

State of Arizona  
House of Representatives  
Forty-eighth Legislature  
First Regular Session  
2007

# HOUSE BILL 2789

## AN ACT

AMENDING SECTION 20-1064, ARIZONA REVISED STATUTES; CHANGING THE DESIGNATION OF TITLE 20, CHAPTER 13, ARIZONA REVISED STATUTES, TO "ACCOUNTABLE HEALTH PLANS"; CHANGING THE DESIGNATION OF TITLE 20, CHAPTER 13, ARTICLE 2, ARIZONA REVISED STATUTES, TO "UNINSURED SMALL BUSINESS HEALTH INSURANCE PLANS"; AMENDING SECTIONS 20-2341, 36-2901.03, 36-2903.01, 36-2912 AND 36-2912.01, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 29, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 36-2923; AMENDING SECTIONS 36-2930, 36-2988, 36-3410, 38-654 AND 46-803, ARIZONA REVISED STATUTES; AMENDING LAWS 2006, CHAPTER 350, SECTION 20; MAKING APPROPRIATIONS; RELATING TO HEALTH AND WELFARE BUDGET RECONCILIATION.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:  
2 Section 1. Section 20-1064, Arizona Revised Statutes, is amended to  
3 read:  
4 20-1064. Examinations; healthcare group  
5 A. The director may conduct an examination of the affairs of any  
6 health care services organization as often as the director deems it necessary  
7 for the protection of the interests of the people of this state and for this  
8 purpose shall have the powers set forth in this title with respect to  
9 examinations of insurers.  
10 B. Unless preempted under federal law or unless federal law imposes  
11 greater requirements than SUBSECTION A OF this section, SUBSECTION A OF this  
12 section applies to a provider sponsored health care services organization.  
13 C. THE DIRECTOR SHALL CONDUCT A FINANCIAL EXAMINATION ON AN ANNUAL  
14 BASIS OF THE HEALTHCARE GROUP PROGRAM ESTABLISHED PURSUANT TO SECTION  
15 36-2912, AS IF HEALTHCARE GROUP WERE A HEALTH CARE SERVICES ORGANIZATION.  
16 THE DIRECTOR SHALL COMPLETE THE FINANCIAL EXAMINATION ON OR BEFORE JANUARY 1,  
17 2008, AND EACH YEAR THEREAFTER, AND SHALL SUBMIT A REPORT OF THE EXAMINATION  
18 TO THE GOVERNOR, THE PRESIDENT OF THE SENATE, THE SPEAKER OF THE HOUSE OF  
19 REPRESENTATIVES, THE AUDITOR GENERAL AND THE DIRECTOR OF THE ARIZONA HEALTH  
20 CARE COST CONTAINMENT SYSTEM ADMINISTRATION. THE DIRECTOR OF THE DEPARTMENT  
21 OF INSURANCE SHALL PROVIDE A COPY OF THE REPORT TO THE SECRETARY OF STATE AND  
22 THE DIRECTOR OF THE ARIZONA STATE LIBRARY, ARCHIVES AND PUBLIC RECORDS. THE  
23 EXAMINATION SHALL:  
24 1. DETERMINE THE HEALTHCARE GROUP PROGRAM'S FULLY-FUNDED ACTUARIAL  
25 RATE.  
26 2. INCLUDE DEMOGRAPHIC INFORMATION ON THE MEMBERSHIP OF THE HEALTHCARE  
27 GROUP PARTICIPANTS, INCLUDING THE COUNTY OF EACH MEMBER'S RESIDENCE AND THE  
28 TYPE OF PLAN IN WHICH THE MEMBER IS ENROLLED.  
29 Sec. 2. Heading change  
30 The chapter heading of title 20, chapter 13, Arizona Revised Statutes,  
31 is changed from "SPECIAL HEALTH INSURANCE PLANS" to "ACCOUNTABLE HEALTH  
32 PLANS".  
33 Sec. 3. Heading change  
34 The article heading of title 20, chapter 13, article 2, Arizona Revised  
35 Statutes, is changed from "SMALL BUSINESS HEALTH INSURANCE PLANS" to  
36 "UNINSURED SMALL BUSINESS HEALTH INSURANCE PLANS".  
37 Sec. 4. Section 20-2341, Arizona Revised Statutes, is amended to read:  
38 20-2341. Uninsured small business health insurance plans;  
39 mandatory coverage exemption; definitions  
40 A. A policy, subscription contract, contract, plan or evidence of  
41 coverage issued to ~~a~~ AN UNINSURED small business by a health care insurer is  
42 not subject to the requirements of any of the following:  
43 1. Section 20-461, subsection A, paragraph 17 and subsection B.  
44 2. Section 20-826, subsection C, paragraph 1.  
45 3. Section 20-826, subsections F, J, K, U, V, W, X and Y.

- 1 4. Sections 20-841, 20-841.01, 20-841.02, 20-841.03, 20-841.04,  
2 20-841.06, 20-841.07 and 20-841.08.
- 3 5. Section 20-841.05, subsections B and E.
- 4 6. Section 20-1057, subsections C, K, L, Y, Z, AA and BB.
- 5 7. Sections 20-1057.01, 20-1057.03, 20-1057.04, 20-1057.05 and  
6 20-1057.08.
- 7 8. Section 20-1057.02, Subsection B.
- 8 9. Section 20-1342, subsection A, paragraph 8, subdivision (a).
- 9 10. Section 20-1342, subsection A, paragraphs 11 and 12.
- 10 11. Section 20-1342, subsections H, I, J and K.
- 11 12. Section 20-1342.01.
- 12 13. Sections 20-1376, 20-1376.01, 20-1376.02, 20-1376.03 and  
13 20-1376.04.
- 14 14. Section 20-1402, subsection A, paragraph 4, subdivision (a).
- 15 15. Section 20-1402, subsection A, paragraphs 7 and 8.
- 16 16. Section 20-1402, subsections H, I, J, K and L.
- 17 17. Section 20-1404, subsection F, paragraph 1.
- 18 18. Section 20-1404, subsections I, Q, R, S, T and U.
- 19 19. Section 20-1406.
- 20 20. Sections 20-1406.01, 20-1406.02, 20-1406.03 and 20-1406.04.
- 21 21. Section 20-1407.
- 22 22. Section 20-2321.
- 23 23. Section 20-2327.
- 24 24. Section 20-2329.
- 25 B. Section 20-2304, subsection B does not apply to a policy,  
26 subscription contract, contract, plan or evidence of coverage issued to ~~a~~ AN  
27 UNINSURED small business pursuant to subsection A of this section.
- 28 C. In this article, unless the context otherwise requires:
  - 29 1. "Health care insurer" means a disability insurer, group disability  
30 insurer, blanket disability insurer, health care services organization,  
31 hospital service corporation, medical service corporation or hospital and  
32 medical service corporation.
  - 33 ~~2. "Small business" means a business that employed at least two but  
34 not more than twenty five persons at any time during the most recent calendar  
35 year and that has been uninsured for at least six months.~~
  - 36 2. "UNINSURED SMALL BUSINESS" MEANS A SMALL EMPLOYER THAT DID NOT  
37 SPONSOR OR PROVIDE A HEALTH BENEFITS PLAN FOR AT LEAST SIX CONSECUTIVE MONTHS  
38 IMMEDIATELY BEFORE THE EFFECTIVE DATE OF COVERAGE PROVIDED PURSUANT TO THIS  
39 SECTION, EXCEPT THAT THIS REQUIREMENT DOES NOT APPLY AT THE RENEWAL OF  
40 COVERAGE PURSUANT TO THIS SECTION.
- 41 Sec. 5. Section 36-2901.03, Arizona Revised Statutes, is amended to  
42 read:
  - 43 36-2901.03. Federal poverty program; eligibility
  - 44 A. The administration shall adopt rules for a streamlined eligibility  
45 determination process for any person who applies to be an eligible person as

1 defined in section 36-2901, paragraph 6, subdivision (a), item (iv). The  
2 administration shall adopt these rules in accordance with state and federal  
3 requirements and the section 1115 waiver.

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

7 C. For persons who the administration determines are eligible pursuant  
8 to this section, the date of eligibility is the first day of the month of  
9 application.

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

13 E. EVERY SIX MONTHS THE ADMINISTRATION SHALL DETERMINE THE CONTINUED  
14 ELIGIBILITY OF ANY ADULT WHO IS AT LEAST TWENTY-ONE YEARS OF AGE AND WHO IS  
15 SUBJECT TO REDETERMINATION OF ELIGIBILITY FOR TEMPORARY ASSISTANCE FOR NEEDY  
16 FAMILIES CASH BENEFITS BY THE DEPARTMENT. ACUTE CARE REDETERMINATIONS  
17 PURSUANT TO THIS SUBSECTION SHALL BEGIN ON THE EFFECTIVE DATE OF THIS  
18 AMENDMENT TO THIS SECTION AND SHALL OCCUR SIMULTANEOUSLY WITH  
19 REDETERMINATIONS OF ELIGIBILITY FOR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES  
20 CASH BENEFITS.

21 Sec. 6. Section 36-2903.01, Arizona Revised Statutes, is amended to  
22 read:

23 36-2903.01. Additional powers and duties

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

30 B. The director shall:

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

37 2. Enter into an interagency agreement with the department to  
38 establish a streamlined eligibility process to determine the eligibility of  
39 all persons defined pursuant to section 36-2901, paragraph 6,  
40 subdivision (a). At the administration's option, the interagency agreement  
41 may allow the administration to determine the eligibility of certain persons  
42 including those defined pursuant to section 36-2901, paragraph 6,  
43 subdivision (a).

