

REFERENCE TITLE: insurance contracts; small employer coverage

State of Arizona
House of Representatives
Forty-eighth Legislature
Second Regular Session
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HB 2658

Introduced by
Representatives Reagan, Adams, Cajero Bedford, Driggs, Murphy: Campbell
CH, Clark, Crandall, Crump, DeSimone, Kavanagh, Konopnicki, Robson, Stump

AN ACT

AMENDING SECTIONS 20-181, 20-182, 20-1380, 20-2301, 20-2304 AND 20-2309,
ARIZONA REVISED STATUTES; RELATING TO INSURANCE CONTRACTS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

2 Section 1. Section 20-181, Arizona Revised Statutes, is amended to
3 read:

4 20-181. Mandated health coverage; report to legislature

5 An organization, ~~or~~ individual OR LEGISLATOR advocating a legislative
6 proposal which would mandate a health coverage or offering of a health
7 coverage by an insurer, hospital, medical, dental or optometric service
8 corporation, health care services organization or any other health care
9 service contractor as a component of individual or group policies shall
10 submit a report to the standing committee of the legislature that has been
11 assigned to consider the proposal and the joint legislative budget committee
12 before the committee OF THE WHOLE considers the proposal. The report shall
13 assess both the social and financial impacts of such coverage, including the
14 effectiveness of the treatment or service proposed, according to the factors
15 prescribed in section 20-182. The legislature is not responsible for the
16 cost of preparing the report.

17 Sec. 2. Section 20-182, Arizona Revised Statutes, is amended to read:

18 20-182. Factors for assessing impact; certification of report

19 A. To the extent that information is available, the report prescribed
20 by section 20-181 shall include, but not be limited to, the following:

21 1. The social impact:

22 (a) The extent to which the treatment or service is generally utilized
23 by a significant portion of the population.

24 (b) The extent to which the insurance coverage is already generally
25 available.

26 (c) If coverage is not generally available, the extent to which the
27 lack of coverage results in persons avoiding necessary health care
28 treatments.

29 (d) If the coverage is not generally available, the extent to which
30 the lack of coverage results in unreasonable financial hardship to a patient.

31 (e) The level of public demand for the treatment or service.

32 (f) The level of public demand for insurance coverage of the treatment
33 or service.

34 (g) The level of interest of collective bargaining agents in
35 negotiating privately for inclusion of this coverage in group contracts.

36 2. The financial impact:

37 (a) The extent to which the coverage will increase or decrease the
38 cost of the treatment or service.

39 (b) The extent to which the coverage will increase the appropriate use
40 of the treatment or service.

41 (c) The extent to which the mandated treatment or service will be a
42 substitute for a more expensive treatment or service.

1 (d) The extent to which the coverage will increase or decrease the
2 administrative expenses of insurers and the premium and administrative
3 expenses of policyholders.

4 (e) The impact of this coverage on the total cost of health care.

5 B. An actuary who is a member of the American academy of actuaries OR
6 THE JOINT LEGISLATIVE BUDGET COMMITTEE shall prepare the financial impact
7 analysis required by subsection A, paragraph 2 of this section and certify
8 that the analysis is consistent with accepted actuarial techniques.

9 C. The report required by section 20-181 shall address the specific
10 language of the proposed mandate. A report on a similar proposal in a
11 different jurisdiction is insufficient and does not meet the requirements of
12 section 20-181.

13 D. An organization, ~~or~~ individual OR LEGISLATOR that does not submit a
14 report required by section 20-181 is not subject to any civil sanction or
15 criminal penalty.

16 Sec. 3. Section 20-1380, Arizona Revised Statutes, is amended to read:
17 20-1380. Guaranteed renewability of individual health coverage

18 A. Except as provided in this section, on request of the insured
19 individual, a health care insurer that provides individual health coverage to
20 the individual shall renew or continue that coverage.

21 B. A health care insurer may nonrenew or discontinue the health
22 insurance coverage of an individual in the individual market only for one or
23 more of the following reasons:

24 1. The individual has failed to pay premiums or contributions pursuant
25 to the terms of the health insurance coverage or the health care insurer has
26 not received premium payments in a timely manner.

27 2. The individual has performed an act or practice that constitutes
28 fraud or has made an intentional misrepresentation of material fact under the
29 terms of the coverage.

