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Senate Engrossed

State of Arizona  
Senate  
Forty-sixth Legislature  
Second Regular Session  
2004

# SENATE BILL 1166

AN ACT

AMENDING SECTIONS 36-2912 AND 36-2913, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 29, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-2912.01; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1

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

2 Section 1. Section 36-2912, Arizona Revised Statutes, is amended to  
3 read:

4 36-2912. Healthcare group coverage; program requirements for  
5 small businesses and public employers; related  
6 requirements; definitions

7 A. The administration shall administer a healthcare group program to  
8 allow willing contractors to deliver health care services to persons defined  
9 as eligible pursuant to section 36-2901, paragraph 6, subdivisions (b), (c),  
10 (d) and (e). **IN THE ABSENCE OF A WILLING CONTRACTOR, THE ADMINISTRATION MAY**  
11 **CONTRACT DIRECTLY WITH ANY HEALTH CARE PROVIDER OR ENTITY. THE**  
12 **ADMINISTRATION MAY ENTER INTO A CONTRACT WITH ANOTHER ENTITY TO PROVIDE**  
13 **ADMINISTRATIVE FUNCTIONS FOR THE HEALTHCARE GROUP PROGRAM.**

14 B. Employers with one eligible employee or up to an average of fifty  
15 eligible employees under section 36-2901, paragraph 6, subdivision (d):

16 1. May contract with the administration to be the exclusive health  
17 benefit plan if the employer has five or fewer eligible employees and enrolls  
18 one hundred per cent of these employees into the health benefit plan.

19 2. May contract with the administration for coverage available  
20 pursuant to this section if the employer has six or more eligible employees  
21 and enrolls eighty per cent of these employees into the healthcare group  
22 program.

23 3. Shall have a minimum of one and a maximum of fifty eligible  
24 employees at the effective date of their first contract with the  
25 administration.

26 C. **THE ADMINISTRATION SHALL NOT ENROLL AN EMPLOYER GROUP IN HEALTHCARE**  
27 **GROUP SOONER THAN ONE HUNDRED EIGHTY DAYS AFTER THE DATE THAT THE EMPLOYER'S**  
28 **HEALTH INSURANCE COVERAGE UNDER AN ACCOUNTABLE HEALTH PLAN IS DISCONTINUED.**  
29 **ENROLLMENT IN HEALTHCARE GROUP IS EFFECTIVE ON THE FIRST DAY OF THE MONTH**  
30 **AFTER THE ONE HUNDRED EIGHTY DAY PERIOD. THIS SUBSECTION DOES NOT APPLY TO**  
31 **AN EMPLOYER GROUP IF THE EMPLOYER'S ACCOUNTABLE HEALTH PLAN DISCONTINUES**  
32 **OFFERING THE HEALTH PLAN OF WHICH THE EMPLOYER IS A MEMBER.**

33 ~~C.~~ D. Employees with proof of other existing health care coverage who  
34 elect not to participate in the healthcare group program shall not be  
35 considered when determining the percentage **OF ENROLLMENT REQUIREMENTS UNDER**  
36 **SUBSECTION B OF THIS SECTION** if ~~the other health care coverage~~ either:

37 1. ~~Is other~~ **Group health coverage IS PROVIDED** through a spouse, parent  
38 or legal guardian, **OR INSURED THROUGH INDIVIDUAL INSURANCE OR ANOTHER**  
39 **EMPLOYER.**

40 2. ~~Is coverage available from~~ **MEDICAL ASSISTANCE IS PROVIDED BY** a  
41 government subsidized health care program.

42 3. **MEDICAL ASSISTANCE IS PROVIDED PURSUANT TO SECTION 36-2982,**  
43 **SUBSECTION I.**

44 ~~D.~~ E. An employer shall not offer coverage made available pursuant to  
45 this section to persons defined as eligible pursuant to section 36-2901,

1 paragraph 6, subdivision (b), (c), (d) or (e) as a substitute for a federally  
2 designated plan.