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

- 1 (a) Establish an expedited eligibility and enrollment process for all  
2 persons who are hospitalized at the time of application.
- 3 (b) Establish performance measures and incentives for the department.
- 4 (c) Establish the process for management evaluation reviews that the  
5 administration shall perform to evaluate the eligibility determination  
6 functions performed by the department.
- 7 (d) Establish eligibility quality control reviews by the  
8 administration.
- 9 (e) Require the department to adopt rules, consistent with the rules  
10 adopted by the administration for a hearing process, that applicants or  
11 members may use for appeals of eligibility determinations or  
12 redeterminations.
- 13 (f) Establish the department's responsibility to place sufficient  
14 eligibility workers at federally qualified health centers to screen for  
15 eligibility and at hospital sites and level one trauma centers to ensure that  
16 persons seeking hospital services are screened on a timely basis for  
17 eligibility for the system, including a process to ensure that applications  
18 for the system can be accepted on a twenty-four hour basis, seven days a  
19 week.
- 20 (g) Withhold payments based on the allowable sanctions for errors in  
21 eligibility determinations or redeterminations or failure to meet performance  
22 measures required by the intergovernmental agreement.
- 23 (h) Recoup from the department all federal fiscal sanctions that  
24 result from the department's inaccurate eligibility determinations. The  
25 director may offset all or part of a sanction if the department submits a  
26 corrective action plan and a strategy to remedy the error.
- 27 4. By rule establish a procedure and time frames for the intake of  
28 grievances and requests for hearings, for the continuation of benefits and  
29 services during the appeal process and for a grievance process at the  
30 contractor level. Notwithstanding sections 41-1092.02, 41-1092.03 and  
31 41-1092.05, the administration shall develop rules to establish the procedure  
32 and time frame for the informal resolution of grievances and appeals. A  
33 grievance that is not related to a claim for payment of system covered  
34 services shall be filed in writing with and received by the administration or  
35 the prepaid capitated provider or program contractor not later than sixty  
36 days after the date of the adverse action, decision or policy implementation  
37 being grieved. A grievance that is related to a claim for payment of system  
38 covered services must be filed in writing and received by the administration  
39 or the prepaid capitated provider or program contractor within twelve months  
40 after the date of service, within twelve months after the date that  
41 eligibility is posted or within sixty days after the date of the denial of a  
42 timely claim submission, whichever is later. A grievance for the denial of a  
43 claim for reimbursement of services may contest the validity of any adverse  
44 action, decision, policy implementation or rule that related to or resulted  
45 in the full or partial denial of the claim. A policy implementation may be

1 subject to a grievance procedure, but it may not be appealed for a hearing.  
2 The administration is not required to participate in a mandatory settlement  
3 conference if it is not a real party in interest. In any proceeding before  
4 the administration, including a grievance or hearing, persons may represent  
5 themselves or be represented by a duly authorized agent who is not charging a  
6 fee. A legal entity may be represented by an officer, partner or employee  
7 who is specifically authorized by the legal entity to represent it in the  
8 particular proceeding.

9 5. Apply for and accept federal funds available under title XIX of the  
10 social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section  
11 1396 (1980)) in support of the system. The application made by the director  
12 pursuant to this paragraph shall be designed to qualify for federal funding  
13 primarily on a prepaid capitated basis. Such funds may be used only for the  
14 support of persons defined as eligible pursuant to title XIX of the social  
15 security act or the approved section 1115 waiver.

16 6. At least thirty days before the implementation of a policy or a  
17 change to an existing policy relating to reimbursement, provide notice to  
18 interested parties. Parties interested in receiving notification of policy  
19 changes shall submit a written request for notification to the  
20 administration.

21 C. The director is authorized to apply for any federal funds available  
22 for the support of programs to investigate and prosecute violations arising  
23 from the administration and operation of the system. Available state funds  
24 appropriated for the administration and operation of the system may be used  
25 as matching funds to secure federal funds pursuant to this subsection.

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

27 1. Authorize advance payments based on estimated liability to a  
28 contractor or a noncontracting provider after the contractor or  
29 noncontracting provider has submitted a claim for services and before the  
30 claim is ultimately resolved. The rules shall specify that any advance  
31 payment shall be conditioned on the execution before payment of a contract  
32 with the contractor or noncontracting provider that requires the  
33 administration to retain a specified percentage, which shall be at least  
34 twenty per cent, of the claimed amount as security and that requires  
35 repayment to the administration if the administration makes any overpayment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11           5. The director shall define by rule the method of determining when a  
12 hospital bill will be considered received and when a hospital's billed  
13 charges will be considered paid. Payment received by a hospital from the  
14 administration pursuant to this subsection or from a contractor either by  
15 contract or pursuant to section 36-2904, subsection I shall be considered  
16 payment of the hospital bill in full, except that a hospital may collect any  
17 unpaid portion of its bill from other third party payors or in situations  
18 covered by title 33, chapter 7, article 3.

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

22           1. For inpatient hospital stays, the administration shall use a  
23 prospective tiered per diem methodology, using hospital peer groups if  
24 analysis shows that cost differences can be attributed to independently  
25 definable features that hospitals within a peer group share. In peer  
26 grouping the administration may consider such factors as length of stay  
27 differences and labor market variations. If there are no cost differences,  
28 the administration shall implement a stop loss-stop gain or similar  
29 mechanism. Any stop loss-stop gain or similar mechanism shall ensure that  
30 the tiered per diem rates assigned to a hospital do not represent less than  
31 ninety per cent of its 1990 base year costs or more than one hundred ten per  
32 cent of its 1990 base year costs, adjusted by an audit factor, during the  
33 period of March 1, 1993 through September 30, 1994. The tiered per diem  
34 rates set for hospitals shall represent no less than eighty-seven and  
35 one-half per cent or more than one hundred twelve and one-half per cent of  
36 its 1990 base year costs, adjusted by an audit factor, from October 1, 1994  
37 through September 30, 1995 and no less than eighty-five per cent or more than  
38 one hundred fifteen per cent of its 1990 base year costs, adjusted by an  
39 audit factor, from October 1, 1995 through September 30, 1996. For the  
40 periods after September 30, 1996 no stop loss-stop gain or similar mechanisms  
41 shall be in effect. An adjustment in the stop loss-stop gain percentage may  
42 be made to ensure that total payments do not increase as a result of this  
43 provision. If peer groups are used the administration shall establish  
44 initial peer group designations for each hospital before implementation of  
45 the per diem system. The administration may also use a negotiated rate

1 methodology. The tiered per diem methodology may include separate  
2 consideration for specialty hospitals that limit their provision of services  
3 to specific patient populations, such as rehabilitative patients or children.  
4 The initial per diem rates shall be based on hospital claims and encounter  
5 data for dates of service November 1, 1990 through October 31, 1991 and  
6 processed through May of 1992.

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

13 3. Through June 30, 2004, for outpatient hospital services, the  
14 administration shall reimburse a hospital by applying a hospital specific  
15 outpatient cost-to-charge ratio to the covered charges. Beginning on July 1,  
16 2004 through June 30, 2005, the administration shall reimburse a hospital by  
17 applying a hospital specific outpatient cost-to-charge ratio to covered  
18 charges. If the hospital increases its charges for outpatient services filed  
19 with the Arizona department of health services pursuant to chapter 4, article  
20 3 of this title, by more than 4.7 per cent for dates of service effective on  
21 or after July 1, 2004, the hospital specific cost-to-charge ratio will be  
22 reduced by the amount that it exceeds 4.7 per cent. If charges exceed 4.7  
23 per cent, the effective date of the increased charges will be the effective  
24 date of the adjusted Arizona health care cost containment system  
25 cost-to-charge ratio. The administration shall develop the methodology for a  
26 capped fee-for-service schedule and a statewide cost-to-charge ratio. Any  
27 covered outpatient service not included in the capped fee-for-service  
28 schedule shall be reimbursed by applying the statewide cost-to-charge ratio  
29 that is based on the services not included in the capped fee-for-service  
30 schedule. Beginning on July 1, 2005, the administration shall reimburse  
31 clean claims with dates of service on or after July 1, 2005, based on the  
32 capped fee-for-service schedule or the statewide cost-to-charge ratio  
33 established pursuant to this paragraph. The administration may make  
34 additional adjustments to the outpatient hospital rates established pursuant  
35 to this section based on other factors, including the number of beds in the  
36 hospital, specialty services available to patients and the geographic  
37 location of the hospital.

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

- 42 (a) An admission face sheet.
- 43 (b) An itemized statement.
- 44 (c) An admission history and physical.
- 45 (d) A discharge summary or an interim summary if the claim is split.

1 (e) An emergency record, if admission was through the emergency room.

2 (f) Operative reports, if applicable.

3 (g) A labor and delivery room report, if applicable.

4 Payment received by a hospital from the administration pursuant to this  
5 subsection or from a contractor either by contract or pursuant to section  
6 36-2904, subsection I is considered payment by the administration or the  
7 contractor of the administration's or contractor's liability for the hospital  
8 bill. A hospital may collect any unpaid portion of its bill from other third  
9 party payors or in situations covered by title 33, chapter 7, article 3.

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

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

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

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

24 6. In developing the reimbursement methodology, if a review of the  
25 reports filed by a hospital pursuant to section 36-125.04 indicates that  
26 further investigation is considered necessary to verify the accuracy of the  
27 information in the reports, the administration may examine the hospital's  
28 records and accounts related to the reporting requirements of section  
29 36-125.04. The administration shall bear the cost incurred in connection  
30 with this examination unless the administration finds that the records  
31 examined are significantly deficient or incorrect, in which case the  
32 administration may charge the cost of the investigation to the hospital  
33 examined.

34 7. Except for privileged medical information, the administration shall  
35 make available for public inspection the cost and charge data and the  
36 calculations used by the administration to determine payments under the  
37 tiered per diem system, provided that individual hospitals are not identified  
38 by name. The administration shall make the data and calculations available  
39 for public inspection during regular business hours and shall provide copies  
40 of the data and calculations to individuals requesting such copies within  
41 thirty days of receipt of a written request. The administration may charge a  
42 reasonable fee for the provision of the data or information.