30 3. The health care insurer has ceased to offer NEW coverage AND HAS
31 DISCONTINUED ALL IN-FORCE COVERAGE in the individual market pursuant to
32 subsection ~~C~~ D of this section.

33 4. If the health care insurer offers health care coverage through a
34 network plan in this state, the individual no longer resides, lives or works
35 in the service area or in an area served by the network plan for which the
36 health care insurer is authorized to do business but only if the coverage is
37 terminated uniformly without regard to any health status-related factor of
38 any covered individual.

39 5. If the health care insurer offers health coverage in the individual
40 market only through one or more bona fide associations, the membership of an
41 individual in the association has ceased but only if that coverage is
42 terminated uniformly without regard to any health status-related factor of
43 any covered individual.

1 C. If a health care insurer decides to discontinue offering a
2 particular policy form offered in the individual market, the health care
3 insurer may discontinue that policy form only if:

4 1. The health care insurer provides notice to the director at least
5 five business days before the health care insurer gives notice to each
6 individual covered under that policy form of the intention to discontinue
7 offering that policy form in this state.

8 2. The health care insurer provides notice to each individual who is
9 covered by that policy form in the individual market at least ninety days
10 before the date of the discontinuation of that policy form.

11 3. The health care insurer offers to each individual in the individual
12 market whose coverage is discontinued pursuant to this subsection the option
13 to purchase all other individual health insurance coverage currently offered
14 by the health care insurer for individuals in that market.

15 4. In exercising the option to discontinue that type of coverage and
16 in offering the option of coverage prescribed in paragraph 3 of this
17 subsection, the health care insurer acts uniformly without regard to any
18 health status-related factor of enrolled individuals or individuals who may
19 become eligible for that coverage.

20 D. If a health care insurer elects to discontinue offering all health
21 insurance coverage in the individual market in this state, the health care
22 insurer may discontinue that coverage only if all of the following occur:

23 1. The health care insurer gives notice to the director at least five
24 business days before the health care insurer gives notice to each individual
25 of the intention to discontinue offering health insurance coverage in the
26 individual market in this state.

27 2. The health care insurer provides notice to each individual of that
28 discontinuation at least one hundred eighty days before the date of the
29 expiration of that coverage.

30 3. The health care insurer discontinues all individual insurance or
31 coverage that was issued or delivered for issuance in this state and does not
32 renew any coverage that was offered or sold in this state.

33 E. If the health care insurer discontinues offering health insurance
34 coverage pursuant to subsection D of this section, the health care insurer
35 shall not issue any health insurance coverage in this state in the individual
36 market for five years after the date that the last individual health
37 insurance coverage was not renewed.

38 F. Subsection C of this section does not apply if the health care
39 insurer modifies the health coverage at the time of renewal and that
40 modification is otherwise consistent with this title and effective on a
41 uniform basis among all individuals covered by that policy form.

42 G. A health care insurer shall provide the certification described in
43 section 20-2310, subsection G if the individual:

44 1. Ceases to be covered under a policy offered by a health care
45 insurer or otherwise becomes covered under a COBRA continuation provision.

1 2. Who was covered under a COBRA continuation provision ceases to be
2 covered under the COBRA continuation provision.

3 3. Requests certification from the health care insurer within
4 twenty-four months after the coverage under a policy offered by a health care
5 insurer ceases.

6 H. The director may use independent contractor examiners pursuant to
7 sections 20-148 and 20-159 to review the higher level of coverage and lower
8 level of coverage policy forms offered by a health care insurer in compliance
9 with this section and section 20-1379. All examination and examination
10 related expenses shall be borne by the insurer and shall be paid by the
11 insurance examiners' revolving fund pursuant to section 20-159.

12 Sec. 4. Section 20-2301, Arizona Revised Statutes, is amended to read:
13 20-2301. Definitions; late enrollee coverage

14 A. In this chapter, unless the context otherwise requires:

15 1. "Accountable health plan" means an entity that offers, issues or
16 otherwise provides a health benefits plan and is approved by the director as
17 an accountable health plan pursuant to section 20-2303.

18 2. "Affiliation period" means a period of two months, or three months
19 for late enrollees, that under the terms of the health benefits plan offered
20 by a health care services organization must expire before the health benefits
21 plan becomes effective and in which the health care services organization is
22 not required to provide health care services or benefits and cannot charge
23 the participant or beneficiary a premium for any coverage during the period.

