

COMMITTEE ON JUDICIARY

HOUSE OF REPRESENTATIVES AMENDMENTS TO H.B. 2625

(Reference to printed bill)

1 Strike everything after the enacting clause and insert:

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 be
6 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 of
11 services with which the corporation has contracted for hospital, medical,
12 dental or optometric services.

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

16 1. Performance of any surgical service that is covered by the terms of
17 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 would
21 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 would
24 have been covered.

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

28 D. Each contract for dental or optometric services shall be so written
29 that the corporation shall pay benefits for contracted dental or optometric
30 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 payable
34 with respect to a newly born child of the insured from the instant of such
35 child's birth, to a child adopted by the insured, regardless of the age at
36 which the child was adopted, and to a child who has been placed for adoption

1 with the insured and for whom the application and approval procedures for
2 adoption pursuant to section 8-105 or 8-108 have been completed to the same
3 extent that such coverage applies to other members of the family. The
4 coverage for newly born or adopted children or children placed for adoption
5 shall include coverage of injury or sickness, including necessary care and
6 treatment of medically diagnosed congenital defects and birth abnormalities.
7 If payment of a specific premium is required to provide coverage for a child,
8 the contract may require that notification of birth, adoption or adoption
9 placement of the child and payment of the required premium must be furnished
10 to the insurer within thirty-one days after the date of birth, adoption or
11 adoption placement in order to have the coverage continue beyond the
12 thirty-one day period.

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

26 G. No corporation may cancel or refuse to renew any subscriber's
27 contract without giving notice of such cancellation or nonrenewal to the
28 subscriber under such contract. A notice by the corporation to the
29 subscriber of cancellation or nonrenewal of a subscription contract shall be
30 mailed to the named subscriber at least forty-five days before the effective
31 date of such cancellation or nonrenewal. The notice shall include or be
32 accompanied by a statement in writing of the reasons for such action by the
33 corporation. Failure of the corporation to comply with this subsection shall
34 invalidate any cancellation or nonrenewal except a cancellation or nonrenewal
35 for nonpayment of premium.

36 H. A contract that provides coverage for surgical services for a
37 mastectomy shall also provide coverage incidental to the patient's covered
38 mastectomy for surgical services for reconstruction of the breast on which
39 the mastectomy was performed, surgery and reconstruction of the other breast
40 to produce a symmetrical appearance, prostheses, treatment of physical

1 complications for all stages of the mastectomy, including lymphedemas, and at
2 least two external postoperative prostheses subject to all of the terms and
3 conditions of the policy.

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

9 1. A baseline mammogram for a woman from age thirty-five to
10 thirty-nine.

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

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

15 J. Any contract that is issued to the insured and that provides
16 coverage for maternity benefits shall also provide that the maternity
17 benefits apply to the costs of the birth of any child legally adopted by the
18 insured if all of the following are true:

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

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

21 3. All preexisting conditions and other limitations have been met by
22 the insured.

23 4. The insured has notified the insurer of the insured's acceptability
24 to adopt children pursuant to section 8-105, within sixty days after such
25 approval or within sixty days after a change in insurance policies, plans or
26 companies.

27 K. The coverage prescribed by subsection J of this section is excess
28 to any other coverage the natural mother may have for maternity benefits
29 except coverage made available to persons pursuant to title 36, chapter 29
30 but not including coverage made available to persons defined as eligible
31 under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If
32 such other coverage exists, the agency, attorney or individual arranging the
33 adoption shall make arrangements for the insurance to pay those costs that
34 may be covered under that policy and shall advise the adopting parent in
35 writing of the existence and extent of the coverage without disclosing any
36 confidential information such as the identity of the natural parent. The
37 insured adopting parents shall notify their insurer of the existence and
38 extent of the other coverage.

1 L. The director may disapprove any contract if the benefits provided
2 in the form of such contract are unreasonable in relation to the premium
3 charged.

4 M. The director shall adopt emergency rules applicable to persons who
5 are leaving active service in the armed forces of the United States and
6 returning to civilian status including:

- 7 1. Conditions of eligibility.
- 8 2. Coverage of dependents.
- 9 3. Preexisting conditions.
- 10 4. Termination of insurance.
- 11 5. Probationary periods.
- 12 6. Limitations.
- 13 7. Exceptions.
- 14 8. Reductions.
- 15 9. Elimination periods.
- 16 10. Requirements for replacement.
- 17 11. Any other condition of subscription contracts.

