

REFERENCE TITLE: **uninsurable individuals; health insurance plan**

State of Arizona
Senate
Fiftieth Legislature
Second Regular Session
2012

SB 1421

Introduced by
Senator Shooter

AN ACT

PROVIDING FOR THE DELAYED REPEAL OF SECTIONS 20-1379, 20-1381 AND 20-1382, ARIZONA REVISED STATUTES; AMENDING SECTION 20-1380, ARIZONA REVISED STATUTES; AMENDING TITLE 20, ARIZONA REVISED STATUTES, BY ADDING CHAPTER 23; MAKING AN APPROPRIATION; RELATING TO THE ASSIGNED RISK HEALTH INSURANCE PROGRAM; PROVIDING FOR CONDITIONAL ENACTMENT.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

2 Section 1. Delayed repeal

3 Section 20-1379, Arizona Revised Statutes, is repealed from and after
4 June 30, 2013.

5 Sec. 2. Section 20-1380, Arizona Revised Statutes, is amended to read:

6 20-1380. Guaranteed renewability of individual health coverage;
7 certificate of creditable coverage; definitions

8 A. Except as provided in this section, on request of the insured
9 individual, a health care insurer that provides individual health coverage to
10 the individual shall renew or continue that coverage.

11 B. A health care insurer may nonrenew or discontinue the health
12 insurance coverage of an individual in the individual market only for one or
13 more of the following reasons:

14 1. The individual has failed to pay premiums or contributions pursuant
15 to the terms of the health insurance coverage or the health care insurer has
16 not received premium payments in a timely manner.

17 2. The individual has performed an act or practice that constitutes
18 fraud or has made an intentional misrepresentation of material fact under the
19 terms of the coverage.

20 3. The health care insurer has ceased to offer new coverage and has
21 discontinued all in-force coverage in the individual market pursuant to
22 subsection D of this section.

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

29 5. If the health care insurer offers health coverage in the individual
30 market only through one or more bona fide associations, the membership of an
31 individual in the association has ceased but only if that coverage is
32 terminated uniformly without regard to any health status-related factor of
33 any covered individual.

34 C. If a health care insurer decides to discontinue offering a
35 particular policy form offered in the individual market, the health care
36 insurer may discontinue that policy form only if:

37 1. The health care insurer provides notice to the director at least
38 five business days before the health care insurer gives notice to each
39 individual covered under that policy form of the intention to discontinue
40 offering that policy form in this state.

41 2. The health care insurer provides notice to each individual who is
42 covered by that policy form in the individual market at least ninety days
43 before the date of the discontinuation of that policy form.

44 3. The health care insurer offers to each individual in the individual
45 market whose coverage is discontinued pursuant to this subsection the option

1 to purchase all other individual health insurance coverage currently offered
2 by the health care insurer for individuals in that market.

3 4. In exercising the option to discontinue that type of coverage and
4 in offering the option of coverage prescribed in paragraph 3 of this
5 subsection, the health care insurer acts uniformly without regard to any
6 health status-related factor of enrolled individuals or individuals who may
7 become eligible for that coverage.

8 D. If a health care insurer elects to discontinue offering all health
9 insurance coverage in the individual market in this state, the health care
10 insurer may discontinue that coverage only if all of the following occur:

11 1. The health care insurer gives notice to the director at least five
12 business days before the health care insurer gives notice to each individual
13 of the intention to discontinue offering health insurance coverage in the
14 individual market in this state.

15 2. The health care insurer provides notice to each individual of that
16 discontinuation at least one hundred eighty days before the date of the
17 expiration of that coverage.

18 3. The health care insurer discontinues all individual insurance or
19 coverage that was issued or delivered for issuance in this state and does not
20 renew any coverage that was offered or sold in this state.

21 E. If the health care insurer discontinues offering health insurance
22 coverage pursuant to subsection D of this section, the health care insurer
23 shall not issue any health insurance coverage in this state in the individual
24 market for five years after the date that the last individual health
25 insurance coverage was not renewed.

26 F. Subsection C of this section does not apply if the health care
27 insurer modifies the health coverage at the time of renewal and that
28 modification is otherwise consistent with this title and effective on a
29 uniform basis among all individuals covered by that policy form.

30 ~~G. A health care insurer shall provide the certification described in
31 section 20-2310, subsection G if the individual:~~

32 ~~1. Ceases to be covered under a policy offered by a health care
33 insurer or otherwise becomes covered under a COBRA continuation provision.~~

34 ~~2. Who was covered under a COBRA continuation provision ceases to be
35 covered under the COBRA continuation provision.~~

36 ~~3. Requests certification from the health care insurer within
37 twenty-four months after the coverage under a policy offered by a health care
38 insurer ceases.~~

39 ~~H. The director may use independent contractor examiners pursuant to
40 sections 20-148 and 20-159 to review the higher level of coverage and lower
41 level of coverage policy forms offered by a health care insurer in compliance
42 with this section and section 20-1379. All examination and examination
43 related expenses shall be borne by the insurer and shall be paid by the
44 insurance examiners' revolving fund pursuant to section 20-159.~~

1 G. A HEALTH CARE INSURER SHALL PROVIDE, WITHOUT CHARGE, A WRITTEN
2 CERTIFICATE OF CREDITABLE COVERAGE AS DESCRIBED IN THIS SECTION FOR
3 CREDITABLE COVERAGE OCCURRING AFTER JUNE 30, 1996 IF THE INDIVIDUAL:

4 1. CEASES TO BE COVERED UNDER A POLICY OFFERED BY A HEALTH CARE
5 INSURER. AN INDIVIDUAL WHO IS COVERED BY A POLICY THAT IS ISSUED ON A GROUP
6 BASIS BY A HEALTH CARE INSURER, THAT IS TERMINATED OR NOT RENEWED AT THE
7 CHOICE OF THE SPONSOR OF THE GROUP AND FOR WHICH THE REPLACEMENT OF THE
8 COVERAGE IS WITHOUT A BREAK IN COVERAGE IS NOT ENTITLED TO RECEIVE THE
9 CERTIFICATION PRESCRIBED IN THIS PARAGRAPH BUT IS INSTEAD ENTITLED TO RECEIVE
10 THE CERTIFICATION PRESCRIBED IN PARAGRAPH 2 OF THIS SUBSECTION.

