Arizona State Senate
Issue Brief

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Note to Reader:

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SMALL BUSINESS HEALTH INSURANCE

INTRODUCTION

Overview

Health insurers include numerous types of organizations and the structure of the insurance issued by these organizations, including the scope, duration and choice of benefits offered, varies. Examples of health insurers include disability, group disability and blanket disability insurers, healthcare services organizations (also known as health maintenance organizations, or HMOs) and hospital and medical service organizations.

Small businesses in Arizona may purchase any type of private health insurance that they can obtain at an affordable price. Because small businesses cannot spread their risk, and thus their costs, over a large number of individuals, the per person costs to insure their employees are often higher than comparable costs for large employers. Small businesses may also have a difficult time absorbing increases in health insurance costs. Furthermore, small businesses often do not have the same bargaining power when negotiating rates and do not have the manpower to devote to the administration of a health insurance benefit. These factors may dissuade small businesses from offering health insurance.

What is a Small Business?

The federal Small Business Act defines a small business as, "one that is independently owned and operated and which is not dominant in its field of operation." Based on this definition, the U.S. Small Business Administration (SBA) has developed standards for what is considered a small business in any given industry. The SBA has established two widely used size standards for small businesses – 500 employees for most manufacturing and mining industries and $7.5 million in average annual receipts for nonmanufacturing industries.

Arizona statute has several varied definitions of small businesses. In statutes related to health insurance, the most common definition of

a small business or small employer is a business with 50 or fewer employees. Although the majority of businesses in Arizona have fewer than 20 employees, more than half of Arizona workers are employed by firms with more than 500 employees.

To increase the affordability and availability of health insurance for small businesses, Arizona has developed several options, which are discussed below.

ACCOUNTABLE HEALTH PLANS

The Department of Insurance (DOI) reports that any Arizona health insurer that wants to offer group health insurance must also qualify as an accountable health plan (AHP). AHPs are statutorily required to offer at least one health plan to small employers (known as a "guaranteed issue" requirement). Effectively, this requires any insurer that offers coverage to medium and large-sized employers to also offer its health benefits plan to small employers, if those employers agree to pay the premiums offered.

In addition, if an AHP offers more than one health benefits plan to small employers, the AHP must offer a choice of all its plans and must accept any small employer that applies for any of the plans and is willing to pay the premium. For the purposes of an AHP, a small employer is any employer that employs at least 2 but not more than 50 employees on a typical business day in one calendar year.

The guaranteed issue requirement applies to insurers that offer most types of coverage, including hospital and medical service corporation policies or certificates, healthcare services organization contracts, multiple employer welfare arrangements or any other product through which health services or health benefits are provided to two or more individuals; certain types of coverage such as worker's compensation, automobile medical payment insurance and limited benefit coverage are excluded.[1]

In Arizona, health insurers are required to pay a 1.95 percent tax on the premiums they collect. Laws 2016, Chapter 358 reduces the rate .05 percent per year until the rate reaches 1.70 percent in 2021.[2] However, AHPs are exempt from this requirement on premiums attributable to small businesses. Statute also restricts AHP premiums offered to small businesses; premiums may only vary by 60 percent of the index rate and increases are limited.[3,4]

Premium Tax Credit and State Subsidy for Small Business Health Insurance

The Legislature established a premium tax credit beginning January 1, 2007, for health insurers that provide individual coverage or coverage for small business with 2 to 25 employees that have been in existence in Arizona for at least one calendar year and have not provided health insurance to their employees for at least six months. For coverage issued to small businesses, the tax credit is the lesser of: 1) $1000 for single coverage or $3000 for family coverage or 2) 50 percent of the health insurance premium. Total credits are capped at $5 million per calendar year.[5]

The Department of Revenue determines whether the small business meets the criteria to allow the health insurer to claim the tax credit for providing coverage to the business. Business may only be determined eligible for three years (initial eligibility plus two annual redeterminations). Health insurers are then required to deduct the amount of the tax credit from the premium paid by the small business for health insurance. In this way, the state subsidizes the cost of the small business's health insurance in the amount of the tax credit.

[1] A.R.S. § 20-2304

[2] Laws 2016, Chapter 358, A.R.S. § 20-224

[3] Statute defines a "base premium rate" as the lowest premium rate that could have been charged by an AHP for each rating period and an "index rate" as the arithmetic average of the applicable base premium rate and the highest premium rate that could have been charged under a rating system by the AHP.

[4] A.R.S. § 20-2311

[5] Laws 2006, Chapter 378, A.R.S. §§ 20-224.05, 43-210

"MANDATE-LITE" INSURANCE OPTIONS

Statute provides requirements for health insurance, including mandates to cover specific services or supplies, offer a choice of providers for some services and allow access to certain services without prior authorization. Every mandate does not apply to every type of insurer and the requirements vary for each type of insurer.

Beginning in September 2006, health insurance that is issued to certain small businesses does not have to include specified coverage requirements. Those requirements include mandated coverage for contraceptives and certain medical foods and supplies, provider choice requirements, and prescription drug authorization and nonformulary drug access procedures. Because this type of health insurance is not required to include certain mandated coverage, it is commonly referred to as "mandate -lite."

