

REFERENCE TITLE: insulin drugs; cost sharing limit

State of Arizona  
Senate  
Fifty-fifth Legislature  
First Regular Session  
2021

## **SB 1725**

Introduced by  
Senators Rios: Alston, Quezada, Steele; Representatives Andrade, Jermaine

AN ACT

AMENDING SECTIONS 20-826, 20-1057, 20-1342, 20-1402, 20-1404 AND 20-2325,  
ARIZONA REVISED STATUTES; RELATING TO HEALTH CARE INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

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

4 20-826. Subscription contracts; definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24 O. Nothing in subsection N of this section:

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

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

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

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

40 1. Blood glucose monitors.

41 2. Blood glucose monitors for the legally blind.

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

44 4. Insulin preparations and glucagon.

45 5. Insulin cartridges.

- 1           6. Drawing up devices and monitors for the visually impaired.
- 2           7. Injection aids.
- 3           8. Insulin cartridges for the legally blind.
- 4           9. Syringes and lancets, including automatic lancing devices.
- 5           10. Prescribed oral agents for controlling blood sugar that are
- 6 included on the plan formulary.

7           11. To the extent coverage is required under medicare, podiatric

8 appliances for prevention of complications associated with diabetes.

9           12. Any other device, medication, equipment or supply for which

10 coverage is required under medicare from and after January 1, 1999. The

11 coverage required in this paragraph is effective six months after the

12 coverage is required under medicare.

13           Q. ~~Nothing in~~ Subsection P of this section ~~prohibits~~ **DOES NOT**

14 **PROHIBIT** a medical service corporation, a hospital service corporation or

15 a hospital, medical, dental and optometric service corporation from

16 imposing deductibles, coinsurance or other cost sharing in relation to

17 benefits for equipment or supplies for the treatment of diabetes, **EXCEPT**

18 **THAT A SERVICE CORPORATION SHALL LIMIT THE TOTAL AMOUNT THAT A SUBSCRIBER**

19 **MUST PAY FOR A COVERED PRESCRIPTION INSULIN DRUG TO NOT MORE THAN \$100 PER**

20 **THIRTY-DAY SUPPLY OF INSULIN, REGARDLESS OF THE AMOUNT OR TYPE OF INSULIN**

21 **REQUIRED TO FILL THE SUBSCRIBER'S PRESCRIPTION. FOR THE PURPOSES OF THIS**

22 **SUBSECTION, "PRESCRIPTION INSULIN DRUG" MEANS ANY PRESCRIPTION MEDICATION**

23 **AS DEFINED IN SECTION 32-1901 THAT IS PRESCRIBED BY A HEALTH CARE**

24 **PROFESSIONAL TO A SUBSCRIBER TO TREAT THE SUBSCRIBER'S CONDITION, THAT**

25 **CONTAINS INSULIN AND THAT IS USED TO TREAT DIABETES.**

26           R. Any hospital or medical service contract that provides coverage

27 for prescription drugs shall not limit or exclude coverage for any

28 prescription drug prescribed for the treatment of cancer on the basis that

29 the prescription drug has not been approved by the United States food and

30 drug administration for the treatment of the specific type of cancer for

31 which the prescription drug has been prescribed, if the prescription drug

32 has been recognized as safe and effective for treatment of that specific

33 type of cancer in one or more of the standard medical reference compendia

34 prescribed in subsection S of this section or medical literature that

35 meets the criteria prescribed in subsection S of this section. The

36 coverage required under this subsection includes covered medically

37 necessary services associated with the administration of the prescription

38 drug. This subsection does not:

39           1. Require coverage of any prescription drug used in the treatment

40 of a type of cancer if the United States food and drug administration has

41 determined that the prescription drug is contraindicated for that type of

42 cancer.

43           2. Require coverage for any experimental prescription drug that is

44 not approved for any indication by the United States food and drug

45 administration.

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

4           4. Notwithstanding section 20-841.05, require reimbursement or  
5 coverage for any prescription drug that is not included in the drug  
6 formulary or list of covered prescription drugs specified in the contract.

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

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

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

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

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

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

21           (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

43           T. A corporation shall not issue or deliver any advertising matter  
44 or sales material to any person in this state until the corporation files  
45 the advertising matter or sales material with the director. This

1 subsection does not require a corporation to have the prior approval of  
2 the director to issue or deliver the advertising matter or sales material.  
3 If the director finds that the advertising matter or sales material, in  
4 whole or in part, is false, deceptive or misleading, the director may  
5 issue an order disapproving the advertising matter or sales material,  
6 directing the corporation to cease and desist from issuing, circulating,  
7 displaying or using the advertising matter or sales material within a  
8 period of time specified by the director but not less than ten days and  
9 imposing any penalties prescribed in this title. At least five days  
10 before issuing an order pursuant to this subsection, the director shall  
11 provide the corporation with a written notice of the basis of the order to  
12 provide the corporation with an opportunity to cure the alleged deficiency  
13 in the advertising matter or sales material within a single five day  
14 period for the particular advertising matter or sales material at issue.  
15 The corporation may appeal the director's order pursuant to title 41,  
16 chapter 6, article 10. Except as otherwise provided in this subsection, a  
17 corporation may obtain a stay of the effectiveness of the order as  
18 prescribed in section 20-162. If the director certifies in the order and  
19 provides a detailed explanation of the reasons in support of the  
20 certification that continued use of the advertising matter or sales  
21 material poses a threat to the health, safety or welfare of the public,  
22 the order may be entered immediately without opportunity for cure and the  
23 effectiveness of the order is not stayed pending the hearing on the notice  
24 of appeal but the hearing shall be promptly instituted and determined.

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

29 V. The metabolic disorders triggering medical foods coverage under  
30 this section shall:

31 1. Be part of the newborn screening program prescribed in section  
32 36-694.

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

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

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

43 W. Medical foods eligible for coverage under this section shall be  
44 prescribed or ordered under the supervision of a physician licensed

1 pursuant to title 32, chapter 13 or 17 as medically necessary for the  
2 therapeutic treatment of an inherited metabolic disease.

3 X. A hospital service corporation or medical service corporation  
4 shall cover at least fifty ~~per cent~~ PERCENT of the cost of medical foods  
5 prescribed to treat inherited metabolic disorders and covered pursuant to  
6 this section. A hospital service corporation or medical service  
7 corporation may limit the maximum annual benefit for medical foods under  
8 this section to ~~five thousand dollars~~ \$5,000, which applies to the cost of  
9 all prescribed modified low protein foods and metabolic formula.