3 ~~E.~~ F. An employee or dependent defined as eligible pursuant to  
4 section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e) may  
5 participate in ~~the system~~ HEALTHCARE GROUP on a voluntary basis only.

6 ~~F.~~ G. Notwithstanding subsection B, paragraph 2 of this section, the  
7 administration shall adopt rules to allow a business that offers ~~system~~  
8 HEALTHCARE GROUP coverage pursuant to this section to continue coverage if it  
9 expands its employment to include more than fifty employees.

10 ~~G.~~ H. The administration shall provide eligible employees with  
11 disclosure information about the health benefit plan.

12 ~~H.~~ I. The director shall:

13 1. Require that any contractor that provides covered services to  
14 persons defined as eligible pursuant to section 36-2901, paragraph 6,  
15 subdivision (a) provide separate audited reports on the assets, liabilities  
16 and financial status of any corporate activity involving providing coverage  
17 pursuant to this section to persons defined as eligible pursuant to section  
18 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).

19 2. Ensure that any health plan not contracted to provide system  
20 covered services to persons defined as eligible pursuant to section 36-2901,  
21 paragraph 6, subdivision (a) has complied with any applicable provisions of  
22 section 36-2906.01. The director may make requests of the director of the  
23 department of insurance on behalf of the administration pursuant to section  
24 36-2906.01.

25 ~~3. Not distribute any appropriated funds, unless specifically~~  
26 ~~authorized by the legislature, to the administration or the administration's~~  
27 ~~contracted plans for the purposes of this section.~~

28 3. BEGINNING ON JULY 1, 2005, REQUIRE THAT A CONTRACTOR, THE  
29 ADMINISTRATION OR AN ACCOUNTABLE HEALTH PLAN NEGOTIATE REIMBURSEMENT RATES  
30 AND NOT USE THE ADMINISTRATION'S REIMBURSEMENT RATES ESTABLISHED PURSUANT TO  
31 SECTION 36-2903.01, SUBSECTION H, AS A DEFAULT REIMBURSEMENT RATE IF A  
32 CONTRACT DOES NOT EXIST BETWEEN A CONTRACTOR AND A PROVIDER.

33 4. USE MONIES FROM THE HEALTHCARE GROUP FUND ESTABLISHED BY SECTION  
34 36-2912.01 FOR THE ADMINISTRATION'S COSTS OF OPERATING THE HEALTHCARE GROUP  
35 PROGRAM.

36 ~~4.~~ 5. Ensure that the contractors are required to meet contract terms  
37 as are necessary in the judgment of the director to ensure adequate  
38 performance by the contractor. Contract provisions shall include, at a  
39 minimum, the maintenance of deposits, performance bonds, financial reserves  
40 or other financial security. The director may waive requirements for the  
41 posting of bonds or security for contractors that have posted other security,  
42 equal to or greater than that required for the healthcare group program, with  
43 the administration or the department of insurance for the performance of  
44 health service contracts if funds would be available to the administration  
45 from the other security on the contractor's default. In waiving, or

1 approving waivers of, any requirements established pursuant to this section,  
2 the director shall ensure that the administration has taken into account all  
3 the obligations to which a contractor's security is associated. The director  
4 may also adopt rules that provide for the withholding or forfeiture of  
5 payments to be made to a contractor for the failure of the contractor to  
6 comply with provisions of its contract or with provisions of adopted rules.

7 ~~5-~~ 6. Adopt rules.

8 ~~6-~~ 7. Provide reinsurance to the contractors for clean claims based  
9 on thresholds established by the administration. For the purposes of this  
10 paragraph, "clean claims" has the same meaning prescribed in section 36-2904.

11 ~~I-~~ J. With respect to services provided by contractors to persons  
12 defined as eligible pursuant to section 36-2901, paragraph 6, subdivision  
13 (b), (c), (d) or (e), a contractor is the payor of last resort and has the  
14 same lien or subrogation rights as those held by health care services  
15 organizations licensed pursuant to title 20, chapter 4, article 9.