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

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

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

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

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

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

5 O. Nothing in subsection N of this section:

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

8 2. Prevents a corporation from imposing deductibles, coinsurance or
9 other cost sharing in relation to benefits for hospital lengths of stay in
10 connection with childbirth for a mother or a newborn child under the
11 contract, except that any coinsurance or other cost sharing for any portion
12 of a period within a hospital length of stay required pursuant to subsection
13 N of this section shall not be greater than the coinsurance or cost sharing
14 for any preceding portion of that stay.

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

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

21 1. Blood glucose monitors.

22 2. Blood glucose monitors for the legally blind.

23 3. Test strips for glucose monitors and visual reading and urine
24 testing strips.

25 4. Insulin preparations and glucagon.

26 5. Insulin cartridges.

27 6. Drawing up devices and monitors for the visually impaired.

28 7. Injection aids.

29 8. Insulin cartridges for the legally blind.

30 9. Syringes and lancets, including automatic lancing devices.

31 10. Prescribed oral agents for controlling blood sugar that are
32 included on the plan formulary.

33 11. To the extent coverage is required under medicare, podiatric
34 appliances for prevention of complications associated with diabetes.

35 12. Any other device, medication, equipment or supply for which
36 coverage is required under medicare from and after January 1, 1999. The
37 coverage required in this paragraph is effective six months after the
38 coverage is required under medicare.

39 Q. Nothing in subsection P of this section prohibits a medical service
40 corporation, a hospital service corporation or a hospital, medical, dental

1 and optometric service corporation from imposing deductibles, coinsurance or
2 other cost sharing in relation to benefits for equipment or supplies for the
3 treatment of diabetes.

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

16 1. Require coverage of any prescription drug used in the treatment of
17 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 not
21 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 of
24 prescription drugs that have not been approved by the United States food and
25 drug administration.

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

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

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

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

37 1. The acceptable standard medical reference compendia are the
38 following:

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

1 (b) The national comprehensive cancer network drugs and biologics
2 compendium.

3 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

1 corporation may obtain a stay of the effectiveness of the order as prescribed
2 in section 20-162. If the director certifies in the order and provides a
3 detailed explanation of the reasons in support of the certification that
4 continued use of the advertising matter or sales material poses a threat to
5 the health, safety or welfare of the public, the order may be entered
6 immediately without opportunity for cure and the effectiveness of the order
7 is not stayed pending the hearing on the notice of appeal but the hearing
8 shall be promptly instituted and determined.

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

13 V. The metabolic disorders triggering medical foods coverage under
14 this section shall:

15 1. Be part of the newborn screening program prescribed in section
16 36-694.

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

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

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

27 W. Medical foods eligible for coverage under this section shall be
28 prescribed or ordered under the supervision of a physician licensed pursuant
29 to title 32, chapter 13 or 17 as medically necessary for the therapeutic
30 treatment of an inherited metabolic disease.

31 X. A hospital service corporation or medical service corporation shall
32 cover at least fifty per cent of the cost of medical foods prescribed to
33 treat inherited metabolic disorders and covered pursuant to this section. A
34 hospital service corporation or medical service corporation may limit the
35 maximum annual benefit for medical foods under this section to five thousand
36 dollars, which applies to the cost of all prescribed modified low protein
37 foods and metabolic formula.

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

1 1. If the contract provides coverage for prescription drugs, the
2 contract shall provide coverage for any prescribed drug or device that is
3 approved by the United States food and drug administration for use as a
4 contraceptive. A corporation may use a drug formulary, multitiered drug
5 formulary or list but that formulary or list shall include oral, implant and
6 injectable contraceptive drugs, intrauterine devices and prescription barrier
7 methods if the corporation does not impose deductibles, coinsurance,
8 copayments or other cost containment measures for contraceptive drugs that
9 are greater than the deductibles, coinsurance, copayments or other cost
10 containment measures for other drugs on the same level of the formulary or
11 list.

12 2. If the contract provides coverage for outpatient health care
13 services, the contract shall provide coverage for outpatient contraceptive
14 services. For the purposes of this paragraph, "outpatient contraceptive
15 services" means consultations, examinations, procedures and medical services
16 provided on an outpatient basis and related to the use of approved United
17 States food and drug administration prescription contraceptive methods to
18 prevent unintended pregnancies.

19 3. This subsection does not apply to contracts issued to individuals
20 on a nongroup basis.

