

REFERENCE TITLE: preexisting condition exclusions; prohibition

State of Arizona
House of Representatives
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Second Regular Session
2010

HB 2291

Introduced by
Representatives McGuire, Heinz, Pancrazi, Sinema, Young Wright, Senator
Rios: Representatives Brown, Campbell CH, Campbell CL, Deschene, Garcia M,
Tovar

AN ACT

AMENDING SECTION 20-826, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 4, ARTICLE 3, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-826.05; AMENDING SECTIONS 20-841.06, 20-1057, 20-1057.03 AND 20-1057.04; AMENDING TITLE 20, CHAPTER 4, ARTICLE 9, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1057.12, ARIZONA REVISED STATUTES; AMENDING SECTION 20-1342, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 6, ARTICLE 4, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1342.06; AMENDING SECTIONS 20-1377, 20-1379 AND 20-1402, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 6, ARTICLE 5, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1402.04; AMENDING SECTION 20-1404, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 6, ARTICLE 5, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1404.04; AMENDING SECTIONS 20-1408, 20-2301, 20-2304, 20-2308, 20-2310 AND 20-2321, ARIZONA REVISED STATUTES; RELATING TO HEALTH INSURANCE COVERAGE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

2 Section 1. Section 20-826, Arizona Revised Statutes, is amended to
3 read:

4 20-826. Subscription contracts: definitions

5 A. A contract between a corporation and its subscribers shall not be
6 issued unless the form of such contract is approved in writing by the
7 director.

8 B. Each contract shall plainly state the services to which the
9 subscriber is entitled and those to which the subscriber is not entitled
10 under the plan, and shall constitute a direct obligation of the providers of
11 services with which the corporation has contracted for hospital, medical,
12 dental or optometric services.

13 C. Each contract, except for dental services or optometric services,
14 shall be so written that the corporation shall pay benefits for each of the
15 following:

16 1. Performance of any surgical service that is covered by the terms of
17 such contract, regardless of the place of service.

18 2. Any home health services that are performed by a licensed home
19 health agency and that a physician has prescribed in lieu of hospital
20 services, as defined by the director, providing the hospital services would
21 have been covered.

22 3. Any diagnostic service that a physician has performed outside a
23 hospital in lieu of inpatient service, providing the inpatient service would
24 have been covered.

25 4. Any service performed in a hospital's outpatient department or in a
26 freestanding surgical facility, if such service would have been covered if
27 performed as an inpatient service.

28 D. Each contract for dental or optometric services shall be so written
29 that the corporation shall pay benefits for contracted dental or optometric
30 services provided by dentists or optometrists.

31 E. Any contract, except accidental death and dismemberment, applied
32 for that provides family coverage, as to such coverage of family members,
33 shall also provide that the benefits applicable for children shall be payable
34 with respect to a newly born child of the insured from the instant of such
35 child's birth, to a child adopted by the insured, regardless of the age at
36 which the child was adopted, and to a child who has been placed for adoption
37 with the insured and for whom the application and approval procedures for
38 adoption pursuant to section 8-105 or 8-108 have been completed to the same
39 extent that such coverage applies to other members of the family. The
40 coverage for newly born or adopted children or children placed for adoption
41 shall include coverage of injury or sickness including necessary care and
42 treatment of medically diagnosed congenital defects and birth abnormalities.
43 If payment of a specific premium is required to provide coverage for a child,
44 the contract may require that notification of birth, adoption or adoption
45 placement of the child and payment of the required premium must be furnished

1 to the insurer within thirty-one days after the date of birth, adoption or
2 adoption placement in order to have the coverage continue beyond the
3 thirty-one day period.

4 F. Each contract that is delivered or issued for delivery in this
5 state after December 25, 1977 and that provides that coverage of a dependent
6 child shall terminate upon attainment of the limiting age for dependent
7 children specified in the contract shall also provide in substance that
8 attainment of such limiting age shall not operate to terminate the coverage
9 of such child while the child is and continues to be both incapable of
10 self-sustaining employment by reason of mental retardation or physical
11 handicap and chiefly dependent upon the subscriber for support and
12 maintenance. Proof of such incapacity and dependency shall be furnished to
13 the corporation by the subscriber within thirty-one days of the child's
14 attainment of the limiting age and subsequently as may be required by the
15 corporation, but not more frequently than annually after the two-year period
16 following the child's attainment of the limiting age.

17 G. No corporation may cancel or refuse to renew any subscriber's
18 contract without giving notice of such cancellation or nonrenewal to the
19 subscriber under such contract. A notice by the corporation to the
20 subscriber of cancellation or nonrenewal of a subscription contract shall be
21 mailed to the named subscriber at least forty-five days before the effective
22 date of such cancellation or nonrenewal. The notice shall include or be
23 accompanied by a statement in writing of the reasons for such action by the
24 corporation. Failure of the corporation to comply with this subsection shall
25 invalidate any cancellation or nonrenewal except a cancellation or nonrenewal
26 for nonpayment of premium.

27 H. A contract that provides coverage for surgical services for a
28 mastectomy shall also provide coverage incidental to the patient's covered
29 mastectomy for surgical services for reconstruction of the breast on which
30 the mastectomy was performed, surgery and reconstruction of the other breast
31 to produce a symmetrical appearance, prostheses, treatment of physical
32 complications for all stages of the mastectomy, including lymphedemas, and at
33 least two external postoperative prostheses subject to all of the terms and
34 conditions of the policy.

35 I. A contract that provides coverage for surgical services for a
36 mastectomy shall also provide coverage for mammography screening performed on
37 dedicated equipment for diagnostic purposes on referral by a patient's
38 physician, subject to all of the terms and conditions of the policy and
39 according to the following guidelines:

40 1. A baseline mammogram for a woman from age thirty-five to
41 thirty-nine.

42 2. A mammogram for a woman from age forty to forty-nine every two
43 years or more frequently based on the recommendation of the woman's
44 physician.

1 3. A mammogram every year for a woman fifty years of age and over.
2 J. Any contract that is issued to the insured and that provides
3 coverage for maternity benefits shall also provide that the maternity
4 benefits apply to the costs of the birth of any child legally adopted by the
5 insured if all of the following are true:
6 1. The child is adopted within one year of birth.
7 2. The insured is legally obligated to pay the costs of birth.
8 3. All ~~preexisting conditions and other~~ limitations have been met by
9 the insured.
10 4. The insured has notified the insurer of the insured's acceptability
11 to adopt children pursuant to section 8-105, within sixty days after such
12 approval or within sixty days after a change in insurance policies, plans or
13 companies.
14 K. The coverage prescribed by subsection J of this section is excess
15 to any other coverage the natural mother may have for maternity benefits
16 except coverage made available to persons pursuant to title 36, chapter 29
17 but not including coverage made available to persons defined as eligible
18 under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If
19 such other coverage exists the agency, attorney or individual arranging the
20 adoption shall make arrangements for the insurance to pay those costs that
21 may be covered under that policy and shall advise the adopting parent in
22 writing of the existence and extent of the coverage without disclosing any
23 confidential information such as the identity of the natural parent. The
24 insured adopting parents shall notify their insurer of the existence and
25 extent of the other coverage.
26 L. The director may disapprove any contract if the benefits provided
27 in the form of such contract are unreasonable in relation to the premium
28 charged.
29 M. The director shall adopt emergency rules applicable to persons who
30 are leaving active service in the armed forces of the United States and
31 returning to civilian status including:
32 1. Conditions of eligibility.
33 2. Coverage of dependents.
34 ~~3. Preexisting conditions.~~
35 ~~4.~~ 3. Termination of insurance.
36 ~~5.~~ 4. Probationary periods.
37 ~~6.~~ 5. Limitations.
38 ~~7.~~ 6. Exceptions.
39 ~~8.~~ 7. Reductions.
40 ~~9.~~ 8. Elimination periods.
41 ~~10.~~ 9. Requirements for replacement.
42 ~~11.~~ 10. Any other condition of subscription contracts.
43 N. Any contract that provides maternity benefits shall not restrict
44 benefits for any hospital length of stay in connection with childbirth for
45 the mother or the newborn child to less than forty-eight hours following a

normal vaginal delivery or ninety-six hours following a cesarean section. The contract shall not require the provider to obtain authorization from the corporation for prescribing the minimum length of stay required by this subsection. The contract may provide that an attending provider in consultation with the mother may discharge the mother or the newborn child before the expiration of the minimum length of stay required by this subsection. The corporation shall not:

1. Deny the mother or the newborn child eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract solely for the purpose of avoiding the requirements of this subsection.

2. Provide monetary payments or rebates to mothers to encourage those mothers to accept less than the minimum protections available pursuant to this subsection.

3. Penalize or otherwise reduce or limit the reimbursement of an attending provider because that provider provided care to any insured under the contract in accordance with this subsection.

4. Provide monetary or other incentives to an attending provider to induce that provider to provide care to an insured under the contract in a manner that is inconsistent with this subsection.

5. Except as described in subsection O of this section, restrict benefits for any portion of a period within the minimum length of stay in a manner that is less favorable than the benefits provided for any preceding portion of that stay.

O. Nothing in subsection N of this section:

1. Requires a mother to give birth in a hospital or to stay in the hospital for a fixed period of time following the birth of the child.

2. Prevents a corporation from imposing deductibles, coinsurance or other cost sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn child under the contract, except that any coinsurance or other cost sharing for any portion of a period within a hospital length of stay required pursuant to subsection N of this section shall not be greater than the coinsurance or cost sharing for any preceding portion of that stay.

3. Prevents a corporation from negotiating the level and type of reimbursement with a provider for care provided in accordance with subsection N of this section.

P. Any contract that provides coverage for diabetes shall also provide coverage for equipment and supplies that are medically necessary and that are prescribed by a health care provider including:

1. Blood glucose monitors.

2. Blood glucose monitors for the legally blind.

3. Test strips for glucose monitors and visual reading and urine testing strips.

- 1 4. Insulin preparations and glucagon.
- 2 5. Insulin cartridges.
- 3 6. Drawing up devices and monitors for the visually impaired.
- 4 7. Injection aids.
- 5 8. Insulin cartridges for the legally blind.
- 6 9. Syringes and lancets including automatic lancing devices.
- 7 10. Prescribed oral agents for controlling blood sugar that are
- 8 included on the plan formulary.
- 9 11. To the extent coverage is required under medicare, podiatric
- 10 appliances for prevention of complications associated with diabetes.
- 11 12. Any other device, medication, equipment or supply for which
- 12 coverage is required under medicare from and after January 1, 1999. The
- 13 coverage required in this paragraph is effective six months after the
- 14 coverage is required under medicare.
- 15 Q. Nothing in subsection P of this section prohibits a medical service
- 16 corporation, a hospital service corporation or a hospital, medical, dental
- 17 and optometric service corporation from imposing deductibles, coinsurance or
- 18 other cost sharing in relation to benefits for equipment or supplies for the
- 19 treatment of diabetes.
- 20 R. Any hospital or medical service contract that provides coverage for
- 21 prescription drugs shall not limit or exclude coverage for any prescription
- 22 drug prescribed for the treatment of cancer on the basis that the
- 23 prescription drug has not been approved by the United States food and drug
- 24 administration for the treatment of the specific type of cancer for which the
- 25 prescription drug has been prescribed, if the prescription drug has been
- 26 recognized as safe and effective for treatment of that specific type of
- 27 cancer in one or more of the standard medical reference compendia prescribed
- 28 in subsection S of this section or medical literature that meets the criteria
- 29 prescribed in subsection S of this section. The coverage required under this
- 30 subsection includes covered medically necessary services associated with the
- 31 administration of the prescription drug. This subsection does not:
- 32 1. Require coverage of any prescription drug used in the treatment of
- 33 a type of cancer if the United States food and drug administration has
- 34 determined that the prescription drug is contraindicated for that type of
- 35 cancer.
- 36 2. Require coverage for any experimental prescription drug that is not
- 37 approved for any indication by the United States food and drug
- 38 administration.
- 39 3. Alter any law with regard to provisions that limit the coverage of
- 40 prescription drugs that have not been approved by the United States food and
- 41 drug administration.
- 42 4. Notwithstanding section 20-841.05, require reimbursement or
- 43 coverage for any prescription drug that is not included in the drug formulary
- 44 or list of covered prescription drugs specified in the contract.

1 5. Notwithstanding section 20-841.05, prohibit a contract from
2 limiting or excluding coverage of a prescription drug, if the decision to
3 limit or exclude coverage of the prescription drug is not based primarily on
4 the coverage of prescription drugs required by this section.

5 6. Prohibit the use of deductibles, coinsurance, copayments or other
6 cost sharing in relation to drug benefits and related medical benefits
7 offered.

8 S. For the purposes of subsection R of this section:

9 1. The acceptable standard medical reference compendia are the
10 following:

11 (a) The American hospital formulary service drug information, a
12 publication of the American society of health system pharmacists.

13 (b) The national comprehensive cancer network drugs and biologics
14 compendium.

15 (c) Thomson Micromedex compendium DrugDex.

16 (d) Elsevier gold standard's clinical pharmacology compendium.

17 (e) Other authoritative compendia as identified by the secretary of
18 the United States department of health and human services.

19 2. Medical literature may be accepted if all of the following apply:

20 (a) At least two articles from major peer reviewed professional
21 medical journals have recognized, based on scientific or medical criteria,
22 the drug's safety and effectiveness for treatment of the indication for which
23 the drug has been prescribed.

24 (b) No article from a major peer reviewed professional medical journal
25 has concluded, based on scientific or medical criteria, that the drug is
26 unsafe or ineffective or that the drug's safety and effectiveness cannot be
27 determined for the treatment of the indication for which the drug has been
28 prescribed.

29 (c) The literature meets the uniform requirements for manuscripts
30 submitted to biomedical journals established by the international committee
31 of medical journal editors or is published in a journal specified by the
32 United States department of health and human services as acceptable peer
33 reviewed medical literature pursuant to section 186(t)(2)(B) of the social
34 security act (42 United States Code section 1395x(t)(2)(B)).

35 T. A corporation shall not issue or deliver any advertising matter or
36 sales material to any person in this state until the corporation files the
37 advertising matter or sales material with the director. This subsection does
38 not require a corporation to have the prior approval of the director to issue
39 or deliver the advertising matter or sales material. If the director finds
40 that the advertising matter or sales material, in whole or in part, is false,
41 deceptive or misleading, the director may issue an order disapproving the
42 advertising matter or sales material, directing the corporation to cease and
43 desist from issuing, circulating, displaying or using the advertising matter
44 or sales material within a period of time specified by the director but not
45 less than ten days and imposing any penalties prescribed in this title. At

1 least five days before issuing an order pursuant to this subsection, the
2 director shall provide the corporation with a written notice of the basis of
3 the order to provide the corporation with an opportunity to cure the alleged
4 deficiency in the advertising matter or sales material within a single five
5 day period for the particular advertising matter or sales material at issue.
6 The corporation may appeal the director's order pursuant to title 41,
7 chapter 6, article 10. Except as otherwise provided in this subsection, a
8 corporation may obtain a stay of the effectiveness of the order as prescribed
9 in section 20-162. If the director certifies in the order and provides a
10 detailed explanation of the reasons in support of the certification that
11 continued use of the advertising matter or sales material poses a threat to
12 the health, safety or welfare of the public, the order may be entered
13 immediately without opportunity for cure and the effectiveness of the order
14 is not stayed pending the hearing on the notice of appeal but the hearing
15 shall be promptly instituted and determined.

16 U. Any contract that is offered by a hospital service corporation or
17 medical service corporation and that contains a prescription drug benefit
18 shall provide coverage of medical foods to treat inherited metabolic
19 disorders as provided by this section.

20 V. The metabolic disorders triggering medical foods coverage under
21 this section shall:

22 1. Be part of the newborn screening program prescribed in section
23 36-694.

24 2. Involve amino acid, carbohydrate or fat metabolism.

25 3. Have medically standard methods of diagnosis, treatment and
26 monitoring including quantification of metabolites in blood, urine or spinal
27 fluid or enzyme or DNA confirmation in tissues.

28 4. Require specially processed or treated medical foods that are
29 generally available only under the supervision and direction of a physician
30 who is licensed pursuant to title 32, chapter 13 or 17 or a registered nurse
31 practitioner who is licensed pursuant to title 32, chapter 15, that must be
32 consumed throughout life and without which the person may suffer serious
33 mental or physical impairment.

34 W. Medical foods eligible for coverage under this section shall be
35 prescribed or ordered under the supervision of a physician licensed pursuant
36 to title 32, chapter 13 or 17 as medically necessary for the therapeutic
37 treatment of an inherited metabolic disease.

38 X. A hospital service corporation or medical service corporation shall
39 cover at least fifty per cent of the cost of medical foods prescribed to
40 treat inherited metabolic disorders and covered pursuant to this section. A
41 hospital service corporation or medical service corporation may limit the
42 maximum annual benefit for medical foods under this section to five thousand
43 dollars, which applies to the cost of all prescribed modified low protein
44 foods and metabolic formula.

Y. Any contract between a corporation and its subscribers is subject to the following:

1. If the contract provides coverage for prescription drugs, the contract shall provide coverage for any prescribed drug or device that is approved by the United States food and drug administration for use as a contraceptive. A corporation may use a drug formulary, multitiered drug formulary or list but that formulary or list shall include oral, implant and injectable contraceptive drugs, intrauterine devices and prescription barrier methods if the corporation does not impose deductibles, coinsurance, copayments or other cost containment measures for contraceptive drugs that are greater than the deductibles, coinsurance, copayments or other cost containment measures for other drugs on the same level of the formulary or list.

2. If the contract provides coverage for outpatient health care services, the contract shall provide coverage for outpatient contraceptive services. For the purposes of this paragraph, "outpatient contraceptive services" means consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of approved United States food and drug administration prescription contraceptive methods to prevent unintended pregnancies.

3. This subsection does not apply to contracts issued to individuals on a nongroup basis.

Z. Notwithstanding subsection Y of this section, a religious employer whose religious tenets prohibit the use of prescribed contraceptive methods may require that the corporation provide a contract without coverage for all United States food and drug administration approved contraceptive methods. A religious employer shall submit a written affidavit to the corporation stating that it is a religious employer. On receipt of the affidavit, the corporation shall issue to the religious employer a contract that excludes coverage of prescription contraceptive methods. The corporation shall retain the affidavit for the duration of the contract and any renewals of the contract. Before enrollment in the plan, every religious employer that invokes this exemption shall provide prospective subscribers written notice that the religious employer refuses to cover all United States food and drug administration approved contraceptive methods for religious reasons. This subsection shall not exclude coverage for prescription contraceptive methods ordered by a health care provider with prescriptive authority for medical indications other than to prevent an unintended pregnancy. A corporation may require the subscriber to first pay for the prescription and then submit a claim to the corporation along with evidence that the prescription is for a noncontraceptive purpose. A corporation may charge an administrative fee for handling these claims. A religious employer shall not discriminate against an employee who independently chooses to obtain insurance coverage or prescriptions for contraceptives from another source.

1 AA. For the purposes of:

2 1. This section:

3 (a) "Inherited metabolic disorder" means a disease caused by an
4 inherited abnormality of body chemistry and includes a disease tested under
5 the newborn screening program prescribed in section 36-694.

6 (b) "Medical foods" means modified low protein foods and metabolic
7 formula.

8 (c) "Metabolic formula" means foods that are all of the following:

9 (i) Formulated to be consumed or administered enterally under the
10 supervision of a physician who is licensed pursuant to title 32, chapter 13
11 or 17.

12 (ii) Processed or formulated to be deficient in one or more of the
13 nutrients present in typical foodstuffs.

14 (iii) Administered for the medical and nutritional management of a
15 person who has limited capacity to metabolize foodstuffs or certain nutrients
16 contained in the foodstuffs or who has other specific nutrient requirements
17 as established by medical evaluation.

18 (iv) Essential to a person's optimal growth, health and metabolic
19 homeostasis.

20 (d) "Modified low protein foods" means foods that are all of the
21 following:

22 (i) Formulated to be consumed or administered enterally under the
23 supervision of a physician who is licensed pursuant to title 32, chapter 13
24 or 17.

25 (ii) Processed or formulated to contain less than one gram of protein
26 per unit of serving, but does not include a natural food that is naturally
27 low in protein.

28 (iii) Administered for the medical and nutritional management of a
29 person who has limited capacity to metabolize foodstuffs or certain nutrients
30 contained in the foodstuffs or who has other specific nutrient requirements
31 as established by medical evaluation.

32 (iv) Essential to a person's optimal growth, health and metabolic
33 homeostasis.

34 2. Subsection E of this section, the term "child", for purposes of
35 initial coverage of an adopted child or a child placed for adoption but not
36 for purposes of termination of coverage of such child, means a person under
37 ~~the age of~~ eighteen years **OF AGE**.

38 3. Subsection Z of this section, "religious employer" means an entity
39 for which all of the following apply:

40 (a) The entity primarily employs persons who share the religious
41 tenets of the entity.

