FIFE SYMINGTON
Governor

JOHN A. GREENE
Director

ARIZONA DEPARTMENT OF INSURANCE

2910 North 44th Street, Suite 210, Phoenix, Arizona 85018-7256 · (602) 912-8456 · FAX: (602) 912-8452

http://www.state.az.us/id

Circular Letter 97-7

TO: All Insurance Industry Representatives, Insurance Trade Associations and Interested Parties

FROM: John A. Greene

Director of Insurance

DATE: July 21, 1997

RE: Implementation of Senate Bill 1321

Senate Bill 1321, signed into law by Governor Symington, implemented in state law provisions of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) enacted by the United States Congress. This Circular letter addresses the obligation of insurers to issue coverage on a guaranteed issuance basis to eligible individuals. This circular letter also addresses the disclosure forms and certificates of prior creditable coverage prescribed by Senate Bill 1321.

This Circular letter first addresses the obligation of insurers to issue coverage on a guaranteed issuance basis to eligible individuals. This obligation began on July 1, 1997 when Senate Bill 1321 became effective.

The circular letter next addresses disclosure requirements that an accountable health plan must follow when offering coverage in the large group market. Separately, the circular letter addresses the additional disclosures that an accountable health plan must make available to small employers when offering coverage in the small group market.

The circular letter then addresses the certificates of prior creditable coverage that all health carriers, including indemnity carriers, service corporations, health care services organizations, accountable health plans and any other disability insurer must issue to individuals who have earned creditable coverage under health care contracts or policies issued by these entities. These certificates serve two primary purposes: 1) to permit a person to demonstrate the satisfaction of preexisting condition requirements when moving from one employer based group to another; and 2) to permit a person to

demonstrate the satisfaction of the standards applicable to becoming an eligible individual in order to secure coverage on a guaranteed issuance basis in the individual market.

The Issuance of Coverage to Eligible Individuals

Senate Bill 1321 established a requirement that all eligible individuals be issued coverage on a guaranteed issuance basis without regard to health-status. This requirement became effective on July 1, 1997. Thus, all health care insurers, including health care services organizations that offer health coverage in the individual market must accept every eligible individual who applies for health coverage after the effective date of this bill.

The law includes three options that each health care insurer may select to comply with the requirement that coverage be made available to all eligible individuals. A health care insurer may make all of its forms available to all eligible individuals. A.R.S. §201379(B). Alternatively, a health care insurer may elect to make two policy forms available to be issued to eligible individuals on a guaranteed issuance basis. A.R.S. §201379(C). These options include either a choice of the health care insurer's two most popular forms, or a choice of two policies with a blend of benefits determined according to the formula contained in Senate Bill 1321.

A health care insurer that chooses an option other than offering all forms to eligible individuals must make a formal election of its choice and must abide by that choice for a minimum of two years. A.R.S. §201379(D). If the forms to be employed by a health care insurer under either of the elective options permitted by A.R.S. §201379(C) require the Department's approval, the health care insurer must offer all forms to eligible individuals pending the Department's approval of the filing.

Beginning with the effective date of this law, individuals may begin to apply to any health care insurer for coverage as an eligible individual. Health care insurers in the individual market **must** accept the applications of the eligible individuals who apply for coverage after that date. Health care insurers **may not refuse** to issue coverage to eligible individuals, even if the health care insurer has not received the Department's approval for forms to be used by the health care insurer under the elective option permitted by the law. Pending the approval of the filings, a health care insurer must offer all products to eligible individuals. The offering of all products to eligible individuals pending the approval of the health care insurer's filings does not constitute a binding two-year election under A.R.S. §201379(D). The election prescribed under this provision applies only when a health care insurer has chosen an option other than the all products option.

Disclosure Forms

Pursuant to A.R.S. § 20-2323, completed disclosure forms must be submitted to the Department of Insurance before being distributed to all employers, both large and small. This law takes effect July 1, 1997.