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

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

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

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

32 Z. Notwithstanding subsection Y of this section, a religiously  
33 affiliated employer may require that the corporation provide a contract  
34 without coverage for specific items or services required under subsection  
35 Y of this section because providing or paying for coverage of the specific  
36 items or services is contrary to the religious beliefs of the religiously  
37 affiliated employer offering the plan. If a religiously affiliated  
38 employer objects to providing coverage for specific items or services  
39 required under subsection Y of this section, a written affidavit shall be  
40 filed with the corporation stating the objection. On receipt of the  
41 affidavit, the corporation shall issue to the religiously affiliated  
42 employer a contract that excludes coverage for specific items or services  
43 required under subsection Y of this section. The corporation shall retain  
44 the affidavit for the duration of the contract and any renewals of the  
45 contract. This subsection shall not exclude coverage for prescription

1 contraceptive methods ordered by a health care provider with prescriptive  
2 authority for medical indications other than for contraceptive,  
3 abortifacient, abortion or sterilization purposes. A religiously  
4 affiliated employer offering the plan may state religious beliefs in its  
5 affidavit and may require the subscriber to first pay for the prescription  
6 and then submit a claim to the hospital service corporation, medical  
7 service corporation or hospital, medical, dental and optometric service  
8 corporation along with evidence that the prescription is not for a purpose  
9 covered by the objection. A hospital service corporation, medical service  
10 corporation or hospital, medical, dental and optometric service  
11 corporation may charge an administrative fee for handling these claims.

12 AA. Subsection Z of this section does not authorize a religiously  
13 affiliated employer to obtain an employee's protected health information  
14 or to violate the health insurance portability and accountability act of  
15 1996 (P.L. 104-191; 110 Stat. 1936) or any federal regulations adopted  
16 pursuant to that act.

17 BB. Subsection Z of this section shall not be construed to restrict  
18 or limit any protections against employment discrimination that are  
19 prescribed in federal or state law.

20 CC. For the purposes of:

21 1. This section:

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

25 (b) "Medical foods" means modified low protein foods and metabolic  
26 formula.

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

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

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

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

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

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

41 (i) Formulated to be consumed or administered enterally under the  
42 supervision of a physician who is licensed pursuant to title 32, chapter  
43 13 or 17.

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

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

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

10 2. Subsection E of this section, "child", for purposes of initial  
11 coverage of an adopted child or a child placed for adoption but not for  
12 purposes of termination of coverage of such child, means a person WHO IS  
13 under eighteen years of age.

14 3. Subsections Z and AA of this section, "religiously affiliated  
15 employer" means either:

16 (a) An entity for which all of the following apply:

17 (i) The entity primarily employs persons who share the religious  
18 tenets of the entity.

19 (ii) The entity primarily serves persons who share the religious  
20 tenets of the entity.

21 (iii) The entity is a nonprofit organization as described in  
22 section 6033(a)(3)(A)(i) or (iii) of the internal revenue code of 1986, as  
23 amended.

24 (b) An entity whose articles of incorporation clearly state that it  
25 is a religiously motivated organization and whose religious beliefs are  
26 central to the organization's operating principles.

27 Sec. 2. Section 20-1057, Arizona Revised Statutes, is amended to  
28 read:

29 20-1057. Evidence of coverage by health care services  
30 organizations; renewability; definitions

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

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

1 premium is required to provide coverage for a child, the contract may  
2 require that notification of birth, adoption or adoption placement of the  
3 child and payment of the required premium must be furnished to the insurer  
4 within thirty-one days after the date of birth, adoption or adoption  
5 placement in order to have the coverage continue beyond the thirty-one day  
6 period.

7 C. Any contract, except accidental death and dismemberment, that  
8 provides coverage for psychiatric, drug abuse or alcoholism services shall  
9 require the health care services organization to provide reimbursement for  
10 ~~such~~ THOSE services in accordance with the terms of the contract without  
11 regard to whether the covered services are rendered in a psychiatric  
12 special hospital or general hospital.

13 D. ~~NO~~ AN evidence of coverage or amendment to the coverage shall  
14 NOT be issued or delivered to any person in this state until a copy of the  
15 form of the evidence of coverage or amendment to the coverage has been  
16 filed with and approved by the director.

17 E. An evidence of coverage shall contain a clear and complete  
18 statement if a contract, or a reasonably complete summary if a certificate  
19 of contract, of:

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

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

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

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

29 F. An evidence of coverage shall not contain provisions or  
30 statements that are unjust, unfair, inequitable, misleading or deceptive,  
31 that encourage misrepresentation or that are untrue.

32 G. The director shall approve any form of evidence of coverage if  
33 the requirements of subsections E and F of this section are met. It is  
34 unlawful to issue such form until approved. If the director does not  
35 disapprove any such form within forty-five days after the filing of the  
36 form, it is deemed approved. If the director disapproves a form of  
37 evidence of coverage, the director shall notify the health care services  
38 organization. In the notice, the director shall specify the reasons for  
39 the director's disapproval. The director shall grant a hearing on such  
40 disapproval within fifteen days after a request for a hearing in writing  
41 is received from the health care services organization.

42 H. A health care services organization shall not cancel or refuse  
43 to renew an enrollee's evidence of coverage that was issued on a group  
44 basis without giving notice of the cancellation or nonrenewal to the  
45 enrollee and, on request of the director, to the department of insurance

1 and financial institutions. A notice by the organization to the enrollee  
2 of cancellation or nonrenewal of the enrollee's evidence of coverage shall  
3 be mailed to the enrollee at least sixty days before the effective date of  
4 such cancellation or nonrenewal. The notice shall include or be  
5 accompanied by a statement in writing of the reasons as stated in the  
6 contract for such action by the organization. Failure of the organization  
7 to comply with this subsection shall invalidate any cancellation or  
8 nonrenewal except a cancellation or nonrenewal for nonpayment of premium,  
9 for fraud or misrepresentation in the application or other enrollment  
10 documents or for loss of eligibility as defined in the evidence of  
11 coverage. A health care services organization shall not cancel an  
12 enrollee's evidence of coverage issued on a group basis because of the  
13 enrollee's or dependent's age, except for loss of eligibility as defined  
14 in the evidence of coverage, sex, health status-related factor, national  
15 origin or frequency of utilization of health care services of the  
16 enrollee. An evidence of coverage issued on a group basis shall clearly  
17 delineate all terms under which the health care services organization may  
18 cancel or refuse to renew an evidence of coverage for an enrollee or  
19 dependent. Nothing in this subsection prohibits the cancellation or  
20 nonrenewal of a health benefits plan contract issued on a group basis for  
21 any of the reasons allowed in section 20-2309. A health care services  
22 organization may cancel or nonrenew an evidence of coverage issued to an  
23 individual on a nongroup basis only for the reasons allowed by subsection  
24 N of this section.