21 ~~7. Notwithstanding subsection Y of this section, a religious employer
22 whose religious tenets prohibit the use of prescribed contraceptive methods
23 may require that the corporation provide a contract without coverage for all
24 United States food and drug administration approved contraceptive methods. A
25 religious employer shall submit a written affidavit to the corporation
26 stating that it is a religious employer. On receipt of the affidavit, the
27 corporation shall issue to the religious employer a contract that excludes
28 coverage of prescription contraceptive methods. The corporation shall retain
29 the affidavit for the duration of the contract and any renewals of the
30 contract. Before enrollment in the plan, every religious employer that
31 invokes this exemption shall provide prospective subscribers written notice
32 that the religious employer refuses to cover all United States food and drug
33 administration approved contraceptive methods for religious reasons. This
34 subsection shall not exclude coverage for prescription contraceptive methods
35 ordered by a health care provider with prescriptive authority for medical
36 indications other than to prevent an unintended pregnancy. A corporation may
37 require the subscriber to first pay for the prescription and then submit a
38 claim to the corporation along with evidence that the prescription is for a
39 noncontraceptive purpose. A corporation may charge an administrative fee for
40 handling these claims. A religious employer shall not discriminate against~~

~~an employee who independently chooses to obtain insurance coverage or prescriptions for contraceptives from another source.~~

Z. NOTWITHSTANDING SUBSECTION Y OF THIS SECTION, A CONTRACT DOES NOT FAIL TO MEET THE REQUIREMENTS OF SUBSECTION Y OF THIS SECTION IF THE CONTRACT'S FAILURE TO PROVIDE COVERAGE OF SPECIFIC ITEMS OR SERVICES REQUIRED UNDER SUBSECTION Y OF THIS SECTION IS BECAUSE PROVIDING OR PAYING FOR COVERAGE OF THE SPECIFIC ITEMS OR SERVICES IS CONTRARY TO THE RELIGIOUS BELIEFS OF THE EMPLOYER, SPONSOR, ISSUER, CORPORATION OR OTHER ENTITY OFFERING THE PLAN OR IS BECAUSE THE COVERAGE IS CONTRARY TO THE RELIGIOUS BELIEFS OF THE PURCHASER OR BENEFICIARY OF THE COVERAGE. IF AN OBJECTION TRIGGERS THIS SUBSECTION, A WRITTEN AFFIDAVIT SHALL BE FILED WITH THE CORPORATION STATING THE OBJECTION. THE CORPORATION SHALL RETAIN THE AFFIDAVIT FOR THE DURATION OF THE CONTRACT AND ANY RENEWALS OF THE CONTRACT.

THIS SUBSECTION SHALL NOT EXCLUDE COVERAGE FOR PRESCRIPTION CONTRACEPTIVE METHODS ORDERED BY A HEALTH CARE PROVIDER WITH PRESCRIPTIVE AUTHORITY FOR MEDICAL INDICATIONS OTHER THAN FOR CONTRACEPTIVE, ABORTIFACIENT, ABORTION OR STERILIZATION PURPOSES. A CORPORATION, EMPLOYER, SPONSOR, ISSUER OR OTHER ENTITY OFFERING THE PLAN MAY STATE RELIGIOUS BELIEFS OR MORAL CONVICTIONS IN ITS AFFIDAVIT THAT REQUIRE THE SUBSCRIBER TO FIRST PAY FOR THE PRESCRIPTION AND THEN SUBMIT A CLAIM TO THE CORPORATION ALONG WITH EVIDENCE THAT THE PRESCRIPTION IS NOT IN WHOLE OR IN PART FOR A PURPOSE COVERED BY THE OBJECTION. A CORPORATION MAY CHARGE AN ADMINISTRATIVE FEE FOR HANDLING THESE CLAIMS.

AA. For the purposes of:

1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

17 2. Subsection E of this section, "child", for purposes of initial
18 coverage of an adopted child or a child placed for adoption but not for
19 purposes of termination of coverage of such child, means a person under
20 eighteen years of age.

