House Engrossed

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

# HOUSE BILL 2498

AN ACT

AMENDING SECTION 36-2912, ARIZONA REVISED STATUTES; AMENDING TITLE 36, CHAPTER 29, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTIONS 36-2912.04 AND 36-2912.05; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

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

36-2912. Healthcare group coverage; program requirements for small businesses; related requirements; definitions

A. The administration shall administer a healthcare group program to allow willing contractors to deliver health care services to persons defined as eligible pursuant to section 36-2901, paragraph 6, ~~subdivisions (b), (c),~~ SUBDIVISION (d) ~~and (e)~~. ~~In the absence of a willing contractor, the administration may contract directly with any health care provider or entity. The administration may enter into a contract with another entity to provide administrative functions for the healthcare group program.~~ AN EMPLOYER GROUP THAT INCLUDES EMPLOYEES OF THIS STATE OR A POLITICAL SUBDIVISION OF THIS STATE IS NOT ELIGIBLE TO RECEIVE SERVICES PURSUANT TO THIS SECTION. THE ADMINISTRATION IS NOT FINANCIALLY RESPONSIBLE FOR THE DELIVERY OF SERVICES OR FOR THE PAYMENT FOR SERVICES PROVIDED PURSUANT TO THIS SECTION.

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

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

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

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

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

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

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

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

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

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

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

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

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

I. The director shall:

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

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

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

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

to a contractor for the failure of the contractor to comply with provisions of its contract or with provisions of adopted rules.

5. Adopt rules.

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

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

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

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

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

(b) Renewability of coverage.

(c) Any preexisting condition exclusion.

(d) The geographic areas served by the contractor.

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

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

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

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

1 3. The minimum employer contribution and group participation rules
2 that apply to any particular type of coverage.
3 4. In the case of a network plan, a map or listing of the areas
4 served.
5 M. A contractor is not required to disclose any information that is
6 proprietary and protected trade secret information under applicable law.
7 N. At least sixty days before the date of expiration of a health
8 benefit plan, the administration shall provide a written notice to the
9 employer of the terms for renewal of the plan.
10 O. The administration may increase or decrease premiums based on
11 actuarial reviews of the projected and actual costs of providing health care
12 benefits to eligible members. Before changing premiums, the administration
13 must give sixty days' written notice to the employer. The administration may
14 cap the amount of the change.
15 P. The administration may consider age, sex, income and community
16 rating when it establishes premiums for the healthcare group program.
17 Q. Except as provided in subsection R of this section, a health
18 benefit plan may not deny, limit or condition the coverage or benefits based
19 on a person's health status-related factors or a lack of evidence of
20 insurability.
21 R. A health benefit plan shall not exclude coverage for preexisting
22 conditions, except that:
23 1. A health benefit plan may exclude coverage for preexisting
24 conditions for a period of not more than twelve months or, in the case of a
25 late enrollee, eighteen months. The exclusion of coverage does not apply to
26 services that are furnished to newborns who were otherwise covered from the
27 time of their birth or to persons who satisfy the portability requirements
28 under this section.
29 2. The contractor shall reduce the period of any applicable
30 preexisting condition exclusion by the aggregate of the periods of creditable
31 coverage that apply to the individual.
32 S. The contractor shall calculate creditable coverage according to the
33 following:
34 1. The contractor shall give an individual credit for each portion of
35 each month the individual was covered by creditable coverage.
36 2. The contractor shall not count a period of creditable coverage for
37 an individual enrolled in a health benefit plan if after the period of
38 coverage and before the enrollment date there were sixty-three consecutive
39 days during which the individual was not covered under any creditable
40 coverage.
41 3. The contractor shall give credit in the calculation of creditable
42 coverage for any period that an individual is in a waiting period for any
43 health coverage.
44 T. The contractor shall not count a period of creditable coverage with
45 respect to enrollment of an individual if, after the most recent period of