Originally, the enacting legislation allowed mandate-lite insurance to be issued to businesses that employ 2 to 25 persons and that have been uninsured for at least six months.[6] In 2007, the applicability of mandate-lite was expanded to include businesses that employ 2 to 50 persons.[7]

HEALTHCARE GROUP

Introduction

In 1981, the Legislature authorized the Arizona Health Care Cost Containment System (AHCCCS) to provide affordable healthcare coverage to self-employed individuals, small businesses with 50 or fewer employees, including sole proprietorships, and political subdivisions (state, counties, cities, towns, school districts and agricultural districts) within the state. In 1985, the Legislature established Healthcare Group (HCG) as a prepaid guaranteed issue medical coverage program for eligible employers, and the program, administered by AHCCCS, began operation the following year.

HCG State Subsidies and Program Expansion

According to AHCCCS, HCG's enrollment peaked in 1997, but began to decline when the general healthcare market started to experience problems because of steep cost increases. As enrollment declined, HCG was left with a membership that was predominantly high acuity, with costly chronic illness management needs. The cost of coverage continued to grow, far exceeding the revenue from premiums. The HCG health plans could not sustain growing program losses. As a result, in FY 2000 the Legislature began to subsidize the program with an appropriation of $8 million to reconcile the health plans' medical costs incurred in excess of premiums collected. Subsidies continued but were cut in half to $4 million in FY 2004.

Despite efforts to increase enrollment and remedy financial hardships, HCG continued to struggle with program losses. In 2007, the Legislature created the HCG Study Committee to study the financial and operational issues associated with HCG and to identify changes necessary to ensure financial stability (Laws 2007, Chapter 263).[8] Specifically, the Study Committee was charged with examining the feasibility of continuing HCG, establishing a high -risk pool or both. In 2013, the Legislature passed legislation that prohibited HCG from enrolling new members after August 1, 2013, repealed HCG effective January 1, 2014, and repealed the HCG Fund effective January 1, 2015.[9]

CONTINUATION COVERAGE

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) requires most private sector group health plans that are maintained by certain employers to offer

[6] Laws 2006, Chapter 229 A.R.S § 20-2341
[7] Laws 2007, Chapter 263 A.R.S. §§ 20-2341 et. seq.
[8] Laws 2007, Chapter 263
[9] Laws 2013 1st S.S., Chapter 10

continuation coverage to covered employees, former employees, spouses, former spouses and dependent children who lose coverage due to certain qualifying events, including: 1) the death of a covered employee; 2) termination or reduction in the hours of a covered employee's employment for reasons other than gross misconduct; 3) a covered employee becoming eligible for Medicare; 4) divorce or legal separation of a covered employee from their spouse; and 5) a dependent child's loss of dependent status. Group health plans that are subject to continuation coverage requirements under the federal COBRA law are those that are maintained by employers with the equivalent of 20 or more employees on more than 50 percent of the employers' typical business days in the previous calendar year.[10] Group health plans that are sponsored by employers with the equivalent of fewer than 20 employees are currently not subject to these same requirements.[11]

Effective January 1, 2019, Laws 2018, Chapter 164 requires group health plans offered by a small employer with at least 1 but not more than 20 employees to offer continuation coverage to enrollees. The same qualifying events for continuation coverage under the federal COBRA law apply to small employers, with one additional qualifying event including when an employer files for bankruptcy within one year before or after an enrollee retires from said employer. If an enrollee chooses to opt in to continuation coverage, they must pay the full cost of coverage plus a maximum 5 percent administrative fee. Continuation coverage may be utilized for no longer than 18 months, 29 months if the enrollee has a disability, or 36 months for qualified dependents that meet certain requirements. Coverage may also end if an enrollee becomes eligible for Medicare, Medicaid or some other form of health insurance.[12]

ASSOCIATION HEALTH PLANS

On June 19, 2018, the U.S. Department of Labor issued a final rule on Association Health Plans in response to President Trump's executive order encouraging the expansion of such healthcare plans.[13] Most notably, the final rule expanded the definition of employer under the Employee Retirement Income Security Act (ERISA) to allow more employer groups or associations to sponsor a single group health plan under ERISA. Specifically, the rule broadens the criteria for a group or association to satisfy the commonality of interest requirement. Members of the same trade, industry, line of business, or profession, or those that maintain principal places of business within a particular state or metropolitan area would be able to offer single group health plans. The rule also established criteria under which working owners, such as sole proprietors and other self-employed individuals could participate in Associations Health Plans. Since Associations Health Plans do not have a prominent presence in the healthcare market currently, it will be up to state legislatures to determine the extent to which these plans will be regulated in relation to premium rates, fraud prevention and budgetary impacts, among other things. The final rule will become effective on September 1, 2018, for fully-insured Association Health Plans; January 1, 2019, for existing self-insured Association Health Plans; and April 1, 2019, for new self-insured association health plans.[14]

[10] U.S. Department of Labor, Health Plans and Benefits: Continuation of Health Coverage-COBRA
[11] 29 U.S.C. §§ 1161-1169
[12] Laws 2018, Chapter 164, A.R.S. § 20-2330
[13] Executive Order 13813
[14] U.S. Department of Labor, 29 C.F.R. Part 2510

ADDITIONAL RESOURCES

- Arizona Department of Insurance
  http://www.id.state.az.us/
- Insurance Statutes: Arizona Revised Statutes, Title 20
- National Conference of State Legislatures
  http://www.ncsl.org/programs/health/SmallBusiness.htm
- "Statistics of U.S. Businesses," U.S. Census Bureau
  http://www.census.gov/econ/susb/
- Related Arizona Revised Statutes: A.R.S. §§ 20-2304, 20-2311, 20-224.05, 20-2341, 36-2912, 36-2912.01 and 43-210