

REFERENCE TITLE: AHCCCS; healthcare group; waiting period.

State of Arizona
Senate
Forty-eighth Legislature
First Regular Session
2007

SB 1560

Introduced by
Senators O'Halleran, Aguirre, Allen: Arzberger

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 the absence of a willing contractor, the administration may
11 contract directly with any health care provider or entity. The
12 administration may enter into a contract with another entity to provide
13 administrative functions for the healthcare group program.

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

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

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

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

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

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

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

39 2. Medical assistance is provided by a government subsidized health
40 care program.

41 3. Medical assistance is provided pursuant to section 36-2982,
42 subsection I.

43 ~~E.~~ D. An employer shall not offer coverage made available pursuant to
44 this section to persons defined as eligible pursuant to section 36-2901,
45 paragraph 6, subdivision (b), (c), (d) or (e) as a substitute for a federally
46 designated plan.

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

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

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

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

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

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

22 3. Use monies from the healthcare group fund established by section
23 36-2912.01 for the administration's costs of operating the healthcare group
24 program.

25 4. Ensure that the contractors are required to meet contract terms as
26 are necessary in the judgment of the director to ensure adequate performance
27 by the contractor. Contract provisions shall include, at a minimum, the
28 maintenance of deposits, performance bonds, financial reserves or other
29 financial security. The director may waive requirements for the posting of
30 bonds or security for contractors that have posted other security, equal to
31 or greater than that required for the healthcare group program, with the
32 administration or the department of insurance for the performance of health
33 service contracts if funds would be available to the administration from the
34 other security on the contractor's default. In waiving, or approving waivers
35 of, any requirements established pursuant to this section, the director shall
36 ensure that the administration has taken into account all the obligations to
37 which a contractor's security is associated. The director may also adopt
38 rules that provide for the withholding or forfeiture of payments to be made
39 to a contractor for the failure of the contractor to comply with provisions
40 of its contract or with provisions of adopted rules.

41 5. Adopt rules.

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

45 ~~J.~~ I. With respect to services provided by contractors to persons
46 defined as eligible pursuant to section 36-2901, paragraph 6, subdivision

1 (b), (c), (d) or (e), a contractor is the payor of last resort and has the
2 same lien or subrogation rights as those held by health care services
3 organizations licensed pursuant to title 20, chapter 4, article 9.

4 ~~K~~ J. The administration shall offer a health benefit plan on a
5 guaranteed issuance basis to small employers as required by this section.
6 All small employers qualify for this guaranteed offer of coverage. The
7 administration shall provide a health benefit plan to each small employer
8 without regard to health status-related factors if the small employer agrees
9 to make the premium payments and to satisfy any other reasonable provisions
10 of the plan and contract. The administration shall offer to all small
11 employers the available health benefit plan and shall accept any small
12 employer that applies and meets the eligibility requirements. In addition to
13 the requirements prescribed in this section, for any offering of any health
14 benefit plan to a small employer, as part of the administration's
15 solicitation and sales materials, the administration shall make a reasonable
16 disclosure to the employer of the availability of the information described
17 in this subsection and, on request of the employer, shall provide that
18 information to the employer. The administration shall provide information
19 concerning the following:

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

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

23 (b) Renewability of coverage.

24 (c) Any preexisting condition exclusion.

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

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

28 ~~L~~ K. The administration shall describe the information required by
29 subsection ~~K~~ J of this section in language that is understandable by the
30 average small employer and with a level of detail that is sufficient to
31 reasonably inform a small employer of the employer's rights and obligations
32 under the health benefit plan. This requirement is satisfied if the
33 administration provides the following information:

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

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

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

39 4. In the case of a network plan, a map or listing of the areas
40 served.

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

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

1 ~~Q.~~ N. The administration may increase or decrease premiums based on
2 actuarial reviews of the projected and actual costs of providing health care
3 benefits to eligible members. Before changing premiums, the administration
4 must give sixty days' written notice to the employer. The administration may
5 cap the amount of the change.

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

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

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

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

20 2. The contractor shall reduce the period of any applicable
21 preexisting condition exclusion by the aggregate of the periods of creditable
22 coverage that apply to the individual.

23 ~~S.~~ R. The contractor shall calculate creditable coverage according to
24 the following:

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

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

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

35 ~~T.~~ S. The contractor shall not count a period of creditable coverage
36 with respect to enrollment of an individual if, after the most recent period
37 of creditable coverage and before the enrollment date, sixty-three
38 consecutive days lapse during all of which the individual was not covered
39 under any creditable coverage. The contractor shall not include in the
40 determination of the period of continuous coverage described in this section
41 any period that an individual is in a waiting period for health insurance
42 coverage offered by a health care insurer or is in a waiting period for
43 benefits under a health benefit plan offered by a contractor. In determining
44 the extent to which an individual has satisfied any portion of any applicable
45 preexisting condition period, the contractor shall count a period of
46 creditable coverage without regard to the specific benefits covered during

1 that period. A contractor shall not impose any preexisting condition
2 exclusion in the case of an individual who is covered under creditable
3 coverage thirty-one days after the individual's date of birth. A contractor
4 shall not impose any preexisting condition exclusion in the case of a child
5 who is adopted or placed for adoption before age eighteen and who is covered
6 under creditable coverage thirty-one days after the adoption or placement for
7 adoption.

