Report of the Director
of the
Arizona Department of Insurance

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On the effect on the cost and availability of health insurance coverage for small groups under the provisions of Chapter 4, Article 14, A.R.S. § 20-1098 through § 20-1098.05.

September 1994

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I. PREFACE

This report describes the effect of the provisions in Chapter 4, Article 14, A.R.S. § 20-1098 through 20-1098.05 on the cost and availability of health insurance coverage for small groups. This article is repealed by Laws 1991, Ch. 299, § 8, effective January 2, 1996.

Readers are reminded that for purposes of this report "small group" is defined as a group of fewer than twenty-five (25) employees formed for purposes other than obtaining insurance coverage.

II. REVIEW OF ISSUES

A. Description of the Legislation

The 1991 Arizona legislature enacted Chapter 4, Article 14, A.R.S. § 20-1098 through 20-1098.05 (Exhibit A) to address the problem of the lack of affordable health insurance for small employers. This legislation created a minimum level benefit small group health insurance plan and removed the requirement it contain all the benefits mandated by law. It then set forth benefits believed to provide the most basic kinds of coverage. The intent was to permit companies to offer a product that would cost less than other group health plans while providing benefits for the basic health care services such as primary, preventative and hospital care. This type coverage has sometimes been referred to as "bare bones coverage". A summary of the bare bones plan is included as Exhibit B.

B. Background

Prior to passage of these laws, group health insurance policies, regardless of the size of the group, were required to provide benefits to cover certain types of services and certain types of providers of services. These required benefits are generally referred to as "mandated benefits". A summary of the benefits mandated in Arizona is included as Exhibit C.

In recent years while health insurance premiums have been escalating small employers were particularly impacted. They experienced large premium increases while at the same time many insurers discontinued marketing insurance to small employers.

As the premiums increased it became more and more difficult for small employers to provide insurance to their employees. Both affordability and availability of health insurance for small employers became an issue.

Some believed that the mandating of certain benefits was responsible for making health insurance expensive and argued that premiums would be less if health insurance plans could be made available which did not contain all the "mandated benefits". A.R.S. § 20-1098.02 provides for an exemption from mandated benefits for certain providers and services. A.R.S. § 20-1098.01 sets forth the minimum level of benefits that must be provided in a health insurance plan an insurer offers under these laws.

C. Methodology

The Department has monitored materials received from companies providing health insurance to identify any "bare bones" products submitted pursuant to A.R.S. § 20-1098.04. A survey of 102 insurers providing group health insurance in Arizona was also conducted. The survey, Exhibit D, included questions regarding the number "bare bones" policies they had issued to small employers and the number of Arizona residents covered by these policies.

III. FINDINGS

A. Survey Results

Of the one hundred two (102) companies surveyed eighty three (83) responded.

Of the eighty three (83) responding, all said they had not issued any of the "bare bones" policies to small groups in Arizona.

Seventy five (75) companies said that these laws have had no effect on other products they offer to small groups. Two (2) stated the law had a moderate effect.

Seventy two (72) companies companies said that these laws had no effect on the price of other products they offer to small groups. Five (5) stated the law had a moderate effect.

Seventy one (71) companies said these laws had no effect on the availability of health insurance coverage they offer to small groups. Four (4) companies said it had a moderate effect. Two (2) said it had a major effect.

Five (5) companies said the laws should be continued, twenty five (25) said they should not be continued, fifty one (51) said they had no opinion.

Companies were asked to comment on the reasons they had not issued any of these policies to small groups. Many noted that they had not found a demand for such a product and that they already had a small group product they were marketing which they felt was affordable and was not as limited in benefits as the "bare bones" policies. Some noted that administrative costs associated with designing and implementing a product that was not particularly in demand was not economically feasible.

B. Department of Insurance Records

The Department has monitored the form and policy filings submitted by companies since enactment of this law. There is no record of receipt of any forms pursuant to A.R.S. § 20-1098.04.