43 8. The prospective tiered per diem payment methodology for inpatient  
44 hospital services shall include a mechanism for the prospective payment of  
45 inpatient hospital capital related costs. The capital payment shall include

1 hospital specific and statewide average amounts. For tiered per diem rates  
2 beginning on October 1, 1999, the capital related cost component is frozen at  
3 the blended rate of forty per cent of the hospital specific capital cost and  
4 sixty per cent of the statewide average capital cost in effect as of January  
5 1, 1999 and as further adjusted by the calculation of tier rates for  
6 maternity and nursery as prescribed by law. The administration shall adjust  
7 the capital related cost component by the data resources incorporated market  
8 basket index for prospective payment system hospitals.

9 9. For graduate medical education programs:

10 (a) Beginning September 30, 1997, the administration shall establish a  
11 separate graduate medical education program to reimburse hospitals that had  
12 graduate medical education programs that were approved by the administration  
13 as of October 1, 1999. The administration shall separately account for  
14 monies for the graduate medical education program based on the total  
15 reimbursement for graduate medical education reimbursed to hospitals by the  
16 system in federal fiscal year 1995-1996 pursuant to the tiered per diem  
17 methodology specified in this section. The graduate medical education  
18 program reimbursement shall be adjusted annually by the increase or decrease  
19 in the index published by the global insight hospital market basket index for  
20 prospective hospital reimbursement. Subject to legislative appropriation, on  
21 an annual basis, each qualified hospital shall receive a single payment from  
22 the graduate medical education program that is equal to the same percentage  
23 of graduate medical education reimbursement that was paid by the system in  
24 federal fiscal year 1995-1996. Any reimbursement for graduate medical  
25 education made by the administration shall not be subject to future  
26 settlements or appeals by the hospitals to the administration. The monies  
27 available under this subdivision shall not exceed the fiscal year 2005-2006  
28 appropriation adjusted annually by the increase or decrease in the index  
29 published by the global insight hospital market basket index for prospective  
30 hospital reimbursement, except for monies distributed for expansions pursuant  
31 to subdivision (b) of this paragraph.

32 (b) Beginning July 1, 2006, the administration shall distribute any  
33 monies appropriated for graduate medical education above the amount  
34 prescribed in subdivision (a) of this paragraph in the following order or  
35 priority:

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

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

43 (iii) For the direct costs of graduate medical education programs  
44 established on or after July 1, 2006. These programs must be approved by the  
45 administration.

1 (c) The administration shall develop, by rule, the formula by which  
2 the monies are distributed.

3 (d) Each graduate medical education program that receives funding  
4 pursuant to subdivision (b) of this paragraph shall identify and report to  
5 the administration the number of new residency positions created by the  
6 funding provided in this paragraph, including positions in rural areas. The  
7 administration shall report to the joint legislative budget committee by  
8 February 1 of each year on the number of new residency positions as reported  
9 by the graduate medical education programs.

10 (e) For the purposes of this paragraph, "graduate medical education  
11 program" means a program, including an approved fellowship, that prepares a  
12 physician for the independent practice of medicine by providing didactic and  
13 clinical education in a medical discipline to a medical student who has  
14 completed a recognized undergraduate medical education program.

15 10. The prospective tiered per diem payment methodology for inpatient  
16 hospital services ~~may~~ SHALL include a mechanism for the payment of claims  
17 with extraordinary operating costs per day. For tiered per diem rates  
18 effective beginning on October 1, 1999, outlier cost thresholds are frozen at  
19 the levels in effect on January 1, 1999 and adjusted annually by the  
20 administration by the ~~data resources incorporated~~ GLOBAL INSIGHT HOSPITAL  
21 market basket index for prospective payment system hospitals. BEGINNING WITH  
22 DATES OF SERVICE ON OR AFTER OCTOBER 1, 2007, THE ADMINISTRATION SHALL PHASE  
23 IN THE USE OF THE MOST RECENT STATEWIDE URBAN AND STATEWIDE RURAL AVERAGE  
24 MEDICARE COST-TO-CHARGE RATIOS OR CENTERS FOR MEDICARE AND MEDICAID SERVICES  
25 APPROVED COST-TO-CHARGE RATIOS TO QUALIFY AND PAY EXTRAORDINARY OPERATING  
26 COSTS. THE ADMINISTRATION SHALL COMPLETE FULL IMPLEMENTATION OF THE PHASE-IN  
27 ON OR BEFORE OCTOBER 1, 2008. COST-TO-CHARGE RATIOS SHALL BE UPDATED  
28 ANNUALLY. ROUTINE MATERNITY CHARGES ARE NOT ELIGIBLE FOR OUTLIER  
29 REIMBURSEMENT.

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

33 I. The director may adopt rules that specify enrollment procedures  
34 including notice to contractors of enrollment. The rules may provide for  
35 varying time limits for enrollment in different situations. The  
36 administration shall specify in contract when a person who has been  
37 determined eligible will be enrolled with that contractor and the date on  
38 which the contractor will be financially responsible for health and medical  
39 services to the person.

40 J. The administration may make direct payments to hospitals for  
41 hospitalization and medical care provided to a member in accordance with this  
42 article and rules. The director may adopt rules to establish the procedures  
43 by which the administration shall pay hospitals pursuant to this subsection  
44 if a contractor fails to make timely payment to a hospital. Such payment  
45 shall be at a level determined pursuant to section 36-2904, subsection H

1 or I. The director may withhold payment due to a contractor in the amount of  
2 any payment made directly to a hospital by the administration on behalf of a  
3 contractor pursuant to this subsection.

4 K. The director shall establish a special unit within the  
5 administration for the purpose of monitoring the third party payment  
6 collections required by contractors and noncontracting providers pursuant to  
7 section 36-2903, subsection B, paragraph 10 and subsection F and section  
8 36-2915, subsection E. The director shall determine by rule:

9 1. The type of third party payments to be monitored pursuant to this  
10 subsection.

11 2. The percentage of third party payments that is collected by a  
12 contractor or noncontracting provider and that the contractor or  
13 noncontracting provider may keep and the percentage of such payments that the  
14 contractor or noncontracting provider may be required to pay to the  
15 administration. Contractors and noncontracting providers must pay to the  
16 administration one hundred per cent of all third party payments that are  
17 collected and that duplicate administration fee-for-service payments. A  
18 contractor that contracts with the administration pursuant to section  
19 36-2904, subsection A may be entitled to retain a percentage of third party  
20 payments if the payments collected and retained by a contractor are reflected  
21 in reduced capitation rates. A contractor may be required to pay the  
22 administration a percentage of third party payments that are collected by a  
23 contractor and that are not reflected in reduced capitation rates.

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

29 1. On written notice from the administration or oral or written notice  
30 from a member that a claim for covered services may be in violation of this  
31 section, the provider that has a contract with a contractor or noncontracting  
32 provider shall investigate the inquiry and verify whether the person was  
33 eligible for services at the time that covered services were provided. If  
34 the claim was paid or should have been paid by the system, the provider that  
35 has a contract with a contractor or noncontracting provider shall not  
36 continue billing the member.

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

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

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

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

7 3. If the administration determines that a provider that has a  
8 contract with a contractor or noncontracting provider has billed a member for  
9 charges that were paid or should have been paid by the administration, the  
10 administration shall send written notification by certified mail or other  
11 service with proof of delivery to the provider that has a contract with a  
12 contractor or noncontracting provider stating that this billing is in  
13 violation of federal and state law. If, twenty-one days or more after  
14 receiving the notification, a provider that has a contract with a contractor  
15 or noncontracting provider knowingly continues billing a member for charges  
16 that were paid or should have been paid by the system, the administration may  
17 assess a civil penalty in an amount equal to three times the amount of the  
18 billing and reduce payment to the provider that has a contract with a  
19 contractor or noncontracting provider accordingly. Receipt of delivery  
20 signed by the addressee or the addressee's employee is prima facie evidence  
21 of knowledge. Civil penalties collected pursuant to this subsection shall be  
22 deposited in the state general fund. Section 36-2918, subsections C, D and  
23 F, relating to the imposition, collection and enforcement of civil penalties,  
24 apply to civil penalties imposed pursuant to this paragraph.

25 M. The administration may conduct postpayment review of all claims  
26 paid by the administration and may recoup any monies erroneously paid. The  
27 director may adopt rules that specify procedures for conducting postpayment  
28 review. A contractor may conduct a postpayment review of all claims paid by  
29 the contractor and may recoup monies that are erroneously paid.

30 N. The director or the director's designee may employ and supervise  
31 personnel necessary to assist the director in performing the functions of the  
32 administration.

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

36 P. Notwithstanding any law to the contrary, on federal approval the  
37 administration may make disproportionate share payments to private hospitals,  
38 county operated hospitals, including hospitals owned or leased by a special  
39 health care district, and state operated institutions for mental disease  
40 beginning October 1, 1991 in accordance with federal law and subject to  
41 legislative appropriation. If at any time the administration receives  
42 written notification from federal authorities of any change or difference in  
43 the actual or estimated amount of federal funds available for  
44 disproportionate share payments from the amount reflected in the legislative  
45 appropriation for such purposes, the administration shall provide written

1 notification of such change or difference to the president and the minority  
2 leader of the senate, the speaker and the minority leader of the house of  
3 representatives, the director of the joint legislative budget committee, the  
4 legislative committee of reference and any hospital trade association within  
5 this state, within three working days not including weekends after receipt of  
6 the notice of the change or difference. In calculating disproportionate  
7 share payments as prescribed in this section, the administration may use  
8 either a methodology based on claims and encounter data that is submitted to  
9 the administration from contractors or a methodology based on data that is  
10 reported to the administration by private hospitals and state operated  
11 institutions for mental disease. The selected methodology applies to all  
12 private hospitals and state operated institutions for mental disease  
13 qualifying for disproportionate share payments.