42 (b) The entity primarily serves persons who share the religious tenets
43 of the entity.

44 (c) The entity is a nonprofit organization as described in section
45 6033(a)(2)(A) (i) or (iii) of the internal revenue code of 1986, as amended.

1 Sec. 2. Title 20, chapter 4, article 3, Arizona Revised Statutes, is
2 amended by adding section 20-826.05, to read:

3 20-826.05. Subscription contracts; preexisting condition
4 limitations or exclusions; prohibition;
5 definitions

6 A. A CONTRACT ISSUED BY A HOSPITAL SERVICE CORPORATION, MEDICAL
7 SERVICE CORPORATION OR HOSPITAL AND MEDICAL SERVICE CORPORATION SHALL NOT
8 IMPOSE ANY PREEXISTING CONDITION LIMITATIONS OR EXCLUSIONS RELATING TO ANY
9 PREEXISTING CONDITION.

10 B. FOR THE PURPOSES OF THIS SECTION:

11 1. "PREEXISTING CONDITION" MEANS A CONDITION, REGARDLESS OF THE CAUSE
12 OF THE CONDITION, FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WAS
13 RECOMMENDED OR RECEIVED BEFORE THE DATE OF THE ENROLLMENT OF THE INDIVIDUAL
14 UNDER A HEALTH INSURANCE POLICY OR OTHER CONTRACT THAT PROVIDES HEALTH
15 COVERAGE BENEFITS. A GENETIC CONDITION IS NOT A PREEXISTING CONDITION IN THE
16 ABSENCE OF A DIAGNOSIS OF THE CONDITION RELATED TO THE GENETIC INFORMATION
17 AND SHALL NOT RESULT IN A PREEXISTING CONDITION LIMITATION OR PREEXISTING
18 CONDITION EXCLUSION.

19 2. "PREEXISTING CONDITION LIMITATION" OR "PREEXISTING CONDITION
20 EXCLUSION" MEANS A LIMITATION OR EXCLUSION OF BENEFITS FOR A PREEXISTING
21 CONDITION UNDER A HEALTH INSURANCE POLICY OR OTHER CONTRACT THAT PROVIDES
22 HEALTH COVERAGE BENEFITS.

23 Sec. 3. Section 20-841.06, Arizona Revised Statutes, is amended to
24 read:

25 20-841.06. Continuity of care; definition

26 A. Any corporation that offers a health benefits plan shall allow any
27 new subscriber whose health care provider is not a member of the provider
28 network, on written request of the subscriber to the corporation, to continue
29 an active course of treatment with that health care provider during a
30 transitional period after the effective date of the enrollment if both of the
31 following apply:

32 1. The subscriber has either:

33 (a) A life threatening disease or condition, in which case the
34 transitional period is not more than thirty days after the effective date of
35 the enrollment.

36 (b) ~~Entered~~ IS IN the third trimester of pregnancy on the effective
37 date of the enrollment, in which case the transitional period includes the
38 delivery and any care up to six weeks after the delivery that is related to
39 the delivery.

40 2. The subscriber's health care provider agrees in writing to do all
41 of the following:

42 (a) Except for copayment, coinsurance or deductible amounts, accept as
43 payment in full reimbursement from the corporation at the rates that are
44 established by the corporation and that are not more than the level of

1 reimbursement applicable to similar services by health care providers within
2 the provider network.

3 (b) Comply with the corporation's quality assurance and utilization
4 review requirements and provide to the corporation any necessary medical
5 information related to the care.

6 (c) Comply with the corporation's policies and procedures pursuant to
7 this article including procedures relating to referrals and obtaining
8 preauthorization, claims handling and treatment plan approval by the
9 corporation.

10 B. A corporation shall allow any subscriber whose health care provider
11 is terminated from the provider network by the corporation except for reasons
12 of medical incompetence or unprofessional conduct, on written request of the
13 subscriber to the corporation, to continue an active course of treatment with
14 that health care provider during a transitional period after the date of the
15 provider's disaffiliation from the provider network, if both of the following
16 apply:

17 1. The subscriber has either:

18 (a) A life threatening disease or condition, in which case the
19 transitional period is not more than thirty days after the date of the
20 provider's disaffiliation from the provider network.

21 (b) ~~Entered~~ IS IN the third trimester of pregnancy on the date of the
22 provider's disaffiliation, in which case the transition period includes the
23 delivery and any care up to six weeks after the delivery that is related to
24 the delivery.

25 2. The subscriber's health care provider agrees in writing to do all
26 of the following:

27 (a) Except for copayment, coinsurance or deductible amounts, continue
28 to accept as payment in full reimbursement from the corporation at the rates
29 applicable before the beginning of the transitional period.

30 (b) Comply with the corporation's quality assurance and utilization
31 review requirements and provide to the corporation any necessary medical
32 information related to the care.

33 (c) Comply with the corporation's policies and procedures pursuant to
34 this article including procedures relating to referrals and obtaining
35 preauthorization, claims handling and treatment plan approval by the
36 corporation.

37 C. This section does not require a corporation to provide coverage for
38 benefits that are not covered by the subscriber's contract. ~~and does not~~
39 ~~diminish or impair any preexisting condition limitation in the contract.~~

40 D. This section does not extend to a health care provider who is not a
41 member of the provider network any contractual rights or remedies beyond
42 those rights or remedies related to and necessary for the provision of
43 covered services to the specific subscriber during the required transitional
44 period.

1 E. This section does not apply to any corporation that holds a
2 certificate of authority to operate either as a dental service corporation or
3 an optometric service corporation.

4 F. For the purposes of this section, "health care provider" means any
5 physician who is licensed in this state pursuant to title 32, chapter 13
6 or 17.

7 Sec. 4. Section 20-1057, Arizona Revised Statutes, is amended to read:
8 20-1057. Evidence of coverage by health care services
9 organizations; renewability; definitions

10 A. Every enrollee in a health care plan shall be issued an evidence of
11 coverage by the responsible health care services organization.

12 B. Any contract, except accidental death and dismemberment, applied
13 for that provides family coverage shall also provide, as to such coverage of
14 family members, that the benefits applicable for children shall be payable
15 with respect to a newly born child of the enrollee from the instant of such
16 child's birth, to a child adopted by the enrollee, regardless of the age at
17 which the child was adopted, and to a child who has been placed for adoption
18 with the enrollee and for whom the application and approval procedures for
19 adoption pursuant to section 8-105 or 8-108 have been completed to the same
20 extent that such coverage applies to other members of the family. The
21 coverage for newly born or adopted children or children placed for adoption
22 shall include coverage of injury or sickness including necessary care and
23 treatment of medically diagnosed congenital defects and birth abnormalities.
24 If payment of a specific premium is required to provide coverage for a child,
25 the contract may require that notification of birth, adoption or adoption
26 placement of the child and payment of the required premium must be furnished
27 to the insurer within thirty-one days after the date of birth, adoption or
28 adoption placement in order to have the coverage continue beyond the
29 thirty-one day period.

30 C. Any contract, except accidental death and dismemberment, that
31 provides coverage for psychiatric, drug abuse or alcoholism services shall
32 require the health care services organization to provide reimbursement for
33 such services in accordance with the terms of the contract without regard to
34 whether the covered services are rendered in a psychiatric special hospital
35 or general hospital.

36 D. No evidence of coverage or amendment to the coverage shall be
37 issued or delivered to any person in this state until a copy of the form of
38 the evidence of coverage or amendment to the coverage has been filed with and
39 approved by the director.

40 E. An evidence of coverage shall contain a clear and complete
41 statement if a contract, or a reasonably complete summary if a certificate of
42 contract, of:

43 1. The health care services and the insurance or other benefits, if
44 any, to which the enrollee is entitled under the health care plan.

1 2. Any limitations of the services, kind of services, benefits or kind
2 of benefits to be provided, including any deductible or copayment feature.

3 3. Where and in what manner information is available as to how
4 services may be obtained.

5 4. The enrollee's obligation, if any, respecting charges for the
6 health care plan.

7 F. An evidence of coverage shall not contain provisions or statements
8 that are unjust, unfair, inequitable, misleading or deceptive, that encourage
9 misrepresentation or that are untrue.

10 G. The director shall approve any form of evidence of coverage if the
11 requirements of subsections E and F of this section are met. It is unlawful
12 to issue such form until approved. If the director does not disapprove any
13 such form within forty-five days after the filing of the form, it is deemed
14 approved. If the director disapproves a form of evidence of coverage, the
15 director shall notify the health care services organization. In the notice,
16 the director shall specify the reasons for the director's disapproval. The
17 director shall grant a hearing on such disapproval within fifteen days after
18 a request for a hearing in writing is received from the health care services
19 organization.

20 H. A health care services organization shall not cancel or refuse to
21 renew an enrollee's evidence of coverage that was issued on a group basis
22 without giving notice of the cancellation or nonrenewal to the enrollee and,
23 on request of the director, to the department of insurance. A notice by the
24 organization to the enrollee of cancellation or nonrenewal of the enrollee's
25 evidence of coverage shall be mailed to the enrollee at least sixty days
26 before the effective date of such cancellation or nonrenewal. The notice
27 shall include or be accompanied by a statement in writing of the reasons as
28 stated in the contract for such action by the organization. Failure of the
29 organization to comply with this subsection shall invalidate any cancellation
30 or nonrenewal except a cancellation or nonrenewal for nonpayment of premium,
31 for fraud or misrepresentation in the application or other enrollment
32 documents or for loss of eligibility as defined in the evidence of coverage.
33 A health care services organization shall not cancel an enrollee's evidence
34 of coverage issued on a group basis because of the enrollee's or dependent's
35 age, except for loss of eligibility as defined in the evidence of coverage,
36 sex, health status-related factor, national origin or frequency of
37 utilization of health care services of the enrollee. An evidence of coverage
38 issued on a group basis shall clearly delineate all terms under which the
39 health care services organization may cancel or refuse to renew an evidence
40 of coverage for an enrollee or dependent. Nothing in this subsection
41 prohibits the cancellation or nonrenewal of a health benefits plan contract
42 issued on a group basis for any of the reasons allowed in section 20-2309. A
43 health care services organization may cancel or nonrenew an evidence of
44 coverage issued to an individual on a nongroup basis only for the reasons
45 allowed by subsection N of this section.

1 I. A health care plan that provides coverage for surgical services for
2 a mastectomy shall also provide coverage incidental to the patient's covered
3 mastectomy for surgical services for reconstruction of the breast on which
4 the mastectomy was performed, surgery and reconstruction of the other breast
5 to produce a symmetrical appearance, prostheses, treatment of physical
6 complications for all stages of the mastectomy, including lymphedemas, and at
7 least two external postoperative prostheses subject to all of the terms and
8 conditions of the policy.

9 J. A contract that provides coverage for surgical services for a
10 mastectomy shall also provide coverage for mammography screening performed on
11 dedicated equipment for diagnostic purposes on referral by a patient's
12 physician, subject to all of the terms and conditions of the policy and
13 according to the following guidelines:

14 1. A baseline mammogram for a woman from age thirty-five to
15 thirty-nine.

16 2. A mammogram for a woman from age forty to forty-nine every two
17 years or more frequently based on the recommendation of the woman's
18 physician.

19 3. A mammogram every year for a woman fifty years of age and over.

20 K. Any contract that is issued to the enrollee and that provides
21 coverage for maternity benefits shall also provide that the maternity
22 benefits apply to the costs of the birth of any child legally adopted by the
23 enrollee if all the following are true:

24 1. The child is adopted within one year of birth.

25 2. The enrollee is legally obligated to pay the costs of birth.

26 3. All ~~preexisting conditions and other~~ limitations have been met and
27 all deductibles and copayments have been paid by the enrollee.

28 4. The enrollee has notified the insurer of the enrollee's
29 acceptability to adopt children pursuant to section 8-105 within sixty days
30 after such approval or within sixty days after a change in insurance
31 policies, plans or companies.

32 L. The coverage prescribed by subsection K of this section is excess
33 to any other coverage the natural mother may have for maternity benefits
34 except coverage made available to persons pursuant to title 36, chapter 29
35 but not including coverage made available to persons defined as eligible
36 under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If
37 such other coverage exists the agency, attorney or individual arranging the
38 adoption shall make arrangements for the insurance to pay those costs that
39 may be covered under that policy and shall advise the adopting parent in
40 writing of the existence and extent of the coverage without disclosing any
41 confidential information such as the identity of the natural parent. The
42 enrollee adopting parents shall notify their health care services
43 organization of the existence and extent of the other coverage. A health
44 care services organization is not required to pay any costs in excess of the
45 amounts it would have been obligated to pay to its hospitals and providers if

1 the natural mother and child had received the maternity and newborn care
2 directly from or through that health care services organization.

3 M. Each health care services organization shall offer membership to
4 the following in a conversion plan that provides the basic health care
5 benefits required by the director:

6 1. Each enrollee including the enrollee's enrolled dependents leaving
7 a group.

8 2. Each enrollee and the enrollee's dependents who would otherwise
9 cease to be eligible for membership because of the age of the enrollee or the
10 enrollee's dependents or the death or the dissolution of marriage of an
11 enrollee.

12 N. A health care services organization shall not cancel or nonrenew an
13 evidence of coverage issued to an individual on a nongroup basis, including a
14 conversion plan, except for any of the following reasons and in compliance
15 with the notice and disclosure requirements contained in subsection H of this
16 section:

17 1. The individual has failed to pay premiums or contributions in
18 accordance with the terms of the evidence of coverage or the health care
19 services organization has not received premium payments in a timely manner.

20 2. The individual has performed an act or practice that constitutes
21 fraud or the individual made an intentional misrepresentation of material
22 fact under the terms of the evidence of coverage.

23 3. The health care services organization has ceased to offer coverage
24 to individuals that is consistent with the requirements of sections 20-1379
25 and 20-1380.

26 4. If the health care services organization offers a health care plan
27 in this state through a network plan, the individual no longer resides, lives
28 or works in the service area served by the network plan or in an area for
29 which the health care services organization is authorized to transact
30 business but only if the coverage is terminated uniformly without regard to
31 any health status-related factor of the covered individual.

32 5. If the health care services organization offers health coverage in
33 this state in the individual market only through one or more bona fide
34 associations, the membership of the individual in the association has ceased
35 but only if that coverage is terminated uniformly without regard to any
36 health status-related factor of any covered individual.

37 O. A conversion plan may be modified if the modification complies with
38 the notice and disclosure provisions for cancellation and nonrenewal under
39 subsection H of this section. A modification of a conversion plan that has
40 already been issued shall not result in the effective elimination of any
41 benefit originally included in the conversion plan.

42 P. Any person who is a United States armed forces reservist, who is
43 ordered to active military duty on or after August 22, 1990 and who was
44 enrolled in a health care plan shall have the right to reinstate such

1 coverage upon release from active military duty subject to the following
2 conditions:

3 1. The reservist shall make written application to the health plan
4 within ninety days of discharge from active military duty or within one year
5 of hospitalization continuing after discharge. Coverage shall be effective
6 upon receipt of the application by the health plan.

7 2. The health plan may exclude from such coverage any health or
8 physical condition arising during and occurring as a direct result of active
9 military duty.

10 Q. The director shall adopt emergency rules that are applicable to
11 persons who are leaving active service in the armed forces of the United
12 States and returning to civilian status consistent with subsection P of this
13 section and that include:

14 1. Conditions of eligibility.

15 2. Coverage of dependents.

16 ~~3. Preexisting conditions.~~

17 ~~4.~~ 3. Termination of insurance.

18 ~~5.~~ 4. Probationary periods.

19 ~~6.~~ 5. Limitations.

20 ~~7.~~ 6. Exceptions.

21 ~~8.~~ 7. Reductions.

22 ~~9.~~ 8. Elimination periods.

23 ~~10.~~ 9. Requirements for replacement.

24 ~~11.~~ 10. Any other conditions of evidences of coverage.

25 R. Any contract that provides maternity benefits shall not restrict
26 benefits for any hospital length of stay in connection with childbirth for
27 the mother or the newborn child to less than forty-eight hours following a
28 normal vaginal delivery or ninety-six hours following a cesarean section.
29 The contract shall not require the provider to obtain authorization from the
30 health care services organization for prescribing the minimum length of stay
31 required by this subsection. The contract may provide that an attending
32 provider in consultation with the mother may discharge the mother or the
33 newborn child before the expiration of the minimum length of stay required by
34 this subsection. The health care services organization shall not:

35 1. Deny the mother or the newborn child eligibility or continued
36 eligibility to enroll or to renew coverage under the terms of the contract
37 solely for the purpose of avoiding the requirements of this subsection.

38 2. Provide monetary payments or rebates to mothers to encourage those
39 mothers to accept less than the minimum protections available pursuant to
40 this subsection.

41 3. Penalize or otherwise reduce or limit the reimbursement of an
42 attending provider because that provider provided care to any insured under
43 the contract in accordance with this subsection.

1 4. Provide monetary or other incentives to an attending provider to
2 induce that provider to provide care to an insured under the contract in a
3 manner that is inconsistent with this subsection.

4 5. Except as described in subsection S of this section, restrict
5 benefits for any portion of a period within the minimum length of stay in a
6 manner that is less favorable than the benefits provided for any preceding
7 portion of that stay.

8 S. Nothing in subsection R of this section:

9 1. Requires a mother to give birth in a hospital or to stay in the
10 hospital for a fixed period of time following the birth of the child.

11 2. Prevents a health care services organization from imposing
12 deductibles, coinsurance or other cost sharing in relation to benefits for
13 hospital lengths of stay in connection with childbirth for a mother or a
14 newborn child under the contract, except that any coinsurance or other cost
15 sharing for any portion of a period within a hospital length of stay required
16 pursuant to subsection R of this section shall not be greater than the
17 coinsurance or cost sharing for any preceding portion of that stay.

18 3. Prevents a health care services organization from negotiating the
19 level and type of reimbursement with a provider for care provided in
20 accordance with subsection R of this section.

21 T. Any contract or evidence of coverage that provides coverage for
22 diabetes shall also provide coverage for equipment and supplies that are
23 medically necessary and that are prescribed by a health care provider
24 including:

25 1. Blood glucose monitors.

26 2. Blood glucose monitors for the legally blind.

27 3. Test strips for glucose monitors and visual reading and urine
28 testing strips.

29 4. Insulin preparations and glucagon.

30 5. Insulin cartridges.

31 6. Drawing up devices and monitors for the visually impaired.

32 7. Injection aids.

33 8. Insulin cartridges for the legally blind.

34 9. Syringes and lancets including automatic lancing devices.

35 10. Prescribed oral agents for controlling blood sugar that are
36 included on the plan formulary.

37 11. To the extent coverage is required under medicare, podiatric
38 appliances for prevention of complications associated with diabetes.

39 12. Any other device, medication, equipment or supply for which
40 coverage is required under medicare from and after January 1, 1999. The
41 coverage required in this paragraph is effective six months after the
42 coverage is required under medicare.

43 U. Nothing in subsection T of this section:

44 1. Entitles a member or enrollee of a health care services
45 organization to equipment or supplies for the treatment of diabetes that are

1 not medically necessary as determined by the health care services
2 organization medical director or the medical director's designee.

3 2. Provides coverage for diabetic supplies obtained by a member or
4 enrollee of a health care services organization without a prescription unless
5 otherwise permitted pursuant to the terms of the health care plan.

6 3. Prohibits a health care services organization from imposing
7 deductibles, coinsurance or other cost sharing in relation to benefits for
8 equipment or supplies for the treatment of diabetes.

9 V. Any contract or evidence of coverage that provides coverage for
10 prescription drugs shall not limit or exclude coverage for any prescription
11 drug prescribed for the treatment of cancer on the basis that the
12 prescription drug has not been approved by the United States food and drug
13 administration for the treatment of the specific type of cancer for which the
14 prescription drug has been prescribed, if the prescription drug has been
15 recognized as safe and effective for treatment of that specific type of
16 cancer in one or more of the standard medical reference compendia prescribed
17 in subsection W of this section or medical literature that meets the criteria
18 prescribed in subsection W of this section. The coverage required under this
19 subsection includes covered medically necessary services associated with the
20 administration of the prescription drug. This subsection does not:

21 1. Require coverage of any prescription drug used in the treatment of
22 a type of cancer if the United States food and drug administration has
23 determined that the prescription drug is contraindicated for that type of
24 cancer.

25 2. Require coverage for any experimental prescription drug that is not
26 approved for any indication by the United States food and drug
27 administration.

28 3. Alter any law with regard to provisions that limit the coverage of
29 prescription drugs that have not been approved by the United States food and
30 drug administration.

31 4. Notwithstanding section 20-1057.02, require reimbursement or
32 coverage for any prescription drug that is not included in the drug formulary
33 or list of covered prescription drugs specified in the contract or evidence
34 of coverage.

