

REFERENCE TITLE: short-term limited duration insurance; notice

State of Arizona  
House of Representatives  
Fifty-fourth Legislature  
First Regular Session  
2019

## **HB 2375**

Introduced by  
Representatives Barto: Allen J, Finchem, Kern, Lawrence, Senator  
Livingston

AN ACT

AMENDING SECTION 20-1379, ARIZONA REVISED STATUTES; AMENDING TITLE 20,  
CHAPTER 6, ARTICLE 4, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1384;  
RELATING TO LIMITED DURATION INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

2 Section 1. Section 20-1379, Arizona Revised Statutes, is amended to  
3 read:

4 20-1379. Guaranteed availability of individual health  
5 insurance coverage; prior group coverage;  
6 definitions

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

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

13 2. Impose any preexisting condition exclusion for that coverage.

14 B. Every health care insurer that offers individual health  
15 insurance coverage in the individual market in this state shall offer all  
16 policy forms of health insurance coverage that are designed for, that are  
17 made generally available and actively marketed to and that enroll both  
18 eligible or other individuals. A health care insurer that offers only one  
19 policy form in the individual market complies with this section by  
20 offering that form to eligible individuals. A health care insurer also  
21 may comply with the requirements of this section by electing to offer at  
22 least two different policy forms to eligible individuals as provided by  
23 subsection C of this section.

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

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

29 2. The offer includes at least either:

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

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

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

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

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

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

10 (a) The health care insurer will not have the capacity to deliver  
11 services adequately to additional individual enrollees because of the  
12 health care insurer's obligations to existing group contract holders and  
13 enrollees and individual enrollees.

14 (b) The health care insurer is applying this paragraph uniformly to  
15 individuals without regard to any health status-related factor of the  
16 individuals and without regard to whether the individuals are eligible  
17 individuals.

18 F. A health care insurer may deny individual health insurance  
19 coverage in the individual market to an eligible individual if the health  
20 care insurer demonstrates to the director that the health care insurer:

21 1. Does not have the financial reserves necessary to underwrite  
22 additional coverage.

23 2. Is denying coverage uniformly to all individuals in the  
24 individual market in this state pursuant to state law and without regard  
25 to any health status-related factor of the individuals and without regard  
26 to whether the individuals are eligible individuals.

27 G. If a health care insurer denies health insurance coverage in  
28 this state pursuant to subsection F of this section, the health care  
29 insurer shall not offer that coverage in the individual market in this  
30 state for one hundred eighty days after the date the coverage is denied or  
31 until the health care insurer demonstrates to the director that the health  
32 care insurer has sufficient financial reserves to underwrite additional  
33 coverage, whichever is later.

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

39 I. Nothing in this section:

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

43 2. Prevents a health care insurer that offers health insurance  
44 coverage in the individual market from establishing premium rates or

1 modifying otherwise applicable copayments or deductibles in return for  
2 adherence to programs of health promotion and disease prevention.

3 3. Requires a health care insurer that offers only short-term  
4 limited duration insurance ~~OR~~ limited benefit coverage ~~OR~~ to individuals  
5 and no other coverage to individuals in the individual market to offer  
6 individual health insurance coverage in the individual market.

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

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

13 1. Ceases to be covered under a policy offered by a health care  
14 insurer. An individual who is covered by a policy that is issued on a  
15 group basis by a health care insurer, that is terminated or not renewed at  
16 the choice of the sponsor of the group and where the replacement of the  
17 coverage is without a break in coverage is not entitled to receive the  
18 certification prescribed in this paragraph but is instead entitled to  
19 receive the certification prescribed in paragraph 2 of this subsection.

20 2. Requests certification from the health care insurer within  
21 twenty-four months after the coverage under a health insurance coverage  
22 policy offered by a health care insurer ceases.

23 K. The certificate of creditable coverage provided by a health care  
24 insurer is a written certification of the period of creditable coverage of  
25 the individual under the health insurance coverage offered by the health  
26 care insurer. The department may enforce and monitor the issuance and  
27 delivery of the notices and certificates by health care insurers as  
28 required by this section, section 20-1380, the health insurance  
29 portability and accountability act of 1996 (P.L. 104-191; 110 Stat. 1936)  
30 and any federal regulations adopted to implement the health insurance  
31 portability and accountability act of 1996.

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

36 1. The date that the certificate is issued.

37 2. The name of the individual or dependent for whom the certificate  
38 applies and any other information that is necessary to allow the issuer  
39 providing the coverage specified in the certificate to identify the  
40 individual, including the individual's identification number under the  
41 policy and the name of the policyholder if the certificate is for or  
42 includes a dependent.

43 3. The name, address and telephone number of the issuer providing  
44 the certificate.



1           0. A health care insurer shall calculate creditable coverage  
2 according to the following rules:

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

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

10          3. The health care insurer shall not include any period that an  
11 individual is in a waiting period or an affiliation period for any health  
12 coverage or is awaiting action by a health care insurer on an application  
13 for the issuance of health insurance coverage when the health care insurer  
14 determines the continuous period pursuant to paragraph 1 of this  
15 subsection.