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

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

38 1. A baseline mammogram for a woman from age thirty-five to  
39 thirty-nine.

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

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

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

- 5 1. The child is adopted within one year of birth.
- 6 2. The enrollee is legally obligated to pay the costs of birth.
- 7 3. All preexisting conditions and other limitations have been met  
8 and all deductibles and copayments have been paid by the enrollee.
- 9 4. The enrollee has notified the insurer of the enrollee's  
10 acceptability to adopt children pursuant to section 8-105 within sixty  
11 days after such approval or within sixty days after a change in insurance  
12 policies, plans or companies.

13 L. The coverage prescribed by subsection K of this section is  
14 excess to any other coverage the natural mother may have for maternity  
15 benefits except coverage made available to persons pursuant to title 36,  
16 chapter 29. If such other coverage exists the agency, attorney or  
17 individual arranging the adoption shall make arrangements for the  
18 insurance to pay those costs that may be covered under that policy and  
19 shall advise the adopting parent in writing of the existence and extent of  
20 the coverage without disclosing any confidential information such as the  
21 identity of the natural parent. The enrollee adopting parents shall  
22 notify their health care services organization of the existence and extent  
23 of the other coverage. A health care services organization is not  
24 required to pay any costs in excess of the amounts it would have been  
25 obligated to pay to its hospitals and providers if the natural mother and  
26 child had received the maternity and newborn care directly from or through  
27 that health care services organization.

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

- 31 1. Each enrollee including the enrollee's enrolled dependents  
32 leaving a group.
- 33 2. Each enrollee and the enrollee's dependents who would otherwise  
34 cease to be eligible for membership because of the age of the enrollee or  
35 the enrollee's dependents or the death or the dissolution of marriage of  
36 an enrollee.

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

- 42 1. The individual has failed to pay premiums or contributions in  
43 accordance with the terms of the evidence of coverage or the health care  
44 services organization has not received premium payments in a timely  
45 manner.

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

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

7           4. If the health care services organization offers a health care  
8 plan in this state through a network plan, the individual no longer  
9 resides, lives or works in the service area served by the network plan or  
10 in an area for which the health care services organization is authorized  
11 to transact business but only if the coverage is terminated uniformly  
12 without regard to any health status-related factor of the covered  
13 individual.

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

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

24           P. Any person who is a United States armed forces reservist, who is  
25 ordered to active military duty on or after August 22, 1990 and who was  
26 enrolled in a health care plan shall have the right to reinstate such  
27 coverage on release from active military duty subject to the following  
28 conditions:

29           1. The reservist shall make written application to the health plan  
30 within ninety days of discharge from active military duty or within one  
31 year of hospitalization continuing after discharge. Coverage shall be  
32 effective on receipt of the application by the health plan.

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

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

- 40           1. Conditions of eligibility.
- 41           2. Coverage of dependents.
- 42           3. Preexisting conditions.
- 43           4. Termination of insurance.
- 44           5. Probationary periods.
- 45           6. Limitations.

1 7. Exceptions.

2 8. Reductions.

3 9. Elimination periods.

4 10. Requirements for replacement.

5 11. Any other conditions of evidences of coverage.

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

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

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

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

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

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

33 S. ~~Nothing in~~ Subsection R of this section **DOES NOT**:

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

37 2. ~~Prevents~~ **PREVENT** a health care services organization from  
38 imposing deductibles, coinsurance or other cost sharing in relation to  
39 benefits for hospital lengths of stay in connection with childbirth for a  
40 mother or a newborn child under the contract, except that any coinsurance  
41 or other cost sharing for any portion of a period within a hospital length  
42 of stay required pursuant to subsection R of this section shall not be  
43 greater than the coinsurance or cost sharing for any preceding portion of  
44 that stay.

1           3. ~~Prevents~~ PREVENT a health care services organization from  
2 negotiating the level and type of reimbursement with a provider for care  
3 provided in accordance with subsection R of this section.

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

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

26           U. ~~Nothing in~~ Subsection T of this section DOES NOT:

27           1. ~~Entitles~~ ENTITLE a member or enrollee of a health care services  
28 organization to equipment or supplies for the treatment of diabetes that  
29 are not medically necessary as determined by the health care services  
30 organization medical director or the medical director's designee.

31           2. ~~Provides~~ PROVIDE coverage for diabetic supplies obtained by a  
32 member or enrollee of a health care services organization without a  
33 prescription unless otherwise allowed pursuant to the terms of the health  
34 care plan.

35           3. ~~Prohibits~~ PROHIBIT a health care services organization from  
36 imposing deductibles, coinsurance or other cost sharing in relation to  
37 benefits for equipment or supplies for the treatment of diabetes, EXCEPT  
38 THAT A HEALTH CARE SERVICES ORGANIZATION SHALL LIMIT THE TOTAL AMOUNT THAT  
39 A MEMBER OR ENROLLEE MUST PAY FOR A COVERED PRESCRIPTION INSULIN DRUG TO  
40 NOT MORE THAN \$100 PER THIRTY-DAY SUPPLY OF INSULIN, REGARDLESS OF THE  
41 AMOUNT OR TYPE OF INSULIN REQUIRED TO FILL THE MEMBER'S OR ENROLLEE'S  
42 PRESCRIPTION. FOR THE PURPOSES OF THIS PARAGRAPH, "PRESCRIPTION INSULIN  
43 DRUG" MEANS ANY PRESCRIPTION MEDICATION AS DEFINED IN SECTION 32-1901 THAT  
44 IS PRESCRIBED BY A HEALTH CARE PROFESSIONAL TO A MEMBER OR ENROLLEE TO

1 TREAT THE MEMBER'S OR ENROLLEE'S CONDITION, THAT CONTAINS INSULIN AND THAT  
2 IS USED TO TREAT DIABETES.

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

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

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

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

26 4. Notwithstanding section 20-1057.02, require reimbursement or  
27 coverage for any prescription drug that is not included in the drug  
28 formulary or list of covered prescription drugs specified in the contract  
29 or evidence of coverage.

30 5. Notwithstanding section 20-1057.02, prohibit a contract or  
31 evidence of coverage from limiting or excluding coverage of a prescription  
32 drug, if the decision to limit or exclude coverage of the prescription  
33 drug is not based primarily on the coverage of prescription drugs required  
34 by this section.