16 ~~J-~~ K. The administration shall offer a health benefit plan on a  
17 guaranteed issuance basis to small employers as required by this  
18 section. All small employers qualify for this guaranteed offer of coverage.  
19 The administration shall provide a health benefit plan to each small employer  
20 without regard to health status-related factors if the small employer agrees  
21 to make the premium payments and to satisfy any other reasonable provisions  
22 of the plan ~~that are not inconsistent with this chapter~~ AND CONTRACT. The  
23 administration shall offer to all small employers the available health  
24 benefit plan and shall accept any small employer that applies and meets the  
25 eligibility requirements. In addition to the requirements prescribed in this  
26 section, for any offering of any health benefit plan to a small employer, as  
27 part of the administration's solicitation and sales materials, the  
28 administration shall make a reasonable disclosure to the employer of the  
29 availability of the information described in this subsection and, on request  
30 of the employer, shall provide that information to the employer. The  
31 administration shall provide information concerning the following:

32 1. Provisions of coverage relating to the following, if applicable:

33 (a) The administration's right to establish premiums and to change  
34 premium rates and the factors that may affect changes in premium rates.

35 (b) Renewability of coverage.

36 (c) Any preexisting condition exclusion.

37 (d) The geographic areas served by the contractor.

38 2. The benefits and premiums available under all health benefit plans  
39 for which the employer is qualified.

40 ~~K-~~ L. The administration shall describe the information required by  
41 subsection ~~J-~~ K of this section in language that is understandable by the  
42 average small employer and with a level of detail that is sufficient to  
43 reasonably inform a small employer of the employer's rights and obligations  
44 under the health benefit plan. This requirement is satisfied if the  
45 administration provides the following information:

1           1. An outline of coverage that describes the benefits in summary form.

2           2. The rate or rating schedule that applies to the product,  
3 preexisting condition exclusion or affiliation period.

4           3. The minimum employer contribution and group participation rules  
5 that apply to any particular type of coverage.

6           4. In the case of a network plan, a map or listing of the areas  
7 served.

8           ~~L~~ M. A contractor is not required to disclose any information that  
9 is proprietary and protected trade secret information under applicable law.

10          ~~M~~ N. At least sixty days before the date of expiration of a health  
11 benefit plan, the administration shall provide a written notice to the  
12 employer of the terms for renewal of the plan.

13          ~~N~~ O. The administration may increase or decrease premiums based on  
14 actuarial reviews of the projected and actual costs of providing health care  
15 benefits to eligible members. Before changing premiums, the administration  
16 must give sixty ~~days~~ DAYS' written notice to the employer. The  
17 administration may cap the amount of the change.

18          ~~O~~ P. The administration may consider age, sex, income and community  
19 rating when it establishes premiums for the healthcare group program.

20          ~~P~~ Q. Except as provided in subsection ~~Q~~ R of this section, a health  
21 benefit plan may not deny, limit or condition the coverage or benefits based  
22 on a person's health status-related factors or a lack of evidence of  
23 insurability.

24          ~~Q~~ R. A health benefit plan shall not exclude coverage for  
25 preexisting conditions, except that:

26           1. A health benefit plan may exclude coverage for preexisting  
27 conditions for a period of not more than twelve months or, in the case of a  
28 late enrollee, eighteen months. The exclusion of coverage does not apply to  
29 services that are furnished to newborns who were otherwise covered from the  
30 time of their birth or to persons who satisfy the portability requirements  
31 under this section.

32           2. The contractor shall reduce the period of any applicable  
33 preexisting condition exclusion by the aggregate of the periods of creditable  
34 coverage that apply to the individual.

35          ~~R~~ S. The contractor shall calculate creditable coverage according to  
36 the following:

37           1. The contractor shall give an individual credit for each portion of  
38 each month the individual was covered by creditable coverage.

