that a member received from HCG/HCGA or an accountable health plan under A.R.S. § 36-2912. Upon request, an HCG Plan that provided continuous coverage to a person shall disclose the coverage provided.~~

ARTICLE 3. ELIGIBILITY AND ENROLLMENT Repeal

R9-27-301. Eligibility Criteria for Employers Repeal

~~A. Criteria for employers:~~

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

~~B. Employer's prior health care coverage. HCGA shall not enroll an employer in Healthcare Group sooner than 180 days after the date that the employer's health care coverage under an accountable health plan is discontinued. An employer's enrollment in HCG is effective on the first day of the month after the 180-day period. The 180-day enrollment restriction does not apply to an employer if the employer's accountable health plan discontinues offering the health plan of which the employer is a member.~~

~~C. Required initial enrollment of a minimum percentage of eligible employees. An employer other than a political subdivision shall meet the following enrollment percentages on the effective date of the first GSA with HCGA:~~

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

~~D. Full time employees with proof of other health care coverage. Full time employees with proof of existing health care coverage who elect not to participate in HCG shall not be considered when determining the required percentage of enrollees, specified in subsection (C), if the health care coverage is one of the following:~~

- ~~1. Group coverage provided through a spouse, parent, legal guardian; or~~
- ~~2. Medical assistance provided by a government subsidized health care program; or~~
- ~~3. Medical assistance provided under A.R.S. § 36-2982; or~~
- ~~4. Individual coverage or health care coverage through another employer.~~

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

~~F. Review and verification of eligibility. HCGA may conduct random reviews for continued eligibility of an employer and the members.~~

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

~~A. Eligibility criteria for employees. An eligible employee shall:~~

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

~~B. Enrollment criteria for eligible employees. An eligible employee and an eligible dependent may receive HCG coverage if all of the following occur:~~

- ~~1. An eligible employee selects health care coverage through HCG;~~
- ~~2. An eligible employee completes and submits all necessary documentation specified by HCGA, including the subscriber enrollment form and health history forms; for the eligible employee and each applying family member; and~~
- ~~3. HCGA receives the full required premium no later than the date specified in the GSA.~~

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

~~D. Eligibility for government subsidized health care programs. HCGA shall provide written information to members who may be eligible for a government subsidized health care program.~~

R9-27-303. Dependent Eligibility Criteria Repeal

~~A. Eligible dependents. An eligible dependent of an employee member includes:~~

- ~~1. A legal spouse;~~
- ~~2. An unmarried child less than the age of 19 or less than the age of 24 if the child is a full-time student, and is:~~
 - ~~a. A natural child,~~
 - ~~b. An adopted child or a child who is placed for adoption,~~

- e. A step child, or
- d. A child for whom the subscriber or enrolled spouse is a legal guardian.
- 3. ~~An unmarried child, as specified in subsection (A)(2), of any age with a disability that existed before the child's 19th birthday, as determined by HCGA through the HCGA Medical Director.~~

B. For the purposes of this Section:

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

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

A. ~~Enrollment. A member who meets the eligibility requirements may select and enroll in HCG coverage under the terms of the GSA at any time. In order not to be considered a late enrollee, an eligible member shall enroll during the qualifying event periods specified in the GSA:~~

- 1. ~~Within 31 days following the effective date of the initial GSA with the employer;~~
- 2. ~~Within 31 days after the qualifying event occurs;~~
- 3. ~~When the open enrollment period occurs as specified in the GSA; or~~
- 4. ~~Within 31 days following the termination of health care coverage for an eligible subscriber or dependent.~~

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

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

- ~~A. Immediate termination of a member's coverage. HCGA may terminate a member's coverage effective immediately for any of the following reasons:~~
- ~~1. Clear and convincing evidence of fraud or misrepresentation regarding enrollment or factors listed in A.R.S. § 36-2912 when the member applies for coverage or obtains services;~~
 - ~~2. Committing or threatening to commit violence toward an employee or an agent of HCGA, an employee or an agent of an HCG Plan, including a network provider or an out-of-network provider.~~
- ~~B. Written notice. For immediate termination of a member's coverage under subsection (A), HCGA shall mail a notice of termination of coverage to the member's last known address within one business day after HCGA terminates a member's coverage. The notice shall state the date and time coverage was terminated and the reason for termination.~~
- ~~C. Termination of a member's coverage with 30 day notice. HCGA may terminate a member's coverage 30 days from the date of the notice for any of the following reasons:~~
- ~~1. Repeated and unreasonable demands for unnecessary or uncovered medical services;~~
 - ~~2. Failure to pay any copayment, coinsurance, or deductible;~~
 - ~~3. Violation of a material provision of the member handbook;~~
 - ~~4. Termination of employment;~~
 - ~~5. Change in status of the member that is required for eligibility under R9-27-302; or~~
 - ~~6. Changes to the eligibility criteria for a dependent under R9-27-303.~~
- ~~D. Written notice. For termination of a member's coverage with 30 days notice under subsection (C), HCGA shall mail a notice of proposed termination to the member's last known address. The notice shall state the reason for proposed termination and the date coverage will be terminated.~~
- ~~E. Termination of an employer group. If HCGA does not receive the full premium payment from an employer for an employer group by the premium due date specified in the GSA, HCGA shall send notice of the final due date to the employer at the employer's last known address. The notice shall advise the employer that HCGA must receive the full premium payment by the final due date contained in the notice and state the reason and date for the~~