11 2. REQUESTS CERTIFICATION FROM THE HEALTH CARE INSURER WITHIN
12 TWENTY-FOUR MONTHS AFTER THE COVERAGE UNDER A HEALTH INSURANCE COVERAGE
13 POLICY OFFERED BY A HEALTH CARE INSURER CEASES.

14 H. THE CERTIFICATE OF CREDITABLE COVERAGE PROVIDED BY A HEALTH CARE
15 INSURER IS A WRITTEN CERTIFICATION OF THE PERIOD OF CREDITABLE COVERAGE OF
16 THE INDIVIDUAL UNDER THE HEALTH INSURANCE COVERAGE OFFERED BY THE HEALTH CARE
17 INSURER. THE DEPARTMENT MAY ENFORCE AND MONITOR THE ISSUANCE AND DELIVERY OF
18 THE NOTICES AND CERTIFICATES BY HEALTH CARE INSURERS AS REQUIRED BY THIS
19 SECTION, THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996
20 (P.L. 104-191; 110 STAT. 1936) AND ANY FEDERAL REGULATIONS ADOPTED TO
21 IMPLEMENT THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996.

22 I. ANY HEALTH CARE INSURER, ACCOUNTABLE HEALTH PLAN OR OTHER ENTITY
23 THAT ISSUES HEALTH CARE COVERAGE IN THIS STATE, AS APPLICABLE, OTHER THAN THE
24 ASSIGNED RISK HEALTH INSURANCE PROGRAM, SHALL ISSUE AND ACCEPT A CERTIFICATE
25 OF CREDITABLE COVERAGE OF THE INDIVIDUAL THAT CONTAINS AT LEAST THE FOLLOWING
26 INFORMATION:

27 1. THE DATE THAT THE CERTIFICATE IS ISSUED.

28 2. THE NAME OF THE INDIVIDUAL OR DEPENDENT FOR WHOM THE CERTIFICATE
29 APPLIES AND ANY OTHER INFORMATION THAT IS NECESSARY TO ALLOW THE ISSUER
30 PROVIDING THE COVERAGE SPECIFIED IN THE CERTIFICATE TO IDENTIFY THE
31 INDIVIDUAL, INCLUDING THE INDIVIDUAL'S IDENTIFICATION NUMBER UNDER THE POLICY
32 AND THE NAME OF THE POLICYHOLDER IF THE CERTIFICATE IS FOR OR INCLUDES A
33 DEPENDENT.

34 3. THE NAME, ADDRESS AND TELEPHONE NUMBER OF THE ISSUER PROVIDING THE
35 CERTIFICATE.

36 4. THE TELEPHONE NUMBER TO CALL FOR FURTHER INFORMATION REGARDING THE
37 CERTIFICATE.

38 5. ONE OF THE FOLLOWING:

39 (a) A STATEMENT THAT THE INDIVIDUAL HAS AT LEAST EIGHTEEN MONTHS OF
40 CREDITABLE COVERAGE. FOR THE PURPOSES OF THIS SUBDIVISION, "EIGHTEEN MONTHS"
41 MEANS FIVE HUNDRED FORTY-SIX DAYS.

42 (b) BOTH THE DATE THAT THE INDIVIDUAL FIRST SOUGHT COVERAGE, AS
43 EVIDENCED BY A SUBSTANTIALLY COMPLETE APPLICATION, AND THE DATE THAT
44 CREDITABLE COVERAGE BEGAN.

1 3. "GENETIC INFORMATION" MEANS INFORMATION ABOUT GENES, GENE PRODUCTS
2 AND INHERITED CHARACTERISTICS THAT MAY DERIVE FROM THE INDIVIDUAL OR A FAMILY
3 MEMBER, INCLUDING INFORMATION REGARDING CARRIER STATUS AND INFORMATION
4 DERIVED FROM LABORATORY TESTS THAT IDENTIFY MUTATIONS IN SPECIFIC GENES OR
5 CHROMOSOMES, PHYSICAL MEDICAL EXAMINATIONS, FAMILY HISTORIES AND DIRECT
6 ANALYSES OF GENES OR CHROMOSOMES.

7 4. "HEALTH CARE INSURER" MEANS A DISABILITY INSURER, GROUP DISABILITY
8 INSURER, BLANKET DISABILITY INSURER, HEALTH CARE SERVICES ORGANIZATION,
9 HOSPITAL SERVICE CORPORATION, MEDICAL SERVICE CORPORATION OR HOSPITAL,
10 MEDICAL, DENTAL AND OPTOMETRIC SERVICE CORPORATION.

11 5. "HEALTH STATUS-RELATED FACTOR" MEANS ANY FACTOR IN RELATION TO THE
12 HEALTH OF THE INDIVIDUAL OR A DEPENDENT OF THE INDIVIDUAL ENROLLED OR TO BE
13 ENROLLED IN A HEALTH CARE INSURER, INCLUDING:

14 (a) HEALTH STATUS.

15 (b) A MEDICAL CONDITION, INCLUDING PHYSICAL AND MENTAL ILLNESS.

16 (c) CLAIMS EXPERIENCE.

17 (d) RECEIPT OF HEALTH CARE.

18 (e) MEDICAL HISTORY.

19 (f) GENETIC INFORMATION.

20 (g) EVIDENCE OF INSURABILITY, INCLUDING CONDITIONS ARISING OUT OF ACTS
21 OF DOMESTIC VIOLENCE AS DEFINED IN SECTION 20-448.

22 (h) THE EXISTENCE OF A PHYSICAL OR MENTAL DISABILITY.

