REFERENCE TITLE: autism; covered benefit denial prohibited

State of Arizona
House of Representatives
Forty-eighth Legislature
Second Regular Session
2008

HB 2847

Introduced by
Representative Konopnicki

AN ACT

AMENDING SECTIONS 20-461 AND 38-651, ARIZONA REVISED STATUTES; RELATING TO INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Section 20-461, Arizona Revised Statutes, is amended to read:

20-461. Unfair claim settlement practices

A. A person shall not commit or perform with such a frequency to indicate as a general business practice any of the following:

1. Misrepresenting pertinent facts or insurance policy provisions relating to coverages at issue.

2. Failing to acknowledge and act reasonably and promptly upon communications with respect to claims arising under an insurance policy.

3. Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under an insurance policy.

4. Refusing to pay claims without conducting a reasonable investigation based upon all available information.

5. Failing to affirm or deny coverage of claims within a reasonable time after proof of loss statements have been completed.

6. Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear.

7. As a property or casualty insurer, failing to recognize a valid assignment of a claim. The property or casualty insurer shall have the rights consistent with the provisions of its insurance policy to receive notice of loss or claim and to all defenses it may have to the loss or claim, but not otherwise to restrict an assignment of a loss or claim after a loss has occurred.

8. Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by the insureds.

9. Attempting to settle a claim for less than the amount to which a reasonable person would have believed he was entitled by reference to written or printed advertising material accompanying or made part of an application.

10. Attempting to settle claims on the basis of an application which was altered without notice to, or knowledge or consent of, the insured.

11. Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which the payments are being made.

12. Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

13. Delaying the investigation or payment of claims by requiring an insured, a claimant or the physician of either to submit a preliminary claim report and then requiring the subsequent submission of formal proof of loss forms, both of which submissions contain substantially the same information.

14. Failing to promptly settle claims if liability has become reasonably clear under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

15. Failing to promptly provide a reasonable explanation of the basis in the insurance policy relative to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

16. Attempting to settle claims for the replacement of any nonmechanical sheet metal or plastic part which generally constitutes the exterior of a motor vehicle, including inner and outer panels, with an aftermarket crash part which is not made by or for the manufacturer of an insured's motor vehicle unless the part meets the specifications of section 44-1292 and unless the consumer is advised in a written notice attached to or printed on a repair estimate which:

(a) Clearly identifies each part.

(b) Contains the following information in ten point or larger type: This estimate has been prepared based on the use of replacement parts supplied by a source other than the manufacturer of your motor vehicle. Warranties applicable to these replacement parts are provided by the manufacturer or distributor of these parts rather than the manufacturer of your vehicle.

17. As an insurer subject to section 20-826, 20-1342, 20-1402 or 20-1404, or as an insurer of the same type as those subject to section 20-826, 20-1342, 20-1402 or 20-1404 that issues policies, contracts, plans, coverages or evidences of coverage for delivery in this state, failing to pay charges for reasonable and necessary services provided by any physician licensed pursuant to title 32, chapter 8, 13 or 17, if the services are within the lawful scope of practice of the physician and the insurance coverage includes diagnosis and treatment of the condition or complaint, regardless of the nomenclature used to describe the condition, complaint or service.

18. Failing to comply with chapter 15 of this title.

19. Denying liability for a claim under a motor vehicle liability policy in effect at the time of an accident without having substantial facts based on reasonable investigation to justify the denial for damages or injuries that are a result of the accident and that were caused by the insured if the denial is based solely on a medical condition that could affect the insured's driving ability.