35 5. Notwithstanding section 20-1057.02, prohibit a contract or evidence
36 of coverage from limiting or excluding coverage of a prescription drug, if
37 the decision to limit or exclude coverage of the prescription drug is not
38 based primarily on the coverage of prescription drugs required by this
39 section.

40 6. Prohibit the use of deductibles, coinsurance, copayments or other
41 cost sharing in relation to drug benefits and related medical benefits
42 offered.

43 W. For the purposes of subsection V of this section:

44 1. The acceptable standard medical reference compendia are the
45 following:

1 (a) The American hospital formulary service drug information, a
2 publication of the American society of health system pharmacists.

3 (b) The national comprehensive cancer network drugs and biologics
4 compendium.

5 (c) Thomson Micromedex compendium DrugDex.

6 (d) Elsevier gold standard's clinical pharmacology compendium.

7 (e) Other authoritative compendia as identified by the secretary of
8 the United States department of health and human services.

9 2. Medical literature may be accepted if all of the following apply:

10 (a) At least two articles from major peer reviewed professional
11 medical journals have recognized, based on scientific or medical criteria,
12 the drug's safety and effectiveness for treatment of the indication for which
13 the drug has been prescribed.

14 (b) No article from a major peer reviewed professional medical journal
15 has concluded, based on scientific or medical criteria, that the drug is
16 unsafe or ineffective or that the drug's safety and effectiveness cannot be
17 determined for the treatment of the indication for which the drug has been
18 prescribed.

19 (c) The literature meets the uniform requirements for manuscripts
20 submitted to biomedical journals established by the international committee
21 of medical journal editors or is published in a journal specified by the
22 United States department of health and human services as acceptable peer
23 reviewed medical literature pursuant to section 186(t)(2)(B) of the social
24 security act (42 United States Code section 1395x(t)(2)(B)).

25 X. A health care services organization shall not issue or deliver any
26 advertising matter or sales material to any person in this state until the
27 health care services organization files the advertising matter or sales
28 material with the director. This subsection does not require a health care
29 services organization to have the prior approval of the director to issue or
30 deliver the advertising matter or sales material. If the director finds that
31 the advertising matter or sales material, in whole or in part, is false,
32 deceptive or misleading, the director may issue an order disapproving the
33 advertising matter or sales material, directing the health care services
34 organization to cease and desist from issuing, circulating, displaying or
35 using the advertising matter or sales material within a period of time
36 specified by the director but not less than ten days and imposing any
37 penalties prescribed in this title. At least five days before issuing an
38 order pursuant to this subsection, the director shall provide the health care
39 services organization with a written notice of the basis of the order to
40 provide the health care services organization with an opportunity to cure the
41 alleged deficiency in the advertising matter or sales material within a
42 single five day period for the particular advertising matter or sales
43 material at issue. The health care services organization may appeal the
44 director's order pursuant to title 41, chapter 6, article 10. Except as
45 otherwise provided in this subsection, a health care services organization

1 may obtain a stay of the effectiveness of the order as prescribed in section
2 20-162. If the director certifies in the order and provides a detailed
3 explanation of the reasons in support of the certification that continued use
4 of the advertising matter or sales material poses a threat to the health,
5 safety or welfare of the public, the order may be entered immediately without
6 opportunity for cure and the effectiveness of the order is not stayed pending
7 the hearing on the notice of appeal but the hearing shall be promptly
8 instituted and determined.

9 Y. Any contract or evidence of coverage that is offered by a health
10 care services organization and that contains a prescription drug benefit
11 shall provide coverage of medical foods to treat inherited metabolic
12 disorders as provided by this section.

13 Z. The metabolic disorders triggering medical foods coverage under
14 this section shall:

15 1. Be part of the newborn screening program prescribed in section
16 36-694.

17 2. Involve amino acid, carbohydrate or fat metabolism.

18 3. Have medically standard methods of diagnosis, treatment and
19 monitoring including quantification of metabolites in blood, urine or spinal
20 fluid or enzyme or DNA confirmation in tissues.

21 4. Require specially processed or treated medical foods that are
22 generally available only under the supervision and direction of a physician
23 who is licensed pursuant to title 32, chapter 13 or 17 or a registered nurse
24 practitioner who is licensed pursuant to title 32, chapter 15, that must be
25 consumed throughout life and without which the person may suffer serious
26 mental or physical impairment.

27 AA. Medical foods eligible for coverage under this section shall be
28 prescribed or ordered under the supervision of a physician licensed pursuant
29 to title 32, chapter 13 or 17 or a registered nurse practitioner who is
30 licensed pursuant to title 32, chapter 15 as medically necessary for the
31 therapeutic treatment of an inherited metabolic disease.

32 BB. A health care services organization shall cover at least fifty per
33 cent of the cost of medical foods prescribed to treat inherited metabolic
34 disorders and covered pursuant to this section. An organization may limit
35 the maximum annual benefit for medical foods under this section to five
36 thousand dollars, which applies to the cost of all prescribed modified low
37 protein foods and metabolic formula.

38 CC. Unless preempted under federal law or unless federal law imposes
39 greater requirements than this section, this section applies to a provider
40 sponsored health care services organization.

41 DD. For the purposes of:

42 1. This section:

43 (a) "Inherited metabolic disorder" means a disease caused by an
44 inherited abnormality of body chemistry and includes a disease tested under
45 the newborn screening program prescribed in section 36-694.

1 (b) "Medical foods" means modified low protein foods and metabolic
2 formula.

3 (c) "Metabolic formula" means foods that are all of the following:

4 (i) Formulated to be consumed or administered enterally under the
5 supervision of a physician who is licensed pursuant to title 32, chapter 13
6 or 17 or a registered nurse practitioner who is licensed pursuant to title
7 32, chapter 15.

8 (ii) Processed or formulated to be deficient in one or more of the
9 nutrients present in typical foodstuffs.

10 (iii) Administered for the medical and nutritional management of a
11 person who has limited capacity to metabolize foodstuffs or certain nutrients
12 contained in the foodstuffs or who has other specific nutrient requirements
13 as established by medical evaluation.

14 (iv) Essential to a person's optimal growth, health and metabolic
15 homeostasis.

16 (d) "Modified low protein foods" means foods that are all of the
17 following:

18 (i) Formulated to be consumed or administered enterally under the
19 supervision of a physician who is licensed pursuant to title 32, chapter 13
20 or 17 or a registered nurse practitioner who is licensed pursuant to title
21 32, chapter 15.

22 (ii) Processed or formulated to contain less than one gram of protein
23 per unit of serving, but does not include a natural food that is naturally
24 low in protein.

25 (iii) Administered for the medical and nutritional management of a
26 person who has limited capacity to metabolize foodstuffs or certain nutrients
27 contained in the foodstuffs or who has other specific nutrient requirements
28 as established by medical evaluation.

29 (iv) Essential to a person's optimal growth, health and metabolic
30 homeostasis.

31 2. Subsection B of this section, "child", for purposes of initial
32 coverage of an adopted child or a child placed for adoption but not for
33 purposes of termination of coverage of such child, means a person under
34 eighteen years of age.

35 Sec. 5. Section 20-1057.03, Arizona Revised Statutes, is amended to
36 read:

37 20-1057.03. Chiropractic care; definitions

38 A. Every health care services organization shall provide coverage for
39 chiropractic services provided by network chiropractic providers pursuant to
40 this section.

41 B. A health care services organization is not required to provide
42 coverage for chiropractic services obtained from a provider who is not a
43 member of the health care services organization's provider network.

1 C. An enrollee may obtain medically necessary chiropractic services
2 from a network chiropractic provider through self-referral for a minimum of
3 twelve visits in an annual contract period, unless the enrollee's evidence of
4 coverage with the health care services organization allows for additional
5 visits or benefits.

6 D. This section does not:

7 1. Require a health care services organization to provide services
8 that are not covered by the enrollee's evidence of coverage. ~~and does not~~
9 ~~diminish or impair any preexisting condition limitation in the evidence of~~
10 ~~coverage.~~

11 2. Prohibit an enrollee from seeking chiropractic services in addition
12 to the limits prescribed in this section from any chiropractic provider if
13 the enrollee accepts financial responsibility for those services.

14 E. Nothing in this section prohibits the use of deductibles,
15 coinsurance, copayments or other cost sharing in relation to the chiropractic
16 benefits offered.

17 F. For the purposes of this section:

18 1. "Chiropractic services" means only nonsurgical and noninvasive
19 treatment of neck and back pain through physiotherapy, musculoskeletal
20 manipulation and other physical corrections of musculoskeletal conditions
21 within the scope of the chiropractic practice.

22 2. "Musculoskeletal" means any function of the musculoskeletal system
23 that is integrated with neurological function and is expressed by biological
24 regulatory mechanisms.

25 3. "Network chiropractic provider" means a chiropractic physician who
26 is licensed pursuant to title 32, chapter 8 and who is under written contract
27 with the health care services organization to provide services pursuant to
28 this section.

29 4. "Self-referral" means obtaining treatment by a provider without
30 referral from a primary care physician.

31 Sec. 6. Section 20-1057.04, Arizona Revised Statutes, is amended to
32 read:

33 20-1057.04. Continuity of care; definition

34 A. A health care services organization shall allow any new enrollee
35 whose health care provider is not a member of the provider network, on
36 written request of the enrollee to the health care services organization, to
37 continue an active course of treatment with that health care provider during
38 a transitional period after the effective date of the enrollment if both of
39 the following apply:

40 1. The enrollee has either:

41 (a) A life threatening disease or condition, in which case the
42 transitional period is not more than thirty days after the effective date of
43 the enrollment.

1 (b) ~~Entered~~ IS IN the third trimester of pregnancy on the effective
2 date of the enrollment, in which case the transitional period includes the
3 delivery and any care up to six weeks after the delivery that is related to
4 the delivery.

5 2. The enrollee's health care provider agrees in writing to do all of
6 the following:

7 (a) Except for copayment, coinsurance or deductible amounts, accept as
8 payment in full reimbursement from the health care services organization at
9 the rates that are established by the health care services organization and
10 that are not more than the level of reimbursement applicable to similar
11 services by health care providers within the provider network.

12 (b) Comply with the health care services organization's quality
13 assurance and utilization review requirements and provide to the health care
14 services organization any necessary medical information related to the care.

15 (c) Comply with the health care services organization's policies and
16 procedures pursuant to this article including procedures relating to
17 referrals and obtaining preauthorization, claims handling and treatment plan
18 approval by the health care services organization.

19 B. A health care services organization shall allow any enrollee whose
20 health care provider is terminated from the provider network by the health
21 care services organization except for reasons of medical incompetence or
22 unprofessional conduct, on written request of the enrollee to the health care
23 services organization, to continue an active course of treatment with that
24 health care provider during a transitional period after the date of the
25 provider's disaffiliation from the provider network, if both of the following
26 apply:

27 1. The enrollee has either:

28 (a) A life threatening disease or condition, in which case the
29 transitional period is not more than thirty days after the date of the
30 provider's disaffiliation from the provider network.

31 (b) ~~Entered~~ IS IN the third trimester of pregnancy on the date of the
32 provider's disaffiliation, in which case the transition period includes the
33 delivery and any care up to six weeks after the delivery that is related to
34 the delivery.

35 2. The enrollee's health care provider agrees in writing to do all of
36 the following:

37 (a) Except for copayment, coinsurance or deductible amounts, continue
38 to accept as payment in full reimbursement from the health care services
39 organization at the rates applicable before the beginning of the transitional
40 period.

41 (b) Comply with the health care services organization's quality
42 assurance and utilization review requirements and provide to the health care
43 services organization any necessary medical information related to the care.

44 (c) Comply with the health care services organization's policies and
45 procedures pursuant to this article including procedures relating to

1 referrals and obtaining preauthorization, claims handling and treatment plan
2 approval by the health care services organization.

3 C. This section does not require a health care services organization
4 to provide coverage for benefits that are not covered by the enrollee's
5 evidence of coverage. ~~and does not diminish or impair any preexisting~~
6 ~~condition limitation in the evidence of coverage.~~

7 D. This section does not extend to a health care provider who is not a
8 member of the provider network any contractual rights or remedies beyond
9 those rights or remedies related to and necessary for the provision of
10 covered services to the specific enrollee during the required transitional
11 period.

12 E. For the purposes of this section, "health care provider" means any
13 physician who is licensed in this state pursuant to title 32, chapter 13
14 or 17.

15 Sec. 7. Title 20, chapter 4, article 9, Arizona Revised Statutes, is
16 amended by adding section 20-1057.12, to read:

17 20-1057.12. Evidence of coverage; preexisting condition
18 limitations or exclusions; prohibition;
19 definitions

20 A. A CONTRACT OR EVIDENCE OF COVERAGE ISSUED BY A HEALTH CARE SERVICES
21 ORGANIZATION SHALL NOT IMPOSE ANY PREEXISTING CONDITION LIMITATIONS OR
22 EXCLUSIONS RELATING TO ANY PREEXISTING CONDITION.

23 B. FOR THE PURPOSES OF THIS SECTION:

24 1. "PREEXISTING CONDITION" MEANS A CONDITION, REGARDLESS OF THE CAUSE
25 OF THE CONDITION, FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WAS
26 RECOMMENDED OR RECEIVED BEFORE THE DATE OF THE ENROLLMENT OF THE INDIVIDUAL
27 UNDER A HEALTH INSURANCE POLICY OR OTHER CONTRACT THAT PROVIDES HEALTH
28 COVERAGE BENEFITS. A GENETIC CONDITION IS NOT A PREEXISTING CONDITION IN THE
29 ABSENCE OF A DIAGNOSIS OF THE CONDITION RELATED TO THE GENETIC INFORMATION
30 AND SHALL NOT RESULT IN A PREEXISTING CONDITION LIMITATION OR PREEXISTING
31 CONDITION EXCLUSION.

32 2. "PREEXISTING CONDITION LIMITATION" OR "PREEXISTING CONDITION
33 EXCLUSION" MEANS A LIMITATION OR EXCLUSION OF BENEFITS FOR A PREEXISTING
34 CONDITION UNDER A HEALTH INSURANCE POLICY OR OTHER CONTRACT THAT PROVIDES
35 HEALTH COVERAGE BENEFITS.

36 Sec. 8. Section 20-1342, Arizona Revised Statutes, is amended to read:

37 20-1342. Scope and format of policy; definitions

38 A. A policy of disability insurance shall not be delivered or issued
39 for delivery to any person in this state unless it otherwise complies with
40 this title and complies with the following:

41 1. The entire money and other considerations shall be expressed in the
42 policy.

43 2. The time when the insurance takes effect and terminates shall be
44 expressed in the policy.

1 3. It shall purport to insure only one person, except that a policy
2 may insure, originally or by subsequent amendment, on the application of the
3 policyholder or the policyholder's spouse, any two or more eligible members
4 of that family, including husband, wife, dependent children or any children
5 under a specified age that does not exceed nineteen years and any other
6 person dependent upon the policyholder. Any policy, except accidental death
7 and dismemberment, applied for that provides family coverage ~~shall~~, as to
8 such coverage of family members, shall also provide that the benefits
9 applicable for children shall be payable with respect to a newly born child
10 of the insured from the instant of such child's birth, to a child adopted by
11 the insured, regardless of the age at which the child was adopted, and to a
12 child who has been placed for adoption with the insured and for whom the
13 application and approval procedures for adoption pursuant to section 8-105 or
14 8-108 have been completed to the same extent that such coverage applies to
15 other members of the family. The coverage for newly born or adopted children
16 or children placed for adoption shall include coverage of injury or sickness
17 including necessary care and treatment of medically diagnosed congenital
18 defects and birth abnormalities. If payment of a specific premium is
19 required to provide coverage for a child, the policy may require that
20 notification of birth, adoption or adoption placement of the child and
21 payment of the required premium must be furnished to the insurer within
22 thirty-one days after the date of birth, adoption or adoption placement in
23 order to have the coverage continue beyond the thirty-one day period.

24 4. The style, arrangement and overall appearance of the policy shall
25 give no undue prominence to any portion of the text, and every printed
26 portion of the text of the policy and of any endorsements or attached papers
27 shall be plainly printed in light-faced type of a style in general use, the
28 size of which shall be uniform and not less than ten point with a lower case
29 unspaced alphabet length of not less than one hundred and twenty point.
30 "Text" shall include all printed matter except the name and address of the
31 insurer, name or title of the policy, the brief description, if any, and
32 captions and subcaptions.

33 5. The exceptions and reductions of indemnity shall be set forth in
34 the policy and, other than those contained in sections 20-1345 through
35 20-1368, shall be printed and, at the insurer's option, either included with
36 the benefit provision to which they apply or under an appropriate caption
37 such as "exceptions", or "exceptions and reductions", except that if an
38 exception or reduction specifically applies only to a particular benefit of
39 the policy, a statement of such exception or reduction shall be included with
40 the benefit provision to which it applies.

41 6. Each such form, including riders and endorsements, shall be
42 identified by a form number in the lower left-hand corner of the first page.

43 7. The policy shall contain no provision purporting to make any
44 portion of the charter, rules, constitution or bylaws of the insurer a part
45 of the policy unless such portion is set forth in full in the policy, except

1 in the case of the incorporation of, or reference to, a statement of rates or
2 classification of risks, or short-rate table filed with the director.

3 8. Each contract shall be so written that the corporation shall pay
4 benefits:

5 (a) For performance of any surgical service that is covered by the
6 terms of such contract, regardless of the place of service.

7 (b) For any home health services that are performed by a licensed home
8 health agency and that a physician has prescribed in lieu of hospital
9 services, as defined by the director, providing the hospital services would
10 have been covered.

11 (c) For any diagnostic service that a physician has performed outside
12 a hospital in lieu of inpatient service, providing the inpatient service
13 would have been covered.

14 (d) For any service performed in a hospital's outpatient department or
15 in a freestanding surgical facility, providing such service would have been
16 covered if performed as an inpatient service.

17 9. A disability insurance policy that provides coverage for the
18 surgical expense of a mastectomy shall also provide coverage incidental to
19 the patient's covered mastectomy for the expense of reconstructive surgery of
20 the breast on which the mastectomy was performed, surgery and reconstruction
21 of the other breast to produce a symmetrical appearance, prostheses,
22 treatment of physical complications for all stages of the mastectomy,
23 including lymphedemas, and at least two external postoperative prostheses
24 subject to all of the terms and conditions of the policy.

25 10. A contract, except a supplemental contract covering a specified
26 disease or other limited benefits, that provides coverage for surgical
27 services for a mastectomy shall also provide coverage for mammography
28 screening performed on dedicated equipment for diagnostic purposes on
29 referral by a patient's physician, subject to all of the terms and conditions
30 of the policy and according to the following guidelines:

31 (a) A baseline mammogram for a woman from age thirty-five to
32 thirty-nine.

33 (b) A mammogram for a woman from age forty to forty-nine every two
34 years or more frequently based on the recommendation of the woman's
35 physician.

36 (c) A mammogram every year for a woman fifty years of age and over.

37 11. Any contract that is issued to the insured and that provides
38 coverage for maternity benefits shall also provide that the maternity
39 benefits apply to the costs of the birth of any child legally adopted by the
40 insured if all the following are true:

41 (a) The child is adopted within one year of birth.

42 (b) The insured is legally obligated to pay the costs of birth.

43 (c) All ~~preexisting conditions and other~~ limitations have been met by
44 the insured.

(d) The insured has notified the insurer of the insured's acceptability to adopt children pursuant to section 8-105, within sixty days after such approval or within sixty days after a change in insurance policies, plans or companies.

12. The coverage prescribed by paragraph 11 of this subsection is excess to any other coverage the natural mother may have for maternity benefits except coverage made available to persons pursuant to title 36, chapter 29, but not including coverage made available to persons defined as eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If such other coverage exists the agency, attorney or individual arranging the adoption shall make arrangements for the insurance to pay those costs that may be covered under that policy and shall advise the adopting parent in writing of the existence and extent of the coverage without disclosing any confidential information such as the identity of the natural parent. The insured adopting parents shall notify their insurer of the existence and extent of the other coverage.

B. Any contract that provides maternity benefits shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than forty-eight hours following a normal vaginal delivery or ninety-six hours following a cesarean section. The contract shall not require the provider to obtain authorization from the insurer for prescribing the minimum length of stay required by this subsection. The contract may provide that an attending provider in consultation with the mother may discharge the mother or the newborn child before the expiration of the minimum length of stay required by this subsection. The insurer shall not:

1. Deny the mother or the newborn child eligibility or continued eligibility to enroll or to renew coverage under the terms of the contract solely for the purpose of avoiding the requirements of this subsection.

2. Provide monetary payments or rebates to mothers to encourage those mothers to accept less than the minimum protections available pursuant to this subsection.

3. Penalize or otherwise reduce or limit the reimbursement of an attending provider because that provider provided care to any insured under the contract in accordance with this subsection.

4. Provide monetary or other incentives to an attending provider to induce that provider to provide care to an insured under the contract in a manner that is inconsistent with this subsection.