23 6. "INDIVIDUAL HEALTH INSURANCE COVERAGE" MEANS HEALTH INSURANCE
24 COVERAGE OFFERED BY A HEALTH CARE INSURER TO INDIVIDUALS IN THE INDIVIDUAL
25 MARKET BUT DOES NOT INCLUDE LIMITED BENEFIT COVERAGE OR SHORT-TERM LIMITED
26 DURATION INSURANCE. A HEALTH CARE INSURER THAT OFFERS LIMITED BENEFIT
27 COVERAGE OR SHORT-TERM LIMITED DURATION INSURANCE TO INDIVIDUALS AND NO OTHER
28 COVERAGE TO INDIVIDUALS IN THE INDIVIDUAL MARKET IS NOT A HEALTH CARE INSURER
29 THAT OFFERS HEALTH INSURANCE COVERAGE IN THE INDIVIDUAL MARKET.

30 7. "LIMITED BENEFIT COVERAGE" HAS THE SAME MEANING PRESCRIBED IN
31 SECTION 20-1137.

32 8. "NETWORK PLAN" MEANS A HEALTH CARE PLAN PROVIDED BY A HEALTH CARE
33 INSURER UNDER WHICH THE FINANCING AND DELIVERY OF HEALTH CARE SERVICES ARE
34 PROVIDED, IN WHOLE OR IN PART, THROUGH A DEFINED SET OF PROVIDERS UNDER
35 CONTRACT WITH THE HEALTH CARE INSURER PURSUANT TO THE DETERMINATION MADE BY
36 THE DIRECTOR PURSUANT TO SECTION 20-1053 REGARDING THE GEOGRAPHIC OR SERVICE
37 AREA IN WHICH A HEALTH CARE INSURER MAY OPERATE.

38 9. "SHORT-TERM LIMITED DURATION INSURANCE" MEANS HEALTH INSURANCE
39 COVERAGE THAT IS OFFERED BY A HEALTH CARE INSURER, THAT REMAINS IN EFFECT FOR
40 NO MORE THAN ONE HUNDRED EIGHTY-FIVE DAYS, THAT CANNOT BE RENEWED OR
41 OTHERWISE CONTINUED FOR MORE THAN ONE HUNDRED EIGHTY DAYS AND THAT IS NOT
42 INTENDED OR MARKETED AS HEALTH INSURANCE COVERAGE SUBJECT TO GUARANTEED
43 ISSUANCE OR GUARANTEED RENEWAL PROVISIONS OF THE LAWS OF THIS STATE BUT THAT
44 IS CREDITABLE COVERAGE WITHIN THE MEANING OF THIS SECTION AND SECTION
45 20-2301.

1 (m) A POLICY OR CONTRACT ISSUED BY A HEALTH CARE INSURER OR AN
2 ACCOUNTABLE HEALTH PLAN TO A MEMBER OF A BONA FIDE ASSOCIATION.

3 (n) THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM ESTABLISHED BY TITLE
4 XXI OF THE SOCIAL SECURITY ACT.

5 5. "DELINQUENCY PROCEEDING" HAS THE SAME MEANING PRESCRIBED IN SECTION
6 20-611.

7 6. "DEPARTMENT" MEANS THE DEPARTMENT OF INSURANCE.

8 7. "DEPENDENT" MEANS ANY OF THE FOLLOWING:

9 (a) A RESIDENT SPOUSE.

10 (b) A RESIDENT UNMARRIED CHILD WHO IS UNDER NINETEEN YEARS OF AGE.

11 (c) A RESIDENT CHILD WHO IS A STUDENT, UNDER TWENTY-THREE YEARS OF AGE
12 AND FINANCIALLY DEPENDENT ON THE PARENT.

13 (d) A RESIDENT CHILD WHO IS AT LEAST NINETEEN YEARS OF AGE AND WHO IS
14 AND CONTINUES TO BE BOTH INCAPABLE OF SELF-SUSTAINING EMPLOYMENT BY REASON OF
15 MENTAL RETARDATION OR PHYSICAL HANDICAP AND CHIEFLY DEPENDENT ON THE PARENT
16 FOR SUPPORT OR MAINTENANCE.

17 8. "ENROLLMENT DATE" MEANS THE FIRST DAY OF COVERAGE OR, IF THERE IS A
18 WAITING PERIOD, THE FIRST DAY OF THE WAITING PERIOD. THE FIRST DAY OF
19 COVERAGE FOR AN INDIVIDUAL ENROLLING IN A GROUP PLAN IS THE FIRST DAY OF
20 COVERAGE UNDER THE GROUP HEALTH PLAN. THE FIRST DAY OF COVERAGE IN THE CASE
21 OF AN INDIVIDUAL COVERED BY HEALTH INSURANCE IN THE INDIVIDUAL MARKET IS THE
22 FIRST DAY OF COVERAGE UNDER THE POLICY OR CONTRACT.

23 9. "ERISA" MEANS THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974
24 (P.L. 93-406; 88 STAT. 829; 29 UNITED STATES CODE SECTIONS 1001 THROUGH
25 1461).

26 10. "GENETIC INFORMATION" MEANS INFORMATION ABOUT GENES, GENE PRODUCTS
27 AND INHERITED CHARACTERISTICS THAT MAY DERIVE FROM THE INDIVIDUAL OR A FAMILY
28 MEMBER, INCLUDING INFORMATION REGARDING CARRIER STATUS AND INFORMATION
29 DERIVED FROM LABORATORY TESTS THAT IDENTIFY MUTATIONS IN SPECIFIC GENES OR
30 CHROMOSOMES, PHYSICAL MEDICAL EXAMINATIONS, FAMILY HISTORIES AND DIRECT
31 ANALYSES OF GENES OR CHROMOSOMES.

32 11. "GOVERNMENT PLAN" HAS THE SAME MEANING PRESCRIBED BY ERISA AND ANY
33 FEDERAL GOVERNMENT PLAN.

34 12. "GROUP HEALTH PLAN" MEANS AN EMPLOYEE WELFARE BENEFIT PLAN AS
35 DEFINED IN SECTION 3 (1) OF ERISA TO THE EXTENT THAT THE PLAN PROVIDES
36 MEDICAL CARE AND INCLUDES ITEMS AND SERVICES PAID FOR AS MEDICAL CARE TO
37 EMPLOYEES OR THEIR DEPENDENTS AS DEFINED UNDER THE TERMS OF THE PLAN DIRECTLY
38 OR THROUGH INSURANCE OR REIMBURSEMENT OR OTHERWISE.