16          4. The health care insurer shall not include any period that an  
17 individual is waiting for approval of an application for health care  
18 coverage, provided the individual submitted an application to the health  
19 care insurer for health care coverage within sixty-three consecutive days  
20 after the individual's most recent creditable coverage.

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

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

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

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

42           (a) An employee welfare benefit plan that provides medical care to  
43 employees or the employees' dependents directly or through insurance,  
44 reimbursement or otherwise pursuant to the employee retirement income

1 security act of 1974 (P.L. 93-406; 88 Stat. 829; 29 United States Code  
2 sections 1001 through 1461).

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

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

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

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

16 2. The individual is not eligible for coverage under:

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

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

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

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

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

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

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

38 Q. Notwithstanding subsection P of this section, an individual is  
39 an eligible individual if:

40 1. The individual is an individual enrollee in a health care  
41 services organization that is domiciled in this state on the date that the  
42 health care services organization is declared insolvent, including any  
43 health care services organization that is not an accountable health plan  
44 as defined in section 20-2301.

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

4           3. The individual satisfies the requirements of an eligible  
5 individual as prescribed in this section other than the required period of  
6 creditable coverage.

7           R. Notwithstanding subsection P of this section, a newborn child,  
8 adopted child or child placed for adoption is an eligible individual if  
9 the child was timely enrolled and otherwise would have met the definition  
10 of an eligible individual as prescribed in this section other than the  
11 required period of creditable coverage and the child is not subject to any  
12 preexisting condition exclusion or limitation if the child has been  
13 continuously covered under health insurance coverage or a health benefits  
14 plan offered by an accountable health plan since birth, adoption or  
15 placement for adoption.

16           S. If a health care insurer imposes a waiting period for coverage  
17 of preexisting conditions, within a reasonable period of time after  
18 receiving an individual's proof of creditable coverage and not later than  
19 the date by which the individual must select an insurance plan, the health  
20 care insurer shall give the individual written disclosure of the insurer's  
21 determination regarding any preexisting condition exclusion period that  
22 applies to that individual. The disclosure shall include all of the  
23 following information:

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

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

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

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

36           U. For the purposes of this section and section 20-1380 as  
37 applicable:

38           1. "Affiliation period" has the same meaning prescribed in section  
39 20-2301.

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

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

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

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

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

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

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

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

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

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

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

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

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

25           (l) A policy or contract, including short-term limited duration  
26 insurance, issued on an individual basis by an insurer, a health care  
27 services organization, a hospital service corporation, a medical service  
28 corporation or a hospital, medical, dental and optometric service  
29 corporation ~~or made available to persons defined as eligible under section~~  
30 ~~36-2901, paragraph 6, subdivision (b), (c), (d) or (e).~~

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

33           4. "Delinquency proceeding" has the same meaning prescribed in  
34 section 20-611.

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

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

- 1           7. "Health care insurer" means a disability insurer, group  
2 disability insurer, blanket disability insurer, health care services  
3 organization, hospital service corporation, medical service corporation or  
4 ~~a~~ hospital, medical, dental and optometric service corporation.
- 5           8. "Health status-related factor" means any factor in relation to  
6 the health of the individual or a dependent of the individual enrolled or  
7 to be enrolled in a health care services organization including:  
8           (a) Health status.  
9           (b) Medical condition, including physical and mental illness.  
10          (c) Claims experience.  
11          (d) Receipt of health care.  
12          (e) Medical history.  
13          (f) Genetic information.  
14          (g) Evidence of insurability, including conditions arising out of  
15 acts of domestic violence as defined in section 20-448.  
16          (h) The existence of a physical or mental disability.
- 17           9. "Higher level of coverage" means a policy form for which the  
18 actuarial value of the benefits under the health insurance coverage  
19 offered by a health care insurer is at least fifteen ~~per cent~~ PERCENT more  
20 than the actuarial value of the health insurance coverage offered by the  
21 health care insurer as a lower level of coverage in this state but not  
22 more than one hundred twenty ~~per cent~~ PERCENT of a policy form weighted  
23 average.
- 24           10. "Individual health insurance coverage" means health insurance  
25 coverage offered by a health care insurer to individuals in the individual  
26 market but does not include limited benefit coverage or short-term limited  
27 duration insurance. A health care insurer that offers limited benefit  
28 coverage or short-term limited duration insurance to individuals and no  
29 other coverage to individuals in the individual market is not a health  
30 care insurer that offers health insurance coverage in the individual  
31 market.
- 32           11. "Limited benefit coverage" has the same meaning prescribed in  
33 section 20-1137.
- 34           12. "Lower level of coverage" means a policy form offered by a  
35 health care insurer for which the actuarial value of the benefits under  
36 the health insurance coverage is at least eighty-five ~~per cent~~ PERCENT but  
37 not more than one hundred ~~per cent~~ PERCENT of the policy form weighted  
38 average.
- 39           13. "Network plan" means a health care plan provided by a health  
40 care insurer under which the financing and delivery of health care  
41 services are provided, in whole or in part, through a defined set of  
42 providers either under contract with a health care insurer licensed  
43 pursuant to chapter 4, article 3 of this title or under contract with a  
44 health care insurer in accordance with the determination made by the

1 director pursuant to section 20-1053 regarding the geographic or service  
2 area in which a health care insurer may operate.