This law specifies the information an accountable health plan must give to employers, and that employers must in turn distribute to their employees. The disclosures to be made by accountable health plans will permit employers considering the purchase or renewal of a health benefits plan to evaluate the contents of competing health benefit plans through the evaluation of standardized forms. These forms will disclose, as applicable:

1. A roster of plan physicians and specialists, including their degree, practice, specialty, and years of practice.

2. The full premium cost of the plan, any co-payments, co-insurance or deductible requirements an enrollee or an enrollee's family may incur.

3. A description of all health care benefits and where and how the enrollee may obtain them.

4. A description of all exclusions and limitations on services and benefits, including emergency and after-hours care, out of plan services, prior authorization procedures, specialist referrals and point of service options.

5. Procedures for filing grievances, including creditable coverage determinations.

6. A statement about whether the accountable health plan imposes limitations on physicians in prescribing drugs from lists and formularies and the extent to which an enrollee will be reimbursed for the cost of a drug not covered on a plan list.

7. A statement about whether the accountable health plan's provider compensation program includes any incentives or penalties intended to encourage plan providers to withhold services, or minimize or avoid referrals to specialists.

8. A statement that the disclosure form constitutes a summary only and that the enrollee should consult the plan's evidence of coverage to determine any governing contract provision.

A.R.S. § 20-2304 established additional disclosures to be made available by accountable health plans to small employers. These additional disclosures include the following items:

1. Factors that may affect changes in premiums.

2. Minimum employer contribution and group contribution rules that apply to a particular type of coverage.

3. In the case of a network plan, a map or list of the areas served.

4. Renewability of coverage.

5. The identification of any applicable preexisting condition exclusions or limitations or any affiliation period requirements.

Notice of the availability of these items and the specific disclosure of these items may be provided in a separate disclosure form or may be included in a blended disclosure form.

Accountable health plans must submit the completed disclosure forms to the Director before their distribution to applicants or to renewing employers. Employers must give employees the disclosure form at the beginning of open enrollment or at least 10 days before the conclusion of any other enrollment. In addition, the new law prohibits an employer from executing a contract with an employer group until the employer has received the disclosure form.

The following steps will be employed by the Department for this submission of disclosure forms:

1. The specimen completed disclosure forms must be directed to the Life and Health Division of the Department of Insurance, and must be accompanied by an original and copy of a cover letter that reflects the time period during which the disclosure form will be in use.

2. The Department will acknowledge receipt of the disclosure forms by stamping the copy of the cover letter and returning it to the carrier that submitted the disclosure form. The Department requests that Certification Form P107 be used in connection with the submission of disclosure forms.

3. Any questions regarding the procedures to be following to submit completed disclosure forms, as well as submissions of completed disclosure forms should be directed to the Life and Health Division, Arizona Department of Insurance, 2910 N. 44th Street, Suite 210, Phoenix, Arizona 85018, phone: (602) 912-8460, fax (602) 912-8453.

Appendix A to this circular letter contains a model of the disclosure form to be used by accountable health plans offering coverage to all employers. Appendix B contains the format that may be followed by those accountable health plans that wish to blend the elements required to be included in disclosures made to all employers along with disclosures to be made to small employers consistent with the requirements of A.R.S. § 20-2304. Appendix C contains the disclosure form that may be made available to small employers to be distributed separately from the form contained in Appendix A.

Certificates of Prior Creditable Coverage

Senate Bill 1321 requires health care insurers, accountable health plans and any other entity issuing health care coverage to issue written certificates of prior creditable coverage, with these certificates to be delivered to individuals whose coverage has terminated. These certificates serve two primary functions. First, certificates enable individuals who leave one employer and move to a second employer to demonstrate their satisfaction of all or part of any applicable preexisting condition or exclusion, in order to receive coverage without any coverage restrictions or exclusions. Second, the certificates permit any person who satisfies all of the tests contained in the law to become an eligible individual, to receive the opportunity to purchase health insurance coverage in the individual market on a guaranteed issuance basis without any underwriting or any preexisting condition limitations applied to the issuance of the coverage.

Revisions to the accountable health plan statutes and the addition of new provisions in the general disability statutes establish identical requirements for the contents of these certificates. A.R.S. §§ 20-1379(J), (K) and (L) and § 20-2310(E), (F) and (G). These statutes require that certificates of creditable coverage be delivered without charge.