5. Except as described in subsection C of this section, restrict benefits for any portion of a period within the minimum length of stay in a manner that is less favorable than the benefits provided for any preceding portion of that stay.

C. Nothing in subsection B of this section:

1. Requires a mother to give birth in a hospital or to stay in the hospital for a fixed period of time following the birth of the child.

2. Prevents an insurer from imposing deductibles, coinsurance or other cost sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn child under the contract, except that any coinsurance or other cost sharing for any portion of a period within a hospital length of stay required pursuant to subsection B of this section shall not be greater than the coinsurance or cost sharing for any preceding portion of that stay.

3. Prevents an insurer from negotiating the level and type of reimbursement with a provider for care provided in accordance with subsection B of this section.

D. Any contract that provides coverage for diabetes shall also provide coverage for equipment and supplies that are medically necessary and that are prescribed by a health care provider including:

1. Blood glucose monitors.
2. Blood glucose monitors for the legally blind.
3. Test strips for glucose monitors and visual reading and urine testing strips.
4. Insulin preparations and glucagon.
5. Insulin cartridges.
6. Drawing up devices and monitors for the visually impaired.
7. Injection aids.
8. Insulin cartridges for the legally blind.
9. Syringes and lancets including automatic lancing devices.
10. Prescribed oral agents for controlling blood sugar that are included on the plan formulary.
11. To the extent coverage is required under medicare, podiatric appliances for prevention of complications associated with diabetes.
12. Any other device, medication, equipment or supply for which coverage is required under medicare from and after January 1, 1999. The coverage required in this paragraph is effective six months after the coverage is required under medicare.

E. Nothing in subsection D of this section:

1. Prohibits a disability insurer from imposing deductibles, coinsurance or other cost sharing in relation to benefits for equipment or supplies for the treatment of diabetes.

2. Requires a policy to provide an insured with outpatient benefits if the policy does not cover outpatient benefits.

F. Any contract that provides coverage for prescription drugs shall not limit or exclude coverage for any prescription drug prescribed for the treatment of cancer on the basis that the prescription drug has not been approved by the United States food and drug administration for the treatment of the specific type of cancer for which the prescription drug has been prescribed, if the prescription drug has been recognized as safe and effective for treatment of that specific type of cancer in one or more of the standard medical reference compendia prescribed in subsection G of this

section or medical literature that meets the criteria prescribed in subsection G of this section. The coverage required under this subsection includes covered medically necessary services associated with the administration of the prescription drug. This subsection does not:

1. Require coverage of any prescription drug used in the treatment of a type of cancer if the United States food and drug administration has determined that the prescription drug is contraindicated for that type of cancer.

2. Require coverage for any experimental prescription drug that is not approved for any indication by the United States food and drug administration.

3. Alter any law with regard to provisions that limit the coverage of prescription drugs that have not been approved by the United States food and drug administration.

4. Require reimbursement or coverage for any prescription drug that is not included in the drug formulary or list of covered prescription drugs specified in the contract.

5. Prohibit a contract from limiting or excluding coverage of a prescription drug, if the decision to limit or exclude coverage of the prescription drug is not based primarily on the coverage of prescription drugs required by this section.

6. Prohibit the use of deductibles, coinsurance, copayments or other cost sharing in relation to drug benefits and related medical benefits offered.

G. For the purposes of subsection F of this section:

1. The acceptable standard medical reference compendia are the following:

(a) The American hospital formulary service drug information, a publication of the American society of health system pharmacists.

(b) The national comprehensive cancer network drugs and biologics compendium.

(c) Thomson Micromedex compendium DrugDex.

(d) Elsevier gold standard's clinical pharmacology compendium.

(e) Other authoritative compendia as identified by the secretary of the United States department of health and human services.

2. Medical literature may be accepted if all of the following apply:

(a) At least two articles from major peer reviewed professional medical journals have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which the drug has been prescribed.

(b) No article from a major peer reviewed professional medical journal has concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug's safety and effectiveness cannot be determined for the treatment of the indication for which the drug has been prescribed.

1 (c) The literature meets the uniform requirements for manuscripts
2 submitted to biomedical journals established by the international committee
3 of medical journal editors or is published in a journal specified by the
4 United States department of health and human services as acceptable peer
5 reviewed medical literature pursuant to section 186(t)(2)(B) of the social
6 security act (42 United States Code section 1395x(t)(2)(B)).

7 H. Any contract that is offered by a disability insurer and that
8 contains a routine outpatient prescription drug benefit shall provide
9 coverage of medical foods to treat inherited metabolic disorders as provided
10 by this section.

11 I. The metabolic disorders triggering medical foods coverage under
12 this section shall:

13 1. Be part of the newborn screening program prescribed in section
14 36-694.

15 2. Involve amino acid, carbohydrate or fat metabolism.

16 3. Have medically standard methods of diagnosis, treatment and
17 monitoring including quantification of metabolites in blood, urine or spinal
18 fluid or enzyme or DNA confirmation in tissues.

19 4. Require specially processed or treated medical foods that are
20 generally available only under the supervision and direction of a physician
21 who is licensed pursuant to title 32, chapter 13 or 17 or a registered nurse
22 practitioner who is licensed pursuant to title 32, chapter 15, that must be
23 consumed throughout life and without which the person may suffer serious
24 mental or physical impairment.

25 J. Medical foods eligible for coverage under this section shall be
26 prescribed or ordered under the supervision of a physician licensed pursuant
27 to title 32, chapter 13 or 17 or a registered nurse practitioner who is
28 licensed pursuant to title 32, chapter 15 as medically necessary for the
29 therapeutic treatment of an inherited metabolic disease.

30 K. An insurer shall cover at least fifty per cent of the cost of
31 medical foods prescribed to treat inherited metabolic disorders and covered
32 pursuant to this section. An insurer may limit the maximum annual benefit
33 for medical foods under this section to five thousand dollars, which applies
34 to the cost of all prescribed modified low protein foods and metabolic
35 formula.

36 L. For the purposes of:

37 1. This section:

38 (a) "Inherited metabolic disorder" means a disease caused by an
39 inherited abnormality of body chemistry and includes a disease tested under
40 the newborn screening program prescribed in section 36-694.

41 (b) "Medical foods" means modified low protein foods and metabolic
42 formula.

1 (c) "Metabolic formula" means foods that are all of the following:

2 (i) Formulated to be consumed or administered enterally under the
3 supervision of a physician who is licensed pursuant to title 32, chapter 13
4 or 17 or a registered nurse practitioner who is licensed pursuant to title
5 32, chapter 15.

6 (ii) Processed or formulated to be deficient in one or more of the
7 nutrients present in typical foodstuffs.

8 (iii) Administered for the medical and nutritional management of a
9 person who has limited capacity to metabolize foodstuffs or certain nutrients
10 contained in the foodstuffs or who has other specific nutrient requirements
11 as established by medical evaluation.

12 (iv) Essential to a person's optimal growth, health and metabolic
13 homeostasis.

14 (d) "Modified low protein foods" means foods that are all of the
15 following:

16 (i) Formulated to be consumed or administered enterally under the
17 supervision of a physician who is licensed pursuant to title 32, chapter 13
18 or 17 or a registered nurse practitioner who is licensed pursuant to title
19 32, chapter 15.

20 (ii) Processed or formulated to contain less than one gram of protein
21 per unit of serving, but does not include a natural food that is naturally
22 low in protein.

23 (iii) Administered for the medical and nutritional management of a
24 person who has limited capacity to metabolize foodstuffs or certain nutrients
25 contained in the foodstuffs or who has other specific nutrient requirements
26 as established by medical evaluation.

27 (iv) Essential to a person's optimal growth, health and metabolic
28 homeostasis.

29 2. Subsection A of this section, the term "child", for purposes of
30 initial coverage of an adopted child or a child placed for adoption but not
31 for purposes of termination of coverage of such child, means a person under
32 ~~the age of~~ eighteen years **OF AGE**.

33 Sec. 9. Title 20, chapter 6, article 4, Arizona Revised Statutes, is
34 amended by adding section 20-1342.06, to read:

35 **20-1342.06. Disability insurance policies; preexisting**
36 **condition limitations or exclusions; prohibition;**
37 **definitions**

38 **A. A POLICY ISSUED BY A DISABILITY INSURER SHALL NOT IMPOSE ANY**
39 **PREEXISTING CONDITION LIMITATIONS OR EXCLUSIONS RELATING TO ANY PREEXISTING**
40 **CONDITION.**

41 **B. FOR THE PURPOSES OF THIS SECTION:**

42 **1. "PREEXISTING CONDITION" MEANS A CONDITION, REGARDLESS OF THE CAUSE**
43 **OF THE CONDITION, FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WAS**
44 **RECOMMENDED OR RECEIVED BEFORE THE DATE OF THE ENROLLMENT OF THE INDIVIDUAL**
45 **UNDER A HEALTH INSURANCE POLICY OR OTHER CONTRACT THAT PROVIDES HEALTH**

1 COVERAGE BENEFITS. A GENETIC CONDITION IS NOT A PREEXISTING CONDITION IN THE
2 ABSENCE OF A DIAGNOSIS OF THE CONDITION RELATED TO THE GENETIC INFORMATION
3 AND SHALL NOT RESULT IN A PREEXISTING CONDITION LIMITATION OR PREEXISTING
4 CONDITION EXCLUSION.

5 2. "PREEXISTING CONDITION LIMITATION" OR "PREEXISTING CONDITION
6 EXCLUSION" MEANS A LIMITATION OR EXCLUSION OF BENEFITS FOR A PREEXISTING
7 CONDITION UNDER A HEALTH INSURANCE POLICY OR OTHER CONTRACT THAT PROVIDES
8 HEALTH COVERAGE BENEFITS.

9 Sec. 10. Section 20-1377, Arizona Revised Statutes, is amended to
10 read:

11 20-1377. Continuation of coverage under individual policies;
12 requirements; exceptions; renewability

13 A. A policy of disability insurance delivered or issued for delivery
14 in this state shall provide for the right of covered family members to
15 continue coverage on the death of the named insured, the entry of a decree of
16 dissolution of marriage of the named insured and any other conditions, other
17 than failure of the insured to pay the required premium, specifically stated
18 in the policy under which coverage would otherwise terminate as to the
19 covered spouse or covered dependent children of the named insured.

20 B. At the option of the insurer, coverage shall either continue under
21 the existing policy or by the issuance of a converted policy with the person
22 exercising the right to convert designated as the named insured. Coverage
23 provided by a conversion policy must provide benefits most similar to the
24 coverage contained in the policy that was terminated. A person entitled to
25 continuation or conversion rights under this section may elect a lesser form
26 of coverage.

27 C. Continuation or conversion of coverage ~~may~~, at the option of the
28 spouse exercising the right, ~~MAY~~ include covered dependent children for whom
29 the spouse has responsibility for care or support.

30 D. The person exercising the continuation or conversion rights shall
31 notify the insurer and make payment of the appropriate premium within
32 thirty-one days following the termination of the existing policy. A monthly
33 premium rate shall be offered to the person exercising continuation or
34 conversion rights, and payment of one monthly premium shall be deemed
35 sufficient consideration to enact the continuation or conversion policy.

36 E. Coverage provided through continuation or conversion shall be
37 without additional evidence of insurability and shall not impose any
38 preexisting condition limitations, exclusions or other contractual time
39 limitations other than those remaining unexpired under the policy or contract
40 from which continuation or conversion is exercised.

41 F. Conversion is not available to a person who is eligible for
42 medicare or eligible for or covered by other similar disability benefits
43 which together with the conversion coverage would constitute overinsurance.

1 G. This section does not apply to disability income policies, to
2 accidental death or dismemberment policies or to single term nonrenewable
3 policies.

4 H. Each policy of disability insurance shall include notice of the
5 continuation and conversion privilege.

6 I. Except as provided in subsection J of this section, any policy,
7 including a conversion or continuation policy, that is issued under this
8 section shall not be cancelled or nonrenewed except for the following
9 reasons:

10 1. The individual has failed to pay premiums or contributions in
11 accordance with the terms of the coverage or the insurer has not received
12 premium payments in a timely manner.

13 2. The individual has performed an act or practice that constitutes
14 fraud or the individual made an intentional misrepresentation of material
15 fact under the terms of the coverage.

16 3. The insurer has ceased to offer coverage to individuals that is
17 consistent with the requirements of sections 20-1379 and 20-1380.

18 4. If the insurer offers health care coverage in this state through a
19 network plan, the individual no longer resides, lives or works in the service
20 area served by the network plan or in an area for which the insurer is
21 authorized to transact business but only if the coverage is terminated
22 uniformly without regard to any health status-related factor of any covered
23 individual.

24 5. If the insurer offers health care coverage in this state in the
25 individual market only through one or more bona fide associations, the
26 membership of the individual in the association has ceased but only if that
27 coverage is terminated uniformly without regard to any health status-related
28 factor of any covered individual.

29 J. An insurer who offers only one form of an individual medical
30 expense policy may modify the conversion policy if the modification complies
31 with the notice and disclosure requirements set forth in the policy and
32 applies uniformly to the policy offered to the general public and to the
33 conversion policy.

34 K. At the time of filing a petition for dissolution of marriage, the
35 clerk of the court shall provide to the petitioner for a dissolution of
36 marriage two copies of the notice of the right of a dependent spouse to
37 convert health insurance coverage under this section. The petitioner shall
38 cause one copy of the notice to be served on the respondent together with a
39 copy of the petition, summons and preliminary injunction. The director shall
40 prepare the notice which must include a summary of this section. The clerk
41 of the court or the director is not liable for damages arising from
42 information contained in or omitted from the notices prepared or provided
43 under this ~~section~~ SUBSECTION.

44 L. Any person who is a United States armed forces reservist, who is
45 ordered to active military duty on or after August 22, 1990 and who had

coverage under an individual disability insurance policy at such time shall have the right to reinstate such coverage upon release from active military duty subject to the following conditions:

1. The reservist shall make written application to the insurer within ninety days of discharge from active military duty or within one year of hospitalization continuing after discharge. Coverage shall be effective upon receipt of ~~THE~~ application by the insurer.

2. The insurer may exclude from such coverage any health or physical condition arising during and occurring as a direct result of active military duty.

M. Each dependent of a person eligible for reinstatement under ~~SUBSECTION L OF~~ this section shall be afforded the same rights and be subject to the same conditions as the insured, if the dependent was insured under the individual disability insurance policy at the time the eligible person entered active duty. Any dependent of such person born during the period of active military duty shall have the same rights as other dependents noted in this ~~section~~ ~~SUBSECTION~~.

N. The director shall adopt emergency rules applicable to persons who are leaving active service in the armed forces of the United States and returning to civilian status consistent with the provisions of subsection L of this section, including:

1. Conditions of eligibility.

2. Coverage of dependents.

~~3. Preexisting conditions.~~

~~4.~~ 3. Termination of insurance.

~~5.~~ 4. Probationary periods.

~~6.~~ 5. Limitations.

~~7.~~ 6. Exceptions.

~~8.~~ 7. Reductions.

~~9.~~ 8. Elimination periods.

~~10.~~ 9. Requirements for replacement.

~~11.~~ 10. Any other conditions of coverage.

Sec. 11. Section 20-1379, Arizona Revised Statutes, is amended to read:

~~20-1379.~~ Guaranteed availability of individual health insurance coverage; prior group coverage; definitions

A. Every health care insurer that offers individual health insurance coverage in the individual market in this state shall provide guaranteed availability of coverage to an eligible individual who desires to enroll in individual health insurance coverage and shall not:

1. Decline to offer that coverage to, or deny enrollment of, that individual.

2. Impose any preexisting condition exclusion for that coverage.

1 B. Every health care insurer that offers individual health insurance
2 coverage in the individual market in this state shall offer all policy forms
3 of health insurance coverage that are designed for, that are made generally
4 available and actively marketed to and that enroll both eligible or other
5 individuals. A health care insurer that offers only one policy form in the
6 individual market complies with this section by offering that form to
7 eligible individuals. A health care insurer also may comply with the
8 requirements of this section by electing to offer at least two different
9 policy forms to eligible individuals as provided by subsection C of this
10 section.

11 C. A health care insurer shall meet the requirements prescribed in
12 subsection B of this section if:

13 1. The health care insurer offers at least two different policy forms,
14 both of which are designed for, are made generally available and actively
15 marketed to and enroll both eligible and other individuals.

16 2. The offer includes at least either:

17 (a) The policy forms with the largest and next to the largest earned
18 premium volume of all policy forms offered by the health care insurer in this
19 state in the individual market during a period not to exceed the preceding
20 two calendar years.

21 (b) A choice of two policy forms with representative coverage,
22 consisting of a lower level of coverage policy form and a higher level of
23 coverage policy form, each of which includes benefits that are substantially
24 similar to other individual health insurance coverage offered by the health
25 care insurer in this state and each of which is covered by a method that
26 provides for risk adjustment, risk spreading or a risk spreading mechanism
27 among the health care insurer's policies.

28 D. The health care insurer's election pursuant to subsection C of this
29 section is effective for policies offered during a period of at least two
30 years.

31 E. If a health care insurer offers individual health insurance
32 coverage in the individual market through a network plan, the health care
33 insurer may do both of the following:

34 1. Limit the individuals who may be enrolled under health insurance
35 coverage to those who live, reside or work within the service area for a
36 network plan.

37 2. Within the service area of a network plan, deny health insurance
38 coverage to individuals if the health care insurer has demonstrated, if
39 required, to the director that both:

40 (a) The health care insurer will not have the capacity to deliver
41 services adequately to additional individual enrollees because of the health
42 care insurer's obligations to existing group contract holders and enrollees
43 and individual enrollees.

1 (b) The health care insurer is applying this paragraph uniformly to
2 individuals without regard to any health status-related factor of the
3 individuals and without regard to whether the individuals are eligible
4 individuals.

5 F. A health care insurer may deny individual health insurance coverage
6 in the individual market to an eligible individual if the health care insurer
7 demonstrates to the director that the health care insurer:

8 1. Does not have the financial reserves necessary to underwrite
9 additional coverage.

10 2. Is denying coverage uniformly to all individuals in the individual
11 market in this state pursuant to state law and without regard to any health
12 status-related factor of the individuals and without regard to whether the
13 individuals are eligible individuals.

14 G. If a health care insurer denies health insurance coverage in this
15 state pursuant to subsection F of this section, the health care insurer shall
16 not offer that coverage in the individual market in this state for one
17 hundred eighty days after the date the coverage is denied or until the health
18 care insurer demonstrates to the director that the health care insurer has
19 sufficient financial reserves to underwrite additional coverage, whichever is
20 later.

21 H. An accountable health plan as defined in section 20-2301 that
22 offers conversion policies on an individual or group basis in connection with
23 a health benefits plan pursuant to this title is not a health care insurer
24 that offers individual health insurance coverage solely because of the offer
25 of a conversion policy.

26 I. Nothing in this section:

27 1. Creates additional restrictions on the amount of the premium rates
28 that a health care insurer may charge an individual for health insurance
29 coverage provided in the individual market.

30 2. Prevents a health care insurer that offers health insurance
31 coverage in the individual market from establishing premium rates or
32 modifying otherwise applicable copayments or deductibles in return for
33 adherence to programs of health promotion and disease prevention.

34 3. Requires a health care insurer that offers only short-term limited
35 duration insurance OR limited benefit coverage ~~or~~ to individuals and no other
36 coverage to individuals in the individual market to offer individual health
37 insurance coverage in the individual market.

38 4. Requires a health care insurer offering health care coverage only
39 on a group basis or through one or more bona fide associations, or both, to
40 offer health insurance coverage in the individual market.

41 J. A health care insurer shall provide, without charge, a written
42 certificate of creditable coverage as described in this section for
43 creditable coverage occurring after June 30, 1996 if the individual:

44 1. Ceases to be covered under a policy offered by a health care
45 insurer. An individual who is covered by a policy that is issued on a group

1 basis by a health care insurer, that is terminated or not renewed at the
2 choice of the sponsor of the group and where the replacement of the coverage
3 is without a break in coverage is not entitled to receive the certification
4 prescribed in this paragraph but is instead entitled to receive the
5 certification prescribed in paragraph 2 of this subsection.

6 2. Requests certification from the health care insurer within
7 twenty-four months after the coverage under a health insurance coverage
8 policy offered by a health care insurer ceases.

9 K. The certificate of creditable coverage provided by a health care
10 insurer is a written certification of the period of creditable coverage of
11 the individual under the health insurance coverage offered by the health care
12 insurer. The department may enforce and monitor the issuance and delivery of
13 the notices and certificates by health care insurers as required by this
14 section, section 20-1380, the health insurance portability and accountability
15 act of 1996 (P.L. 104-191; 110 Stat. 1936) and any federal regulations
16 adopted to implement the health insurance portability and accountability act
17 of 1996.