C. Recent Legislation

The 1993 Arizona legislature enacted Chapter 231, (S.B. 1109), amending Title 20 by adding Chapter 13, Articles 1 and 2, A.R.S. § 20-2301 through 20-2352. These new laws effective January 1, 1994, address group health insurance offered to employers with three (3) or more employees with particular protections applicable to employers with three (3) but not more the forty (40) employees.

IV. CONCLUSIONS

Although insurers are permitted to develop limited benefit health insurance products for small groups that do not include all mandated benefits, they have not done so. There is apparently no demand for such a product and it appears that it would not necessarily be more affordable than other products offered to small groups. These findings along with the enactment of new laws under S.B. 1109 in 1993 indicate little need for continuation or modification of these laws.

V. RECOMMENDATIONS

It is recommended that A.R.S. § 20-1098 through 20-1098.05 be discontinued effective January 2, 1996, as provided in Laws 1991, Ch. 299, § 8.

EXHIBIT A

Statutes

A.R.S. § 20-1098 through § 20-1098.05

[1] Section 32–1101 et seq.
[2] Section 28–1301 et seq.

Historical and Statutory Notes

1993 Reviser's Note:
Pursuant to authority of § 41–1304.02, in subsection A, paragraph 3, subdivision (b), last sentence the words "inspection, except that the director may use this information in any" were inserted after "public" as a correction of a manifest clerical error.

ARTICLE 14. SMALL GROUP HEALTH INSURANCE

Article 14, consisting of §§ 20–1098 to 20–1098.06, was added by Laws 1991, Ch. 299, § 4, effective September 21, 1991.

Repeal

Article 14 is repealed by Laws 1991, Ch. 299, § 8, effective January 2, 1996.

See Historical and Statutory Notes, post.

Historical and Statutory Notes

Laws 1991, Ch. 299, § 8, provides:

"Sec. 8. Delayed repeal

"Title 20, chapter 4, article 14, Arizona Revised Statutes, as added by this act is repealed from and after January 1, 1996."

§ 20–1098. Definition of small group

As used in this article, "small group" means a group of fewer than twenty-five employees that is formed for purposes other than obtaining insurance coverage.

Added by Laws 1991, Ch. 299, § 4.

Repeal

This section is repealed by Laws 1991, Ch. 299, § 8, effective January 2, 1996.

Historical and Statutory Notes

1991 Reviser's Note:
Pursuant to authority of § 41–1304.02, in the section heading "of small group" was added.

§ 20–1098.01. Issuance of small group health insurance policies, subscription contracts and evidences of coverage

A. An insurer, a hospital and medical service corporation and a health care services organization may issue to small groups of fewer than twenty-five employees small group health insurance policies, subscription contracts and evidences of coverage pursuant to this article. Except as provided in § 20–1098.04, subsection B, no insurer, hospital and medical service corporation or health care services organization may issue an insurance policy, subscription contract or evidence of coverage pursuant to this article to employers who had policies, subscription contracts or evidences of coverage in effect during the ninety days immediately preceding the date of application for coverage pursuant hereto.

B. A small group insurance policy, subscription contract or evidence of coverage shall provide to a covered individual the following basic levels of primary, preventive and hospital care:

1. A minimum of fifteen days per calendar year of inpatient hospitalization coverage for acute care, including maternity care. The coinsurance required by the coverage shall not exceed fifty per cent of the cost of care.

2. Obstetrical care, including a minimum of one prenatal office visit per month during the first two trimesters of pregnancy, two office visits per month during the seventh and eighth months of pregnancy and one office visit per week during the ninth month of pregnancy until

termination of the pregnancy. The coinsurance required by the coverage shall not exceed thirty per cent of the cost of care. The coverage shall include:

(a) For each office visit, necessary and appropriate screening, including a history of the patient, a physical examination and any laboratory and diagnostic procedures that the physician deems appropriate based on recognized medical criteria for the risk group to which the patient belongs.

(b) For each office visit if the physician deems it appropriate, prenatal counseling.

(c) Delivery and postpartum care.

3. Well-baby and well-child care, including periodic review by a physician or under a physician's supervision of a child's physical status, including the child's history, a physical examination, a developmental assessment, appropriate immunizations, laboratory tests and anticipatory guidance. The coinsurance required by the coverage shall not exceed thirty per cent of the cost of care. The review under this paragraph shall be performed at the following approximate age intervals:

(a) Birth.