39           2. The contractor shall not count a period of creditable coverage for  
40 an individual enrolled in a health benefit plan if after the period of  
41 coverage and before the enrollment date there were sixty-three consecutive  
42 days during which the individual was not covered under any creditable  
43 coverage.

1           3. The contractor shall give credit in the calculation of creditable  
2 coverage for any period that an individual is in a waiting period for any  
3 health coverage.

4           ~~S.~~ T. The contractor shall not count a period of creditable coverage  
5 with respect to enrollment of an individual if, after the most recent period  
6 of creditable coverage and before the enrollment date, sixty-three  
7 consecutive days lapse during all of which the individual was not covered  
8 under any creditable coverage. The contractor shall not include in the  
9 determination of the period of continuous coverage described in this section  
10 any period that an individual is in a waiting period for health insurance  
11 coverage offered by a health care insurer or is in a waiting period for  
12 benefits under a health benefit plan offered by a contractor. In determining  
13 the extent to which an individual has satisfied any portion of any applicable  
14 preexisting condition period the contractor shall count a period of  
15 creditable coverage without regard to the specific benefits covered during  
16 that period. A contractor shall not impose any preexisting condition  
17 exclusion in the case of an individual who is covered under creditable  
18 coverage thirty-one days after the individual's date of birth. A contractor  
19 shall not impose any preexisting condition exclusion in the case of a child  
20 who is adopted or placed for adoption before age eighteen and who is covered  
21 under creditable coverage thirty-one days after the adoption or placement for  
22 adoption.

23           ~~T.~~ U. The written certification provided by the administration must  
24 include:

25           1. The period of creditable coverage of the individual under the  
26 contractor and any applicable coverage under a COBRA continuation provision.

27           2. Any applicable waiting period or affiliation period imposed on an  
28 individual for any coverage under the health plan.

29           ~~U.~~ V. The administration shall issue and accept a written  
30 certification of the period of creditable coverage of the individual that  
31 contains at least the following information:

32           1. The date that the certificate is issued.

33           2. The name of the individual or dependent for whom the certificate  
34 applies and any other information that is necessary to allow the issuer  
35 providing the coverage specified in the certificate to identify the  
36 individual, including the individual's identification number under the policy  
37 and the name of the policyholder if the certificate is for or includes a  
38 dependent.

39           3. The name, address and telephone number of the issuer providing the  
40 certificate.

41           4. The telephone number to call for further information regarding the  
42 certificate.

43           5. One of the following:

1 (a) A statement that the individual has at least eighteen months of  
2 creditable coverage. For purposes of this subdivision, eighteen months means  
3 five hundred forty-six days.

4 (b) Both the date that the individual first sought coverage, as  
5 evidenced by a substantially complete application, and the date that  
6 creditable coverage began.

7 6. The date creditable coverage ended, unless the certificate  
8 indicates that creditable coverage is continuing from the date of the  
9 certificate.

10 ~~V.~~ W. The administration shall provide any certification pursuant to  
11 this section within thirty days after the event that triggered the issuance  
12 of the certification. Periods of creditable coverage for an individual are  
13 established by presentation of the certifications in this section.

14 ~~W.~~ X. The healthcare group program shall comply with all applicable  
15 federal requirements.

16 Y. HEALTHCARE GROUP MAY PAY A COMMISSION TO AN INSURANCE PRODUCER. TO  
17 RECEIVE A COMMISSION, THE PRODUCER MUST CERTIFY THAT TO THE BEST OF THE  
18 PRODUCER'S KNOWLEDGE THE EMPLOYER GROUP HAS NOT HAD INSURANCE IN THE ONE  
19 HUNDRED EIGHTY DAYS BEFORE APPLYING TO HEALTHCARE GROUP. FOR THE PURPOSES OF  
20 THIS SUBSECTION, "COMMISSION" MEANS A ONE TIME PAYMENT ON THE INITIAL  
21 ENROLLMENT OF AN EMPLOYER.

22 ~~X.~~ Z. For the purposes of this section:

23 1. "ACCOUNTABLE HEALTH PLAN" HAS THE SAME MEANING PRESCRIBED IN  
24 SECTION 20-2301.