8 ~~U.~~ T. The written certification provided by the administration must
9 include:

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

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

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

17 1. The date that the certificate is issued.

18 2. The name of the individual or dependent for whom the certificate
19 applies and any other information that is necessary to allow the issuer
20 providing the coverage specified in the certificate to identify the
21 individual, including the individual's identification number under the policy
22 and the name of the policyholder if the certificate is for or includes a
23 dependent.

24 3. The name, address and telephone number of the issuer providing the
25 certificate.

26 4. The telephone number to call for further information regarding the
27 certificate.

28 5. One of the following:

29 (a) A statement that the individual has at least eighteen months of
30 creditable coverage. For THE purposes of this subdivision, "eighteen months"
31 means five hundred forty-six days.

32 (b) Both the date that the individual first sought coverage, as
33 evidenced by a substantially complete application, and the date that
34 creditable coverage began.

35 6. The date creditable coverage ended, unless the certificate
36 indicates that creditable coverage is continuing from the date of the
37 certificate.

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

42 ~~X.~~ W. The healthcare group program shall comply with all applicable
43 federal requirements.

44 ~~Y.~~ X. Healthcare group may pay a commission to an insurance producer.
45 ~~To receive a commission, the producer must certify that to the best of the~~
46 ~~producer's knowledge the employer group has not had insurance in the one~~

1 ~~hundred eighty days before applying to healthcare group.~~ For the purposes of
2 this subsection, "commission" means a one time payment on the initial
3 enrollment of an employer.

4 ~~Z.~~ Y. On or before June 15 and November 15 of each year, the director
5 shall submit a report to the joint legislative budget committee regarding the
6 number and type of businesses participating in healthcare group and that
7 includes updated information on healthcare group marketing activities. The
8 director, within thirty days of implementation, shall notify the joint
9 legislative budget committee of any changes in healthcare group benefits or
10 cost sharing arrangements.

11 ~~AA.~~ Z. For the purposes of this section:

12 1. "Accountable health plan" has the same meaning prescribed in
13 section 20-2301.

14 2. "COBRA continuation provision" means:

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

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

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

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

21 3. "Creditable coverage" means coverage solely for an individual,
22 other than limited benefits coverage, under any of the following:

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

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

29 (c) A health benefits plan, as defined in section 20-2301, issued by a
30 health plan.

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

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

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

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

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

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

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

42 (k) A health benefit plan pursuant to section 5(e) of the peace corps
43 act (22 United States Code section 2504(e)).

44 (l) A policy or contract, including short-term limited duration
45 insurance, issued on an individual basis by an insurer, a health care
46 services organization, a hospital service corporation, a medical service

1 corporation or a hospital, medical, dental and optometric service corporation
2 or made available to persons defined as eligible under section 36-2901,
3 paragraph 6, subdivisions (b), (c), (d) and (e).

4 (m) A policy or contract issued by a health care insurer or the
5 administration to a member of a bona fide association.

6 4. "Eligible employee" means a person who is one of the following:

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

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

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

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

21 5. "Genetic information" means information about genes, gene products
22 and inherited characteristics that may derive from the individual or a family
23 member, including information regarding carrier status and information
24 derived from laboratory tests that identify mutations in specific genes or
25 chromosomes, physical medical examinations, family histories and direct
26 ~~analysis~~ ANALYSES of genes or chromosomes.

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

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

32 (a) Health status.

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

34 (c) Claims experience.

35 (d) Receipt of health care.

36 (e) Medical history.

37 (f) Genetic information.

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

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

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

43 9. "Late enrollee" means an employee or dependent who requests
44 enrollment in a health benefit plan after the initial enrollment period that
45 is provided under the terms of the health benefit plan if the initial
46 enrollment period is at least thirty-one days. Coverage for a late enrollee

1 begins on the date the person becomes a dependent if a request for enrollment
2 is received within thirty-one days after the person becomes a dependent. An
3 employee or dependent shall not be considered a late enrollee if:

4 (a) The person:

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

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

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

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

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

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

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

30 11. "Preexisting condition limitation" or "preexisting condition
31 exclusion" means a limitation or exclusion of benefits for a preexisting
32 condition under a health benefit plan offered by a contractor.

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

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