18 L. Any health care insurer, accountable health plan or other entity
19 that issues health care coverage in this state, as applicable, shall issue
20 and accept a certificate of creditable coverage of the individual that
21 contains at least the following information:

22 1. The date that the certificate is issued.

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

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

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

33 5. One of the following:

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

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

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

43 7. The consumer assistance telephone number for the department.

1 8. The following statement in at least fourteen point type:

2 Important Notice!

3 Keep this certificate with your important personal records to
4 protect your rights under the health insurance portability and
5 accountability act of 1996 ("HIPAA"). This certificate is proof
6 of your prior health insurance coverage. You may need to show
7 this certificate to have a guaranteed right to buy new health
8 insurance ("Guaranteed issue"). This certificate may also help
9 you avoid waiting periods or exclusions for preexisting
10 conditions. Under HIPAA, these rights are guaranteed only for a
11 very short time period. After your group coverage ends, you
12 must apply for new coverage within 63 days to be protected by
13 HIPAA. If you have questions, call the Arizona department of
14 insurance.

15 M. A health care insurer has satisfied the certification requirement
16 under this section if the insurer offering the health benefits plan provides
17 the certificate of creditable coverage in accordance with this section within
18 thirty days after the event that triggered the issuance of the certificate.

19 N. Periods of creditable coverage for an individual are established by
20 the presentation of the certificate described in this section and section
21 20-2310. In addition to the written certificate of creditable coverage as
22 described in this section, individuals may establish creditable coverage
23 through the presentation of documents or other means. In order to make a
24 determination that is based on the relevant facts and circumstances of the
25 amount of creditable coverage that an individual has, a health care insurer
26 shall take into account all information that the insurer obtains or that is
27 presented to the insurer on behalf of the individual.

28 O. A health care insurer shall calculate creditable coverage according
29 to the following rules:

30 1. The health care insurer shall allow an individual credit for each
31 day the individual was covered by creditable coverage.

32 2. The health care insurer shall not count a period of creditable
33 coverage for an individual enrolled under any form of health insurance
34 coverage if after the period of coverage and before the enrollment date there
35 were sixty-three consecutive days during which the individual was not covered
36 by any creditable coverage.

37 3. The health care insurer shall not include any period that an
38 individual is in a waiting period or an affiliation period for any health
39 coverage or is awaiting action by a health care insurer on an application for
40 the issuance of health insurance coverage when the health care insurer
41 determines the continuous period pursuant to paragraph 1 of this subsection.

42 4. The health care insurer shall not include any period that an
43 individual is waiting for approval of an application for health care
44 coverage, provided the individual submitted an application to the health care

insurer for health care coverage within sixty-three consecutive days after the individual's most recent creditable coverage.

5. The health care insurer shall not count a period of creditable coverage with respect to enrollment of an individual if, after the most recent period of creditable coverage and before the enrollment date, sixty-three consecutive days lapse during all of which the individual was not covered under any creditable coverage. The health care insurer shall not include in the determination of the period of continuous coverage described in this section any period that an individual is in a waiting period for health insurance coverage offered by a health care insurer, is in a waiting period for benefits under a health benefits plan offered by an accountable health plan or is in an affiliation period.

6. In determining the extent to which an individual has satisfied any portion of any applicable preexisting condition period the health care insurer shall count a period of creditable coverage without regard to the specific benefits covered during that period.

P. An individual is an eligible individual if, on the date the individual seeks coverage pursuant to this section, the individual has an aggregate period of creditable coverage as defined and calculated pursuant to this section of at least eighteen months and all of the following apply:

1. The most recent creditable coverage for the individual was under a plan offered by:

(a) An employee welfare benefit plan that provides medical care to employees or the employees' dependents directly or through insurance, reimbursement or otherwise pursuant to the employee retirement income security act of 1974 (P.L. 93-406; 88 Stat. 829; 29 United States Code sections 1001 through 1461).

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

(c) A governmental plan as defined in the employee retirement income security act of 1974, including a plan established or maintained for its employees by the government of the United States or by any agency or instrumentality of the United States.

(d) An accountable health plan as defined in section 20-2301.

(e) A plan made available to a person defined as eligible pursuant to section 36-2901, paragraph 6, subdivision (d) or a dependent pursuant to section 36-2901, paragraph 6, subdivision (e) of a person eligible under section 36-2901, paragraph 6, subdivision (d), provided the person was most recently employed by a business in this state with at least two but not more than fifty full-time employees.

2. The individual is not eligible for coverage under:

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

1 (b) A health benefits plan issued by an accountable health plan as
2 defined in section 20-2301.

3 (c) Part A or part B of title XVIII of the social security act.

4 (d) Title 36, chapter 29, except coverage to persons defined as
5 eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and
6 (e), or any other plan established under title XIX of the social security
7 act, and the individual does not have other health insurance coverage.

8 3. The most recent coverage within the coverage period was not
9 terminated based on any factor described in section 20-2309, subsection B,
10 paragraph 1 or 2 relating to nonpayment of premiums or fraud.

11 4. The individual was offered and elected the option of continuation
12 coverage under a COBRA continuation provision pursuant to the consolidated
13 omnibus budget reconciliation act of 1985 (P.L. 99-272; 100 Stat. 82) or a
14 similar state program.

15 5. The individual exhausted the continuation coverage pursuant to the
16 consolidated omnibus budget reconciliation act of 1985.

17 Q. Notwithstanding subsection P of this section, an individual is an
18 eligible individual if:

19 1. The individual is an individual enrollee in a health care services
20 organization that is domiciled in this state on the date that the health care
21 services organization is declared insolvent, including any health care
22 services organization that is not an accountable health plan as defined in
23 section 20-2301.

24 2. The individual's coverage terminates during the delinquency
25 proceeding, after the health care services organization is declared
26 insolvent.

27 3. The individual satisfies the requirements of an eligible individual
28 as prescribed in this section other than the required period of creditable
29 coverage.

30 R. Notwithstanding subsection P of this section, a newborn child,
31 adopted child or child placed for adoption is an eligible individual if the
32 child was timely enrolled and otherwise would have met the definition of an
33 eligible individual as prescribed in this section other than the required
34 period of creditable coverage. ~~and The child is not subject to any~~
35 ~~preexisting condition exclusion or limitation. if the child has been~~
36 ~~continuously covered under health insurance coverage or a health benefits~~
37 ~~plan offered by an accountable health plan since birth, adoption or placement~~
38 ~~for adoption.~~

39 ~~S. If a health care insurer imposes a waiting period for coverage of~~
40 ~~preexisting conditions, within a reasonable period of time after receiving an~~
41 ~~individual's proof of creditable coverage and not later than the date by~~
42 ~~which the individual must select an insurance plan, the health care insurer~~
43 ~~shall give the individual written disclosure of the insurer's determination~~
44 ~~regarding any preexisting condition exclusion period that applies to that~~
45 ~~individual. The disclosure shall include all of the following information:~~

~~1. The period of creditable coverage allowed toward the waiting period for coverage of preexisting conditions.~~

~~2. The basis for the insurer's determination and the source and substance of any information on which the insurer has relied.~~

~~3. A statement of any right the individual may have to present additional evidence of creditable coverage and to appeal the insurer's determination, including an explanation of any procedures for submission and appeal.~~

~~T.~~ S. This section and section 20-1380 apply to all health insurance coverage that is offered, sold, issued, renewed, in effect or operated in the individual market after June 30, 1997, regardless of when a period of creditable coverage occurs.

~~U.~~ T. For the purposes of this section and section 20-1380 as applicable:

1. "Affiliation period" has the same meaning prescribed in section 20-2301.

2. "Bona fide association" means, for health care coverage issued by a health care insurer, an association that meets the requirements of section 20-2324.

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

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

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

(c) A health benefits plan issued by an accountable health plan as defined in section 20-2301.

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

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

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

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

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

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

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

(k) A health benefit plan pursuant to section 5(e) of the peace corps act (P.L. 87-293; 75 Stat. 612; 22 United States Code sections 2501 through 2523).

(l) A policy or contract, including short-term limited duration insurance, issued on an individual basis by an insurer, a health care

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

5 (m) A policy or contract issued by a health care insurer or an
6 accountable health plan to a member of a bona fide association.

7 4. "Delinquency proceeding" has the same meaning prescribed in section
8 20-611.

9 5. "Different policy forms" means variations between policy forms
10 offered by a health care insurer, including policy forms that have different
11 cost sharing arrangements or different riders.

12 6. "Genetic information" means information about genes, gene products
13 and inherited characteristics that may derive from the individual or a family
14 member, including information regarding carrier status and information
15 derived from laboratory tests that identify mutations in specific genes or
16 chromosomes, physical medical examinations, family histories and direct
17 ~~analysis~~ ANALYSES of genes or chromosomes.

18 7. "Health care insurer" means a disability insurer, group disability
19 insurer, blanket disability insurer, health care services organization,
20 hospital service corporation, medical service corporation or ~~a~~ hospital,
21 medical, dental and optometric service corporation.

22 8. "Health status-related factor" means any factor in relation to the
23 health of the individual or a dependent of the individual enrolled or to be
24 enrolled in a health care services organization including:

25 (a) Health status.

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

27 (c) Claims experience.

28 (d) Receipt of health care.

29 (e) Medical history.

30 (f) Genetic information.

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

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

34 9. "Higher level of coverage" means a policy form for which the
35 actuarial value of the benefits under the health insurance coverage offered
36 by a health care insurer is at least fifteen per cent more than the actuarial
37 value of the health insurance coverage offered by the health care insurer as
38 a lower level of coverage in this state but not more than one hundred twenty
39 per cent of a policy form weighted average.

40 10. "Individual health insurance coverage" means health insurance
41 coverage offered by a health care insurer to individuals in the individual
42 market but does not include limited benefit coverage or short-term limited
43 duration insurance. A health care insurer that offers limited benefit
44 coverage or short-term limited duration insurance to individuals and no other

1 coverage to individuals in the individual market is not a health care insurer
2 that offers health insurance coverage in the individual market.

3 11. "Limited benefit coverage" has the same meaning prescribed in
4 section 20-1137.

5 12. "Lower level of coverage" means a policy form offered by a health
6 care insurer for which the actuarial value of the benefits under the health
7 insurance coverage is at least eighty-five per cent but not more than one
8 hundred per cent of the policy form weighted average.

9 13. "Network plan" means a health care plan provided by a health care
10 insurer under which the financing and delivery of health care services are
11 provided, in whole or in part, through a defined set of providers either
12 under contract with a health care insurer licensed pursuant to chapter 4,
13 article 3 of this title or under contract with a health care insurer in
14 accordance with the determination made by the director pursuant to section
15 20-1053 regarding the geographic or service area in which a health care
16 insurer may operate.

17 14. "Policy form weighted average" means the average actuarial value of
18 the benefits provided by a health care insurer that issues health coverage in
19 this state that is provided by either the health care insurer or, if the data
20 are available, by all health care insurers that issue health coverage in this
21 state in the individual health coverage market during the previous calendar
22 year, except coverage pursuant to this section, weighted by the enrollment
23 for all coverage forms.

24 15. "Preexisting condition" means a condition, regardless of the cause
25 of the condition, for which medical advice, diagnosis, care or treatment was
26 recommended or received ~~within not more than six months~~ before the date of
27 the enrollment of the individual under the health insurance policy or other
28 contract that provides health coverage benefits. A genetic condition is not
29 a preexisting condition in the absence of a diagnosis of the condition
30 related to the genetic information and shall not result in a preexisting
31 condition limitation or preexisting condition exclusion.

32 16. "Preexisting condition limitation" or "preexisting condition
33 exclusion" means a limitation or exclusion of benefits for a preexisting
34 condition under a health insurance policy or other contract that provides
35 health coverage benefits.

36 17. "Short-term limited duration insurance" means health insurance
37 coverage that is offered by a health care insurer, that remains in effect for
38 no more than one hundred eighty-five days, that cannot be renewed or
39 otherwise continued for more than one hundred eighty days and that is not
40 intended or marketed as health insurance coverage subject to guaranteed
41 issuance or guaranteed renewal provisions of the laws of this state but that
42 is creditable coverage within the meaning of this section and section
43 20-2301.

1 Sec. 12. Section 20-1402, Arizona Revised Statutes, is amended to
2 read:

3 20-1402. Provisions of group disability policies; definitions

4 A. Each group disability policy shall contain in substance the
5 following provisions:

6 1. A provision that, in the absence of fraud, all statements made by
7 the policyholder or by any insured person shall be deemed representations and
8 not warranties, and that no statement made for the purpose of effecting
9 insurance shall avoid such insurance or reduce benefits unless contained in a
10 written instrument signed by the policyholder or the insured person, a copy
11 of which has been furnished to the policyholder or to the person or
12 beneficiary.

13 2. A provision that the insurer will furnish to the policyholder, for
14 delivery to each employee or member of the insured group, an individual
15 certificate setting forth in summary form a statement of the essential
16 features of the insurance coverage of the employee or member and to whom
17 benefits are payable. If dependents or family members are included in the
18 coverage additional certificates need not be issued for delivery to the
19 dependents or family members. Any policy, except accidental death and
20 dismemberment, applied for that provides family coverage, as to such coverage
21 of family members, shall also provide that the benefits applicable for
22 children shall be payable with respect to a newly born child of the insured
23 from the instant of such child's birth, to a child adopted by the insured,
24 regardless of the age at which the child was adopted, and to a child who has
25 been placed for adoption with the insured and for whom the application and
26 approval procedures for adoption pursuant to section 8-105 or 8-108 have been
27 completed to the same extent that such coverage applies to other members of
28 the family. The coverage for newly born or adopted children or children
29 placed for adoption shall include coverage of injury or sickness including
30 the necessary care and treatment of medically diagnosed congenital defects
31 and birth abnormalities. If payment of a specific premium is required to
32 provide coverage for a child, the policy may require that notification of
33 birth, adoption or adoption placement of the child and payment of the
34 required premium must be furnished to the insurer within thirty-one days
35 after the date of birth, adoption or adoption placement in order to have the
36 coverage continue beyond such thirty-one day period.

37 3. A provision that to the group originally insured may be added from
38 time to time eligible new employees or members or dependents, as the case may
39 be, in accordance with the terms of the policy.

40 4. Each contract shall be so written that the corporation shall pay
41 benefits:

42 (a) For performance of any surgical service that is covered by the
43 terms of such contract, regardless of the place of service.

44 (b) For any home health services that are performed by a licensed home
45 health agency and that a physician has prescribed in lieu of hospital

1 services, as defined by the director, providing the hospital services would
2 have been covered.

3 (c) For any diagnostic service that a physician has performed outside
4 a hospital in lieu of inpatient service, providing the inpatient service
5 would have been covered.

6 (d) For any service performed in a hospital's outpatient department or
7 in a freestanding surgical facility, providing such service would have been
8 covered if performed as an inpatient service.

9 5. A group disability insurance policy that provides coverage for the
10 surgical expense of a mastectomy shall also provide coverage incidental to
11 the patient's covered mastectomy for the expense of reconstructive surgery of
12 the breast on which the mastectomy was performed, surgery and reconstruction
13 of the other breast to produce a symmetrical appearance, prostheses,
14 treatment of physical complications for all stages of the mastectomy,
15 including lymphedemas, and at least two external postoperative prostheses
16 subject to all of the terms and conditions of the policy.

17 6. A contract, except a supplemental contract covering a specified
18 disease or other limited benefits, that provides coverage for surgical
19 services for a mastectomy shall also provide coverage for mammography
20 screening performed on dedicated equipment for diagnostic purposes on
21 referral by a patient's physician, subject to all of the terms and conditions
22 of the policy and according to the following guidelines:

23 (a) A baseline mammogram for a woman from age thirty-five to
24 thirty-nine.

25 (b) A mammogram for a woman from age forty to forty-nine every two
26 years or more frequently based on the recommendation of the woman's
27 physician.

28 (c) A mammogram every year for a woman fifty years of age and over.

29 7. Any contract that is issued to the insured and that provides
30 coverage for maternity benefits shall also provide that the maternity
31 benefits apply to the costs of the birth of any child legally adopted by the
32 insured if all the following are true:

33 (a) The child is adopted within one year of birth.

34 (b) The insured is legally obligated to pay the costs of birth.

35 (c) All ~~preexisting conditions and other~~ limitations have been met by
36 the insured.

37 (d) The insured has notified the insurer of the insured's
38 acceptability to adopt children pursuant to section 8-105, within sixty days
39 after such approval or within sixty days after a change in insurance
40 policies, plans or companies.

41 8. The coverage prescribed by paragraph 7 of this subsection is excess
42 to any other coverage the natural mother may have for maternity benefits
43 except coverage made available to persons pursuant to title 36, chapter 29,
44 but not including coverage made available to persons defined as eligible
45 under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If

1 such other coverage exists the agency, attorney or individual arranging the
2 adoption shall make arrangements for the insurance to pay those costs that
3 may be covered under that policy and shall advise the adopting parent in
4 writing of the existence and extent of the coverage without disclosing any
5 confidential information such as the identity of the natural parent. The
6 insured adopting parents shall notify their insurer of the existence and
7 extent of the other coverage.

8 B. Any policy that provides maternity benefits shall not restrict
9 benefits for any hospital length of stay in connection with childbirth for
10 the mother or the newborn child to less than forty-eight hours following a
11 normal vaginal delivery or ninety-six hours following a cesarean section.
12 The policy shall not require the provider to obtain authorization from the
13 insurer for prescribing the minimum length of stay required by this
14 subsection. The policy may provide that an attending provider in
15 consultation with the mother may discharge the mother or the newborn child
16 before the expiration of the minimum length of stay required by this
17 subsection. The insurer shall not:

18 1. Deny the mother or the newborn child eligibility or continued
19 eligibility to enroll or to renew coverage under the terms of the policy
20 solely for the purpose of avoiding the requirements of this subsection.

21 2. Provide monetary payments or rebates to mothers to encourage those
22 mothers to accept less than the minimum protections available pursuant to
23 this subsection.

24 3. Penalize or otherwise reduce or limit the reimbursement of an
25 attending provider because that provider provided care to any insured under
26 the policy in accordance with this subsection.

27 4. Provide monetary or other incentives to an attending provider to
28 induce that provider to provide care to an insured under the policy in a
29 manner that is inconsistent with this subsection.

30 5. Except as described in subsection C of this section, restrict
31 benefits for any portion of a period within the minimum length of stay in a
32 manner that is less favorable than the benefits provided for any preceding
33 portion of that stay.

34 C. Nothing in subsection B of this section:

35 1. Requires a mother to give birth in a hospital or to stay in the
36 hospital for a fixed period of time following the birth of the child.

37 2. Prevents an insurer from imposing deductibles, coinsurance or other
38 cost sharing in relation to benefits for hospital lengths of stay in
39 connection with childbirth for a mother or a newborn child under the policy,
40 except that any coinsurance or other cost sharing for any portion of a period
41 within a hospital length of stay required pursuant to subsection B of this
42 section shall not be greater than the coinsurance or cost sharing for any
43 preceding portion of that stay.

1 3. Prevents an insurer from negotiating the level and type of
2 reimbursement with a provider for care provided in accordance with
3 subsection B of this section.

4 D. Any contract that provides coverage for diabetes shall also provide
5 coverage for equipment and supplies that are medically necessary and that are
6 prescribed by a health care provider including:

- 7 1. Blood glucose monitors.
- 8 2. Blood glucose monitors for the legally blind.
- 9 3. Test strips for glucose monitors and visual reading and urine
10 testing strips.
- 11 4. Insulin preparations and glucagon.
- 12 5. Insulin cartridges.
- 13 6. Drawing up devices and monitors for the visually impaired.
- 14 7. Injection aids.
- 15 8. Insulin cartridges for the legally blind.
- 16 9. Syringes and lancets including automatic lancing devices.
- 17 10. Prescribed oral agents for controlling blood sugar that are
18 included on the plan formulary.

19 11. To the extent coverage is required under medicare, podiatric
20 appliances for prevention of complications associated with diabetes.

21 12. Any other device, medication, equipment or supply for which
22 coverage is required under medicare from and after January 1, 1999. The
23 coverage required in this paragraph is effective six months after the
24 coverage is required under medicare.

25 E. Nothing in subsection D of this section prohibits a group
26 disability insurer from imposing deductibles, coinsurance or other cost
27 sharing in relation to benefits for equipment or supplies for the treatment
28 of diabetes.

29 F. Any contract that provides coverage for prescription drugs shall
30 not limit or exclude coverage for any prescription drug prescribed for the
31 treatment of cancer on the basis that the prescription drug has not been
32 approved by the United States food and drug administration for the treatment
33 of the specific type of cancer for which the prescription drug has been
34 prescribed, if the prescription drug has been recognized as safe and
35 effective for treatment of that specific type of cancer in one or more of the
36 standard medical reference compendia prescribed in subsection G of this
37 section or medical literature that meets the criteria prescribed in
38 subsection G of this section. The coverage required under this subsection
39 includes covered medically necessary services associated with the
40 administration of the prescription drug. This subsection does not:

- 41 1. Require coverage of any prescription drug used in the treatment of
42 a type of cancer if the United States food and drug administration has
43 determined that the prescription drug is contraindicated for that type of
44 cancer.