For coverage that does not fall within the scope of the accountable health plan statutes, certificates must be delivered when a person ceases to be covered under a policy offered by a health care insurer or whenever an individual requests its certificate, provided that the individual requests the certificate within 24 months after the coverage has ceased.

With respect to coverage issued by accountable health plans, certificates must be issued when an individual ceases to be covered under a health benefits plan, unless the individual's coverage ceases because the employer moves the entire group's coverage to another benefits plan without any break in coverage. Further, certificates must be issued when a person under a COBRA continuation provision ceases to be covered under the COBRA continuation provision. Finally, in the accountable health plan

context, certificates must be issued if an individual requests a certificate within 24 months after coverage has ceased.

Both A.R.S. §§ 20-1379 and 20-2310 specify that written certification of the period of creditable coverage must include the following information, at a minimum:

1. The date that the certificate is issued.

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

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

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

5. One of the following:

a. A statement that the individual has at least 18 months of creditable coverage. For purposes of this provision, 18 months means 546 days.

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

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

As indicated, health care insurers, accountable health plans, and other entities that issue health care coverage in this state may provide additional information on the certificates of prior creditable coverage beyond that mandated by the law. These certificates, which represent the primary, although not the exclusive means by which individuals may demonstrate prior creditable coverage, were designed with the goal of easing the administrative costs faced by both carriers and individuals in the implementation of this part of the law. To the extent that carriers determine that additional information will assist them (and others) in the implementation of the new laws and its goals, those additional items may be included in the form.

A model certificate of prior creditable coverage accompanies this circular letter as Appendix D. Carriers do not have to use this model form to document creditable coverage to comply with Arizona law. At the same time, carriers should take all steps reasonably necessary to permit the forms to gain ready use and acceptance by ensuring that certificates issued by the carrier include all information required by law in the order prescribed in the statute. In any event, the model certificate prepared by the federal government may also be used to document creditable coverage.

Appendix A -- Required Elements of Disclosure Form prescribed by A.R.S. §202323

GENERAL

ACCOUNTABLE HEALTH PLAN DISCLOSURE FORM

(Company's Name)

* * * * *

Please read this notice carefully.

This notice contains important information you should know before you enroll.

* * * * *

This Disclosure form is only a summary.

* * * The Company's policy, certificate or evidence of coverage should be consulted * * *

to determine governing contractual provisions

[The form should reflect the period of time during which the information is valid. Section headings must be in 12 point boldface type. All other text in the form shall be printed in light-faced ten point type of a style in general use (helvetica, times roman, courier). The text and sequence of the text in all disclosure forms must be in the format outlined below.]

A. COMPANY'S PRIMARY CARE PHYSICIANS ROSTER

Include the physician's degree, practice specialty, the year first licensed to practice medicine and, if different, the year initially licensed to practice in Arizona.

Attach a roster of the company's Primary Care Physicians.

B. PREMIUM

[Premium information may be included on a separate form. However, the information must be attached to the Disclosure Form when given to employees.]

1. State the full premium cost of the plan in concise and specific terms.

2. State any reservations by the Company to change premiums.

C. HOW AND WHERE TO OBTAIN SERVICES

1. Where and in what manner an enrollee may obtain services, including the procedure for selecting or changing primary care physicians.

2. Whether services received outside the Company's plan are covered and in what manner the services are covered.

3. The locations of contracted hospitals and outpatient treatment centers.

D. PRE-AUTHORIZATION AND REFERRAL PROCEDURES

Address the following:

1. The procedures an enrollee must follow, if any, to obtain prior authorization for services.

2. The procedures to be followed by an enrollee for consulting a physician other than the primary care physician.

3. Whether the enrollee's physician, the company's medical director or a committee must first authorize the referral.

4. The necessity of repeating prior authorization if the specialist care is continuing.

5. The circumstances under which the company may retroactively deny coverage for non-emergency treatment that had prior authorization under the company's written policies.