39 13. "HEALTH CARE INSURER" MEANS A DISABILITY INSURER, GROUP DISABILITY
40 INSURER, BLANKET DISABILITY INSURER, HEALTH CARE SERVICES ORGANIZATION,
41 ACCOUNTABLE HEALTH PLAN, HOSPITAL SERVICE CORPORATION, MEDICAL SERVICE
42 CORPORATION OR HOSPITAL, MEDICAL, DENTAL AND OPTOMETRIC SERVICE CORPORATION
43 THAT PROVIDES HEALTH INSURANCE IN THIS STATE.

1 14. "HEALTH CARE PLAN" MEANS A HEALTH CARE INSURER THAT OFFERS HEALTH
2 INSURANCE OR A SELF-INSURED HEALTH PLAN. HEALTH CARE PLAN DOES NOT INCLUDE
3 MEDICARE, MEDICAID OR ANY GOVERNMENTAL PLAN, EXCEPT A PLAN ESTABLISHED OR
4 MAINTAINED FOR ITS EMPLOYEES BY THE GOVERNMENT OF THE UNITED STATES OR BY ANY
5 AGENCY OR INSTRUMENTALITY OF THE UNITED STATES.

6 15. "HEALTH INSURANCE" MEANS A LICENSED HEALTH CARE PLAN OR ARRANGEMENT
7 THAT PAYS FOR OR FURNISHES MEDICAL OR HEALTH CARE SERVICES AND THAT IS ISSUED
8 BY A HEALTH CARE INSURER. HEALTH INSURANCE DOES NOT INCLUDE LONG-TERM CARE
9 INSURANCE, LIMITED BENEFIT COVERAGE AS DEFINED IN SECTION 20-1137, SHORT-TERM
10 INSURANCE, CREDIT INSURANCE, COVERAGE ISSUED AS A SUPPLEMENT TO LIABILITY
11 INSURANCE, INSURANCE ARISING OUT OF WORKERS' COMPENSATION COVERAGE,
12 AUTOMOBILE MEDICAL PAYMENTS COVERAGE OR INSURANCE UNDER WHICH BENEFITS ARE
13 PAYABLE WITH OR WITHOUT REGARD TO FAULT AND THAT IS STATUTORILY REQUIRED TO
14 BE CONTAINED IN ANY LIABILITY INSURANCE POLICY OR EQUIVALENT SELF-INSURANCE.

15 16. "MEDICAL CARE" MEANS AMOUNTS PAID FOR ANY OF THE FOLLOWING:

16 (a) THE DIAGNOSIS, CARE, MITIGATION, TREATMENT OR PREVENTION OF
17 DISEASE OR AMOUNTS PAID FOR THE PURPOSE OF AFFECTING ANY STRUCTURE OR
18 FUNCTION OF THE HUMAN BODY.

19 (b) TRANSPORTATION PRIMARILY FOR AND ESSENTIAL TO MEDICAL CARE UNDER
20 SUBDIVISION (a) OF THIS PARAGRAPH.

21 (c) INSURANCE COVERING MEDICAL CARE UNDER SUBDIVISIONS (a) AND (b) OF
22 THIS PARAGRAPH.

23 17. "MEDICARE" MEANS COVERAGE UNDER BOTH PARTS A AND B OF TITLE XVIII
24 OF THE SOCIAL SECURITY ACT (42 UNITED STATES CODE SECTIONS 1395 THROUGH
25 1395ggg), AS AMENDED.

26 18. "PREEXISTING CONDITION" MEANS A PHYSICAL OR MENTAL CONDITION,
27 REGARDLESS OF THE CAUSE OF THE CONDITION, FOR WHICH MEDICAL ADVICE,
28 DIAGNOSIS, CARE OR TREATMENT WAS RECOMMENDED OR RECEIVED WITHIN THE
29 TWENTY-FOUR MONTH PERIOD ENDING ON THE ENROLLMENT DATE.

30 19. "PREEXISTING CONDITION EXCLUSION" MEANS A LIMITATION OR EXCLUSION
31 OF BENEFITS RELATING TO A PREEXISTING CONDITION BASED ON THE FACT THAT THE
32 CONDITION WAS PRESENT BEFORE THE FIRST DAY OF COVERAGE, WHETHER OR NOT ANY
33 TREATMENT WAS RECOMMENDED OR RECEIVED BEFORE THAT DAY. A PREEXISTING
34 CONDITION EXCLUSION INCLUDES ANY EXCLUSION APPLICABLE TO AN INDIVIDUAL AS A
35 RESULT OF A PRE-ENROLLMENT QUESTIONNAIRE OR PHYSICAL EXAMINATION GIVEN TO THE
36 INDIVIDUAL, OR A REVIEW OF MEDICAL RECORDS RELATING TO THE PRE-ENROLLMENT
37 PERIOD.

38 20. "PROGRAM" MEANS ASSIGNED RISK HEALTH INSURANCE PROGRAM.

39 21. "RESIDENT" MEANS AN INDIVIDUAL WHO IS LEGALLY DOMICILED IN THIS
40 STATE FOR A PERIOD OF AT LEAST THIRTY DAYS, EXCEPT THAT FOR AN ELIGIBLE
41 INDIVIDUAL, THE THIRTY DAY REQUIREMENT DOES NOT APPLY.

42 22. "SHORT-TERM LIMITED DURATION INSURANCE" MEANS HEALTH INSURANCE
43 COVERAGE THAT IS OFFERED BY A HEALTH CARE INSURER, THAT REMAINS IN EFFECT FOR
44 NO MORE THAN ONE HUNDRED EIGHTY-FIVE DAYS, THAT CANNOT BE RENEWED OR
45 OTHERWISE CONTINUED FOR MORE THAN ONE HUNDRED EIGHTY DAYS AND THAT IS NOT

1 INTENDED OR MARKETED AS HEALTH INSURANCE COVERAGE SUBJECT TO GUARANTEED
2 RENEWAL PROVISIONS OF THE LAWS OF THIS STATE BUT THAT IS CREDITABLE COVERAGE
3 WITHIN THE MEANING OF THIS SECTION AND SECTION 20-2301.