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

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

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

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

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

45 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

22 X. A health care services organization shall not issue or deliver  
23 any advertising matter or sales material to any person in this state until  
24 the health care services organization files the advertising matter or  
25 sales material with the director. This subsection does not require a  
26 health care services organization to have the prior approval of the  
27 director to issue or deliver the advertising matter or sales material. If  
28 the director finds that the advertising matter or sales material, in whole  
29 or in part, is false, deceptive or misleading, the director may issue an  
30 order disapproving the advertising matter or sales material, directing the  
31 health care services organization to cease and desist from issuing,  
32 circulating, displaying or using the advertising matter or sales material  
33 within a period of time specified by the director but not less than ten  
34 days and imposing any penalties prescribed in this title. At least five  
35 days before issuing an order pursuant to this subsection, the director  
36 shall provide the health care services organization with a written notice  
37 of the basis of the order to provide the health care services organization  
38 with an opportunity to cure the alleged deficiency in the advertising  
39 matter or sales material within a single five day period for the  
40 particular advertising matter or sales material at issue. The health care  
41 services organization may appeal the director's order pursuant to title  
42 41, chapter 6, article 10. Except as otherwise provided in this  
43 subsection, a health care services organization may obtain a stay of the  
44 effectiveness of the order as prescribed in section 20-162. If the  
45 director certifies in the order and provides a detailed explanation of the

1 reasons in support of the certification that continued use of the  
2 advertising matter or sales material poses a threat to the health, safety  
3 or welfare of the public, the order may be entered immediately without  
4 opportunity for cure and the effectiveness of the order is not stayed  
5 pending the hearing on the notice of appeal but the hearing shall be  
6 promptly instituted and determined.

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

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

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

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

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

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

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

30 BB. A health care services organization shall cover at least fifty  
31 percent of the cost of medical foods prescribed to treat inherited  
32 metabolic disorders and covered pursuant to this section. An organization  
33 may limit the maximum annual benefit for medical foods under this section  
34 to \$5,000, which applies to the cost of all prescribed modified low  
35 protein foods and metabolic formula.

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

39 DD. For the purposes of:

40 1. This section:

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

44 (b) "Medical foods" means modified low protein foods and metabolic  
45 formula.

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

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

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

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

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

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

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

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

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

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

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

33 Sec. 3. Section 20-1342, Arizona Revised Statutes, is amended to  
34 read:

35 20-1342. Scope and format of policy; definitions

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

39 1. The entire money and other considerations shall be expressed in  
40 the policy.

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

43 3. It shall purport to insure only one person, except that a policy  
44 may insure, originally or by subsequent amendment, on the application of  
45 the policyholder or the policyholder's spouse, any two or more eligible

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

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

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

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

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

1 of rates or classification of risks, or short-rate table filed with the  
2 director.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 1 C. ~~Nothing in~~ Subsection B of this section DOES NOT:  
2 1. ~~Requires~~ REQUIRE a mother to give birth in a hospital or to stay  
3 in the hospital for a fixed period of time following the birth of the  
4 child.  
5 2. ~~Prevents~~ PREVENT an insurer from imposing deductibles,  
6 coinsurance or other cost sharing in relation to benefits for hospital  
7 lengths of stay in connection with childbirth for a mother or a newborn  
8 child under the contract, except that any coinsurance or other cost  
9 sharing for any portion of a period within a hospital length of stay  
10 required pursuant to subsection B of this section shall not be greater  
11 than the coinsurance or cost sharing for any preceding portion of that  
12 stay.  
13 3. ~~Prevents~~ PREVENT an insurer from negotiating the level and type  
14 of reimbursement with a provider for care provided in accordance with  
15 subsection B of this section.  
16 D. Any contract that provides coverage for diabetes shall also  
17 provide coverage for equipment and supplies that are medically necessary  
18 and that are prescribed by a health care provider including:  
19 1. Blood glucose monitors.  
20 2. Blood glucose monitors for the legally blind.  
21 3. Test strips for glucose monitors and visual reading and urine  
22 testing strips.  
23 4. Insulin preparations and glucagon.  
24 5. Insulin cartridges.  
25 6. Drawing up devices and monitors for the visually impaired.  
26 7. Injection aids.  
27 8. Insulin cartridges for the legally blind.  
28 9. Syringes and lancets including automatic lancing devices.  
29 10. Prescribed oral agents for controlling blood sugar that are  
30 included on the plan formulary.  
31 11. To the extent coverage is required under medicare, podiatric  
32 appliances for prevention of complications associated with diabetes.  
33 12. Any other device, medication, equipment or supply for which  
34 coverage is required under medicare from and after January 1, 1999. The  
35 coverage required in this paragraph is effective six months after the  
36 coverage is required under medicare.  
37 E. ~~Nothing in~~ Subsection D of this section DOES NOT:  
38 1. ~~Prohibits~~ PROHIBIT a disability insurer from imposing  
39 deductibles, coinsurance or other cost sharing in relation to benefits for  
40 equipment or supplies for the treatment of diabetes, EXCEPT THAT A  
41 DISABILITY INSURER SHALL LIMIT THE TOTAL AMOUNT THAT AN INSURED MUST PAY  
42 FOR A COVERED PRESCRIPTION INSULIN DRUG TO NOT MORE THAN \$100 PER  
43 THIRTY-DAY SUPPLY OF INSULIN, REGARDLESS OF THE AMOUNT OR TYPE OF INSULIN  
44 REQUIRED TO FILL THE INSURED'S PRESCRIPTION. FOR THE PURPOSES OF THIS  
45 PARAGRAPH, "PRESCRIPTION INSULIN DRUG" MEANS ANY PRESCRIPTION MEDICATION

1 AS DEFINED IN SECTION 32-1901 THAT IS PRESCRIBED BY A HEALTH CARE  
2 PROFESSIONAL TO AN INSURED TO TREAT THE INSURED'S CONDITION, THAT CONTAINS  
3 INSULIN AND THAT IS USED TO TREAT DIABETES.

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

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

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

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

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

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

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

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

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

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

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

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

45 (c) Thomson Micromedex compendium DrugDex.

1 (d) Elsevier gold standard's clinical pharmacology compendium.  
2 (e) Other authoritative compendia as identified by the secretary of  
3 the United States department of health and human services.

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

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

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

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

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

26 I. The metabolic disorders triggering medical foods coverage under  
27 this section shall:

28 1. Be part of the newborn screening program prescribed in section  
29 36-694.

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

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

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

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

1 K. An insurer shall cover at least fifty ~~per cent~~ PERCENT of the  
2 cost of medical foods prescribed to treat inherited metabolic disorders  
3 and covered pursuant to this section. An insurer may limit the maximum  
4 annual benefit for medical foods under this section to ~~five thousand~~  
5 ~~dollars~~ \$5,000, which applies to the cost of all prescribed modified low  
6 protein foods and metabolic formula.