21 ~~3. Subsection Z of this section, "religious employer" means an entity
22 for which all of the following apply:~~

23 ~~(a) The entity primarily employs persons who share the religious
24 tenets of the entity.~~

25 ~~(b) The entity primarily serves persons who share the religious tenets
26 of the entity.~~

27 ~~(c) The entity is a nonprofit organization as described in section
28 6033(a)(2)(A) (i) or (iii) of the internal revenue code of 1986, as amended.~~

29 Sec. 2. Section 20-1057.08, Arizona Revised Statutes, is amended to
30 read:

31 20-1057.08. Prescription contraceptive drugs and devices

32 A. If a health care services organization issues evidence of coverage
33 that provides coverage for:

34 1. Prescription drugs, the evidence of coverage shall provide coverage
35 for any prescribed drug or device that is approved by the United States food
36 and drug administration for use as a contraceptive. A health care services
37 organization may use a drug formulary, multitiered drug formulary or list but
38 that formulary or list shall include oral, implant and injectable
39 contraceptive drugs, intrauterine devices and prescription barrier methods if
40 the health care services organization does not impose deductibles,

1 coinsurance, copayments or other cost containment measures for contraceptive
2 drugs that are greater than the deductibles, coinsurance, copayments or other
3 cost containment measures for other drugs on the same level of the formulary
4 or list.

5 2. Outpatient health care services, the evidence of coverage shall
6 provide coverage for outpatient contraceptive services. For the purposes of
7 this paragraph, "outpatient contraceptive services" means consultations,
8 examinations, procedures and medical services provided on an outpatient basis
9 and related to the use of United States food and drug prescription
10 contraceptive methods to prevent unintended pregnancies.

11 B. Notwithstanding subsection A OF THIS SECTION, ~~a religious employer~~
12 ~~whose religious tenets prohibit the use of prescribed contraceptive methods~~
13 ~~may require that the health care services organization provide coverage that~~
14 ~~excludes all federal food and drug administration approved contraceptive~~
15 ~~methods. A religious employer shall submit a written affidavit to the health~~
16 ~~care services organization stating that it is a religious employer. On~~
17 ~~receipt of the affidavit, the health care services organization shall provide~~
18 ~~coverage to the religious employer that excludes prescription contraceptive~~
19 ~~methods.~~ AN EVIDENCE OF COVERAGE DOES NOT FAIL TO MEET THE REQUIREMENTS OF
20 SUBSECTION A OF THIS SECTION IF THE EVIDENCE OF COVERAGE'S FAILURE TO PROVIDE
21 COVERAGE OF SPECIFIC ITEMS OR SERVICES REQUIRED UNDER SUBSECTION A OF THIS
22 SECTION IS BECAUSE PROVIDING OR PAYING FOR COVERAGE OF THE SPECIFIC ITEMS OR
23 SERVICES IS CONTRARY TO THE RELIGIOUS BELIEFS OF THE EMPLOYER, SPONSOR,
24 ISSUER, HEALTH CARE SERVICES ORGANIZATION OR OTHER ENTITY OFFERING THE PLAN
25 OR IS BECAUSE THE COVERAGE IS CONTRARY TO THE RELIGIOUS BELIEFS OF THE
26 PURCHASER OR BENEFICIARY OF THE COVERAGE. IF AN OBJECTION TRIGGERS THIS
27 SUBSECTION, A WRITTEN AFFIDAVIT SHALL BE FILED WITH THE HEALTH CARE SERVICES
28 ORGANIZATION STATING THE OBJECTION. The health care services organization
29 shall retain the affidavit for the duration of the coverage and any renewals
30 of the coverage.

31 ~~C. Before enrollment in the health care plan, every religious employer~~
32 ~~that invokes this exemption shall provide prospective enrollees written~~
33 ~~notice that the religious employer refuses to cover all federal food and drug~~
34 ~~administration approved contraceptive methods for religious reasons.~~

35 ~~D.~~ C. Subsection B OF THIS SECTION does not exclude coverage for
36 prescription contraceptive methods ordered by a health care provider with
37 prescriptive authority for medical indications other than ~~to prevent an~~
38 ~~unintended pregnancy. A health care services organization may require FOR~~
39 CONTRACEPTIVE, ABORTIFACIENT, ABORTION OR STERILIZATION PURPOSES. A HEALTH
40 CARE SERVICES ORGANIZATION, EMPLOYER, SPONSOR, ISSUER OR OTHER ENTITY

1 OFFERING THE PLAN MAY STATE RELIGIOUS BELIEFS IN ITS AFFIDAVIT THAT REQUIRE
2 the enrollee to first pay for the prescription and then submit a claim to the
3 health care services organization along with evidence that the prescription
4 is ~~for a noncontraceptive purpose~~ NOT IN WHOLE OR IN PART FOR A PURPOSE
5 COVERED BY THE OBJECTION. A health care services organization may charge an
6 administrative fee for handling claims under this subsection.