20. AS AN INSURER SUBJECT TO SECTION 20-826, 20-1057, 20-1342, 20-1402 OR 20-1404, OR AS AN INSURER OF THE SAME TYPE AS THOSE SUBJECT TO SECTION 20-826, 20-1057, 20-1342, 20-1402 OR 20-1404 THAT ISSUES POLICIES, CONTRACTS, PLANS, COVERAGES OR EVIDENCES OF COVERAGE FOR DELIVERY IN THIS STATE, DENYING COVERAGE FOR A COVERED BENEFIT AS PRESCRIBED IN THE INSURER'S POLICY, CONTRACT, PLAN, COVERAGE OR EVIDENCE OF COVERAGE SOLELY BASED ON A DIAGNOSIS OF AUTISM SPECTRUM DISORDER.

B. Nothing in subsection A, paragraph 17 of this section shall be construed to prohibit the application of deductibles, coinsurance, preferred provider organization requirements, cost containment measures or quality assurance measures if they are equally applied to all types of physicians referred to in this section, and if any limitation or condition placed upon payment to or upon services, diagnosis or treatment by any physician covered by this section is equally applied to all physicians referred to in subsection A, paragraph ~~16~~ 17 of this section, without discrimination to the usual and customary procedures of any type of physician. A determination under this section of discrimination to the usual and customary procedures of any type of physician shall not be based on whether an insurer applies medical necessity review to a particular type of service or treatment.

C. In prescribing rules to implement this section, the director shall follow, to the extent appropriate, the national association of insurance commissioners unfair claims settlement practices model regulation.

D. Nothing contained in this section is intended to provide any private right or cause of action to or on behalf of any insured or uninsured resident or nonresident of this state. It is, however, the specific intent of this section to provide solely an administrative remedy to the director for any violation of this section or rule related to this section.

E. The director shall deposit, pursuant to sections 35-146 and 35-147, all civil penalties collected pursuant to this article in the state general fund.

Sec. 2. Section 38-651, Arizona Revised Statutes, is amended to read:

38-651. Expenditure of monies for health and accident insurance

A. The department of administration may expend public monies appropriated for such purpose to procure health and accident coverage for full-time officers and employees of the state and its departments and agencies. The department of administration may adopt rules which provide that if an employee dies while the employee's surviving spouse's health insurance is in force, the surviving spouse shall be entitled to no more than thirty-six months of extended coverage at one hundred two per cent of the group rates by paying the premiums. No public monies may be expended to pay all or any part of the premium of health insurance continued in force by the surviving spouse. The department of administration shall seek a variety of plans, including indemnity health insurance, hospital and medical service plans, dental plans and health maintenance organizations. On a recommendation of the department of administration and the review of the joint legislative budget committee, the department of administration may self-insure for the purposes of this subsection. If the department of administration self-insures, the department may contract directly with preferred provider organizations, physician and hospital networks, indemnity health insurers, hospital and medical service plans, dental plans and health maintenance organizations. If the department self-insures, the department shall provide that the self-insurance program include all health coverage

benefits that are mandated pursuant to title 20. The self-insurance program shall include provisions to provide for the protection of the officers and employees, including grievance procedures for claim or treatment denials, creditable coverage determinations, dissatisfaction with care and access to care issues. The department of administration by rule shall designate and adopt performance standards, including cost competitiveness, utilization review issues, network development and access, conversion and implementation, report timeliness, quality outcomes and customer satisfaction for qualifying plans. The qualifying plans for which the standards are adopted include indemnity health insurance, hospital and medical service plans, closed panel medical and dental plans and health maintenance organizations, and for eligibility of officers and employees to participate in such plans. Any indemnity health insurance or hospital and medical service plan designated as a qualifying plan by the department of administration must be open for enrollment to all permanent full-time state employees, except that any plan established prior to June 6, 1977 may be continued as a separate plan. Any closed panel medical or dental plan or health maintenance organization designated as the qualifying plan by the department of administration must be open for enrollment to all permanent full-time state employees residing within the geographic area or area to be served by the plan or organization. Officers and employees may select coverage under the available options.

