

REFERENCE TITLE: **healthcare group; sole proprietors**

State of Arizona
House of Representatives
Forty-ninth Legislature
Second Regular Session
2010

HB 2217

Introduced by
Representative Chabin

AN ACT

AMENDING SECTION 36-2912, ARIZONA REVISED STATUTES; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

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

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

7 A. The administration shall administer a healthcare group program to
8 allow willing contractors to deliver health care services to persons defined
9 as eligible pursuant to section 36-2901, paragraph 6, subdivisions (b), (c),
10 (d) and (e). In counties with a population of less than five hundred
11 thousand persons, the administration may contract directly with any health
12 care provider or entity. The administration may enter into a contract with
13 another entity to provide administrative functions for the healthcare group
14 program.

15 B. Employers with ~~two~~ ONE eligible ~~employees~~ EMPLOYEE or up to an
16 average of fifty eligible employees under section 36-2901, paragraph 6,
17 subdivision (d):

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

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

25 3. Shall have a minimum of ~~two~~ ONE and a maximum of fifty eligible
26 employees at the effective date of their first contract with the
27 administration.

28 C. The administration shall not enroll an employer group in healthcare
29 group sooner than ninety days after the date that the employer's health
30 insurance coverage under an accountable health plan is discontinued.
31 Enrollment in healthcare group is effective on the first day of the month
32 after the ninety day period. This subsection does not apply to an employer
33 group if the employer's accountable health plan discontinues offering the
34 health plan of which the employer is a member.

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

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

41 2. Medical assistance is provided by a government subsidized health
42 care program.

43 3. Medical assistance is provided pursuant to section 36-2982,
44 subsection I.

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

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

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

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

14 I. The director shall:

15 1. Require that any contractor that provides covered services to
16 persons defined as eligible pursuant to section 36-2901, paragraph 6,
17 subdivision (a) provide separate audited reports on the assets, liabilities
18 and financial status of any corporate activity involving providing coverage
19 pursuant to this section to persons defined as eligible pursuant to section
20 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).

21 2. Prohibit the administration and program contractors from
22 reimbursing a noncontracting hospital for services provided to a member at a
23 noncontracting hospital except for services for an emergency medical
24 condition.

25 3. ~~Beginning on July 1, 2005,~~ Require that a contractor, the
26 administration or an accountable health plan negotiate reimbursement rates.
27 The reimbursement rate for an emergency medical condition for a
28 noncontracting hospital is:

29 (a) In counties with a population of more than five hundred thousand
30 persons, one hundred fourteen per cent of the reimbursement rates established
31 pursuant to section 36-2903.01, subsection H. The hospital shall notify the
32 contractor when a member is stabilized.

33 (b) In counties with a population of less than five hundred thousand
34 persons, one hundred twenty-five per cent of the reimbursement rates
35 established pursuant to section 36-2903.01, subsection H. The hospital shall
36 notify the contractor when a member is stabilized.

37 4. Use monies from the healthcare group fund established by section
38 36-2912.01 for the administration's costs of operating the healthcare group
39 program.

40 5. Ensure that the contractors are required to meet contract terms as
41 are necessary in the judgment of the director to ensure adequate performance
42 by the contractor. Contract provisions shall include, at a minimum, the
43 maintenance of deposits, performance bonds, financial reserves or other
44 financial security. The director may waive requirements for the posting of
45 bonds or security for contractors that have posted other security, equal to

1 or greater than that required for the healthcare group program, with the
2 administration or the department of insurance for the performance of health
3 service contracts if funds would be available to the administration from the
4 other security on the contractor's default. In waiving, or approving waivers
5 of, any requirements established pursuant to this section, the director shall
6 ensure that the administration has taken into account all the obligations to
7 which a contractor's security is associated. The director may also adopt
8 rules that provide for the withholding or forfeiture of payments to be made
9 to a contractor for the failure of the contractor to comply with provisions
10 of its contract or with provisions of adopted rules.

11 6. Adopt rules.