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

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

20 S. If the administration implements an electronic claims submission  
21 system it may adopt procedures pursuant to subsection H of this section  
22 requiring documentation different than prescribed under subsection H,  
23 paragraph 4 of this section.

24 Sec. 7. Section 36-2912, Arizona Revised Statutes, is amended to read:

25 36-2912. Healthcare group coverage; program requirements for  
26 small businesses and public employers; related  
27 requirements; definitions

28 A. The administration shall administer a healthcare group program to  
29 allow willing contractors to deliver health care services to persons defined  
30 as eligible pursuant to section 36-2901, paragraph 6, subdivisions (b), (c),  
31 (d) and (e). In the absence of a willing contractor, the administration may  
32 contract directly with any health care provider or entity. The  
33 administration may enter into a contract with another entity to provide  
34 administrative functions for the healthcare group program. **BEGINNING ON THE**  
35 **EFFECTIVE DATE OF THIS AMENDMENT TO THIS SECTION, THE ADMINISTRATION SHALL**  
36 **NOT ACCEPT NEW APPLICATIONS FOR ENROLLMENT IN THE HEALTHCARE GROUP PROGRAM,**  
37 **EXCEPT THAT EMPLOYERS THAT OFFERED COVERAGE PURSUANT TO THIS SECTION BEFORE**  
38 **THE EFFECTIVE DATE OF THIS AMENDMENT TO THIS SECTION MAY ALSO ENROLL**  
39 **EMPLOYEES WHO ARE HIRED AFTER THE EFFECTIVE DATE OF THIS AMENDMENT TO THIS**  
40 **SECTION.**

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

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

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

5           3. Shall have a minimum of one and a maximum of fifty eligible  
6 employees at the effective date of their first contract with the  
7 administration.

8           C. The administration shall not enroll an employer group in healthcare  
9 group sooner than one hundred eighty days after the date that the employer's  
10 health insurance coverage under an accountable health plan is discontinued.  
11 Enrollment in healthcare group is effective on the first day of the month  
12 after the one hundred eighty day period. This subsection does not apply to  
13 an employer group if the employer's accountable health plan discontinues  
14 offering the health plan of which the employer is a member.

15           D. Employees with proof of other existing health care coverage who  
16 elect not to participate in the healthcare group program shall not be  
17 considered when determining the percentage of enrollment requirements under  
18 subsection B of this section if either:

19           1. Group health coverage is provided through a spouse, parent or legal  
20 guardian, or insured through individual insurance or another employer.

21           2. Medical assistance is provided by a government subsidized health  
22 care program.

23           3. Medical assistance is provided pursuant to section 36-2982,  
24 subsection I.

25           E. An employer shall not offer coverage made available pursuant to  
26 this section to persons defined as eligible pursuant to section 36-2901,  
27 paragraph 6, subdivision (b), (c), (d) or (e) as a substitute for a federally  
28 designated plan.

29           F. An employee or dependent defined as eligible pursuant to section  
30 36-2901, paragraph 6, subdivision (b), (c), (d) or (e) may participate in  
31 healthcare group on a voluntary basis only.

32           G. Notwithstanding subsection B, paragraph 2 of this section, the  
33 administration shall adopt rules to allow a business that offers healthcare  
34 group coverage pursuant to this section to continue coverage if it expands  
35 its employment to include more than fifty employees.

36           H. The administration shall provide eligible employees with disclosure  
37 information about the health benefit plan.

38           I. The director shall:

39           1. Require that any contractor that provides covered services to  
40 persons defined as eligible pursuant to section 36-2901, paragraph 6,  
41 subdivision (a) provide separate audited reports on the assets, liabilities  
42 and financial status of any corporate activity involving providing coverage  
43 pursuant to this section to persons defined as eligible pursuant to section  
44 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).

1           2. Beginning on July 1, 2005, require that a contractor, the  
2 administration or an accountable health plan negotiate reimbursement rates  
3 and not use the administration's reimbursement rates established pursuant to  
4 section 36-2903.01, subsection H, as a default reimbursement rate if a  
5 contract does not exist between a contractor and a provider.

6           3. Use monies from the healthcare group fund established by section  
7 36-2912.01 for the administration's costs of operating the healthcare group  
8 program.

9           4. Ensure that the contractors are required to meet contract terms as  
10 are necessary in the judgment of the director to ensure adequate performance  
11 by the contractor. Contract provisions shall include, at a minimum, the  
12 maintenance of deposits, performance bonds, financial reserves or other  
13 financial security. The director may waive requirements for the posting of  
14 bonds or security for contractors that have posted other security, equal to  
15 or greater than that required for the healthcare group program, with the  
16 administration or the department of insurance for the performance of health  
17 service contracts if funds would be available to the administration from the  
18 other security on the contractor's default. In waiving, or approving waivers  
19 of, any requirements established pursuant to this section, the director shall  
20 ensure that the administration has taken into account all the obligations to  
21 which a contractor's security is associated. The director may also adopt  
22 rules that provide for the withholding or forfeiture of payments to be made  
23 to a contractor for the failure of the contractor to comply with provisions  
24 of its contract or with provisions of adopted rules.

25           5. Adopt rules.

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

29           7. BEGINNING ON THE EFFECTIVE DATE OF THIS AMENDMENT TO THIS SECTION,  
30 NOT OFFER PLANS TO MEMBERS WITH NO DEDUCTIBLES OR NO COPAYMENTS.

31           8. BY JANUARY 1, 2008, CHARGE PREMIUMS AND COPAYMENTS TO MEMBERS AT A  
32 LEVEL THAT ENSURES THAT HEALTHCARE GROUP IS FUNDED AT LEAST AT NINETY PER  
33 CENT OF THE FULLY FUNDED ACTUARIAL RATE AS DETERMINED BY THE DEPARTMENT OF  
34 INSURANCE PURSUANT TO SECTION 20-1064.

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

40           K. The administration shall offer a health benefit plan on a  
41 guaranteed issuance basis to small employers as required by this section.  
42 All small employers qualify for this guaranteed offer of coverage. The  
43 administration shall provide a health benefit plan to each small employer  
44 without regard to health status-related factors if the small employer agrees  
45 to make the premium payments and to satisfy any other reasonable provisions

1 of the plan and contract. The administration shall offer to all small  
2 employers the available health benefit plan and shall accept any small  
3 employer that applies and meets the eligibility requirements. In addition to  
4 the requirements prescribed in this section, for any offering of any health  
5 benefit plan to a small employer, as part of the administration's  
6 solicitation and sales materials, the administration shall make a reasonable  
7 disclosure to the employer of the availability of the information described  
8 in this subsection and, on request of the employer, shall provide that  
9 information to the employer. The administration shall provide information  
10 concerning the following:

- 11 1. Provisions of coverage relating to the following, if applicable:  
12 (a) The administration's right to establish premiums and to change  
13 premium rates and the factors that may affect changes in premium rates.  
14 (b) Renewability of coverage.  
15 (c) Any preexisting condition exclusion.  
16 (d) The geographic areas served by the contractor.  
17 2. The benefits and premiums available under all health benefit plans  
18 for which the employer is qualified.

19 L. The administration shall describe the information required by  
20 subsection K of this section in language that is understandable by the  
21 average small employer and with a level of detail that is sufficient to  
22 reasonably inform a small employer of the employer's rights and obligations  
23 under the health benefit plan. This requirement is satisfied if the  
24 administration provides the following information:

- 25 1. An outline of coverage that describes the benefits in summary form.  
26 2. The rate or rating schedule that applies to the product,  
27 preexisting condition exclusion or affiliation period.  
28 3. The minimum employer contribution and group participation rules  
29 that apply to any particular type of coverage.  
30 4. In the case of a network plan, a map or listing of the areas  
31 served.

32 M. A contractor is not required to disclose any information that is  
33 proprietary and protected trade secret information under applicable law.

34 N. At least sixty days before the date of expiration of a health  
35 benefit plan, the administration shall provide a written notice to the  
36 employer of the terms for renewal of the plan.

37 O. The administration may increase or decrease premiums based on  
38 actuarial reviews of the projected and actual costs of providing health care  
39 benefits to eligible members. Before changing premiums, the administration  
40 must give sixty days' written notice to the employer. The administration may  
41 cap the amount of the change.

42 P. The administration may consider age, sex, income and community  
43 rating when it establishes premiums for the healthcare group program.

44 Q. Except as provided in subsection R of this section, a health  
45 benefit plan may not deny, limit or condition the coverage or benefits based

1 on a person's health status-related factors or a lack of evidence of  
2 insurability.

3 R. A health benefit plan shall not exclude coverage for preexisting  
4 conditions, except that:

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

11 2. The contractor shall reduce the period of any applicable  
12 preexisting condition exclusion by the aggregate of the periods of creditable  
13 coverage that apply to the individual.

14 S. The contractor shall calculate creditable coverage according to the  
15 following:

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

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

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

26 T. The contractor shall not count a period of creditable coverage with  
27 respect to enrollment of an individual if, after the most recent period of  
28 creditable coverage and before the enrollment date, sixty-three consecutive  
29 days lapse during all of which the individual was not covered under any  
30 creditable coverage. The contractor shall not include in the determination  
31 of the period of continuous coverage described in this section any period  
32 that an individual is in a waiting period for health insurance coverage  
33 offered by a health care insurer or is in a waiting period for benefits under  
34 a health benefit plan offered by a contractor. In determining the extent to  
35 which an individual has satisfied any portion of any applicable preexisting  
36 condition period the contractor shall count a period of creditable coverage  
37 without regard to the specific benefits covered during that period. A  
38 contractor shall not impose any preexisting condition exclusion in the case  
39 of an individual who is covered under creditable coverage thirty-one days  
40 after the individual's date of birth. A contractor shall not impose any  
41 preexisting condition exclusion in the case of a child who is adopted or  
42 placed for adoption before age eighteen and who is covered under creditable  
43 coverage thirty-one days after the adoption or placement for adoption.