25 ~~1.~~ 2. "COBRA continuation provision" means:

26 (a) Section 4980B, except subsection (f)(1) as it relates to pediatric  
27 vaccines, of the internal revenue code of 1986.

28 (b) Title I, subtitle B, part 6, except section 609, of the employee  
29 retirement income security act of 1974.

30 (c) Title XXII of the public health service act.

31 (d) Any similar provision of the law of this state or any other state.

32 ~~2.~~ 3. "Creditable coverage" means coverage solely for an individual,  
33 other than limited benefits coverage, under any of the following:

34 (a) An employee welfare benefit plan that provides medical care to  
35 employees or the employees' dependents directly or through insurance,  
36 reimbursement or otherwise pursuant to the employee retirement income  
37 security act of 1974.

38 (b) A church plan as defined in the employee retirement income  
39 security act of 1974.

40 (c) A health ~~benefit~~ BENEFITS plan, as defined in section 20-2301,  
41 issued by a health plan.

42 (d) Part A or part B of title XVIII of the social security act.

43 (e) Title XIX of the social security act, other than coverage  
44 consisting solely of benefits under section 1928.

45 (f) Title 10, chapter 55 of the United States Code.

- 1 (g) A medical care program of the Indian health service or of a tribal  
2 organization.
- 3 (h) A health benefits risk pool operated by any state of the United  
4 States.
- 5 (i) A health plan offered pursuant to title 5, chapter 89 of the  
6 United States Code.
- 7 (j) A public health plan as defined by federal law.
- 8 (k) A health benefit plan pursuant to section 5(e) of the peace corps  
9 act (22 United States Code section 2504(e)).
- 10 (l) A policy or contract, including short-term limited duration  
11 insurance, issued on an individual basis by an insurer, a health care  
12 services organization, a hospital service corporation, a medical service  
13 corporation or a hospital, medical, dental and optometric service corporation  
14 or made available to persons defined as eligible under section 36-2901,  
15 paragraph 6, subdivisions (b), (c), (d) and (e).
- 16 (m) A policy or contract issued by a health care insurer or the  
17 administration to a member of a bona fide association.
- 18 ~~3-~~ 4. "Eligible employee" means a person who IS ONE OF THE FOLLOWING:  
19 (a) ELIGIBLE PURSUANT TO SECTION 36-2901, PARAGRAPH 6, SUBDIVISIONS  
20 (b), (c), (d) AND (e).  
21 (b) A PERSON WHO works for an employer for a minimum of twenty hours  
22 per week or who is self-employed for at least twenty hours per week.  
23 (c) AN EMPLOYEE WHO ELECTS COVERAGE PURSUANT TO SECTION 36-2982,  
24 SUBSECTION I. THE RESTRICTION PROHIBITING EMPLOYEES EMPLOYED BY PUBLIC  
25 AGENCIES PRESCRIBED IN SECTION 36-2982, SUBSECTION I DOES NOT APPLY TO THIS  
26 SUBDIVISION.  
27 (d) A PERSON WHO MEETS ALL OF THE ELIGIBILITY REQUIREMENTS, WHO IS  
28 ELIGIBLE FOR A FEDERAL HEALTH COVERAGE TAX CREDIT PURSUANT TO SECTION 35 OF  
29 THE INTERNAL REVENUE CODE OF 1986 AND WHO APPLIES FOR HEALTH CARE COVERAGE  
30 THROUGH THE HEALTHCARE GROUP PROGRAM. THE REQUIREMENT THAT A PERSON BE  
31 EMPLOYED WITH A SMALL BUSINESS THAT ELECTS HEALTHCARE GROUP COVERAGE DOES NOT  
32 APPLY TO THIS ELIGIBILITY GROUP.
- 33 ~~4-~~ 5. "Genetic information" means information about genes, gene  
34 products and inherited characteristics that may derive from the individual or  
35 a family member, including information regarding carrier status and  
36 information derived from laboratory tests that identify mutations in specific  
37 genes or chromosomes, physical medical examinations, family histories and  
38 direct analysis of genes or chromosomes.
- 39 ~~5-~~ 6. "Health benefit plan" means coverage offered by the  
40 administration for the healthcare group program pursuant to this section.
- 41 ~~6-~~ 7. "Health status-related factor" means any factor in relation to  
42 the health of the individual or a dependent of the individual enrolled or to  
43 be enrolled in a health plan including:  
44 (a) Health status.  
45 (b) Medical condition, including physical and mental illness.