B. The department of administration may expend public monies appropriated for such purpose to procure health and accident coverage for the dependents of full-time officers and employees of the state and its departments and agencies. The department of administration shall seek a variety of plans, including indemnity health insurance, hospital and medical service plans, dental plans and health maintenance organizations. On a recommendation of the department of administration and the review of the joint legislative budget committee, the department of administration may self-insure for the purposes of this subsection. If the department of administration self-insures, the department may contract directly with preferred provider organizations, physician and hospital networks, indemnity health insurers, hospital and medical service plans, dental plans and health maintenance organizations. If the department self-insures, the department shall provide that the self-insurance program include all health coverage benefits that are mandated pursuant to title 20. The self-insurance program shall include provisions to provide for the protection of the officers and employees, including grievance procedures for claim or treatment denials, creditable coverage determinations, dissatisfaction with care and access to care issues. The department of administration by rule shall designate and adopt performance standards, including cost competitiveness, utilization review issues, network development and access, conversion and implementation, report timeliness, quality outcomes and customer satisfaction for qualifying plans. The qualifying plans for which the standards are adopted include indemnity health insurance, hospital and medical service plans, closed panel

medical and dental plans and health maintenance organizations, and for eligibility of the dependents of officers and employees to participate in such plans. Any indemnity health insurance or hospital and medical service plan designated as a qualifying plan by the department of administration must be open for enrollment to all permanent full-time state employees, except that any plan established prior to June 6, 1977 may be continued as a separate plan. Any closed panel medical or dental plan or health maintenance organization designated as a qualifying plan by the department of administration must be open for enrollment to all permanent full-time state employees residing within the geographic area or area to be served by the plan or organization. Officers and employees may select coverage under the available options.

C. The department of administration may designate the Arizona health care cost containment system established by title 36, chapter 29 as a qualifying plan for the provision of health and accident coverage to full-time state officers and employees and their dependents. The Arizona health care cost containment system shall not be the exclusive qualifying plan for health and accident coverage for state officers and employees either on a statewide or regional basis.

D. Except as provided in section 38-652, public monies expended pursuant to this section each month shall not exceed:

1. Five hundred dollars multiplied by the number of officers and employees who receive individual coverage.

2. One thousand two hundred dollars multiplied by the number of married couples if both members of the couple are either officers or employees and each receives individual coverage or family coverage.

3. One thousand two hundred dollars multiplied by the number of officers or employees who receive family coverage if the spouses of the officers or employees are not officers or employees.

E. Subsection D of this section:

1. Establishes a total maximum expenditure of public monies pursuant to this section.

2. Does not establish a minimum or maximum expenditure for each individual officer or employee.

F. In order to ensure that an officer or employee does not suffer a financial penalty or receive a financial benefit based on the officer's or employee's age, gender or health status, the department of administration shall consider implementing the following:

1. Requests for proposals for health insurance that specify that the carrier's proposed premiums for each plan be based on the expected age, gender and health status of the entire pool of employees and officers and their family members enrolled in all qualifying plans and not on the age, gender or health status of the individuals expected to enroll in the particular plan for which the premium is proposed.

2. Recommendations from a legislatively established study group on risk adjustments relating to a system for reallocating premium revenues among the contracting qualifying plans to the extent necessary to adjust the revenues received by any carrier to reflect differences between the average age, gender and health status of the enrollees in that carrier's plan or plans and the average age, gender and health status of all enrollees in all qualifying plans.

G. Each officer or employee shall certify on the initial application for family coverage that such officer or employee is not receiving more than the contribution for which eligible pursuant to subsection D of this section. Each officer or employee shall also provide such certification on any change of coverage or marital status.

H. If a qualifying health maintenance organization is not available to an officer or employee within fifty miles of the officer's or employee's residence and the officer or employee is enrolled in a qualifying plan, the officer or employee shall be offered the opportunity to enroll with a health maintenance organization when the option becomes available. If a health maintenance organization is available within fifty miles and it is determined by the department of administration that there is an insufficient number of medical providers in the organization, the department may provide for a change in enrollment from plans designated by the director when additional medical providers join the organization.