6. Whether a Point of Service option is available and how it is structured.

E. EMERGENCY CARE

Address the following:

1. The circumstances under which prior authorization is required for emergency medical care.

2. Whether and where the company provides twenty-four hour emergency services.

3. The procedures for emergency room, nighttime or weekend visits and referrals to specialist physicians.

4. The circumstances under which the company may retroactively deny coverage for emergency medical treatment that had prior authorization under the company's written policies.

F. PRESCRIPTION DRUGS

Address the following:

1. Whether the company physician is restricted to prescribing drugs from a company list or company formulary.

2. The extent to which an enrollee will be reimbursed for the costs of a drug that is not on the company list or company formulary.

G. GRIEVANCE PROCEDURES

The grievance procedures for claim or treatment denials, creditable coverage determinations, dissatisfaction with care, and access to care issues.

H. COMPANY PROVIDER REQUIREMENTS AND COMPENSATION

Whether company provider compensation programs include any incentives or penalties that are intended to encourage plan providers to withhold services or minimize or avoid referrals to specialists. Whether the company provider must comply with any specified numbers, targeted averages, or maximum durations of patient visits. If these types of incentives or penalties are included, provide a concise description of them.

I. EXPLANATION OR JUSTIFICATION FOR USE OF INCENTIVES AND PENALTIES

This section is optional for the company. Any description should be concise.

J. DESCRIPTION OF BENEFITS --

Address the following:

1. Whether services outside the plan are covered and in what manner they are covered.

2. In concise and specific terms, any copayment, coinsurance or deductible requirements that an enrollee or enrollee's family may incur in obtaining coverage under the plan.

3. The health care benefits to which an enrollee would be entitled.

K. LIMITATIONS AND EXCLUSIONS THAT APPLY TO SERVICES AND BENEFITS

List all limitations and exclusion that have not already been disclosed in another section.

Appendix B -- Blended Disclosure Form that combines the required elements of

A.R.S. §§202304 and 20-2323

COMBINED SMALL AND LARGE GROUP

DISCLOSURE FORM

_____

(Company's Name)

*** * * * ***

Please read this notice carefully.

This notice contains important information you should know before you enroll.

*** * * * ***

This Disclosure form is only a summary.

* * * The Company's policy, certificate or evidence of coverage should be consulted * * *

to determine governing contractual provisions

[The form should reflect the period of time during which the information is valid. Section headings must be in 12 point boldface type. All other text in the form shall be printed in light-faced ten point type of a style in general use (helvetica, times roman, courier). The text and sequence of the text in all disclosure forms must be in the format outlined below.]

A. COMPANY'S PRIMARY CARE PHYSICIANS ROSTER

Include the physician's degree, practice specialty, the year first licensed to practice medicine and, if different, the year initially licensed to practice in Arizona.

Attach a roster of the company's Primary Care Physicians.

B. PREMIUM

[Premium information may be included on a separate form. However, the information must be attached to the Disclosure Form when given to employees.]

1. State the full premium cost of the plan in concise and specific terms.

2. State any reservations by the Company to change premiums, and any factors that may affect changes in premium.

3. State the minimum employer contribution and group participation rules that apply to this particular type of coverage.

C. HOW AND WHERE TO OBTAIN SERVICES

1. Where and in what manner an enrollee may obtain services, including the procedure for selecting or changing primary care physicians.

2. Whether services received outside the Company's plan are covered and in what manner the services are covered.

3. The locations of contracted hospitals and outpatient treatment centers.

4. In the case of a network plan, a map or list of the areas served.

D. PRE-AUTHORIZATION AND REFERRAL PROCEDURES

Address the following:

1. The procedures an enrollee must follow, if any, to obtain prior authorization for services.

2. The procedures to be followed by an enrollee for consulting a physician other than the primary care physician.

3. Whether the enrollee's physician, the company's medical director or a committee must first authorize the referral.

4. The necessity of repeating prior authorization if the specialist care is continuing.

5. The circumstances under which the company may retroactively deny coverage for non-emergency treatment that had prior authorization under the company's written policies.

6. Whether a Point of Service option is available and how it is structured.

E. EMERGENCY CARE

Address the following:

1. The circumstances under which prior authorization is required for emergency medical care.

2. Whether and where the company provides twenty-four hour emergency services.

3. The procedures for emergency room, nighttime or weekend visits and referrals to specialist physicians.

4. The circumstances under which the company may retroactively deny coverage for emergency medical treatment that had prior authorization under the company's written policies.