(b) Two months.

(c) Four months.

(d) Six months.

(e) Nine months.

(f) Twelve months.

(g) Fifteen months.

(h) Eighteen months.

(i) Two years.

(j) Three years.

(k) Four years.

(l) Five years.

(m) Six years.

4. An annual office visit for well-woman care including coverage for routine gynecologic examinations and pap smears.

5. A minimum of two office visits per calendar year with a physician for primary care. Coverage for additional primary and nonprimary physician care shall be provided up to a total of five thousand dollars per calendar year. The coinsurance required by the coverage shall not exceed fifty per cent of the cost of care.

6. Coverage of outpatient facility charges of up to two thousand five hundred dollars per calendar year. The coinsurance required by the coverage shall not exceed fifty per cent of the cost of care.

C. The small group insurance policy, subscription contract or evidence of coverage shall include:

1. An exclusion for services that are not medically necessary.

2. Procedures for the preauthorization of health care services except emergency services.

D. The small group insurance policy, subscription contract or evidence of coverage may include:

1. Preferred providers who have entered into written agreements with the insurer, hospital and medical service corporation or health care services organization to provide services at specified levels of reimbursement.

2. Reimbursement procedures for the reimbursement of a covered individual who obtains medical services from a nonpreferred provider. The amount of reimbursement shall not exceed the amount that would have been received if the services had been rendered by a preferred provider minus no more than thirty per cent of the cost of care.

3. Additional managed care and cost control provisions that are not prohibited under this article.

Added by Laws 1991, Ch. 299, § 4. Amended by Laws 1992, Ch. 268, § 1.

Repeal

This section is repealed by Laws 1991, Ch. 299, § 8, effective January 2, 1996.

Historical and Statutory Notes

Laws 1992, Ch. 268, § 2, provides:

"Sec. 2. Applicability

"The provisions of this act shall apply to all small group policies delivered or issued for delivery in this state on or after the effective date of this act and to small group policies previously delivered in this state when the benefits are amended or the policy is renewed."

§ 20–1098.02. Exemption from mandated benefits; providers and services

A. A small group health insurance policy, subscription contract or evidence of coverage may be issued to a small group without satisfying the requirements of § 20–461, subsection A, paragraph 16 and subsection B, § 20–826, subsections C and D, § 20–841, § 20–841.01, § 20–841.02, § 20–1051, paragraphs 1 and 5, § 20–1057, subsection C, § 20–1402, subsection A, paragraph 4, § 20–1404, subsection F, § 20–1406, § 20–1406.01 and § 20–1406.02.

B. If applicable, a small group health insurance policy, subscription contract or evidence of coverage that is issued to a small group shall satisfy the requirements of § 20–826, subsections E, F, H, I, J and K, § 20–1057, subsections B, I, J, K, L and M, § 20–1402, subsection A, paragraphs 2, 5, 6, 7 and 8, § 20–1404, subsections E, G, H, I and J and § 20–1408. The coverages may be subject to coinsurance, managed care and cost control provisions that are applicable under the policy, subscription contract or evidence of coverage.

Added by Laws 1991, Ch. 299, § 4.

Repeal

This section is repealed by Laws 1991, Ch. 299, § 8, effective January 2, 1996.

§ 20–1098.03. Marketing and disclosure requirements

Before a small group health insurance policy, subscription contract or evidence of coverage is issued, the insurer, hospital and medical service corporation or health care services organization shall file for approval by the director copies of all marketing materials that are utilized in marketing the small group coverage. The marketing material shall contain a written disclosure statement that includes:

1. An explanation of the benefits, providers and services that are mandated for a group health insurance policy subscription contract or evidence of coverage but that are not covered by the small group health policy, subscription contract or evidence of coverage.

2. An explanation of the managed care and cost control features of the policy, subscription contract or evidence of coverage and the telephone numbers and mailing addresses that a covered person may use in seeking information or authorization.