I. Notwithstanding the provisions of subsection H of this section, officers and employees who enroll in a qualifying plan and reside outside the area of a qualifying health maintenance organization shall be offered the option to enroll with a qualified health maintenance organization offered through their provider under the same premiums as if they lived within the area boundaries of the qualified health maintenance organization, provided that:

1. All medical services are rendered and received at an office designated by the qualifying health maintenance organization or at a facility referred by the health maintenance organization.

2. All nonemergency or nonurgent travel, ambulatory and other expenses from the residence area of the officer or employee to the designated office of the qualifying health maintenance organization or the facility referred by the health maintenance organization shall be the responsibility of and at the expense of the officer or employee.

3. All emergency or urgent travel, ambulatory and other expenses from the residence area of the officer or employee to the designated office of the qualifying health maintenance organization or the facility referred by the health maintenance organization shall be paid pursuant to any agreement between the health maintenance organization and the officer or employee living outside the area of the qualifying health maintenance organization.

J. The department of administration shall allow any school district in this state that meets the requirements of section 15-388, a charter school in

this state that meets the requirements of section 15-187.01 or a city, town, county, community college district, special taxing district, authority or public entity organized pursuant to the laws of this state that meets the requirements of section 38-656 to participate in the health and accident coverage prescribed in this section, except that participation is only allowed in a health plan that is offered by the department and that is subject to title 20, chapter 1, article 1. A school district, a charter school, a city, a town, a county, a community college district, a special taxing district, an authority or any public entity organized pursuant to the laws of this state rather than the state shall pay directly to the benefits provider the premium for its employees.

K. The department of administration shall determine the actual administrative and operational costs associated with school districts, charter schools, cities, towns, counties, community college districts, special taxing districts, authorities and public entities organized pursuant to the laws of this state participating in the state health and accident insurance coverage. These costs shall be allocated to each school district, charter school, city, town, county, community college district, special taxing district, authority and public entity organized pursuant to the laws of this state based upon the total number of employees participating in the coverage. This subsection only applies to a health plan that is offered by the department and that is subject to title 20, chapter 1, article 1.

L. Insurance providers contracting with the state shall separately maintain records that delineate claims and other expenses attributable to participation of a school district, charter school, city, town, county, community college district, special taxing district, authority and public entity organized pursuant to the laws of this state in the state health and accident insurance coverage and, by November 1 of each year, shall report to the department of administration the extent to which state costs are impacted by participation of school districts, charter schools, cities, towns, counties, community college districts, special taxing districts, authorities and public entities organized pursuant to the laws of this state in the state health and accident insurance coverage. By December 1 of each year, the director of the department of administration shall submit a report to the president of the senate and the speaker of the house of representatives detailing the information provided to the department by the insurance providers and including any recommendations for possible legislative action.

M. Notwithstanding subsection J of this section, any school district in this state that meets the requirements of section 15-388, a charter school in this state that meets the requirements of section 15-187.01 or a city, town, county, community college district, special taxing district, authority or public entity organized pursuant to the laws of this state that meets the requirements of section 38-656 may apply to the department of administration to participate in the self-insurance program that is provided by this section pursuant to rules adopted by the department. A participating entity shall

reimburse the department for all premiums and administrative or other insurance costs. The department shall actuarially prescribe the annual premium for each participating entity to reflect the actual cost of each participating entity.

N. Any person that submits a bid to provide health and accident coverage pursuant to this section shall disclose any court or administrative judgments or orders issued against that person within the last ten years before the submittal.

O. THE DEPARTMENT OR ANY OF THE DEPARTMENT'S CONTRACTORS SHALL NOT DENY COVERAGE FOR A COVERED BENEFIT AS PRESCRIBED IN ANY POLICY, CONTRACT, PLAN, COVERAGE OR EVIDENCE OF COVERAGE SOLELY BASED ON A DIAGNOSIS OF AUTISM SPECTRUM DISORDER.