4 23. "SIGNIFICANT BREAK IN COVERAGE" MEANS A PERIOD OF SIXTY-THREE
5 CONSECUTIVE DAYS DURING ALL OF WHICH THE INDIVIDUAL DOES NOT HAVE ANY
6 CREDITABLE COVERAGE, EXCEPT THAT NEITHER A WAITING PERIOD NOR AN AFFILIATION
7 PERIOD IS TAKEN INTO ACCOUNT IN DETERMINING A SIGNIFICANT BREAK IN COVERAGE.

8 24. "WAITING PERIOD" MEANS, FOR A PERSON SEEKING COVERAGE UNDER A GROUP
9 HEALTH PLAN, THE PERIOD THAT MUST PASS BEFORE COVERAGE FOR AN EMPLOYEE OR
10 DEPENDENT WHO IS OTHERWISE ELIGIBLE TO ENROLL CAN BECOME EFFECTIVE. IN THE
11 INDIVIDUAL MARKET, A WAITING PERIOD BEGINS ON THE DATE THE INDIVIDUAL SUBMITS
12 A SUBSTANTIALLY COMPLETE APPLICATION FOR COVERAGE. IN THE INDIVIDUAL MARKET,
13 THE WAITING PERIOD ENDS, IN THE CASE OF AN APPLICATION THAT RESULTS IN
14 COVERAGE, ON THE DATE COVERAGE BEGINS. IN THE CASE OF AN APPLICATION THAT
15 DOES NOT RESULT IN COVERAGE, THE WAITING PERIOD ENDS ON THE DATE THE
16 APPLICATION IS DENIED BY THE ISSUER OR THE DATE THE OFFER OF COVERAGE LAPSES.

17 20-3302. Assigned risk health insurance program; report

18 A. THE ASSIGNED RISK HEALTH INSURANCE PROGRAM IS ESTABLISHED IN THE
19 DEPARTMENT OF INSURANCE. THE DIRECTOR SHALL APPOINT A MANAGER OR COMMITTEE
20 TO ASSIGN ELIGIBLE INDIVIDUALS TO PARTICIPATING HEALTH CARE PLANS PURSUANT TO
21 SECTION 20-3303.

22 B. ON OR BEFORE JUNE 30 OF EACH YEAR, THE DEPARTMENT SHALL SUBMIT A
23 REPORT TO THE GOVERNOR, THE PRESIDENT OF THE SENATE AND THE SPEAKER OF THE
24 HOUSE OF REPRESENTATIVES AND SHALL PROVIDE A COPY TO THE SECRETARY OF STATE.
25 THE REPORT SHALL SUMMARIZE ACTIVITIES OF THE PROGRAM IN THE PRECEDING
26 CALENDAR YEAR, INCLUDING PROGRAM ENROLLMENT, THE NET WRITTEN AND EARNED
27 PREMIUMS, EXPENSE OF ADMINISTRATION AND PAID AND INCURRED LOSSES.

28 20-3303. Assignment; health care plans; appeals; premiums

29 A. AFTER CONSULTATION WITH HEALTH CARE PLANS IN THIS STATE, THE
30 DIRECTOR SHALL APPROVE A REASONABLE PLAN FOR THE EQUITABLE APPORTIONMENT
31 AMONG THE HEALTH CARE PLANS OF ELIGIBLE UNINSURABLE INDIVIDUALS AND FEDERALLY
32 QUALIFIED ELIGIBLE INDIVIDUALS.

33 B. AFTER A PLAN HAS BEEN APPROVED, ALL HEALTH CARE PLANS IN THIS STATE
34 SHALL SUBSCRIBE TO AND PARTICIPATE IN THE PLAN. ASSIGNMENTS MADE UNDER THIS
35 SECTION SHALL BE BASED ON THE SIZE OF THE HEALTH CARE INSURER, DEMONSTRATED
36 THROUGH REPORTED PREMIUM.

37 C. AN ELIGIBLE UNINSURABLE INDIVIDUAL OR FEDERALLY QUALIFIED ELIGIBLE
38 INDIVIDUAL WHO IS ASSIGNED TO A RISK PLAN UNDER THIS SECTION AND AN AFFECTED
39 HEALTH CARE INSURER MAY APPEAL TO THE DIRECTOR OF THE DEPARTMENT OF INSURANCE
40 FROM ANY RULING OR DECISION OF THE MANAGER OR COMMITTEE DESIGNATED TO OPERATE
41 THE PLAN. WITHIN TEN DAYS AFTER NOTICE OF AN ORDER OR ACT OF THE DIRECTOR, A
42 PERSON WHO IS AGGRIEVED BY THE ORDER OR ACT MAY FILE A PETITION IN THE
43 SUPERIOR COURT IN THE COUNTY IN WHICH THE DIRECTOR IS DOMICILED AGAINST THE
44 DIRECTOR FOR A REVIEW OF THE ORDER OR ACT. THE COURT SHALL SUMMARILY HEAR
45 THE PETITION AND MAY MAKE ANY APPROPRIATE ORDER OR DECREE.

1 D. THE HEALTH CARE PLAN MUST OFFER THE ELIGIBLE INDIVIDUAL COVERAGE IN
2 ITS TWO MOST POPULAR INDIVIDUAL MARKET POLICIES OR DESIGNATE TWO POLICIES
3 THAT ARE SIMILAR TO OTHER POLICIES THE HEALTH CARE PLAN SELLS IN THE
4 INDIVIDUAL MARKET. IF THE HEALTH CARE PLAN DOES NOT HAVE AN INDIVIDUAL
5 PRODUCT, THE HEALTH CARE PLAN MAY MATCH AN APPLICABLE POLICY OF ONE OF THE
6 TOP THREE HEALTH CARE PLANS IN THE INDIVIDUAL MARKET.

