House Engrossed Senate Bill

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JANICE K. BREWER
SECRETARY OF STATE

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CHAPTER 158

SENATE BILL 1204

AN ACT

AMENDING SECTIONS 20-1401 AND 20-2301, ARIZONA REVISED STATUTES; RELATING TO GROUP DISABILITY INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Section 20-1401, Arizona Revised Statutes, is amended to read:

20-1401. Eligible groups

A. Group disability insurance is that form of disability insurance covering groups of persons as defined below, with or without one or more members of their families or one or more of their dependents, or covering one or more members of the families or one or more dependents of persons in such groups, and issued upon the following basis:

1. Under a policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder, insuring at least ~~five~~ TWO employees of the employer, for the benefit of persons other than the employer. The term "employees" as used herein shall be deemed to include the officers, managers and employees of the employer, the individual proprietor or partners if the employer is an individual proprietor or partnership, the officers, managers and employees of subsidiary or affiliated corporations, the individual proprietors, partners and employees of individuals and firms, if the business of the employer and such individual or firm is under common control through stock ownership, contract or otherwise. The term "employees" as used herein shall be deemed to include retired employees. A policy issued to insure employees of a public body may provide that the term "employees" shall include elected or appointed officials.

2. Under a policy issued to an association, including a labor union, which shall have a constitution and bylaws and which has been organized and is maintained in good faith for purposes other than that of obtaining insurance, insuring at least twenty-five members, employees or employees of members of the association for the benefit of persons other than the association or its officers or trustees. The term "employees" as used herein shall be deemed to include retired employees.

3. Under a policy issued to the trustees of a fund established by two or more employers in the same industry or by one or more labor unions or by one or more employers and one or more labor unions, which trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions for the benefit of persons other than the employers or the unions. The term "employees" as used herein shall be deemed to include the officers, managers and employees of the employer, and the individual proprietor or partners if the employer is an individual proprietor or partnership. The term "employees" as used herein shall be deemed to include retired employees. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship.

4. Under a policy issued to any persons or organizations to which a policy of group life insurance may be delivered in this state, to insure any class or classes of individuals that could be insured under such group life policy.

5. Under a policy issued to cover any other substantially similar group which, in the discretion of the director, may be subject to the issuance of a group disability policy or contract.

B. Nothing in this article validates any charge or practice illegal under any rule of law or regulation governing usury, consumer lender loans, retail installment sales or the like, or extends the application of any such rule of law or regulation to any transaction not otherwise subject thereto.

Sec. 2. Section 20-2301, Arizona Revised Statutes, is amended to read:

20-2301. Definitions; late enrollee coverage

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

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

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

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

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

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

6. "COBRA continuation provision" means:

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

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

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

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

7. "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 THIS 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 services organization, a hospital service corporation, a medical service corporation or a hospital, medical, dental and optometric service corporation or made available to persons defined as eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e).

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

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

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

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

11. "Health benefits plan" means a hospital and medical service corporation policy or certificate, a health care services organization contract, a multiple employer welfare arrangement or any other arrangement under which health services or health benefits are provided to two or more individuals. Health benefits plan does not include the following:

(a) Accident only, dental only, vision only, disability income only or long-term care only insurance, fixed or hospital indemnity coverage, limited

1 benefit coverage, specified disease coverage, credit coverage or Taft-Hartley
2 trusts.
3 (b) Coverage that is issued as a supplement to liability insurance.
4 (c) Medicare supplemental insurance.
5 (d) Workers' compensation insurance.
6 (e) Automobile medical payment insurance.
7 12. "Health status-related factor" means any factor in relation to the
8 health of the individual or a dependent of the individual enrolled or to be
9 enrolled in an accountable health plan including:
10 (a) Health status.
11 (b) Medical condition, including physical and mental illness.
12 (c) Claims experience.
13 (d) Receipt of health care.
14 (e) Medical history.
15 (f) Genetic information.
16 (g) Evidence of insurability, including conditions arising out of acts
17 of domestic violence as defined in section 20-448.
18 (h) The existence of a physical or mental disability.
19 13. "Higher level of coverage" means a health benefits plan offered by
20 an accountable health plan for which the actuarial value of the benefits
21 under the coverage is at least fifteen per cent more than the actuarial value
22 of the health benefits plan offered by the accountable health plan as a lower
23 level of coverage in this state but not more than one hundred twenty per cent
24 of a policy form weighted average.
25 14. "Index rate" means, as to a rating period, the arithmetic average
26 of the applicable base premium rate and the highest premium rate that could
27 have been charged under a rating system by the accountable health plan to
28 small employers for a health benefits plan involving the same or similar
29 coverage, family size and composition, and geographic area.
30 15. "Late enrollee" means an employee or dependent who requests
31 enrollment in a health benefits plan after the initial enrollment period that
32 is provided under the terms of the health benefits plan if the initial
33 enrollment period is at least thirty-one days. An employee or dependent
34 shall not be considered a late enrollee if:
35 (a) The person:
36 (i) At the time of the initial enrollment period was covered under a
37 public or private health insurance policy or any other health benefits plan.
38 (ii) Lost coverage under a public or private health insurance policy
39 or any other health benefits plan due to the employee's termination of
40 employment or eligibility, the reduction in the number of hours of
41 employment, the termination of the other plan's coverage, the death of the
42 spouse, legal separation or divorce or the termination of employer
43 contributions toward the coverage.

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

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

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

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

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

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

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

~~18. "Participating provider" means a professional or institutional health care provider that is employed by or has a written contract with an accountable health plan.~~

~~19.~~ 18. "Policy form weighted average" means the average actuarial value of the benefits provided by all health benefits plans issued by either the accountable health plan or, if the data are available, by all accountable health plans in the group market in this state during the previous calendar year, weighted by the enrollment for all coverage forms.

~~20.~~ 19. "Preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within not more than six months before the date of the enrollment of the individual under a health benefits plan issued by an accountable health plan. A genetic condition is not a preexisting condition in the absence of a diagnosis of the condition related to the genetic information and shall not result in a preexisting condition limitation or preexisting condition exclusion.

~~21.~~ 20. "Preexisting condition limitation" or "preexisting condition exclusion" means a limitation or exclusion of benefits for a preexisting condition under a health benefits plan offered by an accountable health plan.

1 ~~22.~~ 21. "Small employer" means an employer who employs at least two
2 but not more than fifty eligible employees on a typical business day during
3 any one calendar year. "EMPLOYEE" AS USED IN THIS PARAGRAPH SHALL INCLUDE
4 THE EMPLOYEES OF THE EMPLOYER, AND THE INDIVIDUAL PROPRIETOR OR SELF-EMPLOYED
5 PERSON IF THE EMPLOYER IS AN INDIVIDUAL PROPRIETOR OR SELF-EMPLOYED PERSON.
6 ~~23.~~ 22. "Taft-Hartley trust" means a jointly-managed trust, as allowed
7 by 29 United States Code sections 141 through 187, that contains a plan of
8 benefits for employees and that is negotiated in a collective bargaining
9 agreement governing the wages, hours and working conditions of the employees,
10 as allowed by 29 United States Code section 157.
11 ~~24.~~ 23. "Waiting period" means the period that must pass before a
12 potential participant or beneficiary in a health benefits plan offered by an
13 accountable health plan is eligible to be covered for benefits as determined
14 by the individual's employer.
15 B. Coverage for a late enrollee begins on the date the person becomes
16 a dependent if a request for enrollment is received within thirty-one days
17 after the person becomes a dependent.

APPROVED BY THE GOVERNOR MAY 1, 2007.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MAY 1, 2007.