

BGA LEGISLATIVE UPDATE



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Two Healthcare Bills Clear First Hurdle in Arizona Legislature

House Bill 2323 would decrease the amount of time a small business with 2 to 50 employees must go without health insurance (the go bare period) to be eligible for “mandate-lite” health insurance policies, health care group. The bill would move from six months to a 90-day waiting period.

House Bill 2324, is aimed at uninsured individuals. HB 2324 would allow insurers to develop a similar product for uninsured individuals. More specifically, the bill enables insurers to offer individuals health insurance products without all the mandates prescribed by law.

Provisions:

- ✦ **Allows a hospital service corporation, medical service corporation, or hospital and medical service corporation to issue health insurance contracts to uninsured individuals exempt from the following coverage mandates:**
 - Services within the scope of practice of an allopathic or osteopathic physician or chiropractor if the policy covers the condition. (20-461.a.17 and B)
 - Dependent children who at attainment of the limiting age are still dependent due to physical or mental disabilities. (20-826.F)
 - Maternity benefits for adopted children. (20-826.J)
 - Medical foods to treat inherited metabolic disorders. (20-826.U)
 - Podiatric and dental surgeries that would have been covered if performed by a physician. (20-841.A)
 - Chiropractic services. (20-841.01)
 - Services provided by a psychologist. (20-841.02)
 - Services provided by a nurse practitioner. (20-841.03)
 - Standing referrals to specialists. (20-841.04)
 - Out-of-network physicians for new subscribers during a transitional period. (20-841.06.A)
 - Physicians recently terminated from the provider network during a transitional period. (20-841.06.B)
 - Medical supplies conveniently accessible to subscribers. (20-841.07)
 - Occupational or physical therapy services obtained out-of-network without a referral. (20-841.08)
 - After hours and formulary drug authorizations. (20-841.05.B)
 - Prescription drugs removed from the provider’s coverage list for sixty days after removal. (20-841.05.E)
- ✦ **Allows a health care services organization to issue an evidence of coverage to an uninsured individual exempt from the following coverage mandates:**
 - Services within the scope of practice of an allopathic or osteopathic physician or chiropractor if the policy covers the condition. (20-461.A.17 and B)
 - Dependent children who at attainment of the limiting age are still dependent due to physical or mental disabilities. (20-826.F)
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Two Healthcare Bills Clear First Hurdle in Arizona Legislature (Cont'd from pg. 1)

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- After hours and formulary drug authorizations. (20-841.05.B)
- Prescription drugs removed from the provider's coverage list for sixty days after removal. (20-841.05.E)
- Allows a disability insurer to issue a policy to an uninsured individual exempt from the following coverage mandates:
 - Services within the scope of practice of an allopathic or osteopathic physician or chiropractor if the policy covers the condition. (20-461.A.17 and B)
 - Dependent children who at attainment of the limiting age are still dependent due to physical or mental disabilities. (20-826.F)
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✦ **Defines uninsured individual**

ON THE NATIONAL FRONT

Compare Major Health Reform Bills

Black, Gould & Associates is providing this [link](#) to a summary comparison of the major health reform bills currently in the House and Senate. The comparison can be accessed [here](#).

CMS Suspends Agent/Broker Compensation Policies for Further Review

On June 26, the Centers for Medicare and Medicaid Services announced that it is suspending implementation of the agent and broker compensation requirements set forth in a June 5 memorandum titled "*2009 Medicare Advantage and Prescription Drug Program Agent and Broker Compensation Refinements and Compensation Rate Adjustment for 2010*."

CMS's actions are in response to issues and concerns raised by stakeholders regarding the requirements, and confusion over whether an initial compensation fee should be paid for 2009 enrollments from a PDP to an MA plan.

A key point of confusion has been whether or not agents will qualify for an initial commission when they enroll into Medicare Advantage plans beneficiaries who have previously had traditional Medicare or a stand-alone prescription drug plan. Otherwise, such a beneficiary would be considered a renewal and the agent would receive the lower renewal compensation level.

CMS is weighing guidance surrounding the definition of a "like plan type" in that an agent moving a beneficiary into a "like" plan receives the lower renewal compensation.

However, for 2010, CMS said agents and brokers should be paid an initial fee for enrollments from a PDP to an MA plan.