24 3. "Base premium rate" means, for each rating period, the lowest
25 premium rate that could have been charged under a rating system by the
26 accountable health plan to small employers for health benefits plans
27 involving the same or similar coverage, family size and composition, and
28 geographic area.

29 4. "Basic health benefit plan" means a plan that is developed by a
30 committee established by the legislature and that is adopted by the director.

31 5. "Bona fide association" means, for a health benefits plan issued by
32 an accountable health plan, an association that meets the requirements of
33 section 20-2324.

34 6. "COBRA continuation provision" means:

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

37 (b) Title I, subtitle B, part 6, except section 609, of the employee
38 retirement income security act of 1974 (P.L. 93-406; 88 Stat. 829; 29 United
39 States Code sections 1001 through 1461).

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

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

42 7. "Creditable coverage" means coverage solely for an individual,
43 other than limited benefits coverage, under any of the following:

44 (a) An employee welfare benefit plan that provides medical care to
45 employees or the employees' dependents directly or through insurance; ~~OR~~

1 reimbursement or otherwise pursuant to the employee retirement income
2 security act of 1974.

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

5 (c) A health benefits plan issued by an accountable health plan as
6 defined in this section.

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

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

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

11 (g) A medical care program of the Indian health service or of a tribal
12 organization.

13 (h) A health benefits risk pool operated by any state of the United
14 States.

15 (i) A health plan offered pursuant to title 5, chapter 89 of the
16 United States Code.

17 (j) A public health plan as defined by federal law.

18 (k) A health benefit plan pursuant to section 5(e) of the peace corps
19 act (P.L. 87-293; 75 Stat. 612; 22 United States Code sections 2501 through
20 2523).

21 (l) A policy or contract, including short-term limited duration
22 insurance, issued on an individual basis by an insurer, a health care
23 services organization, a hospital service corporation, a medical service
24 corporation or a hospital, medical, dental and optometric service corporation
25 or made available to persons defined as eligible under section 36-2901,
26 paragraph 6, subdivisions (b), (c), (d) and (e).

27 (m) A policy or contract issued by a health care insurer or an
28 accountable health plan to a member of a bona fide association.

29 8. "Demographic characteristics" means objective factors an insurer
30 considers in determining premium rates. Demographic characteristics do not
31 include health status-related factors, industry or duration of coverage since
32 issue.

33 9. "Different policy forms" means variations between policy forms
34 offered by a health care insurer, including policy forms that have different
35 cost sharing arrangements or different riders.

36 10. "Genetic information" means information about genes, gene products
37 and inherited characteristics that may derive from the individual or a family
38 member, including information regarding carrier status and information
39 derived from laboratory tests that identify mutations in specific genes or
40 chromosomes, physical medical examinations, family histories and direct
41 ~~analysis~~ ANALYSES of genes or chromosomes.

42 11. "Health benefits plan" means a hospital and medical service
43 corporation policy or certificate, a health care services organization
44 contract, A GROUP DISABILITY POLICY, A CERTIFICATE OF INSURANCE OF A GROUP
45 DISABILITY POLICY THAT IS NOT ISSUED IN THIS STATE, a multiple employer

1 welfare arrangement or any other arrangement under which health services or
2 health benefits are provided to two or more individuals. Health benefits plan
3 does not include the following:

4 (a) Accident only, dental only, vision only, disability income only or
5 long-term care only insurance, fixed or hospital indemnity coverage, limited
6 benefit coverage, specified disease coverage, credit coverage or Taft-Hartley
7 trusts.

8 (b) Coverage that is issued as a supplement to liability insurance.

9 (c) Medicare supplemental insurance.

10 (d) Workers' compensation insurance.

11 (e) Automobile medical payment insurance.

12 12. "Health status-related factor" means any factor in relation to the
13 health of the individual or a dependent of the individual enrolled or to be
14 enrolled in an accountable health plan, including:

15 (a) Health status.

16 (b) Medical condition, including physical and mental illness.

17 (c) Claims experience.

18 (d) Receipt of health care.

19 (e) Medical history.

20 (f) Genetic information.

21 (g) Evidence of insurability, including conditions arising out of acts
22 of domestic violence as defined in section 20-448.

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

24 13. "Higher level of coverage" means a health benefits plan offered by
25 an accountable health plan for which the actuarial value of the benefits
26 under the coverage is at least fifteen per cent more than the actuarial value
27 of the health benefits plan offered by the accountable health plan as a lower
28 level of coverage in this state but not more than one hundred twenty per cent
29 of a policy form weighted average.