- 1 (c) Claims experience.
- 2 (d) Receipt of health care.
- 3 (e) Medical history.
- 4 (f) Genetic information.
- 5 (g) Evidence of insurability, including conditions arising out of acts
- 6 of domestic violence as defined in section 20-448.
- 7 (h) The existence of a physical or mental disability.

8 8. "HOSPITAL" MEANS A HEALTH CARE INSTITUTION LICENSED AS A HOSPITAL  
9 PURSUANT TO CHAPTER 4, ARTICLE 2 OF THIS TITLE.

10 ~~7.~~ 9. "Late enrollee" means an employee or dependent who requests  
11 enrollment in a health benefit plan after the initial enrollment period that  
12 is provided under the terms of the health benefit plan if the initial  
13 enrollment period is at least thirty-one days. Coverage for a late enrollee  
14 begins on the date the person becomes a dependent if a request for enrollment  
15 is received within thirty-one days after the person becomes a dependent. An  
16 employee or dependent shall not be considered a late enrollee if:

- 17 (a) The person:
  - 18 (i) At the time of the initial enrollment period was covered under a
  - 19 public or private health insurance policy or any other health benefit plan.
  - 20 (ii) Lost coverage under a public or private health insurance policy
  - 21 or any other health benefit plan due to the employee's termination of
  - 22 employment or eligibility, the reduction in the number of hours of
  - 23 employment, the termination of the other plan's coverage, the death of the
  - 24 spouse, legal separation or divorce or the termination of employer
  - 25 contributions toward the coverage.
  - 26 (iii) Requests enrollment within thirty-one days after the termination
  - 27 of creditable coverage that is provided under a COBRA continuation provision.
  - 28 (iv) Requests enrollment within thirty-one days after the date of
  - 29 marriage.

30 (b) The person is employed by an employer that offers multiple health  
31 benefit plans and the person elects a different plan during an open  
32 enrollment period.

33 (c) The person becomes a dependent of an eligible person through  
34 marriage, birth, adoption or placement for adoption and requests enrollment  
35 no later than thirty-one days after becoming a dependent.

36 ~~8.~~ 10. "Preexisting condition" means a condition, regardless of the  
37 cause of the condition, for which medical advice, diagnosis, care or  
38 treatment was recommended or received within not more than six months before  
39 the date of the enrollment of the individual under a health benefit plan  
40 issued by a contractor. Preexisting condition does not include a genetic  
41 condition in the absence of a diagnosis of the condition related to the  
42 genetic information.

43 ~~9.~~ 11. "Preexisting condition limitation" or "preexisting condition  
44 exclusion" means a limitation or exclusion of benefits for a preexisting  
45 condition under a health benefit plan offered by a contractor.

1           ~~10.~~ 12. "Small employer" means an employer who employs at least one  
2 but not more than fifty eligible employees on a typical business day during  
3 any one calendar year.

4           ~~11.~~ 13. "Waiting period" means the period that must pass before a  
5 potential participant or eligible employee in a health benefit plan offered  
6 by a health plan is eligible to be covered for benefits as determined by the  
7 individual's employer.