7 L. For the purposes of:

8 1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

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

1           Sec. 4. Section 20-1402, Arizona Revised Statutes, is amended to  
2 read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

31 (c) A mammogram every year for a woman WHO IS fifty years of age  
32 and over.

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

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

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

39 (c) All preexisting conditions and other limitations have been met  
40 by the insured.

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

1           8. The coverage prescribed by paragraph 7 of this subsection is  
2 excess to any other coverage the natural mother may have for maternity  
3 benefits except coverage made available to persons pursuant to title 36,  
4 chapter 29, ~~but not including coverage made available to persons defined~~  
5 ~~as eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d)~~  
6 ~~and (e)~~. If such other coverage exists the agency, attorney or individual  
7 arranging the adoption shall make arrangements for the insurance to pay  
8 those costs that may be covered under that policy and shall advise the  
9 adopting parent in writing of the existence and extent of the coverage  
10 without disclosing any confidential information such as the identity of  
11 the natural parent. The insured adopting parents shall notify their  
12 insurer of the existence and extent of the other coverage.

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

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

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

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

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

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

39           C. ~~Nothing in~~ Subsection B of this section **DOES NOT**:

40           1. ~~Requires~~ **REQUIRE** a mother to give birth in a hospital or to stay  
41 in the hospital for a fixed period of time following the birth of the  
42 child.

43           2. ~~Prevents~~ **PREVENT** an insurer from imposing deductibles,  
44 coinsurance or other cost sharing in relation to benefits for hospital  
45 lengths of stay in connection with childbirth for a mother or a newborn

1 child under the policy, except that any coinsurance or other cost sharing  
2 for any portion of a period within a hospital length of stay required  
3 pursuant to subsection B of this section shall not be greater than the  
4 coinsurance or cost sharing for any preceding portion of that stay.

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

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

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

29 E. ~~Nothing in~~ Subsection D of this section ~~prohibits~~ DOES NOT  
30 PROHIBIT a group disability insurer from imposing deductibles, coinsurance  
31 or other cost sharing in relation to benefits for equipment or supplies  
32 for the treatment of diabetes, EXCEPT THAT A GROUP DISABILITY INSURER  
33 SHALL LIMIT THE TOTAL AMOUNT THAT AN INSURED MUST PAY FOR A COVERED  
34 PRESCRIPTION INSULIN DRUG TO NOT MORE THAN \$100 PER THIRTY-DAY SUPPLY OF  
35 INSULIN, REGARDLESS OF THE AMOUNT OR TYPE OF INSULIN REQUIRED TO FILL THE  
36 INSURED'S PRESCRIPTION. FOR THE PURPOSES OF THIS SUBSECTION,  
37 "PRESCRIPTION INSULIN DRUG" MEANS ANY PRESCRIPTION MEDICATION AS DEFINED  
38 IN SECTION 32-1901 THAT IS PRESCRIBED BY A HEALTH CARE PROFESSIONAL TO AN  
39 INSURED TO TREAT THE INSURED'S CONDITION, THAT CONTAINS INSULIN AND THAT  
40 IS USED TO TREAT DIABETES.

41 F. Any contract that provides coverage for prescription drugs shall  
42 not limit or exclude coverage for any prescription drug prescribed for the  
43 treatment of cancer on the basis that the prescription drug has not been  
44 approved by the United States food and drug administration for the  
45 treatment of the specific type of cancer for which the prescription drug

1 has been prescribed, if the prescription drug has been recognized as safe  
2 and effective for treatment of that specific type of cancer in one or more  
3 of the standard medical reference compendia prescribed in subsection G of  
4 this section or medical literature that meets the criteria prescribed in  
5 subsection G of this section. The coverage required under this subsection  
6 includes covered medically necessary services associated with the  
7 administration of the prescription drug. This subsection does not:

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

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

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

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

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

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

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

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

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

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

35 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

6 (c) The literature meets the uniform requirements for manuscripts  
7 submitted to biomedical journals established by the international  
8 committee of medical journal editors or is published in a journal  
9 specified by the United States department of health and human services as  
10 acceptable peer reviewed medical literature pursuant to section  
11 186(t)(2)(B) of the social security act (42 United States Code section  
12 1395x(t)(2)(B)).

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

17 I. The metabolic disorders triggering medical foods coverage under  
18 this section shall:

19 1. Be part of the newborn screening program prescribed in section  
20 36-694.

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

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

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

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

36 K. An insurer shall cover at least fifty ~~per cent~~ PERCENT of the  
37 cost of medical foods prescribed to treat inherited metabolic disorders  
38 and covered pursuant to this section. An insurer may limit the maximum  
39 annual benefit for medical foods under this section to ~~five thousand~~  
40 ~~dollars~~ \$5,000, which applies to the cost of all prescribed modified low  
41 protein foods and metabolic formula.

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

43 1. Prescription drugs shall also provide coverage for any  
44 prescribed drug or device that is approved by the United States food and  
45 drug administration for use as a contraceptive. A group disability

1 insurer may use a drug formulary, multitiered drug formulary or list but  
2 that formulary or list shall include oral, implant and injectable  
3 contraceptive drugs, intrauterine devices and prescription barrier  
4 methods. ~~if~~ The group disability insurer ~~does~~ MAY not impose deductibles,  
5 coinsurance, copayments or other cost containment measures for  
6 contraceptive drugs that are greater than the deductibles, coinsurance,  
7 copayments or other cost containment measures for other drugs on the same  
8 level of the formulary or list.

9         2. Outpatient health care services shall also provide coverage for  
10 outpatient contraceptive services. For the purposes of this paragraph,  
11 "outpatient contraceptive services" means consultations, examinations,  
12 procedures and medical services provided on an outpatient basis and  
13 related to the use of approved United States food and drug administration  
14 prescription contraceptive methods to prevent unintended pregnancies.