3. An explanation of the primary and preventive care features of the policy, subscription contract or evidence of coverage.

Added by Laws 1991, Ch. 299, § 4.

Repeal

This section is repealed by Laws 1991, Ch. 299, § 8, effective January 2, 1996.

§ 20–1098.04. Submission of forms; exceptions

A. Before a small group health insurance policy, subscription contract or evidence of coverage is issued, the small group health insurer, hospital and medical service corporation or

health care services organization shall file for approval by the director copies of all applications, enrollment forms, policies, subscription contracts, certificates, evidences of coverage, riders, amendments, endorsements, disclosure forms and other forms the director may require. The provisions of § 20–1110 apply to submission of forms under this article.

B. The director is authorized to adopt rules which permit, for good cause shown, an insurer, hospital and medical service corporation or health care service organization to issue and an employer to obtain health insurance coverage pursuant to this article even though the employer has had health insurance coverage within the ninety-day period immediately preceding the first day of coverage pursuant to this article. For the purpose of this section, "good cause shown" shall include circumstances where the employer's prior health insurance coverage was terminated or cancelled or not renewed for reasons other than to obtain coverage pursuant to this article.

C. Notwithstanding the provisions of § 20–1098.01, subsection A, health insurance coverage properly first issued pursuant to the provisions of this article may continue for the period for which coverage was written even though the group size has increased to twenty-five or more employees during the period of such coverage.

Added by Laws 1991, Ch. 299, § 4.

Repeal

This section is repealed by Laws 1991, Ch. 299, § 8 effective January 2, 1996.

§ 20–1098.05. Record keeping and reporting requirements

The director may by rule require each insurer, hospital and medical service corporation or health care services organization issuing an insurance policy, subscription contract or evidence of coverage pursuant to this article to maintain records and to furnish an annual report to the director containing such information as the director may require to analyze the effect of health insurance policies, subscription contracts or evidences of coverage issued pursuant to this article. The annual report and required records shall be in a form required by the director and consistent with the forms, if any, adopted by the national association of insurance commissioners for such purpose.

Added by Laws 1991, Ch. 299, § 4.

Repeal

This section is repealed by Laws 1991, Ch. 299, § 8, effective January 2, 1996.

Historical and Statutory Notes

Laws 1991, ch. 299, § 4 purportedly added a § 20–1098.06 which was designated as a temporary law by the reviser (see reviser's note, post). The provision read:

"§ 20–1098.06. Report by director

"The director of the department of insurance shall make a written report by September 1, 1994 to the governor and the legislature regarding the health insurance policies, subscription contracts or evidences of coverage permitted under this article describing to the extent practicable the effect of this article on the cost and availability of health insurance coverage for small groups, and any recommendations with respect to continuation, modification or discontinuation of the provisions of title 20, chapter 4, article 14, Arizona Revised Statutes."

Reviser's Notes:

1991 Note. Pursuant to authority of § 41–1304.02, in the second sentence "records" was transposed to follow "required".

1991 Note. Laws 1991, Ch. 299, sec. 4 designated part of the text of section 4 as § 20–1098.06, Arizona Revised Statutes. Pursuant to authority of § 41–1304.02, this section is published as temporary law and the references to "title 20, chapter 4, article 14, Arizona Revised Statutes" were substituted for "this article" as conforming language.

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EXHIBIT B

Summary

SUMMARY OF SMALL GROUP HEALTH INSURANCE (BAREBONES)

A.R.S. § 20-1098 through 20-1098.06
Effective 9-21-91

Small group is defined to be a group of fewer than twenty-five (25) employees.

Coverage may only be issued to a group that has been without coverage during the ninety (90) days immediately preceding the date of application. Rules may be adopted, but have not to date, to permit issuance in certain instances.