1 creditable coverage and before the enrollment date, sixty-three consecutive
2 days lapse during all of which the individual was not covered under any
3 creditable coverage. The contractor shall not include in the determination
4 of the period of continuous coverage described in this section any period
5 that an individual is in a waiting period for health insurance coverage
6 offered by a health care insurer or is in a waiting period for benefits under
7 a health benefit plan offered by a contractor. In determining the extent to
8 which an individual has satisfied any portion of any applicable preexisting
9 condition period the contractor shall count a period of creditable coverage
10 without regard to the specific benefits covered during that period. A
11 contractor shall not impose any preexisting condition exclusion in the case
12 of an individual who is covered under creditable coverage thirty-one days
13 after the individual's date of birth. A contractor shall not impose any
14 preexisting condition exclusion in the case of a child who is adopted or
15 placed for adoption before age eighteen and who is covered under creditable
16 coverage thirty-one days after the adoption or placement for adoption.
17 U. The written certification provided by the administration must
18 include:
19 1. The period of creditable coverage of the individual under the
20 contractor and any applicable coverage under a COBRA continuation provision.
21 2. Any applicable waiting period or affiliation period imposed on an
22 individual for any coverage under the health plan.
23 V. The administration shall issue and accept a written certification
24 of the period of creditable coverage of the individual that contains at least
25 the following information:
26 1. The date that the certificate is issued.
27 2. The name of the individual or dependent for whom the certificate
28 applies and any other information that is necessary to allow the issuer
29 providing the coverage specified in the certificate to identify the
30 individual, including the individual's identification number under the policy
31 and the name of the policyholder if the certificate is for or includes a
32 dependent.
33 3. The name, address and telephone number of the issuer providing the
34 certificate.
35 4. The telephone number to call for further information regarding the
36 certificate.
37 5. One of the following:
38 (a) A statement that the individual has at least eighteen months of
39 creditable coverage. For THE purposes of this subdivision, "eighteen months"
40 means five hundred forty-six days.
41 (b) Both the date that the individual first sought coverage, as
42 evidenced by a substantially complete application, and the date that
43 creditable coverage began.

1 6. The date creditable coverage ended, unless the certificate
2 indicates that creditable coverage is continuing from the date of the
3 certificate.
4 W. The administration shall provide any certification pursuant to this
5 section within thirty days after the event that triggered the issuance of the
6 certification. Periods of creditable coverage for an individual are
7 established by presentation of the certifications in this section.
8 X. The healthcare group program shall comply with all applicable
9 federal requirements.
10 Y. Healthcare group may pay a commission to an insurance producer. To
11 receive a commission, the producer must certify that to the best of the
12 producer's knowledge the employer group has not had insurance in the one
13 hundred eighty days before applying to healthcare group. For the purposes of
14 this subsection, "commission" means a one time payment on the initial
15 enrollment of an employer.
16 Z. On or before June 15 and November 15 of each year, the director
17 shall submit a report to the joint legislative budget committee regarding the
18 number and type of businesses participating in healthcare group and that
19 includes updated information on healthcare group marketing activities. The
20 director, within thirty days of implementation, shall notify the joint
21 legislative budget committee of any changes in healthcare group benefits or
22 cost sharing arrangements.
23 AA. For the purposes of this section:
24 1. "Accountable health plan" has the same meaning prescribed in
25 section 20-2301.
26 2. "COBRA continuation provision" means:
27 (a) Section 4980B, except subsection (f)(1) as it relates to pediatric
28 vaccines, of the internal revenue code of 1986.
29 (b) Title I, subtitle B, part 6, except section 609, of the employee
30 retirement income security act of 1974.
31 (c) Title XXII of the public health service act.
32 (d) Any similar provision of the law of this state or any other state.
33 3. "Creditable coverage" means coverage solely for an individual,
34 other than limited benefits coverage, under any of the following:
35 (a) An employee welfare benefit plan that provides medical care to
36 employees or the employees' dependents directly or through insurance,
37 reimbursement or otherwise pursuant to the employee retirement income
38 security act of 1974.
39 (b) A church plan as defined in the employee retirement income security
40 act of 1974.
41 (c) A health benefits plan, as defined in section 20-2301, issued by a
42 health plan.
43 (d) Part A or part B of title XVIII of the social security act.
44 (e) Title XIX of the social security act, other than coverage
45 consisting solely of benefits under section 1928.