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

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

20 K. The administration shall offer a health benefit plan on a
21 guaranteed issuance basis to small employers as required by this section.
22 All small employers qualify for this guaranteed offer of coverage. The
23 administration shall offer to all small employers the available health
24 benefit plan and shall accept any small employer that applies and meets the
25 eligibility requirements. In addition to the requirements prescribed in this
26 section, for any offering of any health benefit plan to a small employer, as
27 part of the administration's solicitation and sales materials, the
28 administration shall make a reasonable disclosure to the employer of the
29 availability of the information described in this subsection and, on request
30 of the employer, shall provide that information to the employer. The
31 administration shall provide information concerning the following:

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

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

35 (b) Renewability of coverage.

36 (c) Any preexisting condition exclusion.

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

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

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

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

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

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

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

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

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

13 O. The administration shall increase or decrease premiums based on
14 actuarial reviews by an independent actuary of the projected and actual costs
15 of providing health care benefits to eligible members. Before changing
16 premiums, the administration must give sixty days' written notice to the
17 employer. For each contract period the administration shall set premiums
18 that in the aggregate cover projected medical and administrative costs for
19 that contract period and that are determined pursuant to generally accepted
20 actuarial principles and practices by an independent actuary.

21 P. The administration shall consider age, sex, health status-related
22 factors, group size, geographic area and community rating when it establishes
23 premiums for the healthcare group program.

24 Q. Except as provided in subsection R of this section, a health
25 benefit plan may not deny, limit or condition the coverage or benefits based
26 on a person's health status-related factors or a lack of evidence of
27 insurability. A health benefit plan shall not provide or offer any service,
28 benefit or coverage that is not part of the health benefit plan contract.

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

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

37 2. The contractor shall reduce the period of any applicable
38 preexisting condition exclusion by the aggregate of the periods of creditable
39 coverage that apply to the individual.

40 S. The contractor shall calculate creditable coverage according to the
41 following:

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

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

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

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

27 U. The written certification provided by the administration must
28 include:

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

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

33 V. The administration shall issue and accept a written certification
34 of the period of creditable coverage of the individual that contains at least
35 the following information:

36 1. The date that the certificate is issued.

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

43 3. The name, address and telephone number of the issuer providing the
44 certificate.

1 4. The telephone number to call for further information regarding the
2 certificate.

3 5. One of the following:

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

7 (b) Both the date that the individual first sought coverage, as
8 evidenced by a substantially complete application, and the date that
9 creditable coverage began.

10 6. The date creditable coverage ended, unless the certificate
11 indicates that creditable coverage is continuing from the date of the
12 certificate.

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

17 X. The healthcare group program shall comply with all applicable
18 federal requirements.

19 Y. Healthcare group may pay a commission to an insurance producer. To
20 receive a commission, the producer must certify that to the best of the
21 producer's knowledge the employer group has not had insurance in the ninety
22 days before applying to healthcare group. For the purposes of this
23 subsection, "commission" means a one time payment on the initial enrollment
24 of an employer.

25 Z. On or before June 15 and November 15 of each year, the director
26 shall submit a report to the joint legislative budget committee regarding the
27 number and type of businesses participating in healthcare group and that
28 includes updated information on healthcare group marketing activities. The
29 director, within thirty days of implementation, shall notify the joint
30 legislative budget committee of any changes in healthcare group benefits or
31 cost sharing arrangements.

32 AA. The administration shall submit the following to the joint
33 legislative budget committee:

34 1. Quarterly reports regarding the financial condition of the
35 healthcare group program. The reports shall include the number of persons
36 and employer groups enrolled in the program and medical loss information and
37 projections.

38 2. An annual financial audit.

39 3. The analysis that is used to determine premiums pursuant to
40 subsection 0 of this section.

41 BB. Beginning July 1, 2009, and each fiscal year thereafter,
42 healthcare group shall limit employer group enrollment to not more than five
43 per cent more than the number of employer groups enrolled in the program at
44 the end of the preceding fiscal year. Healthcare group shall give enrollment
45 priority to uninsured groups.

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

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

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

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

13 5. "Emergency medical condition" has the same meaning prescribed in
14 the emergency medical treatment and **ACTIVE** labor act (P.L. 99-272; 100 Stat.
15 164; 42 United States Code section 1395dd(e)).

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

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

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

27 (a) Health status.

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

29 (c) Claims experience.

30 (d) Receipt of health care.

31 (e) Medical history.

32 (f) Genetic information.

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

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

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

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

1 (a) The person:

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

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

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

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

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

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

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

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

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

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