REQUIRED BASIC LEVELS OF PRIMARY, PREVENTIVE AND HOSPITAL CARE:

In Patient Hospital:	Minimum 15 days per calendar year. Coinsurance may not exceed 50%.
Obstetrical Care:	Minimum of 1 prenatal office visit per month first two trimesters, 2 visits per month 7th and 8th months and 1 visit per week in 9th. month. Must include appropriate lab and diagnostic procedures including prenatal counseling, delivery and postpartum care. Coinsurance may not exceed 30%.
Well-Baby and Well-Child Care:	Periodic review including physical examinations, developmental assessment, immunizations, laboratory tests and anticipatory guidance from birth to 6 years of age. Coinsurance may not exceed 30%.
Well-Woman Care:	An annual routine gynecologic examination and pap smear.
Primary Care:	2 office visits per calendar with physician for primary care. Additional primary and nonprimary physician care up to a total of $5,000 per calendar year. Coinsurance may not exceed 50%.
Outpatient Facility:	Up to $2,500 per calendar year. Coinsurance may not exceed 50%.
Required Exclusions:	Services not medically necessary. Procedures not preauthorized except

	for emergency services.
May Include:	Preferred providers arrangements and other managed care and cost control provisions which are not otherwise prohibited. Reimbursement for nonpreferred providers can not exceed the amount that would have been paid if services had been rendered by a preferred provider minus no more than 30% of the cost of the care.
Mandates Required:	Automatic coverage for children adopted or newly born.
	Breast reconstructive surgery and at least two external postoperative prosthesis.
	Mammography
	Maternity costs for natural mother of an adopted child.
	Certified and registered nurse practitioner.
Mandates NOT Required:	Minimum requirements of a basic health care plan as defined by Department of Health Services. (HMO only)
	Psychiatric special hospital.
	Home health care and diagnostic services and surgery performed outside a hospital in lieu of inpatient service.
	Services provided by dentists, optometrists, chiropractors and psychologists.

EXHIBIT C

Listing of Mandated Benefits

BENEFITS MANDATED BY ARIZONA LAW

	MANDATE	GROUP	INDIVIDUAL	HCSO	HMD&OSC	PPOP
(1)	Provide immediate coverage for 31 days for newly born children.	20-1402(2)	20-1342(A)(3)	20-1057(B)	20-826(E)	20-1007(B)
(2)	Provide immediate coverage for 31 days for children adopted or placed for adoption.	20-1402(2)	20-1342(A)(3)	20-1057(B)	20-826(E)	20-1007(B)
(3)	Provide continuing coverage for handicapped children when they reach the limiting age for dependent children specified in the policy.	20-1407	20-1342.01	N/A	20-826(F)	N/A
(4)	Pay benefits for surgical service covered by a policy regardless of the place of service.	20-1402(4)(a)	20-1342(8)(a)	Included in the definition of HCSO-- 20-1051	20-826(C)(1)	N/A
(5)	Pay benefits for home health services prescribed in lieu of hospital services.	20-1402(4)(b)	20-1342(8)(b)	Included in the definition of HCSO-- 20-1051	20-826(C)(2)	N/A
(6)	Pay benefits for diagnostic service performed outside a hospital in lieu of in-patient service which would have been covered.	20-1402(4)(c)	20-1342(8)(c)	Included in the definition of HCSO-- 20-1051	20-826(C)(3)	N/A

	MANDATE	GROUP	INDIVIDUAL	HCSO	HMO&OSC	PPDP
(7)	Pay benefits for service performed in a hospital's outpatient department or in a freestanding surgical facility, providing such service would have been covered if performed as an in-patient service.	20-1402(4)(d)	20-1342(8)(d)	Included in the definition of HCSO--20-1051	20-826(C)(4)	N/A
(8)	Provide coverage for breast reconstructive surgery and external postoperative prosthesis following a covered mastectomy.	20-1402(5)	20-1342(A)(9)	20-1057(I)	20-826(H)	
(9)	Provide coverage for mammography screening.	20-1402(6)	20-1342(A)(10)	20-1057(J)	20-826(I)	N/A
(10)	Provide maternity benefits for the natural mother of an adopted child if the policy provides maternity benefits.	20-1402(7&8)	20-1342(A)(11&12)	20-1057(K&L)	20-826(J&K)	N/A

ADDITIONAL REQUIREMENTS:

Most policies cannot exclude services performed by chiropractors, dentists, psychologists, optometrists and podiatrists, if the services which are performed are within the scope of their license and are otherwise covered by the policy. This applies to the following type policies:

- Group: §§ 20-1406(A) and (B), 20-1406.01 and 20-1406.02
- Individual: §§ 20-1346(A) and (B), 20-1376.01 and 20-1376.02
- Hospital, Medical, Dental and Optometric Service Corporation: §§ 20-826(D), 20-841.01 and 20-841.02 (This is not applicable to HCSOs)

If a policy provides coverage for psychiatric, drug abuse or alcoholism services, reimbursement for such services shall be made in accordance with the terms of the contract without regard to whether the covered services are rendered in a psychiatric special hospital or general hospital. This applies to the following type policies:

- Group: § 20-1406(C)
- Individual: § 20-1376(C)
- Hospital, Medical, Dental and Optometric Service Corporation: § 20-841(C)
- HSCO: § 20-1057(C)

If a policy provides for or offers reimbursement for a service within the lawful scope of practice of a registered nurse practitioner or a certified registered nurse qualified under the rules adopted by the State Board of Nursing regarding extended nursing practice and licensed pursuant to Title 32, Chapter 15, benefits shall not be denied to a subscriber receiving such a service. Reimbursement for the cost of the service may be made directly to the person licensed pursuant to Title 32, Chapter 15 (A.R.S. § 32-1601 et seq.) or to the subscriber if the cost of the service has not been reimbursed to another provider or health care institution. The following policies and statutes apply:

- Group: § 20-1406.03
- Individual: § 20-1376.03
- Hospital, Medical, Dental and Optometric Service Corporation: § 20-841.03
(This is not applicable to HSCOs)

GROUP = Group Health Insurance
INDIVIDUAL = Individual Health Insurance
HCSO = Health Care Services Organizations (HMO)
HMD&OSC = Hospital, Medical, Dental and Optometric Service Corporations
PPDP = Prepaid Dental Plan Organizations

STATE OF ARIZONA
DEPARTMENT OF INSURANCE

FIFE SYMINGTON
Governor

2910 NORTH 44TH STREET, SUITE 210
PHOENIX, ARIZONA 85018

CHRIS HERSTAM
Director of Insurance

July 18, 1994

Attention:

Re: Small Group Health Insurance
Article 14
A.R.S. § 20-1098- 20-1098.05

The Arizona Department of Insurance is conducting a survey to assess the effect of A.R.S. § 20-1098 thru 20-1098.05. These laws were enacted by the legislature and became effective September 21, 1991. They are scheduled for repeal January 2, 1996. This survey in intended to assess their affect on the cost and availability of health insurance coverage for small groups in Arizona.

Small group as defined in A.R.S. § 20-1098 means a group of fewer than twenty-five employees that is formed for purposes other than obtaining insurance coverage.

The following questions should be answered and this survey returned via mail or FAX no later than August 5, 1994 to:

Arizona Department of Insurance
Health Policy Division
2910 N. 44th. St.
Phoenix, Arizona 85018
FAX 602-912-8453

1. [ ] Yes [ ] No Have you issued any policies to small groups as defined in A.R.S.§ 20-1098.01 in Arizona?

2. If Yes, how many? _____.

3. If you have issued any of the above referenced policies, how many are currently in effect and how many Arizona residents are covered by them?

____ Policies _____ Arizona residents

4. If you have not issued any of theses policies explain why?

_____

_____

5. What effect did these laws have on other products you offer to small groups?

[ ] No effect [ ] Moderate effect [ ] Major effect

6. What affect did these laws have on the price of other products you offer to small groups?

[ ] No effect [ ] Moderate effect [ ] Major effect

7. What effect did these laws have on the availability of health insurance coverage you have offered to small groups?

[ ] No effect [ ] Moderate effect [ ] Major effect

8. Should these laws be continued?

[ ] Yes [ ] No [ ] No opinion

Thank you for your cooperation in completing this survey promptly. Contact us a 602-912-8443 if you should have any questions.

Sincerely

Mary Butterfield
Manager
Health Policy Division
Arizona Department of Insurance