44 U. The written certification provided by the administration must  
45 include:

1           1. The period of creditable coverage of the individual under the  
2 contractor and any applicable coverage under a COBRA continuation provision.  
3           2. Any applicable waiting period or affiliation period imposed on an  
4 individual for any coverage under the health plan.  
5           V. The administration shall issue and accept a written certification  
6 of the period of creditable coverage of the individual that contains at least  
7 the following information:  
8           1. The date that the certificate is issued.  
9           2. The name of the individual or dependent for whom the certificate  
10 applies and any other information that is necessary to allow the issuer  
11 providing the coverage specified in the certificate to identify the  
12 individual, including the individual's identification number under the policy  
13 and the name of the policyholder if the certificate is for or includes a  
14 dependent.  
15           3. The name, address and telephone number of the issuer providing the  
16 certificate.  
17           4. The telephone number to call for further information regarding the  
18 certificate.  
19           5. One of the following:  
20           (a) A statement that the individual has at least eighteen months of  
21 creditable coverage. For THE purposes of this subdivision, "eighteen months"  
22 means five hundred forty-six days.  
23           (b) Both the date that the individual first sought coverage, as  
24 evidenced by a substantially complete application, and the date that  
25 creditable coverage began.  
26           6. The date creditable coverage ended, unless the certificate  
27 indicates that creditable coverage is continuing from the date of the  
28 certificate.  
29           W. The administration shall provide any certification pursuant to this  
30 section within thirty days after the event that triggered the issuance of the  
31 certification. Periods of creditable coverage for an individual are  
32 established by presentation of the certifications in this section.  
33           X. The healthcare group program shall comply with all applicable  
34 federal requirements.  
35           Y. Healthcare group may pay a commission to an insurance producer. To  
36 receive a commission, the producer must certify that to the best of the  
37 producer's knowledge the employer group has not had insurance in the one  
38 hundred eighty days before applying to healthcare group. For the purposes of  
39 this subsection, "commission" means a one time payment on the initial  
40 enrollment of an employer.  
41           Z. On or before June 15 and November 15 of each year, the director  
42 shall submit a report to the joint legislative budget committee regarding the  
43 number and type of businesses participating in healthcare group and that  
44 includes updated information on healthcare group marketing activities. The  
45 director, within thirty days of implementation, shall notify the joint

- 1 legislative budget committee of any changes in healthcare group benefits or  
2 cost sharing arrangements.
- 3 AA. For the purposes of this section:
- 4 1. "Accountable health plan" has the same meaning prescribed in  
5 section 20-2301.
- 6 2. "COBRA continuation provision" means:
- 7 (a) Section 4980B, except subsection (f)(1) as it relates to pediatric  
8 vaccines, of the internal revenue code of 1986.
- 9 (b) Title I, subtitle B, part 6, except section 609, of the employee  
10 retirement income security act of 1974.
- 11 (c) Title XXII of the public health service act.
- 12 (d) Any similar provision of the law of this state or any other state.
- 13 3. "Creditable coverage" means coverage solely for an individual,  
14 other than limited benefits coverage, under any of the following:
- 15 (a) An employee welfare benefit plan that provides medical care to  
16 employees or the employees' dependents directly or through insurance,  
17 reimbursement or otherwise pursuant to the employee retirement income  
18 security act of 1974.
- 19 (b) A church plan as defined in the employee retirement income  
20 security act of 1974.
- 21 (c) A health benefits plan, as defined in section 20-2301, issued by a  
22 health plan.
- 23 (d) Part A or part B of title XVIII of the social security act.
- 24 (e) Title XIX of the social security act, other than coverage  
25 consisting solely of benefits under section 1928.
- 26 (f) Title 10, chapter 55 of the United States Code.
- 27 (g) A medical care program of the Indian health service or of a tribal  
28 organization.
- 29 (h) A health benefits risk pool operated by any state of the United  
30 States.
- 31 (i) A health plan offered pursuant to title 5, chapter 89 of the  
32 United States Code.
- 33 (j) A public health plan as defined by federal law.
- 34 (k) A health benefit plan pursuant to section 5(e) of the peace corps  
35 act (22 United States Code section 2504(e)).
- 36 (l) A policy or contract, including short-term limited duration  
37 insurance, issued on an individual basis by an insurer, a health care  
38 services organization, a hospital service corporation, a medical service  
39 corporation or a hospital, medical, dental and optometric service corporation  
40 or made available to persons defined as eligible under section 36-2901,  
41 paragraph 6, subdivisions (b), (c), (d) and (e).
- 42 (m) A policy or contract issued by a health care insurer or the  
43 administration to a member of a bona fide association.
- 44 4. "Eligible employee" means a person who is one of the following:

1 (a) Eligible pursuant to section 36-2901, paragraph 6, subdivisions  
2 (b), (c), (d) and (e).

3 (b) A person who works for an employer for a minimum of twenty hours  
4 per week or who is self-employed for at least twenty hours per week.

5 (c) An employee who elects coverage pursuant to section 36-2982,  
6 subsection I. The restriction prohibiting employees employed by public  
7 agencies prescribed in section 36-2982, subsection I does not apply to this  
8 subdivision.

9 (d) A person who meets all of the eligibility requirements, who is  
10 eligible for a federal health coverage tax credit pursuant to section 35 of  
11 the internal revenue code of 1986 and who applies for health care coverage  
12 through the healthcare group program. The requirement that a person be  
13 employed with a small business that elects healthcare group coverage does not  
14 apply to this eligibility group.

15 5. "Genetic information" means information about genes, gene products  
16 and inherited characteristics that may derive from the individual or a family  
17 member, including information regarding carrier status and information  
18 derived from laboratory tests that identify mutations in specific genes or  
19 chromosomes, physical medical examinations, family histories and direct  
20 ~~analysis~~ ANALYSES of genes or chromosomes.

21 6. "Health benefit plan" means coverage offered by the administration  
22 for the healthcare group program pursuant to this section.

23 7. "Health status-related factor" means any factor in relation to the  
24 health of the individual or a dependent of the individual enrolled or to be  
25 enrolled in a health plan including:

- 26 (a) Health status.
- 27 (b) Medical condition, including physical and mental illness.
- 28 (c) Claims experience.
- 29 (d) Receipt of health care.
- 30 (e) Medical history.
- 31 (f) Genetic information.
- 32 (g) Evidence of insurability, including conditions arising out of acts  
33 of domestic violence as defined in section 20-448.

34 (h) The existence of a physical or mental disability.

35 8. "Hospital" means a health care institution licensed as a hospital  
36 pursuant to chapter 4, article 2 of this title.

37 9. "Late enrollee" means an employee or dependent who requests  
38 enrollment in a health benefit plan after the initial enrollment period that  
39 is provided under the terms of the health benefit plan if the initial  
40 enrollment period is at least thirty-one days. Coverage for a late enrollee  
41 begins on the date the person becomes a dependent if a request for enrollment  
42 is received within thirty-one days after the person becomes a dependent. An  
43 employee or dependent shall not be considered a late enrollee if:

- 44 (a) The person:

1 (i) At the time of the initial enrollment period was covered under a  
2 public or private health insurance policy or any other health benefit plan.

3 (ii) Lost coverage under a public or private health insurance policy  
4 or any other health benefit plan due to the employee's termination of  
5 employment or eligibility, the reduction in the number of hours of  
6 employment, the termination of the other plan's coverage, the death of the  
7 spouse, legal separation or divorce or the termination of employer  
8 contributions toward the coverage.

9 (iii) Requests enrollment within thirty-one days after the termination  
10 of creditable coverage that is provided under a COBRA continuation provision.

11 (iv) Requests enrollment within thirty-one days after the date of  
12 marriage.

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

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

19 10. "Preexisting condition" means a condition, regardless of the cause  
20 of the condition, for which medical advice, diagnosis, care or treatment was  
21 recommended or received within not more than six months before the date of  
22 the enrollment of the individual under a health benefit plan issued by a  
23 contractor. Preexisting condition does not include a genetic condition in  
24 the absence of a diagnosis of the condition related to the genetic  
25 information.

26 11. "Preexisting condition limitation" or "preexisting condition  
27 exclusion" means a limitation or exclusion of benefits for a preexisting  
28 condition under a health benefit plan offered by a contractor.

29 12. "Small employer" means an employer who employs at least one but not  
30 more than fifty eligible employees on a typical business day during any one  
31 calendar year.

32 13. "Waiting period" means the period that must pass before a potential  
33 participant or eligible employee in a health benefit plan offered by a health  
34 plan is eligible to be covered for benefits as determined by the individual's  
35 employer.

36 Sec. 8. Section 36-2912.01, Arizona Revised Statutes, is amended to  
37 read:

38 36-2912.01. Healthcare group fund; nonlapsing

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

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

43 2. Gifts, grants and donations.

44 3. Legislative appropriations.

45 B. The administration shall administer the fund.

1 C. Monies in the fund are continuously appropriated and are exempt  
2 from the provisions of section 35-190 relating to the lapsing of  
3 appropriations. Administrative costs to operate the program are subject to  
4 legislative appropriation.

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

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

11 F. Subject to legislative appropriation, the administration may use  
12 fund monies from premiums to pay the administrative costs for the  
13 administration to operate the healthcare group program. FOR THE PURPOSES OF  
14 THIS SUBSECTION, "administrative costs":

15 1. INCLUDES ALL COSTS TO SUPPORT AND SUPERVISE THE WORK DONE BY  
16 PRIVATE HEALTH PLANS.

17 2. Do not include commissions or fees paid by the healthcare program  
18 to insurance producers.