1 2. Require coverage for any experimental prescription drug that is not
2 approved for any indication by the United States food and drug
3 administration.

4 3. Alter any law with regard to provisions that limit the coverage of
5 prescription drugs that have not been approved by the United States food and
6 drug administration.

7 4. Require reimbursement or coverage for any prescription drug that is
8 not included in the drug formulary or list of covered prescription drugs
9 specified in the contract.

10 5. Prohibit a contract from limiting or excluding coverage of a
11 prescription drug, if the decision to limit or exclude coverage of the
12 prescription drug is not based primarily on the coverage of prescription
13 drugs required by this section.

14 6. Prohibit the use of deductibles, coinsurance, copayments or other
15 cost sharing in relation to drug benefits and related medical benefits
16 offered.

17 G. For the purposes of subsection F of this section:

18 1. The acceptable standard medical reference compendia are the
19 following:

20 (a) The American hospital formulary service drug information, a
21 publication of the American society of health system pharmacists.

22 (b) The national comprehensive cancer network drugs and biologics
23 compendium.

24 (c) Thomson Micromedex compendium DrugDex.

25 (d) Elsevier gold standard's clinical pharmacology compendium.

26 (e) Other authoritative compendia as identified by the secretary of
27 the United States department of health and human services.

28 2. Medical literature may be accepted if all of the following apply:

29 (a) At least two articles from major peer reviewed professional
30 medical journals have recognized, based on scientific or medical criteria,
31 the drug's safety and effectiveness for treatment of the indication for which
32 the drug has been prescribed.

33 (b) No article from a major peer reviewed professional medical journal
34 has concluded, based on scientific or medical criteria, that the drug is
35 unsafe or ineffective or that the drug's safety and effectiveness cannot be
36 determined for the treatment of the indication for which the drug has been
37 prescribed.

38 (c) The literature meets the uniform requirements for manuscripts
39 submitted to biomedical journals established by the international committee
40 of medical journal editors or is published in a journal specified by the
41 United States department of health and human services as acceptable peer
42 reviewed medical literature pursuant to section 186(t)(2)(B) of the social
43 security act (42 United States Code section 1395x(t)(2)(B)).

1 H. Any contract that is offered by a group disability insurer and that
2 contains a prescription drug benefit shall provide coverage of medical foods
3 to treat inherited metabolic disorders as provided by this section.

4 I. The metabolic disorders triggering medical foods coverage under
5 this section shall:

6 1. Be part of the newborn screening program prescribed in section
7 36-694.

8 2. Involve amino acid, carbohydrate or fat metabolism.

9 3. Have medically standard methods of diagnosis, treatment and
10 monitoring including quantification of metabolites in blood, urine or spinal
11 fluid or enzyme or DNA confirmation in tissues.

12 4. Require specially processed or treated medical foods that are
13 generally available only under the supervision and direction of a physician
14 who is licensed pursuant to title 32, chapter 13 or 17 or a registered nurse
15 practitioner who is licensed pursuant to title 32, chapter 15, that must be
16 consumed throughout life and without which the person may suffer serious
17 mental or physical impairment.

18 J. Medical foods eligible for coverage under this section shall be
19 prescribed or ordered under the supervision of a physician licensed pursuant
20 to title 32, chapter 13 or 17 or a registered nurse practitioner who is
21 licensed pursuant to title 32, chapter 15 as medically necessary for the
22 therapeutic treatment of an inherited metabolic disease.

23 K. An insurer shall cover at least fifty per cent of the cost of
24 medical foods prescribed to treat inherited metabolic disorders and covered
25 pursuant to this section. An insurer may limit the maximum annual benefit
26 for medical foods under this section to five thousand dollars, which applies
27 to the cost of all prescribed modified low protein foods and metabolic
28 formula.

29 L. Any group disability policy that provides coverage for:

30 1. Prescription drugs shall also provide coverage for any prescribed
31 drug or device that is approved by the United States food and drug
32 administration for use as a contraceptive. A group disability insurer may
33 use a drug formulary, multitiered drug formulary or list but that formulary
34 or list shall include oral, implant and injectable contraceptive drugs,
35 intrauterine devices and prescription barrier methods if the group disability
36 insurer does not impose deductibles, coinsurance, copayments or other cost
37 containment measures for contraceptive drugs that are greater than the
38 deductibles, coinsurance, copayments or other cost containment measures for
39 other drugs on the same level of the formulary or list.

40 2. Outpatient health care services shall also provide coverage for
41 outpatient contraceptive services. For the purposes of this paragraph,
42 "outpatient contraceptive services" means consultations, examinations,
43 procedures and medical services provided on an outpatient basis and related
44 to the use of approved United States food and drug administration
45 prescription contraceptive methods to prevent unintended pregnancies.

1 M. Notwithstanding subsection L of this section, a religious employer
2 whose religious tenets prohibit the use of prescribed contraceptive methods
3 may require that the insurer provide a group disability policy without
4 coverage for all United States food and drug administration approved
5 contraceptive methods. A religious employer shall submit a written affidavit
6 to the insurer stating that it is a religious employer. On receipt of the
7 affidavit, the insurer shall issue to the religious employer a group
8 disability policy that excludes coverage of prescription contraceptive
9 methods. The insurer shall retain the affidavit for the duration of the
10 group disability policy and any renewals of the policy. Before a policy is
11 issued, every religious employer that invokes this exemption shall provide
12 prospective insureds written notice that the religious employer refuses to
13 cover all United States food and drug administration approved contraceptive
14 methods for religious reasons. This subsection shall not exclude coverage
15 for prescription contraceptive methods ordered by a health care provider with
16 prescriptive authority for medical indications other than to prevent an
17 unintended pregnancy. An insurer may require the insured to first pay for
18 the prescription and then submit a claim to the insurer along with evidence
19 that the prescription is for a noncontraceptive purpose. An insurer may
20 charge an administrative fee for handling these claims. A religious employer
21 shall not discriminate against an employee who independently chooses to
22 obtain insurance coverage or prescriptions for contraceptives from another
23 source.

24 N. For the purposes of:

25 1. This section:

26 (a) "Inherited metabolic disorder" means a disease caused by an
27 inherited abnormality of body chemistry and includes a disease tested under
28 the newborn screening program prescribed in section 36-694.

29 (b) "Medical foods" means modified low protein foods and metabolic
30 formula.

31 (c) "Metabolic formula" means foods that are all of the following:

32 (i) Formulated to be consumed or administered enterally under the
33 supervision of a physician who is licensed pursuant to title 32, chapter 13
34 or 17 or a registered nurse practitioner who is licensed pursuant to title
35 32, chapter 15.

36 (ii) Processed or formulated to be deficient in one or more of the
37 nutrients present in typical foodstuffs.

38 (iii) Administered for the medical and nutritional management of a
39 person who has limited capacity to metabolize foodstuffs or certain nutrients
40 contained in the foodstuffs or who has other specific nutrient requirements
41 as established by medical evaluation.

42 (iv) Essential to a person's optimal growth, health and metabolic
43 homeostasis.

1 (d) "Modified low protein foods" means foods that are all of the
2 following:

3 (i) Formulated to be consumed or administered enterally under the
4 supervision of a physician who is licensed pursuant to title 32, chapter 13
5 or 17 or a registered nurse practitioner who is licensed pursuant to title
6 32, chapter 15.

7 (ii) Processed or formulated to contain less than one gram of protein
8 per unit of serving, but does not include a natural food that is naturally
9 low in protein.

10 (iii) Administered for the medical and nutritional management of a
11 person who has limited capacity to metabolize foodstuffs or certain nutrients
12 contained in the foodstuffs or who has other specific nutrient requirements
13 as established by medical evaluation.

14 (iv) Essential to a person's optimal growth, health and metabolic
15 homeostasis.

16 2. Subsection A of this section, the term "child", for purposes of
17 initial coverage of an adopted child or a child placed for adoption but not
18 for purposes of termination of coverage of such child, means a person under
19 ~~the age of~~ eighteen years **OF AGE**.

20 3. Subsection M of this section, "religious employer" means an entity
21 for which all of the following apply:

22 (a) The entity primarily employs persons who share the religious
23 tenets of the entity.

24 (b) The entity serves primarily persons who share the religious tenets
25 of the entity.

26 (c) The entity is a nonprofit organization as described in section
27 6033(a)(2)(A)(i) or (iii) of the internal revenue code of 1986, as amended.

28 Sec. 13. Title 20, chapter 6, article 5, Arizona Revised Statutes, is
29 amended by adding section 20-1402.04, to read:

30 **20-1402.04. Group disability policies: preexisting condition**
31 **limitations or exclusions: prohibition:**
32 **definitions**

33 **A. A POLICY ISSUED BY A GROUP DISABILITY INSURER SHALL NOT IMPOSE ANY**
34 **PREEXISTING CONDITION LIMITATIONS OR EXCLUSIONS RELATING TO ANY PREEXISTING**
35 **CONDITION.**

36 **B. FOR THE PURPOSES OF THIS SECTION:**

37 **1. "PREEXISTING CONDITION" MEANS A CONDITION, REGARDLESS OF THE CAUSE**
38 **OF THE CONDITION, FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WAS**
39 **RECOMMENDED OR RECEIVED BEFORE THE DATE OF THE ENROLLMENT OF THE INDIVIDUAL**
40 **UNDER A HEALTH INSURANCE POLICY OR OTHER CONTRACT THAT PROVIDES HEALTH**
41 **COVERAGE BENEFITS. A GENETIC CONDITION IS NOT A PREEXISTING CONDITION IN THE**
42 **ABSENCE OF A DIAGNOSIS OF THE CONDITION RELATED TO THE GENETIC INFORMATION**
43 **AND SHALL NOT RESULT IN A PREEXISTING CONDITION LIMITATION OR PREEXISTING**
44 **CONDITION EXCLUSION.**

1 2. "PREEXISTING CONDITION LIMITATION" OR "PREEXISTING CONDITION
2 EXCLUSION" MEANS A LIMITATION OR EXCLUSION OF BENEFITS FOR A PREEXISTING
3 CONDITION UNDER A HEALTH INSURANCE POLICY OR OTHER CONTRACT THAT PROVIDES
4 HEALTH COVERAGE BENEFITS.

5 Sec. 14. Section 20-1404, Arizona Revised Statutes, is amended to
6 read:

7 20-1404. Blanket disability insurance; definitions

8 A. Blanket disability insurance is that form of disability insurance
9 covering special groups of persons as enumerated in one of the following
10 paragraphs:

11 1. Under a policy or contract issued to any common carrier, which
12 shall be deemed the policyholder, covering a group defined as all persons who
13 may become passengers on such common carrier.

14 2. Under a policy or contract issued to an employer, who shall be
15 deemed the policyholder, covering all employees or any group of employees
16 defined by reference to exceptional hazards incident to such employment.
17 Dependents of the employees and guests of the employer may also be included
18 where exposed to the same hazards.

19 3. Under a policy or contract issued to a college, school or other
20 institution of learning or to the head or principal thereof, who or which
21 shall be deemed the policyholder, covering students or teachers.

22 4. Under a policy or contract issued in the name of any volunteer fire
23 department or first aid or other such volunteer group, or agency having
24 jurisdiction thereof, which shall be deemed the policyholder, covering all of
25 the members of such fire department or group.

26 5. Under a policy or contract issued to a creditor, who shall be
27 deemed the policyholder, to insure debtors of the creditor.

28 6. Under a policy or contract issued to a sports team or to a camp or
29 sponsor thereof, which team or camp or sponsor thereof shall be deemed the
30 policyholder, covering members or campers.

31 7. Under a policy or contract that is issued to any other
32 substantially similar group and that, in the discretion of the director, may
33 be subject to the issuance of a blanket disability policy or contract.

34 B. An individual application need not be required from a person
35 covered under a blanket disability policy or contract, nor shall it be
36 necessary for the insurer to furnish each person with a certificate.

37 C. All benefits under any blanket disability policy shall be payable
38 to the person insured, or to the insured's designated beneficiary or
39 beneficiaries, or to the insured's estate, except that if the person insured
40 is a minor, such benefits may be made payable to the insured's parent or
41 guardian or any other person actually supporting the insured, and except that
42 the policy may provide that all or any portion of any indemnities provided by
43 any such policy on account of hospital, nursing, medical or surgical
44 services, at the insurer's option, may be paid directly to the hospital or
45 person rendering such services, but the policy may not require that the

1 service be rendered by a particular hospital or person. Payment so made
2 shall discharge the insurer's obligation with respect to the amount of
3 insurance so paid.

4 D. Nothing contained in this section shall be deemed to affect the
5 legal liability of policyholders for the death of or injury to any member of
6 the group.

7 E. Any policy or contract, except accidental death and dismemberment,
8 applied for that provides family coverage, as to such coverage of family
9 members, shall also provide that the benefits applicable for children shall
10 be payable with respect to a newly born child of the insured from the instant
11 of such child's birth, to a child adopted by the insured, regardless of the
12 age at which the child was adopted, and to a child who has been placed for
13 adoption with the insured and for whom the application and approval
14 procedures for adoption pursuant to section 8-105 or 8-108 have been
15 completed to the same extent that such coverage applies to other members of
16 the family. The coverage for newly born or adopted children or children
17 placed for adoption shall include coverage of injury or sickness including
18 necessary care and treatment of medically diagnosed congenital defects and
19 birth abnormalities. If payment of a specific premium is required to provide
20 coverage for a child, the policy or contract may require that notification of
21 birth, adoption or adoption placement of the child and payment of the
22 required premium must be furnished to the insurer within thirty-one days
23 after the date of birth, adoption or adoption placement in order to have the
24 coverage continue beyond the thirty-one day period.

25 F. Each policy or contract shall be so written that the insurer shall
26 pay benefits:

27 1. For performance of any surgical service that is covered by the
28 terms of such contract, regardless of the place of service.

29 2. For any home health services that are performed by a licensed home
30 health agency and that a physician has prescribed in lieu of hospital
31 services, as defined by the director, providing the hospital services would
32 have been covered.

33 3. For any diagnostic service that a physician has performed outside a
34 hospital in lieu of inpatient service, providing the inpatient service would
35 have been covered.

36 4. For any service performed in a hospital's outpatient department or
37 in a freestanding surgical facility, providing such service would have been
38 covered if performed as an inpatient service.

39 G. A blanket disability insurance policy that provides coverage for
40 the surgical expense of a mastectomy shall also provide coverage incidental
41 to the patient's covered mastectomy for the expense of reconstructive surgery
42 of the breast on which the mastectomy was performed, surgery and
43 reconstruction of the other breast to produce a symmetrical appearance,
44 prostheses, treatment of physical complications for all stages of the

1 mastectomy, including lymphedemas, and at least two external postoperative
2 prostheses subject to all of the terms and conditions of the policy.

3 H. A contract that provides coverage for surgical services for a
4 mastectomy shall also provide coverage for mammography screening performed on
5 dedicated equipment for diagnostic purposes on referral by a patient's
6 physician, subject to all of the terms and conditions of the policy and
7 according to the following guidelines:

8 1. A baseline mammogram for a woman from age thirty-five to
9 thirty-nine.

10 2. A mammogram for a woman from age forty to forty-nine every two
11 years or more frequently based on the recommendation of the woman's
12 physician.

13 3. A mammogram every year for a woman fifty years of age and over.

14 I. Any contract that is issued to the insured and that provides
15 coverage for maternity benefits shall also provide that the maternity
16 benefits apply to the costs of the birth of any child legally adopted by the
17 insured if all the following are true:

18 1. The child is adopted within one year of birth.

19 2. The insured is legally obligated to pay the costs of birth.

20 3. All ~~preexisting conditions and other~~ limitations have been met by
21 the insured.

22 4. The insured has notified the insurer of his acceptability to adopt
23 children pursuant to section 8-105, within sixty days after such approval or
24 within sixty days after a change in insurance policies, plans or companies.

25 J. The coverage prescribed by subsection I of this section is excess
26 to any other coverage the natural mother may have for maternity benefits
27 except coverage made available to persons pursuant to title 36, chapter 29,
28 but not including coverage made available to persons defined as eligible
29 under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If
30 such other coverage exists the agency, attorney or individual arranging the
31 adoption shall make arrangements for the insurance to pay those costs that
32 may be covered under that policy and shall advise the adopting parent in
33 writing of the existence and extent of the coverage without disclosing any
34 confidential information such as the identity of the natural parent. The
35 insured adopting parents shall notify their insurer of the existence and
36 extent of the other coverage.

37 K. Any contract that provides maternity benefits shall not restrict
38 benefits for any hospital length of stay in connection with childbirth for
39 the mother or the newborn child to less than forty-eight hours following a
40 normal vaginal delivery or ninety-six hours following a cesarean section.
41 The contract shall not require the provider to obtain authorization from the
42 insurer for prescribing the minimum length of stay required by this
43 subsection. The contract may provide that an attending provider in
44 consultation with the mother may discharge the mother or the newborn child

1 before the expiration of the minimum length of stay required by this
2 subsection. The insurer shall not:

3 1. Deny the mother or the newborn child eligibility or continued
4 eligibility to enroll or to renew coverage under the terms of the contract
5 solely for the purpose of avoiding the requirements of this subsection.

6 2. Provide monetary payments or rebates to mothers to encourage those
7 mothers to accept less than the minimum protections available pursuant to
8 this subsection.

9 3. Penalize or otherwise reduce or limit the reimbursement of an
10 attending provider because that provider provided care to any insured under
11 the contract in accordance with this subsection.

12 4. Provide monetary or other incentives to an attending provider to
13 induce that provider to provide care to an insured under the contract in a
14 manner that is inconsistent with this subsection.

15 5. Except as described in subsection L of this section, restrict
16 benefits for any portion of a period within the minimum length of stay in a
17 manner that is less favorable than the benefits provided for any preceding
18 portion of that stay.

19 L. Nothing in subsection K of this section:

20 1. Requires a mother to give birth in a hospital or to stay in the
21 hospital for a fixed period of time following the birth of the child.

22 2. Prevents an insurer from imposing deductibles, coinsurance or other
23 cost sharing in relation to benefits for hospital lengths of stay in
24 connection with childbirth for a mother or a newborn child under the
25 contract, except that any coinsurance or other cost sharing for any portion
26 of a period within a hospital length of stay required pursuant to subsection
27 K of this section shall not be greater than the coinsurance or cost sharing
28 for any preceding portion of that stay.

29 3. Prevents an insurer from negotiating the level and type of
30 reimbursement with a provider for care provided in accordance with subsection
31 K of this section.

32 M. Any contract that provides coverage for diabetes shall also provide
33 coverage for equipment and supplies that are medically necessary and that are
34 prescribed by a health care provider including:

35 1. Blood glucose monitors.

36 2. Blood glucose monitors for the legally blind.

37 3. Test strips for glucose monitors and visual reading and urine
38 testing strips.

39 4. Insulin preparations and glucagon.

40 5. Insulin cartridges.

41 6. Drawing up devices and monitors for the visually impaired.

42 7. Injection aids.

43 8. Insulin cartridges for the legally blind.

44 9. Syringes and lancets including automatic lancing devices.

1 10. Prescribed oral agents for controlling blood sugar that are
2 included on the plan formulary.

3 11. To the extent coverage is required under medicare, podiatric
4 appliances for prevention of complications associated with diabetes.

5 12. Any other device, medication, equipment or supply for which
6 coverage is required under medicare from and after January 1, 1999. The
7 coverage required in this paragraph is effective six months after the
8 coverage is required under medicare.

9 N. Nothing in subsection M of this section prohibits a blanket
10 disability insurer from imposing deductibles, coinsurance or other cost
11 sharing in relation to benefits for equipment or supplies for the treatment
12 of diabetes.

13 O. Any contract that provides coverage for prescription drugs shall
14 not limit or exclude coverage for any prescription drug prescribed for the
15 treatment of cancer on the basis that the prescription drug has not been
16 approved by the United States food and drug administration for the treatment
17 of the specific type of cancer for which the prescription drug has been
18 prescribed, if the prescription drug has been recognized as safe and
19 effective for treatment of that specific type of cancer in one or more of the
20 standard medical reference compendia prescribed in subsection P of this
21 section or medical literature that meets the criteria prescribed in
22 subsection P of this section. The coverage required under this subsection
23 includes covered medically necessary services associated with the
24 administration of the prescription drug. This subsection does not:

25 1. Require coverage of any prescription drug used in the treatment of
26 a type of cancer if the United States food and drug administration has
27 determined that the prescription drug is contraindicated for that type of
28 cancer.

29 2. Require coverage for any experimental prescription drug that is not
30 approved for any indication by the United States food and drug
31 administration.