30 14. "Index rate" means, as to a rating period, the arithmetic average
31 of the applicable base premium rate and the highest premium rate that could
32 have been charged under a rating system by the accountable health plan to
33 small employers for a health benefits plan involving the same or similar
34 coverage, family size and composition, and geographic area.

35 15. "Late enrollee" means an employee or dependent who requests
36 enrollment in a health benefits plan after the initial enrollment period that
37 is provided under the terms of the health benefits plan if the initial
38 enrollment period is at least thirty-one days. An employee or dependent
39 shall not be considered a late enrollee if:

40 (a) The person:

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

43 (ii) Lost coverage under a public or private health insurance policy
44 or any other health benefits plan due to the employee's termination of
45 employment or eligibility, the reduction in the number of hours of

1 employment, the termination of the other plan's coverage, the death of the
2 spouse, legal separation or divorce or the termination of employer
3 contributions toward the coverage.

4 (iii) Requests enrollment within thirty-one days after the termination
5 of creditable coverage that is provided under a public or private health
6 insurance or other health benefits plan.

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

9 (b) The person is employed by an employer that offers multiple health
10 benefits plans and the person elects a different plan during an open
11 enrollment period.

12 (c) A court orders that coverage be provided for a spouse or minor
13 child under a covered employee's health benefits plan and the person requests
14 enrollment within thirty-one days after the court order is issued.

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

18 16. "Lower level of coverage" means a health benefits plan offered by
19 an accountable health plan for which the actuarial value of the benefits
20 under the health benefits plan is at least eighty-five per cent but not more
21 than one hundred per cent of the policy form weighted average.

22 17. "Network plan" means a health benefits plan provided by an
23 accountable health plan under which the financing and delivery of health
24 benefits are provided, in whole or in part, through a defined set of
25 providers under contract with the accountable health plan in accordance with
26 the determination made by the director pursuant to section 20-1053 regarding
27 the geographic or service area in which an accountable health plan may
28 operate.

29 18. "Policy form weighted average" means the average actuarial value of
30 the benefits provided by all health benefits plans issued by either the
31 accountable health plan or, if the data are available, by all accountable
32 health plans in the group market in this state during the previous calendar
33 year, weighted by the enrollment for all coverage forms.

34 19. "Preexisting condition" means a condition, regardless of the cause
35 of the condition, for which medical advice, diagnosis, care or treatment was
36 recommended or received within not more than six months before the date of
37 the enrollment of the individual under a health benefits plan issued by an
38 accountable health plan. A genetic condition is not a preexisting condition
39 in the absence of a diagnosis of the condition related to the genetic
40 information and shall not result in a preexisting condition limitation or
41 preexisting condition exclusion.

42 20. "Preexisting condition limitation" or "preexisting condition
43 exclusion" means a limitation or exclusion of benefits for a preexisting
44 condition under a health benefits plan offered by an accountable health plan.

1 21. "Small employer" means an employer who employs at least two but not
2 more than fifty eligible employees on a typical business day during any one
3 calendar year. As used in this paragraph, "employee" shall include the
4 employees of the employer and the individual proprietor or self-employed
5 person if the employer is an individual proprietor or self-employed person.

6 22. "Taft-Hartley trust" means a jointly-managed trust, as allowed by
7 29 United States Code sections 141 through 187, that contains a plan of
8 benefits for employees and that is negotiated in a collective bargaining
9 agreement governing the wages, hours and working conditions of the employees,
10 as allowed by 29 United States Code section 157.

11 23. "Waiting period" means the period that must pass before a potential
12 participant or beneficiary in a health benefits plan offered by an
13 accountable health plan is eligible to be covered for benefits as determined
14 by the individual's employer.

15 B. Coverage for a late enrollee begins on the date the person becomes
16 a dependent if a request for enrollment is received within thirty-one days
17 after the person becomes a dependent.

18 Sec. 5. Section 20-2304, Arizona Revised Statutes, is amended to read:
19 20-2304. Availability of insurance; premium tax exemption

20 A. ~~Beginning on July 1, 1997,~~ As a condition of doing business in this
21 state, each accountable health plan shall offer at least one health benefits
22 plan on a guaranteed issuance basis to small employers as required by this
23 section. All small employers qualify for this guaranteed offer of coverage.
24 The accountable health plan shall provide a health benefits plan to each
25 small employer without regard to health status-related factors if the small
26 employer agrees to make the premium payments and to satisfy any other
27 reasonable provisions of the plan that are not inconsistent with this
28 chapter.