19 Sec. 9. Title 36, chapter 29, article 1, Arizona Revised Statutes, is  
20 amended by adding section 36-2923, to read:

21 36-2923. Insurer claims data reporting requirements;  
22 administration as payor of last resort; report;  
23 definition

24 A. A HEALTH CARE INSURER SHALL:

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

33 2. ACCEPT THE STATE'S RIGHT OF RECOVERY FROM A THIRD PARTY PAYOR  
34 PURSUANT TO SECTION 36-2903 AND THE ASSIGNMENT TO THIS STATE OF ANY RIGHT OF  
35 AN INDIVIDUAL OR OTHER ENTITY TO PAYMENT FROM THE THIRD PARTY PAYOR FOR AN  
36 ITEM OR SERVICE FOR WHICH PAYMENT HAS BEEN MADE PURSUANT TO THIS CHAPTER.  
37 THIS PARAGRAPH DOES NOT EXPAND THE SCOPE OF COVERAGE, BENEFITS OR RIGHTS  
38 UNDER THE POLICY ISSUED BY THE HEALTH CARE INSURER.

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

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

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

7           (b) AN ACTION BY THIS STATE TO ENFORCE ITS RIGHTS WITH RESPECT TO THE  
8 CLAIM IS COMMENCED WITHIN SIX YEARS AFTER THE STATE SUBMITTED THE CLAIM. THE  
9 HEALTH CARE INSURER MAY DENY THE CLAIM SUBMITTED BY THE STATE IF THE HEALTH  
10 CARE INSURER HAS ALREADY PAID THE CLAIM IN ACCORDANCE WITH THE BENEFIT PLAN  
11 UNDER WHICH THE MEMBER WAS COVERED BY THE HEALTH CARE INSURER ON THE DATE OF  
12 SERVICE.

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

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

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

20           C. THE DIRECTOR SHALL SUBMIT A COPY OF EACH REPORT TO THE GOVERNOR,  
21 THE PRESIDENT OF THE SENATE AND THE SPEAKER OF THE HOUSE OF REPRESENTATIVES  
22 AND SHALL PROVIDE A COPY OF EACH REPORT TO THE SECRETARY OF STATE AND THE  
23 DIRECTOR OF THE ARIZONA STATE LIBRARY, ARCHIVES AND PUBLIC RECORDS.

24           D. ANY INFORMATION OBTAINED BY THE DIRECTOR OR THE ADMINISTRATION  
25 UNDER THIS SECTION SHALL BE MAINTAINED AS CONFIDENTIAL AS REQUIRED BY THE  
26 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (P.L. 104-191;  
27 110 STAT. 1936) AND OTHER APPLICABLE LAW AND SHALL BE USED SOLELY FOR THE  
28 PURPOSE OF DETERMINING WHETHER A HEALTH CARE INSURER WAS ALSO PROVIDING  
29 COVERAGE TO AN INDIVIDUAL DURING THE PERIOD THAT THE INDIVIDUAL WAS AN  
30 ELIGIBLE MEMBER, FOR THE PURPOSES OF AVOIDING PAYMENTS BY THE SYSTEM FOR  
31 SERVICES COVERED THROUGH OTHER INSURANCE AND FOR ENFORCING THE  
32 ADMINISTRATION'S RIGHT TO ASSIGNMENT UNDER SUBSECTION A OF THIS SECTION.

33           E. FOR THE PURPOSES OF THIS SECTION, "HEALTH CARE INSURER" MEANS A  
34 SELF-INSURED HEALTH BENEFIT PLAN, A GROUP HEALTH PLAN AS DEFINED IN SECTION  
35 607(1) OF THE EMPLOYMENT RETIREMENT INCOME SECURITY ACT OF 1974, A PHARMACY  
36 BENEFIT MANAGER AND ANY OTHER PARTY THAT BY STATUTE, CONTRACT OR AGREEMENT IS  
37 RESPONSIBLE FOR PAYING FOR ITEMS OR SERVICES PROVIDED TO AN ELIGIBLE PERSON  
38 UNDER THIS CHAPTER, INCLUDING:

39           1. AN ENTITY TRANSACTING DISABILITY INSURANCE AS DEFINED IN SECTION  
40 20-253.

41           2. HOSPITAL SERVICE CORPORATIONS, MEDICAL SERVICE CORPORATIONS, DENTAL  
42 SERVICE CORPORATIONS, OPTOMETRIC SERVICE CORPORATIONS AND HOSPITAL, MEDICAL,  
43 DENTAL AND OPTOMETRIC SERVICE CORPORATIONS AS DEFINED IN SECTION 20-822.

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

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



1 D. Unless otherwise required by the administration, the health plans  
2 shall provide medically necessary health and medical services as required by  
3 section 36-2907.

4 E. A person who is enrolled in the program must notify the  
5 administration when the person becomes eligible for medicare benefits through  
6 42 United States Code section 426(b) or section 426-1. A person who is  
7 enrolled in the program and who becomes eligible for medicare benefits is  
8 ineligible for the program.

9 F. If the director determines that monies may be insufficient for the  
10 program, the administration may stop processing applications until the  
11 administration is able to verify that funding is sufficient to fund the  
12 program.

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

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

24 Sec. 11. Section 36-2988, Arizona Revised Statutes, is amended to  
25 read:

26 36-2988. Delivery of services; health plans; requirements

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

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

33 C. As determined by the director, reinsurance may be provided against  
34 expenses in excess of a specified amount on behalf of any member for covered  
35 emergency services, inpatient services or outpatient services in the same  
36 manner as reinsurance provided under article 1 of this chapter. Subject to  
37 the approval of the director, reinsurance may be obtained against expenses in  
38 excess of a specified amount on behalf of any member.

39 D. Notwithstanding any other law, the administration may procure,  
40 provide or coordinate covered services by interagency agreement with  
41 authorized agencies of this state for distinct groups of members, including  
42 persons eligible for children's rehabilitative services through the  
43 department of health services and members eligible for comprehensive medical  
44 and dental benefits through the department of economic security.

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

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

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

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

21 I. The administration and contractors shall not contract for any  
22 services or functions related to this article with a school district,  
23 including contracting for the delivery of services, screening, outreach or  
24 information that involves the use of school staff and facilities. ~~A school~~  
25 ~~district may perform outreach and information activities that relate to this~~  
26 ~~article.~~ A SCHOOL DISTRICT MAY DISTRIBUTE INFORMATION PROVIDED BY THE  
27 ADMINISTRATION TO POTENTIALLY ELIGIBLE PUPILS AND THEIR FAMILIES REGARDING  
28 AVAILABLE SERVICES AND PROGRAMS. Outreach and information activities  
29 performed by a school district shall not reduce or interfere with classroom  
30 instruction time.

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

33 Sec. 12. Section 36-3410, Arizona Revised Statutes, is amended to  
34 read:

35 36-3410. Regional behavioral health authorities; contracts;  
36 monthly summaries; inspection; copying fee;  
37 children's behavioral health services; transfers;  
38 prohibition

39 A. If the department contracts with behavioral health contractors  
40 which would act as regional behavioral health authorities or directly with a  
41 service provider for behavioral health services, the department and each  
42 behavioral health contractor or service provider shall prepare and make  
43 available monthly summary statements, in a format prescribed by the  
44 department, that separately detail by title XIX and nontitle XIX and by  
45 service category and service type, as defined by contract with the

1 department, the number of clients served, the units of service provided and  
2 the state and federal monies distributed through the department to each  
3 regional behavioral health authority or direct contract service provider and  
4 the amounts distributed by each regional behavioral health authority or  
5 direct contract service provider to their subcontractors. The director may  
6 require additional information in the monthly statement which the director  
7 determines to be critical for proper regulation and oversight of the regional  
8 behavioral health authority or the direct contract service provider.

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

13 C. BEHAVIORAL HEALTH CONTRACTORS UNDER CONTRACT WITH THE DEPARTMENT TO  
14 ACT AS REGIONAL BEHAVIORAL HEALTH AUTHORITIES MAY PERFORM ONLY MANAGED CARE  
15 FUNCTIONS. REGIONAL BEHAVIORAL HEALTH AUTHORITIES AND THEIR SUBSIDIARIES  
16 SHALL NOT DELIVER BEHAVIORAL HEALTH SERVICES DIRECTLY TO CLIENTS. THE  
17 PROHIBITION ON REGIONAL BEHAVIORAL HEALTH AUTHORITIES AND THEIR SUBSIDIARIES  
18 DELIVERING BEHAVIORAL HEALTH SERVICES DIRECTLY TO CLIENTS SHALL BE FULLY  
19 IMPLEMENTED BY SEPTEMBER 1, 2009.

20 ~~B.~~ D. In the contracts specified under subsection A of this section,  
21 the department may include a provision to charge for services provided at the  
22 state hospital. The charges are only for clients on whose behalf the  
23 contractor has been paid by the department.

24 ~~C.~~ E. The summaries and the contracts on which they are based are  
25 open to public inspection. The department and each regional behavioral  
26 health authority or direct contract service provider shall make the summaries  
27 available for inspection and copying at the office of each regional  
28 behavioral health authority or direct contract service provider and at the  
29 department.

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

34 ~~E.~~ G. Copying fees received by the department, pursuant to subsection  
35 ~~D.~~ F of this section, shall be placed in the state general fund.

36 ~~F.~~ H. Monies appropriated for fiscal year 2001-2002 and each fiscal  
37 year thereafter for children's behavioral health services shall be spent on  
38 services only as prescribed by the appropriation and may not be used for any  
39 other purpose.

40 I. MONIES APPROPRIATED FOR FISCAL YEAR 2007-2008 AND EACH FISCAL YEAR  
41 THEREAFTER FOR SERIOUSLY MENTALLY ILL SERVICES SHALL BE SPENT ON SERVICES  
42 ONLY AS PRESCRIBED BY THE APPROPRIATION AND MAY NOT BE USED FOR ANY OTHER  
43 PURPOSE.