1 (f) Title 10, chapter 55 of the United States Code.
2 (g) A medical care program of the Indian health service or of a tribal
3 organization.
4 (h) A health benefits risk pool operated by any state of the United
5 States.
6 (i) A health plan offered pursuant to title 5, chapter 89 of the United
7 States Code.
8 (j) A public health plan as defined by federal law.
9 (k) A health benefit plan pursuant to section 5(e) of the peace corps
10 act (22 United States Code section 2504(e)).
11 (l) A policy or contract, including short-term limited duration
12 insurance, issued on an individual basis by an insurer, a health care
13 services organization, a hospital service corporation, a medical service
14 corporation or a hospital, medical, dental and optometric service corporation
15 or made available to persons defined as eligible under section 36-2901,
16 paragraph 6, ~~subdivisions (b), (c),~~ SUBDIVISION (d) ~~and (e)~~.
17 (m) A policy or contract issued by a health care insurer or the
18 administration to a member of a bona fide association.
19 4. "Eligible employee" means a person who is one of the following:
20 (a) Eligible pursuant to section 36-2901, paragraph 6, subdivisions
21 (b), (c), (d) and (e).
22 (b) A person who works for an employer for a minimum of twenty hours
23 per week or who is self-employed for at least twenty hours per week.
24 (c) An employee who elects coverage pursuant to section 36-2982,
25 subsection I. The restriction prohibiting employees employed by public
26 agencies prescribed in section 36-2982, subsection I does not apply to this
27 subdivision.
28 (d) A person who meets all of the eligibility requirements, who is
29 eligible for a federal health coverage tax credit pursuant to section 35 of
30 the internal revenue code of 1986 and who applies for health care coverage
31 through the healthcare group program. The requirement that a person be
32 employed with a small business that elects healthcare group coverage does not
33 apply to this eligibility group.
34 5. "Genetic information" means information about genes, gene products
35 and inherited characteristics that may derive from the individual or a family
36 member, including information regarding carrier status and information
37 derived from laboratory tests that identify mutations in specific genes or
38 chromosomes, physical medical examinations, family histories and direct
39 analysis of genes or chromosomes.
40 6. "Health benefit plan" means coverage offered by the administration
41 for the healthcare group program pursuant to this section.
42 7. "Health status-related factor" means any factor in relation to the
43 health of the individual or a dependent of the individual enrolled or to be
44 enrolled in a health plan including:

1 (a) Health status.
2 (b) Medical condition, including physical and mental illness.
3 (c) Claims experience.
4 (d) Receipt of health care.
5 (e) Medical history.
6 (f) Genetic information.
7 (g) Evidence of insurability, including conditions arising out of acts
8 of domestic violence as defined in section 20-448.
9 (h) The existence of a physical or mental disability.
10 8. "Hospital" means a health care institution licensed as a hospital
11 pursuant to chapter 4, article 2 of this title.
12 9. "Late enrollee" means an employee or dependent who requests
13 enrollment in a health benefit plan after the initial enrollment period that
14 is provided under the terms of the health benefit plan if the initial
15 enrollment period is at least thirty-one days. Coverage for a late enrollee
16 begins on the date the person becomes a dependent if a request for enrollment
17 is received within thirty-one days after the person becomes a dependent. An
18 employee or dependent shall not be considered a late enrollee if:
19 (a) The person:
20 (i) At the time of the initial enrollment period was covered under a
21 public or private health insurance policy or any other health benefit plan.
22 (ii) Lost coverage under a public or private health insurance policy or
23 any other health benefit plan due to the employee's termination of employment
24 or eligibility, the reduction in the number of hours of employment, the
25 termination of the other plan's coverage, the death of the spouse, legal
26 separation or divorce or the termination of employer contributions toward the
27 coverage.
28 (iii) Requests enrollment within thirty-one days after the termination of
29 creditable coverage that is provided under a COBRA continuation provision.
30 (iv) Requests enrollment within thirty-one days after the date of
31 marriage.
32 (b) The person is employed by an employer that offers multiple health
33 benefit plans and the person elects a different plan during an open
34 enrollment period.
35 (c) The person becomes a dependent of an eligible person through
36 marriage, birth, adoption or placement for adoption and requests enrollment
37 no later than thirty-one days after becoming a dependent.
38 10. "Preexisting condition" means a condition, regardless of the cause
39 of the condition, for which medical advice, diagnosis, care or treatment was
40 recommended or received within not more than six months before the date of
41 the enrollment of the individual under a health benefit plan issued by a
42 contractor. Preexisting condition does not include a genetic condition in
43 the absence of a diagnosis of the condition related to the genetic
44 information.