15         M. Notwithstanding subsection L of this section, a religiously  
16 affiliated employer may require that the insurer provide a group  
17 disability policy without coverage for specific items or services required  
18 under subsection L of this section because providing or paying for  
19 coverage of the specific items or services is contrary to the religious  
20 beliefs of the religiously affiliated employer offering the plan. If a  
21 religiously affiliated employer objects to providing coverage for specific  
22 items or services required under subsection L of this section, a written  
23 affidavit shall be filed with the insurer stating the objection. On  
24 receipt of the affidavit, the insurer shall issue to the religiously  
25 affiliated employer a group disability policy that excludes coverage for  
26 specific items or services required under subsection L of this section.  
27 The insurer shall retain the affidavit for the duration of the group  
28 disability policy and any renewals of the policy. This subsection shall  
29 not exclude coverage for prescription contraceptive methods ordered by a  
30 health care provider with prescriptive authority for medical indications  
31 other than for contraceptive, abortifacient, abortion or sterilization  
32 purposes. A religiously affiliated employer offering the policy may state  
33 religious beliefs in its affidavit and may require the insured to first  
34 pay for the prescription and then submit a claim to the insurer along with  
35 evidence that the prescription is not for a purpose covered by the  
36 objection. An insurer may charge an administrative fee for handling these  
37 claims.

38         N. Subsection M of this section does not authorize a religiously  
39 affiliated employer to obtain an employee's protected health information  
40 or to violate the health insurance portability and accountability act of  
41 1996 (P.L. 104-191; 110 Stat. 1936) or any federal regulations adopted  
42 pursuant to that act.

43         O. Subsection M of this section shall not be construed to restrict  
44 or limit any protections against employment discrimination that are  
45 prescribed in federal or state law.

1 P. For the purposes of:

2 1. This section:

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

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

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

9 (i) Formulated to be consumed or administered enterally under the  
10 supervision of a physician who is licensed pursuant to title 32, chapter  
11 13 or 17 or a registered nurse practitioner who is licensed pursuant to  
12 title 32, chapter 15.

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

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

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

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

23 (i) Formulated to be consumed or administered enterally under the  
24 supervision of a physician who is licensed pursuant to title 32, chapter  
25 13 or 17 or a registered nurse practitioner who is licensed pursuant to  
26 title 32, chapter 15.

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

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

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

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

40 3. Subsections M and N of this section, "religiously affiliated  
41 employer" means either:

42 (a) An entity for which all of the following apply:

43 (i) The entity primarily employs persons who share the religious  
44 tenets of the entity.

1 (ii) The entity serves primarily persons who share the religious  
2 tenets of the entity.

3 (iii) The entity is a nonprofit organization as described in  
4 section 6033(a)(3)(A)(i) or (iii) of the internal revenue code of 1986, as  
5 amended.

6 (b) An entity whose articles of incorporation clearly state that it  
7 is a religiously motivated organization and whose religious beliefs are  
8 central to the organization's operating principles.

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

11 20-1404. Blanket disability insurance; definitions

12 A. Blanket disability insurance is that form of disability  
13 insurance covering special groups of persons as enumerated in one of the  
14 following paragraphs:

15 1. Under a policy or contract issued to any common carrier or to  
16 any operator, owner or lessee of a means of transportation, which shall be  
17 deemed the policyholder, covering a group defined as all persons who may  
18 become passengers on such common carrier or means of transportation.

19 2. Under a policy or contract issued to an employer, who shall be  
20 deemed the policyholder, covering all employees or any group of employees  
21 defined by reference to hazards incident to an activity or activities or  
22 operations of the policyholder. Dependents of the employees and guests of  
23 the employer or employees may also be included where exposed to the same  
24 hazards.

25 3. Under a policy or contract issued to a college, school or other  
26 institution of learning or to the head or principal thereof, who or which  
27 shall be deemed the policyholder, covering students, teachers, employees  
28 or volunteers.

29 4. Under a policy or contract issued in the name of any volunteer  
30 fire department or any first aid, civil defense or other such volunteer  
31 group, or agency having jurisdiction thereof, which shall be deemed the  
32 policyholder, covering all or any group of the members, participants or  
33 volunteers of the fire department or first aid, civil defense or other  
34 group.

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

37 6. Under a policy or contract issued to a sports team or to a camp  
38 or sponsor thereof, which team or camp or sponsor thereof shall be deemed  
39 the policyholder, covering members, campers, employees, officials,  
40 supervisors or volunteers.

41 7. Under a policy or contract issued to an incorporated or  
42 unincorporated religious, charitable, recreational, educational or civic  
43 organization, or branch thereof, which organization shall be deemed the  
44 policyholder, covering any group of members, participants or volunteers  
45 defined by reference to hazards incident to an activity or activities or

1 operations sponsored or supervised by or on the premises of the  
2 policyholder.

3 8. Under a policy or contract issued to a newspaper or other  
4 publisher, which shall be deemed the policyholder, covering its carriers.

5 9. Under a policy or contract issued to a restaurant, hotel, motel,  
6 resort, innkeeper or other group with a high degree of potential customer  
7 liability, which shall be deemed the policyholder, covering patrons or  
8 guests.

9 10. Under a policy or contract issued to a health care provider or  
10 other arranger of health services, which shall be deemed the policyholder,  
11 covering patients, donors or surrogates provided that the coverage is not  
12 made a condition of receiving care.

13 11. Under a policy or contract issued to a bank, financial vendor  
14 or other financial institution, or to a parent holding company or to the  
15 trustee, trustees or agent designated by one or more banks, financial  
16 vendors or other financial institutions, which shall be deemed the  
17 policyholder, covering account holders, debtors, guarantors or purchasers.

18 12. Under a policy or contract issued to an incorporated or  
19 unincorporated association of persons having a common interest or calling,  
20 which association shall be deemed the policyholder, formed for purposes  
21 other than obtaining insurance, covering members of such association.

22 13. Under a policy or contract issued to a travel agency or other  
23 organization that provides travel-related services, which agency or  
24 organization shall be deemed the policyholder, to cover all persons for  
25 whom travel-related services are provided.

26 14. Under a policy or contract issued to a qualified marketplace  
27 platform, which is deemed the policyholder, covering qualified marketplace  
28 contractors that have executed a written contract with the qualified  
29 marketplace platform. For the purposes of this paragraph, "qualified  
30 marketplace contractor" and "qualified marketplace platform" have the same  
31 meanings prescribed in section 20-485.

32 15. Under a policy or contract that is issued to any other  
33 substantially similar group and that, in the discretion of the director,  
34 may be subject to the issuance of a blanket disability policy or contract.  
35 The director may exercise discretion on an individual risk basis or class  
36 of risks, or both.

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

40 C. All benefits under any blanket disability policy shall be  
41 payable to the person insured, or to the insured's designated beneficiary  
42 or beneficiaries, or to the insured's estate, except that if the person  
43 insured is a minor, such benefits may be made payable to the insured's  
44 parent or guardian or any other person actually supporting the insured,  
45 and except that the policy may provide that all or any portion of any

1 indemnities provided by any such policy on account of hospital, nursing,  
2 medical or surgical services, at the insurer's option, may be paid  
3 directly to the hospital or person rendering such services, but the policy  
4 may not require that the service be rendered by a particular hospital or  
5 person. Payment so made shall discharge the insurer's obligation with  
6 respect to the amount of insurance so paid.