1           Sec. 13. Section 38-654, Arizona Revised Statutes, is amended to read:  
2           38-654. Special employee health insurance trust fund; purpose;  
3                     investment of monies; use of monies; exemption from  
4                     lapsing; annual report

5           A. There is established a special employee health insurance trust fund  
6 for the purpose of administering the state employee health insurance benefit  
7 plans. The fund shall consist of legislative appropriations, monies  
8 collected from the employer and employees for the health insurance benefit  
9 plans and investment earnings on monies collected from employees. The fund  
10 shall be administered by the director of the department of administration.  
11 Monies in the fund that are determined by the legislature to be for  
12 administrative expenses of the department of administration, including monies  
13 authorized by subsection D, paragraph 4 of this section, are subject to  
14 legislative appropriation.

15           B. On notice from the department of administration, the state  
16 treasurer shall invest and divest monies in the fund as provided by section  
17 35-313, and monies earned from investment shall be credited to the fund.  
18 There shall be a separate accounting of monies contributed by the employer,  
19 monies collected from state employees and investment earnings on monies  
20 collected from employees. Monies collected from state employees for health  
21 insurance benefit plans shall be expended prior to expenditure of monies  
22 contributed by the employer.

23           C. The director of the department of administration may authorize the  
24 employer health insurance contributions by fund to be payable in advance  
25 whether the budget unit is funded in whole or in part by state monies. By  
26 July 15 each year, the joint legislative budget committee staff shall  
27 determine the amount appropriated for employer health insurance  
28 contributions. The department of administration may transfer to the special  
29 employee health insurance trust fund in whole or in part the amount  
30 appropriated to budget units for employer health insurance contributions as  
31 deemed necessary.

32           D. Monies in the fund shall be used by the department of  
33 administration for the following purposes for the benefit of officers and  
34 employees who participate in a health insurance benefit plan pursuant to this  
35 article:

36           1. To administer a health insurance benefit program for state officers  
37 and employees.

38           2. To pay health insurance premiums, claims costs and related  
39 administrative expenses.

40           3. To apply against future premiums, claims costs and related  
41 administrative expenses.

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

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

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

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

11 H. The department of administration shall submit an annual report on  
12 the financial status of the special employee insurance trust fund to the  
13 governor, the president of the senate, the speaker of the house of  
14 representatives, the chairpersons of the house and senate appropriations  
15 committees and the joint legislative budget committee staff by March 1 ~~of~~  
16 ~~each year~~. The report shall include:

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

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

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

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

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

32 1. AN ESTIMATE OF THE COSTS OR SAVINGS ASSOCIATED WITH THE CHANGE.

33 2. AN EXPLANATION OF WHY THE CHANGE WAS IMPLEMENTED BEFORE THE NEXT  
34 PLAN YEAR.

35 Sec. 14. Section 46-803, Arizona Revised Statutes, is amended to read:

36 46-803. Eligibility for child care assistance

37 A. The department shall provide child care assistance to eligible  
38 families who are attempting to achieve independence from the cash assistance  
39 program and who need child care assistance in support of and as specified in  
40 their personal responsibility agreement pursuant to chapters 1 and 2 of this  
41 title.

42 B. The department shall provide child care assistance to eligible  
43 families who are transitioning off of cash assistance due to increased  
44 earnings or child support income in order to accept or maintain employment.  
45 Eligible families must request this assistance within six months after the

1 cash assistance case closure. Child care assistance may be provided for up  
2 to twenty-four months after the case closure and shall cease whenever the  
3 family income exceeds one hundred sixty-five per cent of the federal poverty  
4 level.

5 C. The department shall provide child care assistance to eligible  
6 families who are diverted from cash assistance pursuant to section 46-298 in  
7 order to obtain or maintain employment. Child care assistance may be  
8 provided for up to twenty-four months after the case closure and shall cease  
9 whenever the family income exceeds one hundred sixty-five per cent of the  
10 federal poverty level.

11 D. The department may provide child care assistance to support  
12 eligible families with incomes of one hundred sixty-five per cent or less of  
13 the federal poverty level to accept or maintain employment. Priority for  
14 this child care assistance shall be given to families with incomes of one  
15 hundred per cent or less of the federal poverty level.

16 E. The department may provide child care assistance to families  
17 referred by child protective services and to children in foster care pursuant  
18 to title 8, chapter 5 to support child protection.

19 F. The department may provide child care assistance to special  
20 circumstance families whose incomes are one hundred sixty-five per cent or  
21 less of the federal poverty level and who are unable to provide child care  
22 for a portion of a twenty-four hour day due to a crisis situation of domestic  
23 violence or homelessness, or a physical, mental, emotional or medical  
24 condition, participation in a drug treatment or drug rehabilitation program  
25 or court ordered community restitution. Priority for this child care  
26 assistance shall be given to families with incomes of one hundred per cent or  
27 less of the federal poverty level.

28 G. In lieu of the employment activity required in subsection B, C or D  
29 of this section, the department may allow eligible families with teenaged  
30 custodial parents under twenty years of age to complete a high school diploma  
31 or its equivalent or engage in remedial education activities reasonably  
32 related to employment goals.

33 H. The department may provide supplemental child care assistance for  
34 department approved education and training activities if the eligible parent,  
35 legal guardian or caretaker relative is working at least a monthly average of  
36 twenty hours per week and this education and training are reasonably related  
37 to employment goals. The eligible parent, legal guardian or caretaker  
38 relative must demonstrate satisfactory progress in the education or training  
39 activity.

40 I. Beginning March 12, 2003, the department shall establish waiting  
41 lists for child care assistance and prioritize child care assistance for  
42 different eligibility categories in order to manage within appropriated and  
43 available monies. Priority of children on the waiting list shall start with  
44 those families at one hundred per cent of the federal poverty level and  
45 continue with each successive ten per cent increase in the federal poverty

1 level until the maximum allowable federal poverty level of one hundred  
2 sixty-five per cent. Priority shall be given regardless of time spent on the  
3 waiting list.

4 J. The department shall establish criteria for denying, reducing or  
5 terminating child care assistance that include:

6 1. Whether there is a parent, legal guardian or caretaker relative  
7 available to care for the child.

8 2. Financial or programmatic eligibility changes or ineligibility.

9 3. Failure to cooperate with the requirements of the department to  
10 determine or redetermine eligibility.

11 4. Hours of child care need that fall within the child's compulsory  
12 academic school hours.

13 5. Reasonably accessible and available publicly funded early childhood  
14 education programs.

15 6. Whether an otherwise eligible family has been sanctioned and cash  
16 assistance has been terminated pursuant to chapter 2 of this title.

17 7. Other circumstances of a similar nature.

18 8. Whether sufficient monies exist for the assistance.

19 K. Families receiving child care assistance under subsection D or F of  
20 this section are also subject to the following requirements for such child  
21 care assistance:

22 1. Each ~~child~~ FAMILY is limited to no more than ~~sixty~~ FORTY-EIGHT  
23 cumulative months of child care assistance. The department may provide an  
24 extension if the family can prove that the family is making efforts to  
25 improve skills and move towards self-sufficiency.

26 2. Families are limited to no more than six children receiving child  
27 care assistance.

28 3. Copayments shall be imposed for all children receiving child care  
29 assistance. Copayments for each child may be higher for the first child in  
30 child care than for additional children in child care.

31 L. The department shall review each case at least once a year to  
32 evaluate eligibility for child care assistance.

33 M. The department shall report on December 31 and June 30 of each year  
34 to the joint legislative budget committee the total number of families who  
35 applied for child care assistance and the total number of families who were  
36 denied assistance under this section because the parents, legal guardians or  
37 caretaker relatives who applied for assistance were not citizens or legal  
38 residents of the United States or were not otherwise lawfully present in the  
39 United States.

40 N. This section shall be enforced without regard to race, religion,  
41 gender, ethnicity or national origin.

42 O. Notwithstanding section 35-173, monies appropriated for the  
43 purposes of this section shall not be used for any other purpose without the  
44 approval of the joint legislative budget committee.

1 P. The department shall refer all child care subsidy recipients to  
2 child support enforcement and to local workforce services and provide  
3 information on the earned income tax credit.

4 Sec. 15. Laws 2006, chapter 350, section 20 is amended to read:

5 Sec. 20. Department of economic security; Navajo senior center;  
6 appropriation

7 The sum of \$350,000 is appropriated from the state general fund in  
8 fiscal year 2006-2007 to the department of economic security for distribution  
9 to the Navajo Tribe as one-time funding for senior citizen centers. THIS  
10 APPROPRIATION IS EXEMPT FROM THE PROVISIONS OF SECTION 35-190, ARIZONA  
11 REVISED STATUTES, RELATING TO LAPSING OF APPROPRIATIONS.

12 Sec. 16. AHCCCS; acute care redeterminations; report

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

22 Sec. 17. County acute care contribution; fiscal year 2007-2008

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

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

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

1 pursuant to section 42-5029, subsection D, paragraph 2, Arizona Revised  
2 Statutes, plus interest on that amount pursuant to section 44-1201, Arizona  
3 Revised Statutes, retroactive to the first day the funding was due. If the  
4 monies the state treasurer withholds are insufficient to meet that county's  
5 funding requirements as specified in subsection A of this section, the state  
6 treasurer shall withhold from any other monies payable to that county from  
7 whatever state funding source is available an amount necessary to fulfill  
8 that county's requirement. The state treasurer shall not withhold  
9 distributions from the highway user revenue fund pursuant to title 28,  
10 chapter 18, article 2, Arizona Revised Statutes.