8           Sec. 2. Title 36, chapter 29, article 1, Arizona Revised Statutes, is  
9 amended by adding section 36-2912.01, to read:

10           36-2912.01. Healthcare group fund; nonlapsing

11           A. THE HEALTHCARE GROUP FUND IS ESTABLISHED CONSISTING OF:

12           1. PREMIUMS PAID BY SMALL EMPLOYERS AND ELIGIBLE EMPLOYEES, INCLUDING  
13 EMPLOYEE CONTRIBUTIONS, FOR THE COST OF PROVIDING HOSPITALIZATION AND MEDICAL  
14 CARE UNDER THE SYSTEM.

15           2. GIFTS, GRANTS AND DONATIONS.

16           3. LEGISLATIVE APPROPRIATIONS.

17           B. THE ADMINISTRATION SHALL ADMINISTER THE FUND.

18           C. MONIES IN THE FUND ARE CONTINUOUSLY APPROPRIATED AND ARE EXEMPT  
19 FROM THE PROVISIONS OF SECTION 35-190 RELATING TO THE LAPSING OF  
20 APPROPRIATIONS.

21           D. ON NOTICE FROM THE ADMINISTRATION, THE STATE TREASURER SHALL INVEST  
22 AND DIVEST MONIES IN THE FUND AS PROVIDED BY SECTION 35-313, AND MONIES  
23 EARNED FROM INVESTMENT SHALL BE CREDITED TO THE FUND.

24           E. THE ADMINISTRATION SHALL USE FUND MONIES TO PAY THE ADMINISTRATIVE  
25 COSTS AND THE COST OF PROVIDING HOSPITALIZATION AND MEDICAL CARE FOR SMALL  
26 EMPLOYERS AND ELIGIBLE EMPLOYEES AS DEFINED IN SECTION 36-2912.

27           F. THE ADMINISTRATION MAY USE UP TO SIX PER CENT OF FUND MONIES FROM  
28 PREMIUMS TO PAY THE ADMINISTRATIVE COSTS FOR THE ADMINISTRATION TO OPERATE  
29 THE HEALTHCARE GROUP PROGRAM. ADMINISTRATIVE COSTS DO NOT INCLUDE  
30 COMMISSIONS OR FEES PAID BY THE HEALTHCARE PROGRAM TO INSURANCE PRODUCERS.

31           Sec. 3. Section 36-2913, Arizona Revised Statutes, is amended to read:

32           36-2913. Systems funds; funding

33           A. The Arizona health care cost containment system fund, long-term  
34 care system fund and the third party liability fund are established. The  
35 funds shall be used to pay administrative and program costs associated with  
36 the operation of the system established pursuant to this article and the  
37 long-term care system established pursuant to article 2 of this chapter.

38           B. Separate accounts, including but not limited to a reserve fund, may  
39 be established within the funds. Different accounts within the funds shall  
40 be established in order to separately account for expense and income activity  
41 associated with the system established pursuant to this article and article 2  
42 of this chapter.

43           C. The Arizona health care cost containment system fund and long-term  
44 care system fund shall be comprised of:

1           1. Monies paid by each of the counties of this state of the amounts  
2 determined or withheld by the state treasurer pursuant to section 11-292.

3           2. Monies paid by each county resolving to participate in the system  
4 equal to the actual cost, as limited by the board of supervisors, together  
5 with employee contributions of providing hospitalization and medical care  
6 under the system to full-time officers and employees of the county and its  
7 departments and agencies.

8           3. Monies paid by this state equal to the actual cost, as limited by  
9 section 38-651, together with employee contributions of providing  
10 hospitalization and medical care under the system to full-time officers and  
11 employees of this state, of its departments and agencies and of cities, towns  
12 and school districts of this state.

13           4. Monies drawn against appropriations made by this state for the  
14 costs of operating the Arizona health care cost containment system or the  
15 long-term care system. Monies shall be drawn against appropriations and  
16 transferred from the fund from which they were appropriated on an as needed  
17 basis only.

18           5. Gifts, donations and grants from any source.

19           6. Federal monies made available to this state for the operation of  
20 the Arizona health care cost containment system or the long-term care system.

21           7. Interest paid on monies deposited in the fund.