F. PRESCRIPTION DRUGS

Address the following:

1. Whether the company physician is restricted to prescribing drugs from a company list or company formulary.

2. The extent to which an enrollee will be reimbursed for the costs of a drug that is not on the company list or company formulary.

G. GRIEVANCE PROCEDURES

The grievance procedures for claim or treatment denials, creditable coverage determinations, dissatisfaction with care, and access to care issues.

H. COMPANY PROVIDER REQUIREMENTS AND COMPENSATION

Whether company provider compensation programs include any incentives or penalties that are intended to encourage plan providers to withhold services or minimize or avoid referrals to specialists. Whether the company provider must comply with any specified numbers, targeted averages, or maximum durations of patient visits. If these types of incentives or penalties are included, provide a concise description of them.

I. EXPLANATION OR JUSTIFICATION FOR USE OF INCENTIVES AND PENALTIES

This section is optional for the company. Any description should be concise.

J. DESCRIPTION OF BENEFITS -- RENEWABILITY OF COVERAGE

Address the following:

1. Whether services outside the plan are covered and in what manner they are covered.

2. In concise and specific terms, any copayment, coinsurance or deductible requirements that an enrollee or enrollee's family may incur in obtaining coverage under the plan.

3. The health care benefits to which an enrollee would be entitled.

4. Renewability of coverage.

K. LIMITATIONS AND EXCLUSIONS THAT APPLY TO SERVICES AND BENEFITS

List all limitations and exclusion that have not already been disclosed in another section. Specifically include any preexisting condition exclusions or limitations or any affiliation period requirements.

APPENDIX C -- Elements of Disclosure Form to be Made Available Pursuant to A.R.S. §20-2304

SMALL EMPLOYER GROUP DISCLOSURE FORM

_____

(Company's Name)

*** * * * ***

Please read this notice carefully <u>together</u> with

the general Accountable Health Plan Disclosure Form

This notice contains important information you should know before you enroll.

* * * * *

This Disclosure form is only a summary.

* * * The Company's policy, certificate or evidence of coverage should be consulted * * *

to determine governing contractual provisions

[The form should reflect the period of time during which the information is valid. Section headings must be in 12 point boldface type. All other text in the form shall be printed in light-faced ten point type of a style in general use (helvetica, times roman, courier). The text and sequence of the text in all disclosure forms must be in the format outlined below.]

B. PREMIUM

[Premium information may be included on a separate form. However, the information must be attached to the Disclosure Form when given to employees.]

1. State any factors that may affect changes in premium.

2. State the minimum employer contribution and group participation rules that apply to this particular type of coverage.

C. HOW AND WHERE TO OBTAIN SERVICES

1. In the case of a network plan, a map or list of the areas served.

J. DESCRIPTION OF BENEFITS -- RENEWABILITY OF COVERAGE

Address the following:

1. Renewability of coverage.

K. LIMITATIONS AND EXCLUSIONS THAT APPLY TO SERVICES AND BENEFITS

Specifically include any preexisting condition exclusions or limitations or any affiliation period requirements.

Appendix D

CERTIFICATE OF PRIOR CREDITABLE COVERAGE

*** IMPORTANT** - This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within

the 6-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or your family, and insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

1. Date of this certificate: _____

2. Name of health care insurer or accountable health plan:

_____

3. Name of participant: _____

4. Identification number of participant: _____

5. Name of any dependents to whom this certificate applies:

_____

6. Name, address, and telephone number of health care insurer or accountable health plan:
_____

7. For further information, call:_____

8. If the individual(s) identified in line 3 and line 5 has at least 18 months of creditable coverage (disregarding periods of coverage before a 63-day break), check here ____ and skip lines 9 and 10.

9. Date waiting period or affiliation period (if any) began: _____

10. Date coverage began: _____

11. Date coverage ended: _____ (or check if coverage is continuing as of the date of this certificate: _____).

Note: separate certificates will be furnished if information is not identical for the participant and each beneficiary.