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

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

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

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

36 Sec. 18. ALTCs; county contributions

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

40	1. Apache	\$ 584,100
41	2. Cochise	\$ 5,350,300
42	3. Coconino	\$ 1,752,600
43	4. Gila	\$ 2,248,600
44	5. Graham	\$ 1,042,800
45	6. Greenlee	\$ 129,100

1	7. La Paz	\$ 841,400
2	8. Maricopa	\$150,143,900
3	9. Mohave	\$ 7,851,100
4	10. Navajo	\$ 2,416,200
5	11. Pima	\$ 38,846,800
6	12. Pinal	\$ 10,781,400
7	13. Santa Cruz	\$ 1,791,100
8	14. Yavapai	\$ 8,443,500
9	15. Yuma	\$ 6,340,300

10 Sec. 19. Hospitalization and medical care contribution; fiscal  
11 year 2006-2007

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

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

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

1 county's requirement. The state treasurer shall not withhold distributions  
2 from the highway user revenue fund pursuant to title 28, chapter 18, article  
3 2, Arizona Revised Statutes.

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

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

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

18 Sec. 20. Child care eligibility levels; report

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

25 Sec. 21. Competency restoration treatment; county and city  
26 reimbursement; fiscal year 2007-2008; deposit; tax  
27 withholding

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

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

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

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

3 Sec. 22. Health insurance premiums; department of  
4 administration

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

9 Sec. 23. Children's health insurance program; parents  
10 eligibility; fiscal year 2007-2008

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

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

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

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

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

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

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

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

4 Sec. 24. AHCCCS; exclusions from outlier payment report

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

13 Sec. 25. AHCCCS; exemption from rule making

14 The Arizona health care cost containment system administration is  
15 exempt from rule making requirements of title 41, chapter 6, Arizona Revised  
16 Statutes, until October 1, 2008 in order to implement a revised outlier  
17 reimbursement methodology pursuant to this act.

18 Sec. 26. AHCCCS; nonemergency transportation report

19 The Arizona health care cost containment system administration shall  
20 report to the joint legislative budget committee on or before December 15,  
21 2007 on nonemergency transportation usage. The report shall include, at a  
22 minimum, the estimated costs of emergency and nonemergency transportation and  
23 potential cost-saving modifications to nonemergency transportation  
24 utilization.

25 Sec. 27. Health savings account pilot program; review

26 A. The department of administration shall design a pilot program for  
27 the use of health savings accounts with a qualifying state-sponsored high  
28 deductible health plan, as defined in Public Law 108-173, for active state  
29 employees eligible pursuant to section 38-651, Arizona Revised Statutes. On  
30 or before December 1, 2007, the department shall submit the pilot program  
31 design to the joint legislative budget committee for review. The program  
32 design report may include multiple options for final implementation, which  
33 may include various levels of state participation or benefit design. For  
34 each option, the pilot program design shall include:

35 1. Benefit design, including deductible amounts, for the qualifying  
36 high deductible health plan.

37 2. Premium amounts for the qualifying high deductible health plan.

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

40 4. Employer and employee contribution strategy for health savings  
41 account deposits.

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

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

1           7. Investment options for account holders.  
2           8. Administrative and claim costs.  
3           9. Actuarial assumptions, including demographic, participation and  
4 utilization assumptions, used in program design.  
5           10. Impact analysis of offering the high deductible option on existing  
6 health plans.  
7           11. The potential cost of including retirees.  
8           B. The department of administration shall implement the pilot program  
9 no later than the beginning of the 2008-2009 state employee health insurance  
10 plan year.  
11           C. The total average per person employer cost of the pilot program,  
12 including the contributions for the health savings account and the high  
13 deductible health plan, shall not exceed the total average per person  
14 employer cost of the self-insured state employee health benefits program for  
15 the same fiscal year.  
16           D. On or before November 1, 2008, and each year thereafter, the  
17 department shall submit a report to the joint legislative budget committee  
18 detailing the enrollment and expenditures for the pilot program in total and  
19 by plan option.  
20           E. This pilot program shall be operated through September 30, 2012.  
21           Sec. 28. Delayed repeal  
22           Section 27 of this act, relating to the health savings account pilot  
23 program, is repealed from and after September 30, 2012.  
24           Sec. 29. Health reimbursement account pilot program; review  
25           A. The department of administration shall design a pilot program for  
26 the use by active state employees eligible pursuant to section 38-651,  
27 Arizona Revised Statutes, of health reimbursement accounts with a qualifying  
28 state-sponsored high deductible health plan. On or before December 1, 2007,  
29 the department shall submit the pilot program design to the joint legislative  
30 budget committee for review. The program design report may include multiple  
31 options for final implementation, which may include various levels of state  
32 participation or benefit design. For each option, the pilot program design  
33 shall include:  
34           1. A high deductible health plan that may be the same as a health plan  
35 designed for use with a health savings account as required by section 24 of  
36 this act.  
37           2. Benefit design, including deductible amounts, for the qualifying  
38 high deductible health plan.  
39           3. Premium amounts for the qualifying high deductible health plan.  
40           4. Employee and employer contribution strategy for the high deductible  
41 health plan premiums.  
42           5. Employer contribution strategy for health reimbursement account.  
43           6. Administrative and claim costs.  
44           7. Actuarial assumptions, including demographic, participation and  
45 utilization assumptions, used in program design.

1           8. Impact analysis of offering the high deductible option on existing  
2 health plans.

3           9. The potential cost of including retirees.

4           B. The department of administration shall implement the pilot program  
5 no later than the beginning of the 2008-2009 state employee health insurance  
6 plan year.

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

12           D. On or before November 1, 2008, and each year thereafter, the  
13 department shall submit a report to the joint legislative budget committee  
14 detailing the enrollment and expenditures for the pilot program in total and  
15 by plan option.

16           E. This pilot program shall be operated through September 30, 2012.

17           Sec. 30. AHCCCS; healthcare group study committee; members;  
18 duties

19           A. The healthcare group study committee is established consisting of  
20 the following members:

21           1. Three members of the house of representatives who are appointed by  
22 the speaker of the house of representatives, not more than two of whom are  
23 members of the same political party.

24           2. Three members of the senate who are appointed by the president of  
25 the senate, not more than two of whom are members of the same political  
26 party.

27           3. The director of the Arizona health care cost containment system  
28 administration or the director's designee.

29           4. One representative of a hospital, medical, dental or optometric  
30 service corporation who is appointed by the speaker of the house of  
31 representatives.

32           5. One representative of a health care services organization who is  
33 appointed by the president of the senate.

34           6. One representative of a disability or group disability insurer who  
35 is appointed by the speaker of the house of representatives.

36           7. One representative of a hospital and health care association who is  
37 appointed by the president of the senate.

38           8. One representative of a provider of services pursuant to section  
39 36-2912, Arizona Revised Statutes, who is appointed by the president of the  
40 senate.

41           9. One representative of a provider of services pursuant to section  
42 36-2912, Arizona Revised Statutes, who is appointed by the speaker of the  
43 house of representatives.

44           B. Appointed members serve at the pleasure of the person who made the  
45 appointment.

1 C. Committee members are not eligible to receive compensation, but  
2 members appointed by the speaker of the house of representatives or the  
3 president of the senate are eligible for reimbursement of expenses under  
4 title 38, chapter 4, article 2, Arizona Revised Statutes.

5 D. The committee shall:

6 1. Determine whether the Arizona health care cost containment system  
7 administration or a separate board should oversee the risk pool.

8 2. Outline an operations plan, recommend a rating strategy under which  
9 risk pool rates are at least two hundred per cent of standard individual  
10 market rates, determine how the risk pool can be the source for portability  
11 coverage under the health insurance portability and accountability act of  
12 1996 (P.L. 104-191; 110 Stat. 1936) and develop a plan for other technical  
13 functions.

14 3. Ensure that the risk pool recommendation identifies state general  
15 fund monies or another broad funding source.

16 4. Submit a report of its findings and recommendations on or before  
17 February 1, 2008 to the governor, the president of the senate and the speaker  
18 of the house of representatives and provide a copy of this report to the  
19 secretary of state and the director of the Arizona state library, archives  
20 and public records.

21 Sec. 31. Delayed repeal

22 Section 30 of this act, relating to the healthcare group study  
23 committee, is repealed from and after September 30, 2008.

24 Sec. 32. Appropriation; healthcare group program; exemption

25 A. The sum of \$8,000,000 is appropriated from the state general fund  
26 in fiscal year 2007-2008 to the Arizona health care cost containment system  
27 administration for the healthcare group program.

28 B. The appropriation made in subsection A of this section is exempt  
29 from the provisions of section 35-190, Arizona Revised Statutes, relating to  
30 lapsing of appropriations.

31 Sec. 33. Vital records; fund balances; appropriation;  
32 retroactivity

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

37 B. This section is effective retroactively to June 30, 2007.

38 Sec. 34. Appropriation; financial audit of healthcare group;  
39 exemption

40 A. The sum of \$200,000 is appropriated from the medically needy  
41 account established by section 36-774, Arizona Revised Statutes, in fiscal  
42 year 2007-2008 to the department of insurance for a financial audit of  
43 healthcare group. The department shall complete the audit on or before  
44 January 1, 2008.

1           B. The appropriation made in subsection A of this section is exempt  
2 from the provisions of section 35-190, Arizona Revised Statutes, relating to  
3 lapsing of appropriations.

4           Sec. 35. Appropriations: regenerative tissue repository:  
5                                   exemption

6           A. The sum of \$3,000,000 is appropriated from the state general fund  
7 in each of the fiscal years 2007-2008, 2008-2009, 2009-2010, 2010-2011 and  
8 2011-2012 to the Arizona biomedical research commission for centralized  
9 Arizona repositories of diverse types of human stem cells of nonembryonic  
10 origin obtained in this state. The commission shall establish a competitive  
11 request for proposal process to establish the repositories.

12           B. The appropriations made in subsection A of this section are exempt  
13 from the provisions of section 35-190, Arizona Revised Statutes, relating to  
14 lapsing of appropriations.

15           Sec. 36. Retroactivity

16           Section 20-2341, Arizona Revised Statutes, as amended by this act,  
17 applies retroactively to September 21, 2006.