22           ~~8. Monies paid by the owners of eligible businesses in this state,  
23 including employee contributions, for the actual cost of providing  
24 hospitalization and medical care under the system to their full-time  
25 employees together with interest paid on monies deposited in the fund.  
26 Administrative costs of the system to operate the eligible businesses program  
27 are subject to legislative appropriation.~~

28           ~~9.~~ 8. Reimbursements for data collection.

29           D. The third party liability fund is comprised of monies paid by third  
30 party payors and lien and estate recoveries.

31           E. All monies in the funds other than monies appropriated by the state  
32 shall not lapse.

33           F. All monies drawn against appropriations made by this state  
34 remaining in the funds at the end of the fiscal year shall revert to the fund  
35 from which they were appropriated and drawn, and the appropriation shall  
36 lapse in accordance with section 35-190. Notwithstanding the provisions of  
37 section 35-191, subsection B, the period for administrative adjustments shall  
38 extend for only six months for appropriations made for system covered  
39 services.

40           G. Notwithstanding sections 35-190 and 35-191, all approved claims for  
41 system covered services presented after the close of the fiscal year in which  
42 they were incurred shall be paid either in accordance with subsection F of  
43 this section or in the current fiscal year with the monies available in the  
44 funds established by this section.

1 H. Claims for system covered services that are determined valid by the  
2 director pursuant to section 36-2904, subsection G and the department's  
3 grievance and appeal procedure shall be paid from the funds established by  
4 this section.

5 I. For purposes of this section, system covered services exclude  
6 administrative charges for operating expenses.

7 J. All payments for claims from the funds established by this section  
8 shall be accounted for by the administration by the fiscal year in which the  
9 claims were incurred, regardless of the fiscal year in which the payments  
10 were made.

11 K. Notwithstanding any other law, county owned or contracted providers  
12 and special health care district owned or contracted providers are subject to  
13 all claims processing and payment requirements or limitations of this chapter  
14 that are applicable to noncounty providers.

15 Sec. 4. Healthcare group; bare period; exception

16 Notwithstanding section 36-2912, subsection C, Arizona Revised  
17 Statutes, an employer who has signed and submitted to healthcare group a  
18 group service agreement to enroll employees with healthcare group before the  
19 effective date of this act does not have to meet the one hundred eighty day  
20 waiting period required by section 36-2912, subsection B, Arizona Revised  
21 Statutes, as amended by this act. If an employer requests healthcare group  
22 to cancel the group service agreement submitted before the effective date of  
23 this act or the employer does not provide all necessary documentation  
24 requested by healthcare group to complete the application process within  
25 ninety days from the original date of submittal to healthcare group, the  
26 provisions of section 36-2912, subsection B, Arizona Revised Statutes, as  
27 amended by this act, apply.

28 Sec. 5. Arizona health care cost containment system; healthcare  
29 group; joint legislative budget committee review;  
30 report

31 A. On or before October 1, 2007, the Arizona health care cost  
32 containment system shall submit a report on healthcare group to the joint  
33 legislative budget committee containing the following information:

- 34 1. A review of the medical costs and premiums charged.
- 35 2. An analysis of client satisfaction.
- 36 3. Enrollment information.
- 37 4. The average annual income of enrollees.
- 38 5. The total monies collected from enrollees.
- 39 6. Information necessary to analyze and evaluate the effectiveness or  
40 impact of continuing healthcare group.
- 41 7. An analysis of the impact of healthcare group on the uninsured  
42 population in this state.
- 43 8. An analysis on the impact of healthcare group on health care  
44 provider reimbursement rates.

1           B. On or before December 1, 2007, the joint legislative budget  
2 committee shall review the report submitted by the Arizona health care cost  
3 containment system on healthcare group and submit a report to the governor,  
4 the president of the senate, the speaker of the house of representatives and  
5 the chairs of the senate health committee and house of representatives health  
6 committee and provide a copy of this report to the secretary of state and the  
7 director of the Arizona state library, archives and public records.