~~termination of coverage for the employer group if the full premium is not received by the final due date.~~

~~F. Exclusion of member from eligibility and enrollment. HCGA may exclude, as ineligible to enroll or re-enroll, any member whose prior health care coverage has been terminated by HCGA for any of the following reasons:~~

- ~~1. Clear and convincing evidence of fraud or misrepresentation regarding enrollment or criteria listed in R9-27-302 and R9-27-303 when the member applies for coverage or obtains services;~~
- ~~2. Committing or threatening to commit violence toward an employee or an agent of HCGA, an employee or an agent of an HCG Plan, including a network provider, or an out-of-network provider;~~
- ~~3. Repeated and unreasonable demands for unnecessary or uncovered medical services;~~
- ~~4. Failure to pay any copayment, coinsurance, or deductible;~~
- ~~5. Violation of a material provision of the member handbook.~~

~~G. Exclusion of an employer from eligibility and enrollment. HCGA may exclude, as ineligible to enroll or re-enroll, an employer whose prior health care coverage has been terminated by HCGA for any of the following reasons:~~

- ~~1. Violating a provision of the GSA;~~
- ~~2. Committing or threatening to commit violence toward an employee or an agent of HCGA, an employee or an agent of an HCG Plan, including a network provider, or an out-of-network provider;~~
- ~~3. Clear and convincing evidence of fraud or misrepresentation regarding eligibility and enrollment criteria for an employer in R9-27-301.~~

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

~~A. Except as specified in subsection (B), HCG coverage for a member shall terminate on the date specified in the notice mailed to the member as provided in R9-27-310(B), (D), or (E).~~

~~B. HCGA shall provide and pay for health care services for a member who is an inpatient on the effective date of termination of coverage until the HCG Plan Medical Director or designee determines that care in the hospital is no longer medically necessary, provided that HCGA~~

~~continues to receive timely paid premiums for the member. Coverage for all other members, except the member who is an inpatient, shall terminate as provided in subsection (A).~~

~~R9-27-312. Continuation Coverage~~ Repeal

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

~~ARTICLE 5. GENERAL PROVISIONS AND STANDARDS~~ Repeal

~~R9-27-509. Information to Subscribers~~ Repeal

~~A. Member handbook. HCGA shall produce and distribute a printed member handbook to each subscriber by the effective date of coverage or as otherwise stated in the GSA. The member handbook shall include the following:~~

- ~~1. A description of all available services and an explanation of any service limitations, exclusions from coverage, and charges for services, when applicable;~~
- ~~2. An explanation of the procedure for obtaining covered services, including a notice stating that the HCG Plan is only liable for services authorized by a member's primary care provider or the HCG Plan;~~
- ~~3. Procedures for obtaining emergency medical services;~~
- ~~4. An explanation of the procedure for obtaining emergency medical services outside the network of an HCG Plan;~~
- ~~5. Circumstances under which a member may lose coverage;~~
- ~~6. A description of the grievance and request for hearing procedures;~~
- ~~7. Copayment, coinsurance, and deductible schedules;~~
- ~~8. Information on obtaining health services and on the maintenance of personal and family health; and~~
- ~~9. Information regarding medically necessary emergency transportation offered by an HCG Plan.~~

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

ARTICLE 7. STANDARDS FOR PAYMENTS Repeal

R9-27-702. Charges to Members Repeal

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

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

R9-27-703. Payments by an HCG Plan Repeal

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

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

- ~~B. An HCG Plan shall reimburse a network provider for covered services as specified in the subcontract between the HCG Plan and the provider.~~
- ~~C. If a member receives emergency medical services from a provider other than a network provider, or if an HCG Plan authorizes services to be delivered by, or refers a member to a provider other than a network provider, the HCG Plan shall reimburse the provider for covered services at the lesser of billed charges or an amount negotiated with the provider less any copayment, coinsurance, or deductible as described in the GSA.~~
- ~~D. An HCG Plan shall adjudicate claims from providers within 60 days of receipt of a clean claim from the provider unless a different time is specified in the subcontract between the HCG Plan and the provider.~~

~~R9-27-704. Liability of an HCG Plan to a Noncontracting Hospital for the Provision of Emergency and Post-stabilization Services to Members Repeal~~

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

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