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

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

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

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

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

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

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

43 G. A blanket disability insurance policy that provides coverage for  
44 the surgical expense of a mastectomy shall also provide coverage  
45 incidental to the patient's covered mastectomy for the expense of

1 reconstructive surgery of the breast on which the mastectomy was  
2 performed, surgery and reconstruction of the other breast to produce a  
3 symmetrical appearance, prostheses, treatment of physical complications  
4 for all stages of the mastectomy, including lymphedemas, and at least two  
5 external postoperative prostheses subject to all of the terms and  
6 conditions of the policy.

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

12 1. A baseline mammogram for a woman from age thirty-five to  
13 thirty-nine.

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

17 3. A mammogram every year for a woman WHO IS fifty years of age and  
18 over.

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

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

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

25 3. All preexisting conditions and other limitations have been met  
26 by the insured.

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

31 J. The coverage prescribed by subsection I of this section is  
32 excess to any other coverage the natural mother may have for maternity  
33 benefits except coverage made available to persons pursuant to title 36,  
34 chapter 29. If such other coverage exists the agency, attorney or  
35 individual arranging the adoption shall make arrangements for the  
36 insurance to pay those costs that may be covered under that policy and  
37 shall advise the adopting parent in writing of the existence and extent of  
38 the coverage without disclosing any confidential information such as the  
39 identity of the natural parent. The insured adopting parents shall notify  
40 their insurer of the existence and extent of the other coverage.

41 K. Any contract that provides maternity benefits shall not restrict  
42 benefits for any hospital length of stay in connection with childbirth for  
43 the mother or the newborn child to less than forty-eight hours following a  
44 normal vaginal delivery or ninety-six hours following a cesarean section.  
45 The contract shall not require the provider to obtain authorization from

1 the insurer for prescribing the minimum length of stay required by this  
2 subsection. The contract may provide that an attending provider in  
3 consultation with the mother may discharge the mother or the newborn child  
4 before the expiration of the minimum length of stay required by this  
5 subsection. The insurer shall not:

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

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

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

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

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

22 L. ~~Nothing in~~ Subsection K of this section **DOES NOT**:

23 1. ~~Requires~~ **REQUIRE** a mother to give birth in a hospital or to stay  
24 in the hospital for a fixed period of time following the birth of the  
25 child.

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

34 3. ~~Prevents~~ **PREVENT** an insurer from negotiating the level and type  
35 of reimbursement with a provider for care provided in accordance with  
36 subsection K of this section.

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

40 1. Blood glucose monitors.

41 2. Blood glucose monitors for the legally blind.

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

44 4. Insulin preparations and glucagon.

45 5. Insulin cartridges.

- 1           6. Drawing up devices and monitors for the visually impaired.
- 2           7. Injection aids.
- 3           8. Insulin cartridges for the legally blind.
- 4           9. Syringes and lancets including automatic lancing devices.
- 5           10. Prescribed oral agents for controlling blood sugar that are
- 6 included on the plan formulary.
- 7           11. To the extent coverage is required under medicare, podiatric
- 8 appliances for prevention of complications associated with diabetes.
- 9           12. Any other device, medication, equipment or supply for which
- 10 coverage is required under medicare from and after January 1, 1999. The
- 11 coverage required in this paragraph is effective six months after the
- 12 coverage is required under medicare.
- 13           N. ~~Nothing in~~ Subsection M of this section ~~prohibits~~ DOES NOT
- 14 PROHIBIT a blanket disability insurer from imposing deductibles,
- 15 coinsurance or other cost sharing in relation to benefits for equipment or
- 16 supplies for the treatment of diabetes, EXCEPT THAT A BLANKET DISABILITY
- 17 INSURER SHALL LIMIT THE TOTAL AMOUNT THAT AN INSURED MUST PAY FOR A
- 18 COVERED PRESCRIPTION INSULIN DRUG TO NOT MORE THAN \$100 PER THIRTY-DAY
- 19 SUPPLY OF INSULIN, REGARDLESS OF THE AMOUNT OR TYPE OF INSULIN REQUIRED TO
- 20 FILL THE INSURED'S PRESCRIPTION. FOR THE PURPOSES OF THIS SUBSECTION,
- 21 "PRESCRIPTION INSULIN DRUG" MEANS ANY PRESCRIPTION MEDICATION AS DEFINED
- 22 IN SECTION 32-1901 THAT IS PRESCRIBED BY A HEALTH CARE PROFESSIONAL TO AN
- 23 INSURED TO TREAT THE INSURED'S CONDITION, THAT CONTAINS INSULIN AND THAT
- 24 IS USED TO TREAT DIABETES.
- 25           O. Any contract that provides coverage for prescription drugs shall
- 26 not limit or exclude coverage for any prescription drug prescribed for the
- 27 treatment of cancer on the basis that the prescription drug has not been
- 28 approved by the United States food and drug administration for the
- 29 treatment of the specific type of cancer for which the prescription drug
- 30 has been prescribed, if the prescription drug has been recognized as safe
- 31 and effective for treatment of that specific type of cancer in one or more
- 32 of the standard medical reference compendia prescribed in subsection P of
- 33 this section or medical literature that meets the criteria prescribed in
- 34 subsection P of this section. The coverage required under this subsection
- 35 includes covered medically necessary services associated with the
- 36 administration of the prescription drug. This subsection does not:
- 37           1. Require coverage of any prescription drug used in the treatment
- 38 of a type of cancer if the United States food and drug administration has
- 39 determined that the prescription drug is contraindicated for that type of
- 40 cancer.
- 41           2. Require coverage for any experimental prescription drug that is
- 42 not approved for any indication by the United States food and drug
- 43 administration.

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

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

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

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

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

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

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

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

21           (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

43           Q. Any contract that is offered by a blanket disability insurer and  
44 that contains a prescription drug benefit shall provide coverage of

1 medical foods to treat inherited metabolic disorders as provided by this  
2 section.

3 R. The metabolic disorders triggering medical foods coverage under  
4 this section shall:

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

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

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

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

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

22 T. An insurer shall cover at least fifty percent of the cost of  
23 medical foods prescribed to treat inherited metabolic disorders and  
24 covered pursuant to this section. An insurer may limit the maximum annual  
25 benefit for medical foods under this section to \$5,000, which applies to  
26 the cost of all prescribed modified low protein foods and metabolic  
27 formula.