7 ~~E. A religious employer shall not discriminate against an employee who~~
8 ~~independently chooses to obtain insurance coverage or prescriptions for~~
9 ~~contraceptives from another source.~~

10 ~~F.~~ D. This section does not apply to evidences of coverage issued to
11 individuals on a nongroup basis.

12 ~~G. For the purposes of this section, "religious employer" means an~~
13 ~~entity for which all of the following apply:~~

14 ~~1. The entity primarily employs persons who share the religious tenets~~
15 ~~of the entity.~~

16 ~~2. The entity serves primarily persons who share the religious tenets~~
17 ~~of the entity.~~

18 ~~3. The entity is a nonprofit organization as described in section~~
19 ~~6033(a)(2)(A)i or iii of the internal revenue code of 1986, as amended.~~

20 Sec. 3. Section 20-1402, Arizona Revised Statutes, is amended to read:

21 20-1402. Provisions of group disability policies: definitions

22 A. Each group disability policy shall contain in substance the
23 following provisions:

24 1. A provision that, in the absence of fraud, all statements made by
25 the policyholder or by any insured person shall be deemed representations and
26 not warranties, and that no statement made for the purpose of effecting
27 insurance shall avoid such insurance or reduce benefits unless contained in a
28 written instrument signed by the policyholder or the insured person, a copy
29 of which has been furnished to the policyholder or to the person or
30 beneficiary.

31 2. A provision that the insurer will furnish to the policyholder, for
32 delivery to each employee or member of the insured group, an individual
33 certificate setting forth in summary form a statement of the essential
34 features of the insurance coverage of the employee or member and to whom
35 benefits are payable. If dependents or family members are included in the
36 coverage additional certificates need not be issued for delivery to the
37 dependents or family members. Any policy, except accidental death and
38 dismemberment, applied for that provides family coverage, as to such coverage
39 of family members, shall also provide that the benefits applicable for
40 children shall be payable with respect to a newly born child of the insured

1 from the instant of such child's birth, to a child adopted by the insured,
2 regardless of the age at which the child was adopted, and to a child who has
3 been placed for adoption with the insured and for whom the application and
4 approval procedures for adoption pursuant to section 8-105 or 8-108 have been
5 completed to the same extent that such coverage applies to other members of
6 the family. The coverage for newly born or adopted children or children
7 placed for adoption shall include coverage of injury or sickness including
8 the necessary care and treatment of medically diagnosed congenital defects
9 and birth abnormalities. If payment of a specific premium is required to
10 provide coverage for a child, the policy may require that notification of
11 birth, adoption or adoption placement of the child and payment of the
12 required premium must be furnished to the insurer within thirty-one days
13 after the date of birth, adoption or adoption placement in order to have the
14 coverage continue beyond such thirty-one day period.

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

18 4. Each contract shall be so written that the corporation shall pay
19 benefits:

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

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

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

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

32 5. A group disability insurance policy that provides coverage for the
33 surgical expense of a mastectomy shall also provide coverage incidental to
34 the patient's covered mastectomy for the expense of reconstructive surgery of
35 the breast on which the mastectomy was performed, surgery and reconstruction
36 of the other breast to produce a symmetrical appearance, prostheses,
37 treatment of physical complications for all stages of the mastectomy,
38 including lymphedemas, and at least two external postoperative prostheses
39 subject to all of the terms and conditions of the policy.

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

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

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

12 (c) A mammogram every year for a woman fifty years of age and over.

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

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

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

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

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

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

37 B. Any policy that provides maternity benefits shall not restrict
38 benefits for any hospital length of stay in connection with childbirth for
39 the mother or the newborn child to less than forty-eight hours following a
40 normal vaginal delivery or ninety-six hours following a cesarean section.

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

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

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

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

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

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

23 C. Nothing in subsection B of this section:

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

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

33 3. Prevents an insurer from negotiating the level and type of
34 reimbursement with a provider for care provided in accordance with
35 subsection B of this section.

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

39 1. Blood glucose monitors.

40 2. Blood glucose monitors for the legally blind.

1 3. Test strips for glucose monitors and visual reading and urine
2 testing strips.

3 4. Insulin preparations and glucagon.

4 5. Insulin cartridges.

5 6. Drawing up devices and monitors for the visually impaired.

6 7. Injection aids.

7 8. Insulin cartridges for the legally blind.

8 9. Syringes and lancets including automatic lancing devices.

9 10. Prescribed oral agents for controlling blood sugar that are
10 included on the plan formulary.