29 B. If an accountable health plan offers more than one health benefits
30 plan to small employers, the accountable health plan shall offer a choice of
31 all health benefits plans that the accountable health plan offers to small
32 employers and shall accept any small employer that applies for any of those
33 plans.

34 C. In addition to the requirements prescribed in section 20-2323, for
35 any offering of any health benefits plan to a small employer, as part of the
36 accountable health plan's solicitation and sales materials, an accountable
37 health plan shall make a reasonable disclosure to the employer of the
38 availability of the information described in this subsection and, on request
39 of the employer, shall provide that information to the employer. The
40 accountable health plan shall provide information concerning the following:

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

42 (a) The accountable health plan's right to change premium rates and
43 the factors that may affect changes in premium rates.

44 (b) Renewability of coverage.

45 (c) Any preexisting condition exclusion.

- 1 (d) Any affiliation period applied by a health care services
2 organization.
- 3 (e) The geographic areas served by health care services organizations.
4 2. The benefits and premiums available under all health benefits plans
5 for which the employer is qualified.
- 6 D. The accountable health plan shall describe the information required
7 by subsection C of this section in language that is understandable by the
8 average small employer and with a level of detail that is sufficient to
9 reasonably inform a small employer of the employer's rights and obligations
10 under the health benefits plan. This requirement is satisfied if the
11 accountable health plan provides each of the following for each product the
12 accountable health plan offers:
- 13 1. An outline of coverage that describes the benefits in summary form.
14 2. The rate or rating schedule that applies to the product,
15 preexisting condition exclusion or affiliation period.
- 16 3. The minimum employer contribution and group participation rules
17 that apply to any particular type of coverage.
- 18 4. In the case of a network plan, a map or listing of the areas
19 served.
- 20 E. An accountable health plan is not required to disclose any
21 information that is proprietary and protected trade secret information under
22 applicable law.
- 23 F. An accountable health plan that issues a health benefits
24 plan through a network plan may limit the employers that may apply for any
25 health benefits plan offered by the accountable health plan to those eligible
26 individuals who live, work, ~~or~~ or reside in the service area for the network
27 plan of the accountable health plan.
- 28 G. On approval of the director, an accountable health plan may refuse
29 to enroll a qualified small employer in a health benefits plan or in a
30 geographic area served by the plan if the accountable health plan
31 demonstrates that its financial or administrative capacity to serve
32 previously enrolled groups and individuals would be impaired. An accountable
33 health plan that refuses to enroll a qualified small employer may not enroll
34 an employer of the same or larger size until the earlier of:
- 35 1. The date on which the director determines that the accountable
36 health plan has the capacity to enroll a qualified small employer.
- 37 2. The date on which the accountable health plan enrolls a qualified
38 small employer.
- 39 H. An accountable health plan that offers coverage to a qualified
40 small employer shall offer coverage to all of the eligible employees of the
41 qualified small employer and their eligible dependents.
- 42 I. An accountable health plan may request health screening and
43 underwriting information on prospective enrollees to evaluate the risks
44 associated with a qualified small employer who applies for coverage. The
45 accountable health plan may use this information for the purposes of setting

1 premiums, evaluating plan offerings and making reinsurance decisions. An
2 accountable health plan shall not use this information to deny coverage to a
3 qualified small employer or to an eligible employee or to an eligible
4 dependent, except a late enrollee who attempts to enroll outside an open
5 enrollment period.

6 J. ~~Notwithstanding the requirements of section 20-224, subsection B~~
7 ~~and sections 20-837, 20-1010 and 20-1060, beginning July 1, 1996, accountable~~
8 ~~health plans shall pay a premium tax of one per cent of the net premiums~~
9 ~~received for health benefits plans issued to small employers. Beginning July~~
10 ~~1, 1997,~~ Accountable health plans are exempt from the premium taxes that are
11 required by this subsection, section 20-224, subsection B and sections
12 20-837, 20-1010 and 20-1060, for the net premiums received for health
13 benefits plans issued to small employers, **INCLUDING THE NET PREMIUMS**
14 **COLLECTED FROM COVERAGE ISSUED PURSUANT TO SECTION 20-2313, SUBSECTION C.**
15 Each accountable health plan shall notify the small employers to whom it
16 provides coverage of the reductions in the premium tax as specified in this
17 subsection.