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

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

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

1 V. Notwithstanding subsection U of this section, a religiously  
2 affiliated employer may require that the insurer provide a blanket  
3 disability policy without coverage for specific items or services required  
4 under subsection U of this section because providing or paying for  
5 coverage of the specific items or services is contrary to the religious  
6 beliefs of the religiously affiliated employer offering the plan. If a  
7 religiously affiliated employer objects to providing coverage for specific  
8 items or services required under subsection U of this section, a written  
9 affidavit shall be filed with the insurer stating the objection. On  
10 receipt of the affidavit, the insurer shall issue to the religiously  
11 affiliated employer a blanket disability policy that excludes coverage for  
12 specific items or services required under subsection U of this section.  
13 The insurer shall retain the affidavit for the duration of the blanket  
14 disability policy and any renewals of the policy. This subsection shall  
15 not exclude coverage for prescription contraceptive methods ordered by a  
16 health care provider with prescriptive authority for medical indications  
17 other than for contraceptive, abortifacient, abortion or sterilization  
18 purposes. A religiously affiliated employer offering the policy may state  
19 religious beliefs in its affidavit and may require the insured to first  
20 pay for the prescription and then submit a claim to the insurer along with  
21 evidence that the prescription is not for a purpose covered by the  
22 objection. An insurer may charge an administrative fee for handling these  
23 claims under this subsection.

24 W. Subsection V of this section does not authorize a religiously  
25 affiliated employer to obtain an employee's protected health information  
26 or to violate the health insurance portability and accountability act of  
27 1996 (P.L. 104-191; 110 Stat. 1936) or any federal regulations adopted  
28 pursuant to that act.

29 X. Subsection V of this section shall not be construed to restrict  
30 or limit any protections against employment discrimination that are  
31 prescribed in federal or state law.

32 Y. For the purposes of:

33 1. This section:

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

37 (b) "Medical foods" means modified low protein foods and metabolic  
38 formula.

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

40 (i) Formulated to be consumed or administered enterally under the  
41 supervision of a physician who is licensed pursuant to title 32, chapter  
42 13 or 17 or a registered nurse practitioner who is licensed pursuant to  
43 title 32, chapter 15.

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

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

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

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

9 (i) Formulated to be consumed or administered enterally under the  
10 supervision of a physician who is licensed pursuant to title 32, chapter  
11 13 or 17 or a registered nurse practitioner who is licensed pursuant to  
12 title 32, chapter 15.

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

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

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

22 2. Subsection E of this section, the term "child", for purposes of  
23 initial coverage of an adopted child or a child placed for adoption but  
24 not for purposes of termination of coverage of such child, means a person  
25 under eighteen years of age.

26 3. Subsections V and W of this section, "religiously affiliated  
27 employer" means either:

28 (a) An entity for which all of the following apply:

29 (i) The entity primarily employs persons who share the religious  
30 tenets of the entity.

31 (ii) The entity serves primarily persons who share the religious  
32 tenets of the entity.

33 (iii) The entity is a nonprofit organization as described in  
34 section 6033(a)(3)(A)(i) or (iii) of the internal revenue code of 1986, as  
35 amended.

36 (b) An entity whose articles of incorporation clearly state that it  
37 is a religiously motivated organization and whose religious beliefs are  
38 central to the organization's operating principles.

39 Sec. 6. Section 20-2325, Arizona Revised Statutes, is amended to  
40 read:

41 20-2325. Diabetes; equipment; supplies

42 A. Any health benefits plan that is offered by an accountable  
43 health plan and that provides coverage for diabetes shall also provide  
44 coverage for equipment and supplies that are medically necessary and that  
45 are prescribed by a health care provider, including:

- 1 1. Blood glucose monitors.
- 2 2. Blood glucose monitors for the legally blind.
- 3 3. Test strips for glucose monitors and visual reading and urine
- 4 testing strips.
- 5 4. Insulin preparations and glucagon.
- 6 5. Insulin cartridges.
- 7 6. Drawing up devices and monitors for the visually impaired.
- 8 7. Injection aids.
- 9 8. Insulin cartridges for the legally blind.
- 10 9. Syringes and lancets including automatic lancing devices.
- 11 10. Prescribed oral agents for controlling blood sugar that are
- 12 included on the plan formulary.
- 13 11. To the extent coverage is required under medicare, podiatric
- 14 appliances for prevention of complications associated with diabetes.
- 15 12. Any other device, medication, equipment or supply for which
- 16 coverage is required under medicare from and after January 1, 1999. The
- 17 coverage required in this paragraph is effective six months after the
- 18 coverage is required under medicare.
- 19 B. ~~Nothing in~~ Subsection A of this section DOES NOT:
- 20 1. ~~Entitles~~ ENTITLE a member or enrollee of an accountable health
- 21 plan to equipment or supplies for the treatment of diabetes that are not
- 22 medically necessary as determined by the accountable health plan's medical
- 23 director or the medical director's designee.
- 24 2. ~~Provides~~ PROVIDE coverage for diabetic supplies obtained by a
- 25 member or enrollee of an accountable health plan without a prescription
- 26 unless otherwise ~~permitted~~ ALLOWED pursuant to the terms of the health
- 27 benefits plan.
- 28 3. ~~Prohibits~~ PROHIBIT an accountable health plan from imposing
- 29 deductibles, coinsurance or other cost sharing in relation to benefits for
- 30 equipment or supplies for the treatment of diabetes, EXCEPT THAT AN
- 31 ACCOUNTABLE HEALTH PLAN SHALL LIMIT THE TOTAL AMOUNT THAT A MEMBER OR
- 32 ENROLLEE MUST PAY FOR A COVERED PRESCRIPTION INSULIN DRUG TO NOT MORE THAN
- 33 \$100 PER THIRTY-DAY SUPPLY OF INSULIN, REGARDLESS OF THE AMOUNT OR TYPE OF
- 34 INSULIN REQUIRED TO FILL THE MEMBER'S OR ENROLLEE'S PRESCRIPTION. FOR THE
- 35 PURPOSES OF THIS PARAGRAPH, "PRESCRIPTION INSULIN DRUG" MEANS ANY
- 36 PRESCRIPTION MEDICATION AS DEFINED IN SECTION 32-1901 THAT IS PRESCRIBED
- 37 BY A HEALTH CARE PROFESSIONAL TO A MEMBER OR ENROLLEE TO TREAT THE
- 38 MEMBER'S OR ENROLLEE'S CONDITION, THAT CONTAINS INSULIN AND THAT IS USED
- 39 TO TREAT DIABETES.