11 11. To the extent coverage is required under medicare, podiatric
12 appliances for prevention of complications associated with diabetes.

13 12. Any other device, medication, equipment or supply for which
14 coverage is required under medicare from and after January 1, 1999. The
15 coverage required in this paragraph is effective six months after the
16 coverage is required under medicare.

17 E. Nothing in subsection D of this section prohibits a group
18 disability insurer from imposing deductibles, coinsurance or other cost
19 sharing in relation to benefits for equipment or supplies for the treatment
20 of diabetes.

21 F. Any contract that provides coverage for prescription drugs shall
22 not limit or exclude coverage for any prescription drug prescribed for the
23 treatment of cancer on the basis that the prescription drug has not been
24 approved by the United States food and drug administration for the treatment
25 of the specific type of cancer for which the prescription drug has been
26 prescribed, if the prescription drug has been recognized as safe and
27 effective for treatment of that specific type of cancer in one or more of the
28 standard medical reference compendia prescribed in subsection G of this
29 section or medical literature that meets the criteria prescribed in
30 subsection G of this section. The coverage required under this subsection
31 includes covered medically necessary services associated with the
32 administration of the prescription drug. This subsection does not:

33 1. Require coverage of any prescription drug used in the treatment of
34 a type of cancer if the United States food and drug administration has
35 determined that the prescription drug is contraindicated for that type of
36 cancer.

37 2. Require coverage for any experimental prescription drug that is not
38 approved for any indication by the United States food and drug
39 administration.

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

4 4. Require reimbursement or coverage for any prescription drug that is
5 not included in the drug formulary or list of covered prescription drugs
6 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 other
12 cost sharing in relation to drug benefits and related medical benefits
13 offered.

14 G. For the purposes of subsection F 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 apply:

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

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

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

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

4 I. The metabolic disorders triggering medical foods coverage under
5 this section shall:

6 1. Be part of the newborn screening program prescribed in section
7 36-694.

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

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

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

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

23 K. An insurer shall cover at least fifty per cent of the cost of
24 medical foods prescribed to treat inherited metabolic disorders and covered
25 pursuant to this section. An insurer may limit the maximum annual benefit
26 for medical foods under this section to five thousand dollars, which applies
27 to the cost of all prescribed modified low protein foods and metabolic
28 formula.

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

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

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

7 M. Notwithstanding subsection L of this section, ~~a religious employer~~
8 ~~whose religious tenets prohibit the use of prescribed contraceptive methods~~
9 ~~may require that the insurer provide a group disability policy without~~
10 ~~coverage for all United States food and drug administration approved~~
11 ~~contraceptive methods. A religious employer shall submit a written affidavit~~
12 ~~to the insurer stating that it is a religious employer. On receipt of the~~
13 ~~affidavit, the insurer shall issue to the religious employer a group~~
14 ~~disability policy that excludes coverage of prescription contraceptive~~
15 ~~methods.~~ A GROUP DISABILITY POLICY DOES NOT FAIL TO MEET THE REQUIREMENTS OF
16 SUBSECTION L OF THIS SECTION IF THE POLICY'S FAILURE TO PROVIDE COVERAGE OF
17 SPECIFIC ITEMS OR SERVICES REQUIRED UNDER SUBSECTION L OF THIS SECTION IS
18 BECAUSE PROVIDING OR PAYING FOR COVERAGE OF THE SPECIFIC ITEMS OR SERVICES IS
19 CONTRARY TO THE RELIGIOUS BELIEFS OF THE EMPLOYER, SPONSOR, ISSUER, INSURER
20 OR OTHER ENTITY OFFERING THE PLAN OR IS BECAUSE THE COVERAGE IS CONTRARY TO
21 THE RELIGIOUS BELIEFS OF THE PURCHASER OR BENEFICIARY OF THE COVERAGE. IF AN
22 OBJECTION TRIGGERS THIS SUBSECTION, A WRITTEN AFFIDAVIT SHALL BE FILED WITH
23 THE INSURER STATING THE OBJECTION. The insurer shall retain the affidavit
24 for the duration of the group disability policy and any renewals of the
25 policy. ~~Before a policy is issued, every religious employer that invokes~~
26 ~~this exemption shall provide prospective insureds written notice that the~~
27 ~~religious employer refuses to cover all United States food and drug~~
28 ~~administration approved contraceptive methods for religious reasons.~~ This
29 subsection shall not exclude coverage for prescription contraceptive methods
30 ordered by a health care provider with prescriptive authority for medical
31 indications other than ~~to prevent an unintended pregnancy~~ FOR CONTRACEPTIVE,
32 ABORTIFACIENT, ABORTION OR STERILIZATION PURPOSES. An insurer, EMPLOYER,
33 SPONSOR, ISSUER OR OTHER ENTITY OFFERING THE POLICY may STATE RELIGIOUS
34 BELIEFS IN ITS AFFIDAVIT THAT require the insured to first pay for the
35 prescription and then submit a claim to the insurer along with evidence that
36 the prescription is ~~for a noncontraceptive purpose~~ NOT IN WHOLE OR IN PART
37 FOR A PURPOSE COVERED BY THE OBJECTION. An insurer may charge an
38 administrative fee for handling these claims. ~~A religious employer shall not~~
39 ~~discriminate against an employee who independently chooses to obtain~~
40 ~~insurance coverage or prescriptions for contraceptives from another source.~~