32 3. Alter any law with regard to provisions that limit the coverage of
33 prescription drugs that have not been approved by the United States food and
34 drug administration.

35 4. Require reimbursement or coverage for any prescription drug that is
36 not included in the drug formulary or list of covered prescription drugs
37 specified in the contract.

38 5. Prohibit a contract from limiting or excluding coverage of a
39 prescription drug, if the decision to limit or exclude coverage of the
40 prescription drug is not based primarily on the coverage of prescription
41 drugs required by this section.

42 6. Prohibit the use of deductibles, coinsurance, copayments or other
43 cost sharing in relation to drug benefits and related medical benefits
44 offered.

1 P. For the purposes of subsection 0 of this section:

2 1. The acceptable standard medical reference compendia are the
3 following:

4 (a) The American hospital formulary service drug information, a
5 publication of the American society of health system pharmacists.

6 (b) The national comprehensive cancer network drugs and biologics
7 compendium.

8 (c) Thomson Micromedex compendium DrugDex.

9 (d) Elsevier gold standard's clinical pharmacology compendium.

10 (e) Other authoritative compendia as identified by the secretary of
11 the United States department of health and human services.

12 2. Medical literature may be accepted if all of the following apply:

13 (a) At least two articles from major peer reviewed professional
14 medical journals have recognized, based on scientific or medical criteria,
15 the drug's safety and effectiveness for treatment of the indication for which
16 the drug has been prescribed.

17 (b) No article from a major peer reviewed professional medical journal
18 has concluded, based on scientific or medical criteria, that the drug is
19 unsafe or ineffective or that the drug's safety and effectiveness cannot be
20 determined for the treatment of the indication for which the drug has been
21 prescribed.

22 (c) The literature meets the uniform requirements for manuscripts
23 submitted to biomedical journals established by the international committee
24 of medical journal editors or is published in a journal specified by the
25 United States department of health and human services as acceptable peer
26 reviewed medical literature pursuant to section 186(t)(2)(B) of the social
27 security act (42 United States Code section 1395x(t)(2)(B)).

28 Q. Any contract that is offered by a blanket disability insurer and
29 that contains a prescription drug benefit shall provide coverage of medical
30 foods to treat inherited metabolic disorders as provided by this section.

31 R. The metabolic disorders triggering medical foods coverage under
32 this section shall:

33 1. Be part of the newborn screening program prescribed in section
34 36-694.

35 2. Involve amino acid, carbohydrate or fat metabolism.

36 3. Have medically standard methods of diagnosis, treatment and
37 monitoring including quantification of metabolites in blood, urine or spinal
38 fluid or enzyme or DNA confirmation in tissues.

39 4. Require specially processed or treated medical foods that are
40 generally available only under the supervision and direction of a physician
41 who is licensed pursuant to title 32, chapter 13 or 17 or a registered nurse
42 practitioner who is licensed pursuant to title 32, chapter 15, that must be
43 consumed throughout life and without which the person may suffer serious
44 mental or physical impairment.

1 S. Medical foods eligible for coverage under this section shall be
2 prescribed or ordered under the supervision of a physician licensed pursuant
3 to title 32, chapter 13 or 17 or a registered nurse practitioner who is
4 licensed pursuant to title 32, chapter 15 as medically necessary for the
5 therapeutic treatment of an inherited metabolic disease.

6 T. An insurer shall cover at least fifty per cent of the cost of
7 medical foods prescribed to treat inherited metabolic disorders and covered
8 pursuant to this section. An insurer may limit the maximum annual benefit
9 for medical foods under this section to five thousand dollars which applies
10 to the cost of all prescribed modified low protein foods and metabolic
11 formula.

12 U. Any blanket disability policy that provides coverage for:

13 1. Prescription drugs shall also provide coverage for any prescribed
14 drug or device that is approved by the United States food and drug
15 administration for use as a contraceptive. A blanket disability insurer may
16 use a drug formulary, multitiered drug formulary or list but that formulary
17 or list shall include oral, implant and injectable contraceptive drugs,
18 intrauterine devices and prescription barrier methods if the blanket
19 disability insurer does not impose deductibles, coinsurance, copayments or
20 other cost containment measures for contraceptive drugs that are greater than
21 the deductibles, coinsurance, copayments or other cost containment measures
22 for other drugs on the same level of the formulary or list.

23 2. Outpatient health care services shall also provide coverage for
24 outpatient contraceptive services. For the purposes of this paragraph,
25 "outpatient contraceptive services" means consultations, examinations,
26 procedures and medical services provided on an outpatient basis and related
27 to the use of approved United States food and drug administration
28 prescription contraceptive methods to prevent unintended pregnancies.

29 V. Notwithstanding subsection U of this section, a religious employer
30 whose religious tenets prohibit the use of prescribed contraceptive methods
31 may require that the insurer provide a blanket disability policy without
32 coverage for all United States food and drug administration approved
33 contraceptive methods. A religious employer shall submit a written affidavit
34 to the insurer stating that it is a religious employer. On receipt of the
35 affidavit, the insurer shall issue to the religious employer a blanket
36 disability policy that excludes coverage of prescription contraceptive
37 methods. The insurer shall retain the affidavit for the duration of the
38 blanket disability policy and any renewals of the policy. Before a policy is
39 issued, every religious employer that invokes this exemption shall provide
40 prospective insureds written notice that the religious employer refuses to
41 cover all United States food and drug administration approved contraceptive
42 methods for religious reasons. This subsection shall not exclude coverage
43 for prescription contraceptive methods ordered by a health care provider with
44 prescriptive authority for medical indications other than to prevent an
45 unintended pregnancy. An insurer may require the insured to first pay for

1 the prescription and then submit a claim to the insurer along with evidence
 2 that the prescription is for a noncontraceptive purpose. An insurer may
 3 charge an administrative fee for handling these claims under this subsection.
 4 A religious employer shall not discriminate against an employee who
 5 independently chooses to obtain insurance coverage or prescriptions for
 6 contraceptives from another source.

7 W. For the purposes of:

8 1. This section:

9 (a) "Inherited metabolic disorder" means a disease caused by an
 10 inherited abnormality of body chemistry and includes a disease tested under
 11 the newborn screening program prescribed in section 36-694.

12 (b) "Medical foods" means modified low protein foods and metabolic
 13 formula.

14 (c) "Metabolic formula" means foods that are all of the following:

15 (i) Formulated to be consumed or administered enterally under the
 16 supervision of a physician who is licensed pursuant to title 32, chapter 13
 17 or 17 or a registered nurse practitioner who is licensed pursuant to title
 18 32, chapter 15.

19 (ii) Processed or formulated to be deficient in one or more of the
 20 nutrients present in typical foodstuffs.

21 (iii) Administered for the medical and nutritional management of a
 22 person who has limited capacity to metabolize foodstuffs or certain nutrients
 23 contained in the foodstuffs or who has other specific nutrient requirements
 24 as established by medical evaluation.

25 (iv) Essential to a person's optimal growth, health and metabolic
 26 homeostasis.

27 (d) "Modified low protein foods" means foods that are all of the
 28 following:

29 (i) Formulated to be consumed or administered enterally under the
 30 supervision of a physician who is licensed pursuant to title 32, chapter 13
 31 or 17 or a registered nurse practitioner who is licensed pursuant to title
 32 32, chapter 15.

33 (ii) Processed or formulated to contain less than one gram of protein
 34 per unit of serving, but does not include a natural food that is naturally
 35 low in protein.

36 (iii) Administered for the medical and nutritional management of a
 37 person who has limited capacity to metabolize foodstuffs or certain nutrients
 38 contained in the foodstuffs or who has other specific nutrient requirements
 39 as established by medical evaluation.

40 (iv) Essential to a person's optimal growth, health and metabolic
 41 homeostasis.

42 2. Subsection E of this section, the term "child", for purposes of
 43 initial coverage of an adopted child or a child placed for adoption but not
 44 for purposes of termination of coverage of such child, means a person under
 45 ~~the age of~~ eighteen years **OF AGE**.

1 3. Subsection V of this section, "religious employer" means an entity
2 for which all of the following apply:

3 (a) The entity primarily employs persons who share the religious
4 tenets of the entity.

5 (b) The entity serves primarily persons who share the religious tenets
6 of the entity.

7 (c) The entity is a nonprofit organization as described in section
8 6033(a)(2)(A)(i) or (iii) of the internal revenue code of 1986, as amended.

9 Sec. 15. Title 20, chapter 6, article 5, Arizona Revised Statutes, is
10 amended by adding section 20-1404.04, to read:

11 20-1404.04. Blanket disability policies; preexisting condition
12 limitations or exclusions; prohibition;
13 definitions

14 A. A POLICY ISSUED BY A BLANKET DISABILITY INSURER SHALL NOT IMPOSE
15 ANY PREEXISTING CONDITION LIMITATIONS OR EXCLUSIONS RELATING TO ANY
16 PREEXISTING CONDITION.

17 B. FOR THE PURPOSES OF THIS SECTION:

18 1. "PREEXISTING CONDITION" MEANS A CONDITION, REGARDLESS OF THE CAUSE
19 OF THE CONDITION, FOR WHICH MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WAS
20 RECOMMENDED OR RECEIVED BEFORE THE DATE OF THE ENROLLMENT OF THE INDIVIDUAL
21 UNDER A HEALTH INSURANCE POLICY OR OTHER CONTRACT THAT PROVIDES HEALTH
22 COVERAGE BENEFITS. A GENETIC CONDITION IS NOT A PREEXISTING CONDITION IN THE
23 ABSENCE OF A DIAGNOSIS OF THE CONDITION RELATED TO THE GENETIC INFORMATION
24 AND SHALL NOT RESULT IN A PREEXISTING CONDITION LIMITATION OR PREEXISTING
25 CONDITION EXCLUSION.

26 2. "PREEXISTING CONDITION LIMITATION" OR "PREEXISTING CONDITION
27 EXCLUSION" MEANS A LIMITATION OR EXCLUSION OF BENEFITS FOR A PREEXISTING
28 CONDITION UNDER A HEALTH INSURANCE POLICY OR OTHER CONTRACT THAT PROVIDES
29 HEALTH COVERAGE BENEFITS.

30 Sec. 16. Section 20-1408, Arizona Revised Statutes, is amended to
31 read:

32 20-1408. Right to obtain individual policy; requirements;
33 exceptions; definition

34 A. Each group disability insurance policy delivered or issued for
35 delivery in this state shall provide for the right of all persons covered
36 under the group contract to convert to an individual disability policy on the
37 death of the named insured, the entry of a decree of dissolution of marriage
38 or any other condition other than the failure of the insured to pay the
39 required premium specifically stated in the policy under which coverage would
40 otherwise terminate as to a covered spouse or covered dependent children of
41 the named insured.

42 B. All persons exercising their right to an individual disability
43 policy under subsection A OF THIS SECTION are entitled to have an individual
44 disability policy issued to them by the issuer on a form provided for
45 conversion which provides coverage most similar to that provided under the

1 group policy. Each person entitled to have a conversion policy issued to him
2 may elect a lesser form of coverage.

3 C. A written application and the first premium payment for the
4 converted policy shall be made to the insurer within thirty-one days
5 following termination of coverage under the existing policy. A monthly
6 premium rate shall be offered to the person exercising continuation or
7 conversion rights, and payment of one monthly premium shall be deemed
8 sufficient consideration to enact the continuation or conversion policy. The
9 effective date of the conversion policy is the day following the termination
10 of insurance under the group policy.

11 D. Coverage provided through the conversion policy shall be without
12 additional evidence of insurability and shall not impose any preexisting
13 condition limitations, exclusions or other contractual time limitations other
14 than those remaining unexpired under the policy or contract from which
15 conversion is exercised.

16 E. Conversion of coverage ~~may~~, at the option of the spouse exercising
17 the right, ~~MAY~~ include covered dependent children for whom the spouse has
18 responsibility for care or support.

19 F. The insurer may elect to provide group insurance coverage in lieu
20 of the issuance of a converted individual policy.

21 G. Each certificate of coverage shall include notice of the conversion
22 privilege.

23 H. This section does not apply to disability income policies, to
24 accidental death or dismemberment policies or to single term nonrenewable
25 policies.

26 I. Conversion is not available to a person eligible for medicare or
27 eligible for or covered by other similar disability benefits which together
28 with the conversion coverage would constitute overinsurance.

29 J. At the time of filing a petition for dissolution of marriage, the
30 clerk of the court shall provide to the petitioner for a dissolution of
31 marriage two copies of the notice of the right of a dependent spouse to
32 convert health insurance coverage under this section. The petitioner shall
33 cause one copy of the notice to be served on the respondent together with a
34 copy of the petition, summons and preliminary injunction. The director shall
35 prepare the notice which must include a summary of this section. The clerk
36 of the court or the director is not liable for damages arising from
37 information contained in or omitted from the notices prepared or provided
38 under this ~~section~~ SUBSECTION.

39 K. This section also applies to blanket accident and sickness
40 insurance policies and to all disability insurance issued by hospital,
41 medical, dental and optometric service corporations, health care services
42 organizations and fraternal benefit societies.

43 L. Any person who is a United States armed forces reservist, who is
44 ordered to active military duty on or after August 22, 1990 and who had
45 coverage under a disability insurance policy provided by the person's

1 employer at such time shall have the right to reinstate such coverage upon
2 release from active military duty subject to the following conditions:

3 1. Following reemployment by the reservist's former employer, the
4 reservist shall make written application to the insurer within ninety days of
5 discharge from active military duty or within one year of hospitalization
6 continuing after discharge. Coverage shall be effective upon receipt of
7 application by the insurer.

8 2. The coverage reinstated shall be the same coverage provided by the
9 employer to other employees and their dependents in the employer group health
10 insurance plan at the time of application.

11 3. The insurer may exclude from such coverage any health or physical
12 condition arising during and occurring as a direct result of active military
13 duty.

14 M. Each dependent of a person eligible for reinstatement under
15 ~~SUBSECTION L OF~~ this ~~provision~~ ~~SECTION~~ shall be afforded the same rights and
16 be subject to the same conditions as the insured, if the dependent was
17 insured under the disability insurance policy at the time the eligible person
18 entered active duty. Any dependent of such person born during the period of
19 active military duty shall have the same rights as other dependents noted in
20 this ~~section~~ ~~SUBSECTION~~.

21 N. The director shall adopt emergency rules applicable to persons who
22 are leaving active service in the armed forces of the United States and
23 returning to civilian status consistent with the provisions of subsection L
24 of this section, including:

- 25 1. Conditions of eligibility.
- 26 2. Coverage of dependents.
- 27 ~~3. Preexisting conditions.~~
- 28 ~~4.~~ 3. Termination of insurance.
- 29 ~~5.~~ 4. Probationary periods.
- 30 ~~6.~~ 5. Limitations.
- 31 ~~7.~~ 6. Exceptions.
- 32 ~~8.~~ 7. Reductions.
- 33 ~~9.~~ 8. Elimination periods.
- 34 ~~10.~~ 9. Requirements for replacement.
- 35 ~~11.~~ 10. Any other conditions of group and blanket disability
36 contracts.

37 0. A group policy or any conversion policy that is issued under this
38 section shall not be cancelled or nonrenewed except if:

39 1. The individual has failed to pay premiums or contributions pursuant
40 to the terms of the health insurance coverage or the insurer has not received
41 premium payments in a timely manner.

42 2. The individual has performed an act or practice that constitutes
43 fraud or has made an intentional misrepresentation of material fact under the
44 terms of the coverage.

1 3. The insurer has ceased to offer coverage to individuals that is
2 consistent with the requirements of sections 20-1379 and 20-1380.

3 4. In the case of an insurer that offers health care coverage in this
4 state through a network plan, no member of the group resides, lives or works
5 in the service area served by the network plan or in an area for which the
6 insurer is authorized to transact business but only if the coverage is
7 terminated uniformly without regard to any health status-related factor of
8 any covered individual.

9 5. In the case of an insurer who offers health coverage in the group
10 market only through one or more bona fide associations, the membership of an
11 employer in the association has ceased but only if that coverage is
12 terminated uniformly without regard to any health status-related factor or
13 any covered individual.

14 P. A conversion policy may be modified if the modification complies
15 with the notice and disclosure requirements set forth in the group policy and
16 evidence of coverage. A modification of a conversion policy which has
17 already been issued to an insured shall not result in the effective
18 elimination of any benefit originally included in the conversion policy.

19 Q. For the purposes of this section, "network plan" means a health
20 care plan provided by an insurer under which the financing and delivery of
21 health care services are provided, in whole or in part, through a defined set
22 of providers under contract with the insurer.

23 Sec. 17. Section 20-2301, Arizona Revised Statutes, is amended to
24 read:

25 20-2301. Definitions: late enrollee coverage

26 A. In this chapter, unless the context otherwise requires:

27 1. "Accountable health plan" means an entity that offers, issues or
28 otherwise provides a health benefits plan and **THAT** is approved by the
29 director as an accountable health plan pursuant to section 20-2303.

30 2. "Affiliation period" means a period of two months, or three months
31 for late enrollees, that under the terms of the health benefits plan offered
32 by a health care services organization must expire before the health benefits
33 plan becomes effective and in which the health care services organization is
34 not required to provide health care services or benefits and cannot charge
35 the participant or beneficiary a premium for any coverage during the period.

36 3. "Base premium rate" means, for each rating period, the lowest
37 premium rate that could have been charged under a rating system by the
38 accountable health plan to small employers for health benefits plans
39 involving the same or similar coverage, family size and composition, and
40 geographic area.

41 4. "Basic health benefit plan" means a plan that is developed by a
42 committee established by the legislature and that is adopted by the director.

43 5. "Bona fide association" means, for a health benefits plan issued by
44 an accountable health plan, an association that meets the requirements of
45 section 20-2324.

1 6. "COBRA continuation provision" means:

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

4 (b) Title I, subtitle B, part 6, except section 609, of the employee
5 retirement income security act of 1974 (P.L. 93-406; 88 Stat. 829; 29 United
6 States Code sections 1001 through 1461).

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

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

9 7. "Creditable coverage" means coverage solely for an individual,
10 other than limited benefits coverage, under any of the following:

11 (a) An employee welfare benefit plan that provides medical care to
12 employees or the employees' dependents directly or through insurance or
13 reimbursement or otherwise pursuant to the employee retirement income
14 security act of 1974.

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

17 (c) A health benefits plan issued by an accountable health plan as
18 defined in this section.

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

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

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

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

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

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

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

30 (k) A health benefit plan pursuant to section 5(e) of the peace corps
31 act (P.L. 87-293; 75 Stat. 612; 22 United States Code sections 2501 through
32 2523).

33 (l) A policy or contract, including short-term limited duration
34 insurance, issued on an individual basis by an insurer, a health care
35 services organization, a hospital service corporation, a medical service
36 corporation or a hospital, medical, dental and optometric service corporation
37 or made available to persons defined as eligible under section 36-2901,
38 paragraph 6, subdivisions (b), (c), (d) and (e).

39 (m) A policy or contract issued by a health care insurer or an
40 accountable health plan to a member of a bona fide association.

41 8. "Demographic characteristics" means objective factors an insurer
42 considers in determining premium rates. Demographic characteristics do not
43 include health status-related factors, industry or duration of coverage since
44 issue.

1 9. "Different policy forms" means variations between policy forms
2 offered by a health care insurer, including policy forms that have different
3 cost sharing arrangements or different riders.

4 10. "Genetic information" means information about genes, gene products
5 and inherited characteristics that may derive from the individual or a family
6 member, including information regarding carrier status and information
7 derived from laboratory tests that identify mutations in specific genes or
8 chromosomes, physical medical examinations, family histories and direct
9 analyses of genes or chromosomes.

10 11. "Health benefits plan" means a hospital and medical service
11 corporation policy or certificate, a health care services organization
12 contract, a group disability policy, a certificate of insurance of a group
13 disability policy that is not issued in this state, a multiple employer
14 welfare arrangement or any other arrangement under which health services or
15 health benefits are provided to two or more individuals. Health benefits plan
16 does not include the following:

17 (a) Accident only, dental only, vision only, disability income only or
18 long-term care only insurance, fixed or hospital indemnity coverage, limited
19 benefit coverage, specified disease coverage, credit coverage or Taft-Hartley
20 trusts.

21 (b) Coverage that is issued as a supplement to liability insurance.

22 (c) Medicare supplemental insurance.

23 (d) Workers' compensation insurance.

24 (e) Automobile medical payment insurance.

25 12. "Health status-related factor" means any factor in relation to the
26 health of the individual or a dependent of the individual enrolled or to be
27 enrolled in an accountable health plan, including:

28 (a) Health status.

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

30 (c) Claims experience.

31 (d) Receipt of health care.

32 (e) Medical history.

33 (f) Genetic information.

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

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

37 13. "Higher level of coverage" means a health benefits plan offered by
38 an accountable health plan for which the actuarial value of the benefits
39 under the coverage is at least fifteen per cent more than the actuarial value
40 of the health benefits plan offered by the accountable health plan as a lower
41 level of coverage in this state but not more than one hundred twenty per cent
42 of a policy form weighted average.