7 E. PREMIUMS CHARGED TO UNINSURABLE INDIVIDUALS AND FEDERALLY QUALIFIED
8 ELIGIBLE INDIVIDUALS MAY NOT EXCEED ONE HUNDRED FIFTY PER CENT OF THE PREMIUM
9 FOR THE APPLICABLE STANDARD RISK RATE THAT WOULD APPLY TO THE COVERAGE IN
10 THIS STATE. THE DEPARTMENT SHALL DETERMINE A STANDARD RISK RATE BY
11 CONSIDERING THE PREMIUM RATES CHARGED FOR SIMILAR BENEFITS AND COST-SHARING
12 BY HEALTH CARE INSURERS OFFERING HEALTH INSURANCE COVERAGE TO INDIVIDUALS IN
13 THIS STATE. THE STANDARD RISK RATE SHALL BE ESTABLISHED USING REASONABLE
14 ACTUARIAL TECHNIQUES THAT REFLECT ANTICIPATED EXPERIENCE AND EXPENSES.
15 PREMIUM RATES MAY VARY BASED ON AGE, GENDER AND GEOGRAPHICAL LOCATION AND MAY
16 APPLY TO INDIVIDUAL RISKS.

17 20-3304. Eligibility

18 FROM AND AFTER JUNE 30, 2013, UNINSURABLE INDIVIDUALS AS DESCRIBED IN
19 SECTION 20-3305 AND FEDERALLY QUALIFIED ELIGIBLE INDIVIDUALS AS DESCRIBED IN
20 SECTION 20-3306 ARE ELIGIBLE FOR PROGRAM COVERAGE.

21 20-3305. Eligibility for uninsurable individuals

22 A. FROM AND AFTER JUNE 30, 2013, AN INDIVIDUAL IS UNINSURABLE AND
23 ELIGIBLE FOR PROGRAM COVERAGE IF THE INDIVIDUAL IS AND CONTINUES TO BE A
24 RESIDENT OF THIS STATE AND PROVIDES EVIDENCE OF REJECTION OR REFUSAL TO ISSUE
25 HEALTH INSURANCE FOR HEALTH REASONS BY TWO HEALTH CARE INSURERS IN THIS STATE
26 WITHIN THE PAST YEAR. A REJECTION OR REFUSAL BY A HEALTH CARE INSURER THAT
27 OFFERS ONLY STOP LOSS, EXCESS OF LOSS OR REINSURANCE COVERAGE WITH RESPECT TO
28 THE APPLICANT IS NOT SUFFICIENT EVIDENCE OF REJECTION OR REFUSAL.

29 B. FROM AND AFTER JUNE 30, 2013, AN INDIVIDUAL IS NOT ELIGIBLE FOR
30 PROGRAM COVERAGE PURSUANT TO SUBSECTION A OF THIS SECTION IF:

31 1. THE INDIVIDUAL HAS OR OBTAINS HEALTH INSURANCE COVERAGE OR WOULD BE
32 ELIGIBLE FOR HEALTH INSURANCE COVERAGE IF THE INDIVIDUAL ELECTED TO OBTAIN
33 IT, EXCEPT THAT AN INDIVIDUAL MAY MAINTAIN PROGRAM COVERAGE FOR THE PERIOD OF
34 TIME THE INDIVIDUAL IS SATISFYING A PREEXISTING CONDITION WAITING PERIOD
35 UNDER ANOTHER HEALTH INSURANCE POLICY.

36 2. THE INDIVIDUAL IS ELIGIBLE FOR HEALTH CARE BENEFITS UNDER TITLE 36,
37 CHAPTER 29, MEDICARE OR ANY OTHER GOVERNMENT PROGRAM.

38 3. THE INDIVIDUAL VOLUNTARILY TERMINATED HEALTH INSURANCE COVERAGE
39 UNLESS TWELVE MONTHS HAVE PASSED SINCE THE TERMINATION.

40 4. THE INDIVIDUAL IS AN INMATE OR RESIDENT OF A PUBLIC INSTITUTION.

41 5. THE INDIVIDUAL'S HEALTH CARE PLAN PREMIUMS ARE PAID FOR OR
42 REIMBURSED UNDER ANY GOVERNMENT SPONSORED PROGRAM OR BY ANY GOVERNMENT
43 AGENCY.

1 C. FROM AND AFTER JUNE 30, 2013, EXCEPT UNDER THE CIRCUMSTANCES
2 DESCRIBED IN SUBSECTION B OF THIS SECTION, AN INDIVIDUAL WHO CEASES TO MEET
3 THE ELIGIBILITY REQUIREMENTS OF THIS SECTION MAY BE TERMINATED AT THE END OF
4 THE POLICY PERIOD FOR WHICH THE NECESSARY PREMIUMS HAVE BEEN PAID.

5 D. FROM AND AFTER JUNE 30, 2013, NOTWITHSTANDING SUBSECTION A OF THIS
6 SECTION, AN INDIVIDUAL IS AN ELIGIBLE INDIVIDUAL IF:

7 1. THE INDIVIDUAL IS AN INDIVIDUAL ENROLLEE IN A HEALTH CARE SERVICES
8 ORGANIZATION THAT IS DOMICILED IN THIS STATE ON THE DATE THAT THE HEALTH CARE
9 SERVICES ORGANIZATION IS DECLARED INSOLVENT, INCLUDING ANY HEALTH CARE
10 SERVICES ORGANIZATION THAT IS NOT AN ACCOUNTABLE HEALTH PLAN AS DEFINED IN
11 SECTION 20-2301.

12 2. THE INDIVIDUAL'S COVERAGE TERMINATES DURING THE DELINQUENCY
13 PROCEEDING, AFTER THE HEALTH CARE SERVICES ORGANIZATION IS DECLARED
14 INSOLVENT.

15 3. THE INDIVIDUAL SATISFIES THE REQUIREMENTS OF AN ELIGIBLE INDIVIDUAL
16 AS PRESCRIBED IN THIS SECTION OTHER THAN THE REQUIRED PERIOD OF CREDITABLE
17 COVERAGE.