1 N. 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 under
5 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 13
11 or 17 or a registered nurse practitioner who is licensed pursuant to title
12 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 nutrients
17 contained in the foodstuffs or who has other specific nutrient requirements
18 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 13
25 or 17 or a registered nurse practitioner who is licensed pursuant to title
26 32, chapter 15.

27 (ii) Processed or formulated to contain less than one gram of protein
28 per unit of serving, but does not include a natural food that is naturally
29 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 nutrients
32 contained in the foodstuffs or who has other specific nutrient requirements
33 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 not
38 for purposes of termination of coverage of such child, means a person under
39 the age of eighteen years.

1 ~~3. Subsection M of this section, "religious employer" means an entity~~
2 ~~for which all of the following apply:~~

3 ~~(a) The entity primarily employs persons who share the religious~~
4 ~~tenets of the entity.~~

5 ~~(b) The entity serves primarily persons who share the religious tenets~~
6 ~~of the entity.~~

7 ~~(c) The entity is a nonprofit organization as described in section~~
8 ~~6033(a)(2)(A)(i) or (iii) of the internal revenue code of 1986, as amended.~~

9 Sec. 4. Section 20-1404, Arizona Revised Statutes, is amended to read:

10 20-1404. Blanket disability insurance: definitions

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

14 1. Under a policy or contract issued to any common carrier, which
15 shall be deemed the policyholder, covering a group defined as all persons who
16 may become passengers on such common carrier.

17 2. Under a policy or contract issued to an employer, who shall be
18 deemed the policyholder, covering all employees or any group of employees
19 defined by reference to exceptional hazards incident to such employment.
20 Dependents of the employees and guests of the employer may also be included
21 where exposed to the same hazards.

22 3. Under a policy or contract issued to a college, school or other
23 institution of learning or to the head or principal thereof, who or which
24 shall be deemed the policyholder, covering students or teachers.

25 4. Under a policy or contract issued in the name of any volunteer fire
26 department or first aid or other such volunteer group, or agency having
27 jurisdiction thereof, which shall be deemed the policyholder, covering all of
28 the members of such fire department or group.

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

31 6. Under a policy or contract issued to a sports team or to a camp or
32 sponsor thereof, which team or camp or sponsor thereof shall be deemed the
33 policyholder, covering members or campers.

34 7. Under a policy or contract that is issued to any other
35 substantially similar group and that, in the discretion of the director, may
36 be subject to the issuance of a blanket disability policy or contract.

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.

1 C. All benefits under any blanket disability policy shall be payable
2 to the person insured, or to the insured's designated beneficiary or
3 beneficiaries, or to the insured's estate, except that if the person insured
4 is a minor, such benefits may be made payable to the insured's parent or
5 guardian or any other person actually supporting the insured, and except that
6 the policy may provide that all or any portion of any indemnities provided by
7 any such policy on account of hospital, nursing, medical or surgical
8 services, at the insurer's option, may be paid directly to the hospital or
9 person rendering such services, but the policy may not require that the
10 service be rendered by a particular hospital or person. Payment so made
11 shall discharge the insurer's obligation with respect to the amount of
12 insurance so paid.

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

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

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

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

38 2. For any home health services that are performed by a licensed home
39 health agency and that a physician has prescribed in lieu of hospital

1 services, as defined by the director, providing the hospital services would
2 have been covered.

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

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

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

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

22 1. A baseline mammogram for a woman from age thirty-five to
23 thirty-nine.