43 14. "Index rate" means, as to a rating period, the arithmetic average
44 of the applicable base premium rate and the highest premium rate that could
45 have been charged under a rating system by the accountable health plan to

1 small employers for a health benefits plan involving the same or similar
2 coverage, family size and composition, and geographic area.

3 15. "Late enrollee" means an employee or dependent who requests
4 enrollment in a health benefits plan after the initial enrollment period that
5 is provided under the terms of the health benefits plan if the initial
6 enrollment period is at least thirty-one days. An employee or dependent
7 shall not be considered a late enrollee if:

8 (a) The person:

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

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

17 (iii) Requests enrollment within thirty-one days after the termination
18 of creditable coverage that is provided under a public or private health
19 insurance or other health benefits plan.

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

22 (b) The person is employed by an employer that offers multiple health
23 benefits plans and the person elects a different plan during an open
24 enrollment period.

25 (c) A court orders that coverage be provided for a spouse or minor
26 child under a covered employee's health benefits plan and the person requests
27 enrollment within thirty-one days after the court order is issued.

28 (d) The person becomes a dependent of a covered person through
29 marriage, birth, adoption or placement for adoption and requests enrollment
30 no later than thirty-one days after becoming a dependent.

31 16. "Lower level of coverage" means a health benefits plan offered by
32 an accountable health plan for which the actuarial value of the benefits
33 under the health benefits plan is at least eighty-five per cent but not more
34 than one hundred per cent of the policy form weighted average.

35 17. "Network plan" means a health benefits plan provided by an
36 accountable health plan under which the financing and delivery of health
37 benefits are provided, in whole or in part, through a defined set of
38 providers under contract with the accountable health plan in accordance with
39 the determination made by the director pursuant to section 20-1053 regarding
40 the geographic or service area in which an accountable health plan may
41 operate.

42 18. "Policy form weighted average" means the average actuarial value of
43 the benefits provided by all health benefits plans issued by either the
44 accountable health plan or, if the data are available, by all accountable

1 health plans in the group market in this state during the previous calendar
2 year, weighted by the enrollment for all coverage forms.

3 19. "Preexisting condition" means a condition, regardless of the cause
4 of the condition, for which medical advice, diagnosis, care or treatment was
5 recommended or received ~~within not more than six months~~ before the date of
6 the enrollment of the individual under a health benefits plan issued by an
7 accountable health plan. A genetic condition is not a preexisting condition
8 in the absence of a diagnosis of the condition related to the genetic
9 information and shall not result in a preexisting condition limitation or
10 preexisting condition exclusion.

11 20. "Preexisting condition limitation" or "preexisting condition
12 exclusion" means a limitation or exclusion of benefits for a preexisting
13 condition under a health benefits plan offered by an accountable health plan.

14 21. "Small employer" means an employer who employs at least two but not
15 more than fifty eligible employees on a typical business day during any one
16 calendar year. As used in this paragraph, "employee" shall include the
17 employees of the employer and the individual proprietor or self-employed
18 person if the employer is an individual proprietor or self-employed person.

19 22. "Taft-Hartley trust" means a jointly-managed trust, as allowed by
20 29 United States Code sections 141 through 187, that contains a plan of
21 benefits for employees and that is negotiated in a collective bargaining
22 agreement governing the wages, hours and working conditions of the employees,
23 as allowed by 29 United States Code section 157.

24 23. "Waiting period" means the period that must pass before a potential
25 participant or beneficiary in a health benefits plan offered by an
26 accountable health plan is eligible to be covered for benefits as determined
27 by the individual's employer.

28 B. Coverage for a late enrollee begins on the date the person becomes
29 a dependent if a request for enrollment is received within thirty-one days
30 after the person becomes a dependent.

31 Sec. 18. Section 20-2304, Arizona Revised Statutes, is amended to
32 read:

33 20-2304. Availability of insurance; premium tax exemption

34 A. As a condition of doing business in this state, each accountable
35 health plan shall offer at least one health benefits plan on a guaranteed
36 issuance basis to small employers as required by this section. All small
37 employers qualify for this guaranteed offer of coverage. The accountable
38 health plan shall provide a health benefits plan to each small employer
39 without regard to health status-related factors if the small employer agrees
40 to make the premium payments and to satisfy any other reasonable provisions
41 of the plan that are not inconsistent with this chapter.

42 B. If an accountable health plan offers more than one health benefits
43 plan to small employers, the accountable health plan shall offer a choice of
44 all health benefits plans that the accountable health plan offers to small

1 employers and shall accept any small employer that applies for any of those
2 plans.

3 C. In addition to the requirements prescribed in section 20-2323, for
4 any offering of any health benefits plan to a small employer, as part of the
5 accountable health plan's solicitation and sales materials, an accountable
6 health plan shall make a reasonable disclosure to the employer of the
7 availability of the information described in this subsection and, on request
8 of the employer, shall provide that information to the employer. The
9 accountable health plan shall provide information concerning the following:

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

11 (a) The accountable health plan's right to change premium rates and
12 the factors that may affect changes in premium rates.

13 (b) Renewability of coverage.

14 ~~(c) Any preexisting condition exclusion.~~

15 ~~(d)~~ (c) Any affiliation period applied by a health care services
16 organization.

17 ~~(e)~~ (d) The geographic areas served by health care services
18 organizations.

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

21 D. The accountable health plan shall describe the information required
22 by subsection C of this section in language that is understandable by the
23 average small employer and with a level of detail that is sufficient to
24 reasonably inform a small employer of the employer's rights and obligations
25 under the health benefits plan. This requirement is satisfied if the
26 accountable health plan provides each of the following for each product the
27 accountable health plan offers:

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

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

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

33 4. In the case of a network plan, a map or listing of the areas
34 served.

35 E. An accountable health plan is not required to disclose any
36 information that is proprietary and protected trade secret information under
37 applicable law.

38 F. An accountable health plan that issues a health benefits plan
39 through a network plan may limit the employers that may apply for any health
40 benefits plan offered by the accountable health plan to those eligible
41 individuals who live, work or reside in the service area for the network plan
42 of the accountable health plan.

43 G. On approval of the director, an accountable health plan may refuse
44 to enroll a qualified small employer in a health benefits plan or in a
45 geographic area served by the plan if the accountable health plan

1 demonstrates that its financial or administrative capacity to serve
 2 previously enrolled groups and individuals would be impaired. An accountable
 3 health plan that refuses to enroll a qualified small employer may not enroll
 4 an employer of the same or larger size until the earlier of:

5 1. The date on which the director determines that the accountable
 6 health plan has the capacity to enroll a qualified small employer.

7 2. The date on which the accountable health plan enrolls a qualified
 8 small employer.

9 H. An accountable health plan that offers coverage to a qualified
 10 small employer shall offer coverage to all of the eligible employees of the
 11 qualified small employer and their eligible dependents.

12 I. An accountable health plan may request health screening and
 13 underwriting information on prospective enrollees to evaluate the risks
 14 associated with a qualified small employer who applies for coverage. The
 15 accountable health plan may use this information for the purposes of setting
 16 premiums, evaluating plan offerings and making reinsurance decisions. An
 17 accountable health plan shall not use this information to deny coverage to a
 18 qualified small employer or to an eligible employee or to an eligible
 19 dependent, except a late enrollee who attempts to enroll outside an open
 20 enrollment period.

21 J. Accountable health plans are exempt from the premium taxes that are
 22 required by section 20-224, subsection B and sections 20-837, 20-1010 and
 23 20-1060 for the net premiums received for health benefits plans issued to
 24 small employers, including the net premiums collected from coverage issued
 25 pursuant to section 20-2313, subsection C. Each accountable health plan
 26 shall notify the small employers to whom it provides coverage of the
 27 reductions in the premium tax as specified in this subsection.

28 K. The director may use independent contractor examiners pursuant to
 29 sections 20-148 and 20-159 to review the higher level of coverage and lower
 30 level of coverage health benefits plans offered by an accountable health plan
 31 insurer in compliance with this section. All examination and examination
 32 related expenses shall be borne by the insurer and shall be paid by the
 33 insurance examiners' revolving fund pursuant to section 20-159.

34 Sec. 19. Section 20-2308, Arizona Revised Statutes, is amended to
 35 read:

36 20-2308. Portability

37 A newborn child, adopted child or child placed for adoption is an
 38 eligible individual if the child was timely enrolled and otherwise would have
 39 met the definition of an eligible individual as prescribed in section 20-1379
 40 other than the required period of creditable coverage. ~~and The child is not~~
 41 ~~IS NOT~~ subject to any preexisting condition exclusion or limitation. ~~if the~~
 42 ~~child has been continuously covered under health insurance coverage or a~~
 43 ~~health benefits plan offered by an accountable health plan since birth,~~
 44 ~~adoption or placement for adoption.~~

1 Sec. 20. Section 20-2310, Arizona Revised Statutes, is amended to
2 read:

3 20-2310. Discrimination prohibited; preexisting conditions;
4 wellness programs

5 A. ~~Except as provided in subsection B of this section,~~ A health
6 benefits plan may not deny, limit or condition the coverage or benefits based
7 on a person's health status-related factors or a lack of evidence of
8 insurability.

9 B. A health benefits plan shall not **LIMIT OR** exclude coverage for
10 preexisting conditions. ~~, except that:~~

11 ~~1. A health benefits plan may exclude coverage for preexisting~~
12 ~~conditions for a period of not more than twelve months or, in the case of a~~
13 ~~late enrollee, eighteen months. The exclusion of coverage does not apply to~~
14 ~~services that are furnished to newborns who were otherwise covered from the~~
15 ~~time of their birth or to persons who satisfy the portability requirements~~
16 ~~under section 20-2308.~~

17 ~~2. The accountable health plan shall reduce the period of any~~
18 ~~applicable preexisting condition exclusion by the aggregate of the periods of~~
19 ~~creditable coverage that apply to the individual.~~

20 C. A health benefits plan shall not include an affiliation period in a
21 policy unless the affiliation period satisfies the requirements prescribed in
22 45 Code of Federal Regulations section 146.119(b).

23 D. On request of a health benefits plan, a person who provides
24 coverage during a period of continuous coverage with respect to a covered
25 individual shall promptly disclose the coverage provided to the covered
26 individual, the period of the coverage and the benefits provided under the
27 coverage.

28 E. The accountable health plan shall calculate creditable coverage
29 according to the following rules:

30 1. The accountable health plan shall give an individual credit for
31 each day the individual was covered by creditable coverage.

32 2. The accountable health plan shall not count a period of creditable
33 coverage for an individual enrolled in a health benefits plan if after the
34 period of coverage and before the enrollment date there were sixty-three
35 consecutive days during which the individual was not covered under any
36 creditable coverage.

37 3. The accountable health plan shall give credit in the calculation of
38 creditable coverage for any period that an individual is in a waiting period
39 or an affiliation period for any health coverage.

40 4. The accountable health plan shall not count a period of creditable
41 coverage with respect to enrollment of an individual if, after the most
42 recent period of creditable coverage and before the enrollment date,
43 sixty-three consecutive days lapse during all of which the individual was not
44 covered under any creditable coverage. The accountable health plan shall not
45 include in the determination of the period of continuous coverage described

1 in this section any period that an individual is in a waiting period for
2 health insurance coverage offered by a health care insurer, is in a waiting
3 period for benefits under a health benefits plan offered by an accountable
4 health plan or is in an affiliation period.

5 ~~5. In determining the extent to which an individual has satisfied any~~
6 ~~portion of any applicable preexisting condition period the accountable health~~
7 ~~plan shall count a period of creditable coverage without regard to the~~
8 ~~specific benefits covered during that period.~~

9 ~~6. An accountable health plan shall not impose any preexisting~~
10 ~~condition exclusion in the case of an individual who is covered under~~
11 ~~creditable coverage thirty-one days after the individual's date of birth.~~

12 ~~7. An accountable health plan shall not impose any preexisting~~
13 ~~condition exclusion in the case of a child who is adopted or placed for~~
14 ~~adoption before age eighteen and who is covered under creditable coverage~~
15 ~~thirty-one days after the adoption or placement for adoption.~~

16 F. An accountable health plan shall provide the certificate of
17 creditable coverage described in subsection G of this section without charge
18 for creditable coverage occurring after June 30, 1996 if the individual:

19 1. Ceases to be covered under a health benefits plan offered by an
20 accountable health plan or otherwise becomes covered under a COBRA
21 continuation provision. An individual who is covered by a health benefits
22 plan that is offered by an accountable health plan, that is terminated or not
23 renewed at the choice of the employer and where the replacement of the health
24 benefits plan is without a break in coverage is not entitled to receive the
25 certification prescribed in this paragraph but is instead entitled to receive
26 the certifications prescribed in paragraphs 2 and 3 of this subsection.

27 2. Who was covered under a COBRA continuation provision ceases to be
28 covered under the COBRA continuation provision.

29 3. Requests certification from the accountable health plan within
30 twenty-four months after the coverage under a health benefits plan offered by
31 an accountable health plan ceases.

32 G. The certificate of creditable coverage provided by an accountable
33 health plan is a written certification of:

34 1. The period of creditable coverage of the individual under the
35 accountable health plan and any applicable coverage under a COBRA
36 continuation provision.

37 2. Any applicable waiting period or affiliation period imposed on an
38 individual for any coverage under the accountable health plan.

39 H. Any accountable health plan that issues health benefits plans in
40 this state, as applicable, shall issue and accept a written certificate of
41 creditable coverage of the individual that contains at least the following
42 information:

43 1. The date that the certificate is issued.

44 2. The name of the individual or dependent for whom the certificate
45 applies and any other information that is necessary to allow the issuer

1 providing the coverage specified in the certificate to identify the
2 individual, including the individual's identification number under the policy
3 and the name of the policyholder if the certificate is for or includes a
4 dependent.

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

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

9 5. One of the following:

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

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

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

19 7. The consumer assistance telephone number for the department.

20 8. The following statement in at least fourteen point type:

21 Important notice!

22 Keep this certificate with your important personal records to
23 protect your rights under the health insurance portability and
24 accountability act of 1996 ("HIPAA"). This certificate is proof
25 of your prior health insurance coverage. You may need to show
26 this certificate to have a guaranteed right to buy new health
27 insurance ("Guaranteed issue"). This certificate may also help
28 you avoid waiting periods or exclusions for preexisting
29 conditions. Under HIPAA, these rights are guaranteed only for a
30 very short time period. After your group coverage ends, you
31 must apply for new coverage within 63 days to be protected by
32 HIPAA. If you have questions, call the Arizona department of
33 insurance.

34 I. An accountable health plan may provide any certification pursuant
35 to subsection F, paragraph 1 of this section at the same time the accountable
36 health plan sends the notice required by the applicable COBRA continuation
37 provision.

38 J. An accountable health plan has satisfied the certification
39 requirement under this section if the accountable health plan offering the
40 health benefits plan provides the prescribed certificate in accordance with
41 this section within thirty days after the event that triggered the issuance
42 of the certification.

43 ~~K. If an accountable health plan imposes a waiting period for coverage~~
44 ~~of preexisting conditions, within a reasonable period of time after receiving~~
45 ~~an individual's proof of creditable coverage and not later than the date by~~

~~which the individual must select an insurance plan, the accountable health plan shall give the individual written disclosure of the accountable health plan's determination regarding any preexisting condition exclusion period that applies to that individual. The disclosure shall include all of the following information:~~

~~1. The period of creditable coverage allowed toward the waiting period for coverage of preexisting conditions.~~

~~2. The basis for the accountable health plan's determination and the source and substance of any information on which the accountable health plan has relied.~~

~~3. A statement of any right the individual may have to present additional evidence of creditable coverage and to appeal the accountable health plan's determination, including an explanation of any procedures for submission and appeal.~~

~~L.~~ K. Periods of creditable coverage for an individual are established by presentation of the written certifications described in this section and section 20-1379. In addition to written certification of the period of creditable coverage as described in this section, individuals may establish creditable coverage through the presentation of documents or other means. In order to make a determination that is based on the relevant facts and circumstances of the amount of creditable coverage that an individual has, an accountable health plan shall take into account all information that the plan obtains or that is presented to the plan on behalf of the individual.

~~M.~~ L. The department may enforce and monitor the issuance and delivery of the notices and certificates by accountable health plans and insurers as required by this section, the health insurance portability and accountability act of 1996 (P.L. 104-191; 110 Stat. 1936) and any federal regulations adopted to implement the health insurance portability and accountability act of 1996.

~~N.~~ M. This section does not prohibit any health benefits plan from providing or offering to provide rewards or incentives under a wellness program that satisfies the requirements for an exception from the general prohibition against discrimination based on a health factor under the health insurance portability and accountability act of 1996 (P.L. 104-191; 110 stat. 1936), including any federal regulations that are adopted pursuant to that act.

Sec. 21. Section 20-2321, Arizona Revised Statutes, is amended to read:

20-2321. Maternity benefits; adoption; coverage

A. A contract that is issued to an enrollee pursuant to this article and that provides coverage for maternity benefits shall also provide that the maternity benefits apply to the costs of the birth of a child who is legally adopted by the enrollee if all of the following are true:

1. The child is adopted within one year of birth.

1 2. The enrollee is legally obligated to pay the costs of birth.

2 3. All ~~preexisting conditions and other~~ limitations have been met and
3 all deductibles and copayments have been paid by the enrollee.

4 4. The enrollee has notified the insurer of the enrollee's
5 acceptability to adopt children pursuant to section 8-105 within sixty days
6 after this approval or within sixty days after a change in insurance
7 policies, plans or companies.

8 B. The coverage prescribed by subsection A of this section is excess
9 to any other coverage the natural mother may have for maternity benefits
10 except coverage made available to persons pursuant to title 36, chapter 29
11 but not including coverage made available to persons defined as eligible
12 under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e).

13 C. If other coverage exists the agency, attorney or individual
14 arranging the adoption shall make arrangements for the insurance to pay those
15 costs that may be covered under that policy and shall advise the adopting
16 parent in writing of the existence and extent of the coverage without
17 disclosing any confidential information such as the identity of the natural
18 parent.

19 D. The enrollee adopting parents shall notify their accountable health
20 plan of the existence and extent of the other coverage.

21 E. An accountable health plan is not required to pay any costs in
22 excess of the amounts it would have been obligated to pay to its hospitals
23 and providers if the natural mother and child had received the maternity and
24 newborn care directly from or through that accountable health plan.

25 F. Beginning January 1, 1998, any contract that provides maternity
26 benefits shall not restrict benefits for any hospital length of stay in
27 connection with childbirth for the mother or the newborn child to less than
28 forty-eight hours following a normal vaginal delivery or ninety-six hours
29 following a cesarean section. The contract shall not require the provider to
30 obtain authorization from the accountable health plan for prescribing the
31 minimum length of stay required by this subsection. The contract may provide
32 that an attending provider in consultation with the mother may discharge the
33 mother or the newborn child before the expiration of the minimum length of
34 stay required by this subsection. The accountable health plan shall not:

35 1. Deny the mother or the newborn child eligibility or continued
36 eligibility to enroll or to renew coverage under the terms of the contract
37 solely for the purpose of avoiding the requirements of this subsection.

38 2. Provide monetary payments or rebates to mothers to encourage those
39 mothers to accept less than the minimum protections available pursuant to
40 this subsection.

41 3. Penalize or otherwise reduce or limit the reimbursement of an
42 attending provider because that provider provided care to any insured under
43 the contract in accordance with this subsection.

1 4. Provide monetary or other incentives to an attending provider to
2 induce that provider to provide care to an insured under the contract in a
3 manner that is inconsistent with this subsection.

4 5. Except as described in subsection G of this section, restrict
5 benefits for any portion of a period within the minimum length of stay in a
6 manner that is less favorable than the benefits provided for any preceding
7 portion of that stay.

8 G. Nothing in subsection F of this section:

9 1. Requires a mother to give birth in a hospital or to stay in the
10 hospital for a fixed period of time following the birth of the child.

11 2. Prevents an accountable health plan from imposing deductibles,
12 coinsurance or other cost sharing in relation to benefits for hospital
13 lengths of stay in connection with childbirth for a mother or a newborn child
14 under the contract, except that any coinsurance or other cost sharing for any
15 portion of a period within a hospital length of stay required pursuant to
16 subsection F of this section shall not be greater than the coinsurance or
17 cost sharing for any preceding portion of that stay.

18 3. Prevents an accountable health plan from negotiating the level and
19 type of reimbursement with a provider for care provided in accordance with
20 subsection F of this section.

21 H. An accountable health plan shall not impose any preexisting
22 condition exclusions or limitations relating to pregnancy as a preexisting
23 condition.

24 Sec. 22. Applicability

25 This act applies to contracts, policies and evidences of coverage
26 issued or renewed from and after December 31, 2010.