1 11. "Preexisting condition limitation" or "preexisting condition
2 exclusion" means a limitation or exclusion of benefits for a preexisting
3 condition under a health benefit plan offered by a contractor.
4 12. "Small employer" means an employer who employs at least one but not
5 more than fifty eligible employees on a typical business day during any one
6 calendar year.
7 13. "Waiting period" means the period that must pass before a potential
8 participant or eligible employee in a health benefit plan offered by a health
9 plan is eligible to be covered for benefits as determined by the individual's
10 employer.
11 Sec. 2. Title 36, chapter 29, article 1, Arizona Revised Statutes, is
12 amended by adding sections 36-2912.04 and 36-2912.05, to read:
13 36-2912.04. Health benefit plans; application of health care
14 services organization or group disability laws;
15 coverage
16 A. A CONTRACTOR THAT PROVIDES SERVICES PURSUANT TO SECTION 36-2912
17 SHALL BE A HEALTH CARE SERVICES ORGANIZATION OR A GROUP DISABILITY INSURER.
18 B. A CONTRACTOR THAT IS A HEALTH CARE SERVICES ORGANIZATION IS SUBJECT
19 TO TITLE 20, CHAPTER 4, ARTICLE 9, EXCEPT THAT THE CONTRACTOR IS NOT SUBJECT
20 TO THE FOLLOWING:
21 1. SECTION 20-1057, SUBSECTIONS B, C, E, I, J, K, L, M, N, O, R, S, T,
22 U, V, W, Y, Z, AA, BB, CC AND DD.
23 2. SECTION 20-1057.01.
24 3. SECTION 20-1057.02, SUBSECTION B.
25 4. SECTION 20-1057.03.
26 5. SECTION 20-1057.04.
27 6. SECTION 20-1057.05.
28 7. SECTION 20-1057.07.
29 8. SECTION 20-1057.08.
30 9. SECTION 20-1057.10.
31 C. A CONTRACTOR THAT IS A GROUP DISABILITY INSURER IS SUBJECT TO TITLE
32 20, CHAPTER 6, ARTICLE 5, EXCEPT THAT THE GROUP DISABILITY INSURER IS NOT
33 SUBJECT TO THE FOLLOWING:
34 1. SECTION 20-1402, SUBSECTION A, PARAGRAPHS 1, 2, 5, 6, 7 AND 8.
35 2. SECTION 20-1402, SUBSECTIONS B, C, D, E, F, G, H, I, J, K, L AND M.
36 3. SECTION 20-1402.01.
37 4. SECTION 20-1402.02.
38 5. SECTION 20-1406.
39 6. SECTION 20-1406.01.
40 7. SECTION 20-1406.02.
41 8. SECTION 20-1406.03.
42 9. SECTION 20-1406.04.
43 10. SECTION 20-1407.
44 11. SECTION 20-1410.

1 36-2912.05. Health benefit plan; cancer screening examinations;
2 coverage
3 A HEALTH BENEFIT PLAN THAT IS OFFERED BY A CONTRACTOR TO PERSONS
4 DEFINED AS ELIGIBLE PURSUANT TO SECTION 36-2912 SHALL PROVIDE COVERAGE FOR
5 THE FOLLOWING CANCER SCREENING EXAMINATIONS ON REFERRAL BY A PATIENT'S
6 PHYSICIAN, SUBJECT TO ALL OF THE TERMS AND CONDITIONS OF THE POLICY OR
7 CONTRACT AND ACCORDING TO THE RECOMMENDATIONS THAT ARE ESTABLISHED BY THE
8 UNITED STATES PREVENTIVE SERVICES TASK FORCE FOR THE FOLLOWING:
9 1. COLON AND RECTAL CANCER SCREENING FOR A PERSON WHO IS AT LEAST
10 FIFTY YEARS OF AGE.
11 2. MAMMOGRAPHY SCREENING.
12 3. BREAST CANCER SCREENING.
13 4. PROSTATE CANCER SCREENING.
14 Sec. 3. Effective date
15 This act is effective from and after August 31, 2008.