3 14. "Policy form weighted average" means the average actuarial  
4 value of the benefits provided by a health care insurer that issues health  
5 coverage in this state that is provided by either the health care insurer  
6 or, if the data are available, by all health care insurers that issue  
7 health coverage in this state in the individual health coverage market  
8 during the previous calendar year, except coverage pursuant to this  
9 section, weighted by the enrollment for all coverage forms.

10 15. "Preexisting condition" means a condition, regardless of the  
11 cause of the condition, for which medical advice, diagnosis, care or  
12 treatment was recommended or received within not more than six months  
13 before the date of the enrollment of the individual under the health  
14 insurance policy or other contract that provides health coverage benefits.  
15 A genetic condition is not a preexisting condition in the absence of a  
16 diagnosis of the condition related to the genetic information and shall  
17 not result in a preexisting condition limitation or preexisting condition  
18 exclusion.

19 16. "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 17. "Short-term limited duration insurance" ~~means health insurance~~  
24 ~~coverage that is offered by a health care insurer, that remains in effect~~  
25 ~~for no more than one hundred eighty-five days, that cannot be renewed or~~  
26 ~~otherwise continued for more than one hundred eighty days~~ HAS THE SAME  
27 MEANING PRESCRIBED IN SECTION 20-1384 and ~~that~~ is not intended or marketed  
28 as health insurance coverage subject to guaranteed issuance or guaranteed  
29 renewal provisions of the laws of this state but that is creditable  
30 coverage within the meaning of this section and section 20-2301.

31 Sec. 2. Title 20, chapter 6, article 4, Arizona Revised Statutes,  
32 is amended by adding section 20-1384, to read:

33 20-1384. Short-term limited duration insurance; notice;  
34 definitions

35 A. ALL POLICIES OR CERTIFICATES ISSUED, DELIVERED OR RENEWED IN  
36 THIS STATE FOR SHORT-TERM LIMITED DURATION INSURANCE SHALL DISPLAY ON THE  
37 POLICY'S FACT PAGE AND IN ANY APPLICATION MATERIALS PROVIDED IN CONNECTION  
38 WITH ENROLLMENT IN SUCH COVERAGE THE FOLLOWING FEDERAL DISCLOSURE IN AT  
39 LEAST FOURTEEN-POINT TYPE:

40 NOTICE

41 THIS COVERAGE IS NOT REQUIRED TO COMPLY WITH CERTAIN FEDERAL  
42 MARKET REQUIREMENTS FOR HEALTH INSURANCE, PRINCIPALLY THOSE  
43 CONTAINED IN THE AFFORDABLE CARE ACT. BE SURE TO CHECK YOUR  
44 POLICY CAREFULLY TO MAKE SURE YOU ARE AWARE OF ANY EXCLUSIONS  
45 OR LIMITATIONS REGARDING COVERAGE OF PREEXISTING CONDITIONS OR

1 HEALTH BENEFITS (SUCH AS HOSPITALIZATION, EMERGENCY SERVICES,  
2 MATERNITY CARE, PREVENTIVE CARE, PRESCRIPTION DRUGS AND MENTAL  
3 HEALTH AND SUBSTANCE USE DISORDER SERVICES). YOUR POLICY  
4 MIGHT ALSO HAVE LIFETIME OR ANNUAL DOLLAR LIMITS ON HEALTH  
5 BENEFITS, OR BOTH. IF THIS COVERAGE EXPIRES OR YOU LOSE  
6 ELIGIBILITY FOR THIS COVERAGE, YOU MIGHT HAVE TO WAIT UNTIL AN  
7 OPEN ENROLLMENT PERIOD TO GET OTHER HEALTH INSURANCE COVERAGE.

8 B. A HEALTH CARE INSURER SHALL PROVIDE NOTICE TO THE INSURED BEFORE  
9 EXPIRATION THAT THE POLICY NEEDS TO BE RENEWED OR IS EXPIRING.

10 C. FOR THE PURPOSES OF THIS SECTION:

11 1. "HEALTH CARE INSURER" HAS THE SAME MEANING PRESCRIBED IN SECTION  
12 20-1379.

13 2. "SHORT-TERM LIMITED DURATION INSURANCE" MEANS HEALTH INSURANCE  
14 COVERAGE THAT IS OFFERED BY A HEALTH CARE INSURER, THAT HAS AN EXPIRATION  
15 DATE SPECIFIED IN THE CONTRACT THAT IS LESS THAN TWELVE MONTHS AFTER THE  
16 ORIGINAL EFFECTIVE DATE OF THE CONTRACT AND, TAKING INTO ACCOUNT RENEWALS  
17 OR EXTENSIONS, THAT HAS A DURATION OF NOT LONGER THAN THIRTY-SIX MONTHS.