18 E. FROM AND AFTER JUNE 30, 2013, NOTWITHSTANDING SUBSECTION A OF THIS
19 SECTION, A NEWBORN CHILD OF AN ELIGIBLE INDIVIDUAL, ADOPTED CHILD OF AN
20 ELIGIBLE INDIVIDUAL OR CHILD PLACED FOR ADOPTION WITH AN ELIGIBLE INDIVIDUAL
21 IS AN ELIGIBLE INDIVIDUAL IF THE CHILD WAS ENROLLED WITHIN THIRTY DAYS AND
22 OTHERWISE WOULD HAVE MET THE DEFINITION OF AN ELIGIBLE INDIVIDUAL AS
23 PRESCRIBED IN THIS SECTION OTHER THAN THE REQUIRED PERIOD OF CREDITABLE
24 COVERAGE AND THE CHILD IS NOT SUBJECT TO ANY PREEXISTING CONDITION EXCLUSION
25 OR LIMITATION IF THE CHILD HAS BEEN COVERED UNDER HEALTH INSURANCE COVERAGE
26 OR A HEALTH BENEFITS PLAN OFFERED BY AN ACCOUNTABLE HEALTH PLAN SINCE BIRTH,
27 ADOPTION OR PLACEMENT FOR ADOPTION WITH NO SIGNIFICANT BREAK IN COVERAGE.

28 20-3306. Eligibility standards for federally qualified
29 individuals

30 A. FROM AND AFTER JUNE 30, 2013, AN INDIVIDUAL IS A FEDERALLY
31 QUALIFIED INDIVIDUAL AND ELIGIBLE FOR PROGRAM COVERAGE IF ALL THE FOLLOWING
32 APPLY:

33 1. THE INDIVIDUAL HAS NOT EXPERIENCED A SIGNIFICANT BREAK IN COVERAGE.
34 2. THE INDIVIDUAL CONTINUES TO BE A RESIDENT OF THIS STATE.
35 3. THE INDIVIDUAL HAS AN AGGREGATE PERIOD OF CREDITABLE COVERAGE AS
36 DEFINED AND CALCULATED PURSUANT TO THIS ARTICLE OF AT LEAST EIGHTEEN MONTHS.

37 4. THE MOST RECENT CREDITABLE COVERAGE FOR THE INDIVIDUAL WAS UNDER A
38 PLAN OFFERED BY:

39 (a) AN EMPLOYEE WELFARE BENEFIT PLAN THAT PROVIDES MEDICAL CARE TO
40 EMPLOYEES OR THE EMPLOYEES' DEPENDENTS DIRECTLY OR THROUGH INSURANCE OR
41 REIMBURSEMENT OR OTHERWISE PURSUANT TO ERISA.

42 (b) A CHURCH PLAN.

43 (c) A GOVERNMENT PLAN, INCLUDING A PLAN ESTABLISHED OR MAINTAINED FOR
44 ITS EMPLOYEES BY THE GOVERNMENT OF THE UNITED STATES OR BY ANY AGENCY OR
45 INSTRUMENTALITY OF THE UNITED STATES.

1 (d) AN ACCOUNTABLE HEALTH PLAN AS DEFINED IN SECTION 20-2301.
2 (e) A PLAN MADE AVAILABLE TO A PERSON DEFINED AS ELIGIBLE PURSUANT TO
3 SECTION 36-2901, PARAGRAPH 6, SUBDIVISION (d) OR A DEPENDENT PURSUANT TO
4 SECTION 36-2901, PARAGRAPH 6, SUBDIVISION (e) OF A PERSON ELIGIBLE UNDER
5 SECTION 36-2901, PARAGRAPH 6, SUBDIVISION (d), IF THE PERSON WAS MOST
6 RECENTLY EMPLOYED BY A BUSINESS IN THIS STATE WITH AT LEAST TWO BUT NOT MORE
7 THAN FIFTY FULL-TIME EMPLOYEES.
8 (f) A FEDERAL PREEXISTING CONDITION INSURANCE PLAN.
9 5. THE INDIVIDUAL IS NOT ELIGIBLE FOR COVERAGE UNDER:
10 (a) AN EMPLOYEE WELFARE BENEFIT PLAN THAT PROVIDES MEDICAL CARE TO
11 EMPLOYEES OR THE EMPLOYEES' DEPENDENTS DIRECTLY OR THROUGH INSURANCE OR
12 REIMBURSEMENT OR OTHERWISE PURSUANT TO ERISA.
13 (b) A HEALTH BENEFITS PLAN ISSUED BY AN ACCOUNTABLE HEALTH PLAN AS
14 DEFINED IN SECTION 20-2301.
15 (c) PART A OR PART B OF TITLE XVIII OF THE SOCIAL SECURITY ACT.
16 (d) TITLE 36, CHAPTER 29, EXCEPT COVERAGE TO PERSONS DEFINED AS
17 ELIGIBLE UNDER SECTION 36-2901, PARAGRAPH 6, SUBDIVISIONS (b), (c), (d) AND
18 (e), OR ANY OTHER PLAN ESTABLISHED UNDER TITLE XIX OF THE SOCIAL SECURITY
19 ACT, AND THE INDIVIDUAL DOES NOT HAVE OTHER HEALTH INSURANCE COVERAGE.
20 6. THE MOST RECENT COVERAGE WITHIN THE COVERAGE PERIOD WAS NOT
21 TERMINATED BASED ON ANY FACTOR DESCRIBED IN SECTION 20-2309, SUBSECTION B,
22 PARAGRAPH 1 OR 2 RELATING TO THE INDIVIDUAL'S NONPAYMENT OF PREMIUMS OR
23 FRAUD.
24 7. THE INDIVIDUAL WAS OFFERED, ELECTED THE OPTION OF AND EXHAUSTED
25 CONTINUATION COVERAGE UNDER A COBRA CONTINUATION PROVISION PURSUANT TO THE
26 CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (P.L. 99-272; 100
27 STAT. 82) OR A SIMILAR STATE PROGRAM.
28 B. FROM AND AFTER JUNE 30, 2013, NOTWITHSTANDING SUBSECTION A OF THIS
29 SECTION, A NEWBORN CHILD OF AN ELIGIBLE INDIVIDUAL, ADOPTED CHILD OF AN
30 ELIGIBLE INDIVIDUAL OR CHILD PLACED FOR ADOPTION WITH AN ELIGIBLE INDIVIDUAL
31 IS AN ELIGIBLE INDIVIDUAL IF THE CHILD WAS ENROLLED WITHIN THIRTY DAYS AND
32 OTHERWISE WOULD HAVE MET THE DEFINITION OF AN ELIGIBLE INDIVIDUAL AS
33 PRESCRIBED IN THIS SECTION OTHER THAN THE REQUIRED PERIOD OF CREDITABLE
34 COVERAGE AND THE CHILD IS NOT SUBJECT TO ANY PREEXISTING CONDITION EXCLUSION
35 OR LIMITATION IF THE CHILD HAS BEEN COVERED UNDER HEALTH INSURANCE COVERAGE
36 OR A HEALTH BENEFITS PLAN OFFERED BY AN ACCOUNTABLE HEALTH PLAN SINCE BIRTH,
37 ADOPTION OR PLACEMENT FOR ADOPTION WITH NO SIGNIFICANT BREAK IN COVERAGE.
38 20-3307. Dependent coverage
39 FROM AND AFTER JUNE 30, 2013, EACH DEPENDENT OF AN ELIGIBLE UNINSURABLE
40 INDIVIDUAL OR A FEDERALLY QUALIFIED ELIGIBLE INDIVIDUAL IS ELIGIBLE FOR
41 PROGRAM COVERAGE AT THE PROGRAM PREMIUMS ESTABLISHED PURSUANT TO SECTION
42 20-3303. THE PARENT SHALL FURNISH PROOF OF INCAPACITY AND DEPENDENCY TO THE
43 PROGRAM WITHIN THIRTY-ONE DAYS AFTER THE CHILD ATTAINS NINETEEN YEARS OF AGE
44 AND SUBSEQUENTLY AS THE PROGRAM REQUIRES, BUT NOT MORE FREQUENTLY THAN
45 ANNUALLY.