18 K. The director may use independent contractor examiners pursuant to
19 sections 20-148 and 20-159 to review the higher level of coverage and lower
20 level of coverage health benefits plans offered by an accountable health plan
21 insurer in compliance with this section. All examination and examination
22 related expenses shall be borne by the insurer and shall be paid by the
23 insurance examiners' revolving fund pursuant to section 20-159.

24 Sec. 6. Section 20-2309, Arizona Revised Statutes, is amended to read:
25 **20-2309. Renewability**

26 A. At least sixty days before the date of expiration of a health
27 benefits plan, an accountable health plan that provides a health benefits
28 plan shall provide for written notice to the employer of the terms for
29 renewal of the plan. The notice shall include an explanation of the extent
30 to which any increase in premiums is due to actual or expected claims
31 experience of the individuals covered under the employer's health benefits
32 plan contract.

33 B. An accountable health plan may refuse to renew or may terminate a
34 health benefits plan only if:

35 1. The employer fails to pay premiums or contributions in accordance
36 with the terms of the health benefits plan of the accountable health plan or
37 the accountable health plan does not receive premium payments in a timely
38 manner.

39 2. The employer committed an act or practice that constitutes fraud or
40 made an intentional misrepresentation of material fact under the terms of the
41 health benefits plan.

42 3. The employer has failed to comply with a material plan provision
43 relating to individual or employer participation rules as prescribed in
44 subsection C of this section.

1 4. The accountable health plan has ceased to offer NEW coverage AND
2 HAS TERMINATED OR CEASED TO RENEW ALL IN-FORCE COVERAGE in the group market
3 pursuant to this section.

4 5. In the case of an accountable health plan that offers a health
5 benefits plan through a network plan in this state, there is no longer any
6 enrollee in connection with the accountable health plan who lives, resides or
7 works in the service area of the accountable health plan or in the area
8 served by the network plan for which the accountable health plan is
9 authorized to do business and the accountable health plan would deny
10 enrollment pursuant to section 20-2304, subsection G.

11 6. In the case of an accountable health plan that offers a health
12 benefits plan in the group market only through one or more bona fide
13 associations, the membership of an employer in the association has ceased but
14 only if that coverage is terminated uniformly without regard to any health
15 status-related factor or any covered individual.

16 7. THE TERMINATION OR NONRENEWAL OCCURS ON THE POLICY'S RENEWAL DATE.

17 C. An accountable health plan may require that a minimum percentage of
18 employees who are not covered under a spouse's or parent's employer's health
19 benefits plan be enrolled in a plan if the percentage is applied uniformly to
20 all plans that are offered to employers of comparable size.

21 D. An accountable health plan is not required to renew a health
22 benefits plan with respect to an employer or individual if the accountable
23 health plan:

24 1. Elects not to renew all of its health benefits plans that are
25 issued to employers or individuals in this state.

26 2. Provides notice to the director at least five business days before
27 the accountable health plan gives notice to each employer or individual
28 covered under a health benefits plan of the intention to discontinue offering
29 any health benefits plans in this state.

30 3. Provides notice of termination to each employer or individual
31 covered under a plan at least one hundred eighty days before the expiration
32 date of the plan. If the accountable health plan terminates coverage, the
33 accountable health plan may not issue a health benefits plan to an employer
34 in this state during the five year period beginning on the termination date
35 of the last plan that was not renewed.

36 E. If an accountable health plan decides to discontinue offering a
37 particular health benefits plan offered in the group market, the accountable
38 health plan may discontinue that coverage only if the accountable health
39 plan:

40 1. Provides notice to the director at least five business days before
41 the accountable health plan gives notice to each employer or individual
42 covered under that health benefits plan of the intention to discontinue
43 offering that health benefits plan in this state.

1 2. Provides notice to each employer or individual covered under that
2 health benefits plan at least ninety days before the date of the
3 discontinuation of that coverage.

4 3. Offers to each employer whose coverage is discontinued pursuant to
5 this subsection the option to purchase all other health benefits plans
6 currently offered by the accountable health plan for employers in the group
7 market uniformly without regard to any health status-related factor of any
8 employee or a spouse or a dependent of the employee enrolled or individuals
9 who may become eligible for that coverage.