1 20-3308. Cessation of coverage

2 PROGRAM COVERAGE CEASES:

- 3 1. ON THE DATE AN INDIVIDUAL IS NO LONGER A RESIDENT OF THIS STATE.
4 2. ON THE DATE AN INDIVIDUAL REQUESTS COVERAGE TO END.
5 3. ON THE DEATH OF THE COVERED INDIVIDUAL.
6 4. ON THE DATE STATE LAW REQUIRES CANCELLATION OF THE POLICY.
7 5. AT THE OPTION OF THE HEALTH CARE PLAN, THIRTY DAYS AFTER THE HEALTH
8 CARE PLAN MAKES ANY INQUIRY CONCERNING THE INDIVIDUAL'S ELIGIBILITY OR PLACE
9 OF RESIDENCE TO WHICH THE INDIVIDUAL DOES NOT REPLY.
10 6. ON THE DATE AN INDIVIDUAL'S COVERAGE HAS LAPSED DUE TO FAILURE TO
11 PAY PREMIUMS, SUBJECT TO ANY GRACE PERIOD PROVIDED BY THE HEALTH CARE PLAN.
12 7. ON THE DATE A HEALTH CARE PLAN HAS PAID OUT ONE MILLION DOLLARS IN
13 BENEFITS ON BEHALF OF THE INDIVIDUAL. THE DEPARTMENT MAY INCREASE THIS
14 AMOUNT FOR PROGRAM COVERAGE IF THE INCREASE APPLIES UNIFORMLY TO ALL
15 INDIVIDUALS IN A SPECIFIC POLICY OFFERING UNDER THE PROGRAM AND WITHOUT
16 REGARD TO HEALTH STATUS.

17 20-3309. Premium tax exemption

18 HEALTH CARE PLANS ARE EXEMPT FROM THE PREMIUM TAXES THAT ARE REQUIRED
19 BY SECTION 20-224, SUBSECTION B AND SECTIONS 20-837, 20-1010 AND 20-1060 FOR
20 THE NET PREMIUMS RECEIVED FOR HEALTH INSURANCE ISSUED UNDER THIS CHAPTER TO
21 ELIGIBLE UNINSURABLE INDIVIDUALS AND FEDERALLY QUALIFIED ELIGIBLE
22 INDIVIDUALS.

23 20-3310. Program termination

24 THE PROGRAM ESTABLISHED BY THIS CHAPTER ENDS ON JANUARY 1, 2024
25 PURSUANT TO SECTION 41-3102.

26 Sec. 5. Eligibility of individuals who have portable coverage

27 Notwithstanding section 20-3304, Arizona Revised Statutes, as added by
28 this act, an individual and the individual's dependents who have coverage as
29 of the effective date of title 20, chapter 23, Arizona Revised Statutes, as
30 added by this act, pursuant to section 20-1379, Arizona Revised Statutes, are
31 eligible for coverage under the assigned risk health insurance program that
32 is established by this act.

33 Sec. 6. Audit report

34 On or before September 15, 2018, or five years after title 20, chapter
35 23, Arizona Revised Statutes, as added by this act, becomes effective, the
36 auditor general shall complete an audit of the assigned risk health insurance
37 program established by this act and shall submit a report of its findings and
38 recommendations to the governor, the president of the senate and the speaker
39 of the house of representatives.

40 Sec. 7. Appropriation; department of insurance; exemption

41 A. The sum of \$_____ is appropriated from the state general fund in
42 fiscal year 2012-2013 to the department of insurance for personnel and
43 administrative costs involved in establishing and administering the assigned
44 risk health insurance program established by title 20, chapter 23, Arizona
45 Revised Statutes, as added by this act.

1 B. The appropriation made in subsection A of this section is exempt
2 from the provisions of section 35-190, Arizona Revised Statutes, relating to
3 lapsing of appropriations.

4 Sec. 8. Conforming legislation

5 The legislative council staff shall prepare proposed legislation
6 conforming the Arizona Revised Statutes to the provision of this act for
7 consideration in the legislative session immediately following the effective
8 date of this act.

9 Sec. 9. Conditional enactment; notice

10 A. This act does not become effective unless the United States Supreme
11 Court declares the federal patient protection and affordable care act
12 (P.L. 111-148), as amended by the federal health care and education
13 reconciliation act of 2010 (P.L. 111-152), in its entirety, unconstitutional.

14 B. The director of the department of insurance shall notify in writing
15 the director of the Arizona legislative council of this date.