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

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

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

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

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

34 3. All preexisting conditions and other limitations have been met by
35 the insured.

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

39 J. The coverage prescribed by subsection I of this section is excess
40 to any other coverage the natural mother may have for maternity benefits

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

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

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

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

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

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

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

37 L. Nothing in subsection K of this section:

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

1 2. Prevents an insurer from imposing deductibles, coinsurance or other
2 cost sharing in relation to benefits for hospital lengths of stay in
3 connection with childbirth for a mother or a newborn child under the
4 contract, except that any coinsurance or other cost sharing for any portion
5 of a period within a hospital length of stay required pursuant to subsection
6 K of this section shall not be greater than the coinsurance or cost sharing
7 for any preceding portion of that stay.

8 3. Prevents an insurer from negotiating the level and type of
9 reimbursement with a provider for care provided in accordance with subsection
10 K of this section.

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

- 14 1. Blood glucose monitors.
- 15 2. Blood glucose monitors for the legally blind.
- 16 3. Test strips for glucose monitors and visual reading and urine
17 testing strips.
- 18 4. Insulin preparations and glucagon.
- 19 5. Insulin cartridges.
- 20 6. Drawing up devices and monitors for the visually impaired.
- 21 7. Injection aids.
- 22 8. Insulin cartridges for the legally blind.
- 23 9. Syringes and lancets including automatic lancing devices.
- 24 10. Prescribed oral agents for controlling blood sugar that are
25 included on the plan formulary.

26 11. To the extent coverage is required under medicare, podiatric
27 appliances for prevention of complications associated with diabetes.

28 12. Any other device, medication, equipment or supply for which
29 coverage is required under medicare from and after January 1, 1999. The
30 coverage required in this paragraph is effective six months after the
31 coverage is required under medicare.

32 N. Nothing in subsection M of this section prohibits a blanket
33 disability insurer from imposing deductibles, coinsurance or other cost
34 sharing in relation to benefits for equipment or supplies for the treatment
35 of diabetes.

36 O. Any contract that provides coverage for prescription drugs shall
37 not limit or exclude coverage for any prescription drug prescribed for the
38 treatment of cancer on the basis that the prescription drug has not been
39 approved by the United States food and drug administration for the treatment
40 of the specific type of cancer for which the prescription drug has been

1 prescribed, if the prescription drug has been recognized as safe and
2 effective for treatment of that specific type of cancer in one or more of the
3 standard medical reference compendia prescribed in subsection P of this
4 section or medical literature that meets the criteria prescribed in
5 subsection P 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 of
9 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 not
13 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 of
16 prescription drugs that have not been approved by the United States food and
17 drug administration.

18 4. Require reimbursement or coverage for any prescription drug that is
19 not included in the drug formulary or list of covered prescription drugs
20 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 other
26 cost sharing in relation to drug benefits and related medical benefits
27 offered.

28 P. For the purposes of subsection O 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 apply:

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

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

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

16 Q. Any contract that is offered by a blanket disability insurer and
17 that contains a prescription drug benefit shall provide coverage of medical
18 foods to treat inherited metabolic disorders as provided by this section.

19 R. The metabolic disorders triggering medical foods coverage under
20 this section shall:

21 1. Be part of the newborn screening program prescribed in section
22 36-694.

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

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

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

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

38 T. An insurer shall cover at least fifty per cent of the cost of
39 medical foods prescribed to treat inherited metabolic disorders and covered
40 pursuant to this section. An insurer may limit the maximum annual benefit

1 for medical foods under this section to five thousand dollars which applies
2 to the cost of all prescribed modified low protein foods and metabolic
3 formula.

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

5 1. Prescription drugs shall also provide coverage for any prescribed
6 drug or device that is approved by the United States food and drug
7 administration for use as a contraceptive. A blanket disability insurer may
8 use a drug formulary, multitiered drug formulary or list but that formulary
9 or list shall include oral, implant and injectable contraceptive drugs,
10 intrauterine devices and prescription barrier methods if the blanket
11 disability insurer does not impose deductibles, coinsurance, copayments or
12 other cost containment measures for contraceptive drugs that are greater than
13 the deductibles, coinsurance, copayments or other cost containment measures
14 for other drugs on the same level of the formulary or list.

15 2. Outpatient health care services shall also provide coverage for
16 outpatient contraceptive services. For the purposes of this paragraph,
17 "outpatient contraceptive services" means consultations, examinations,
18 procedures and medical services provided on an outpatient basis and related
19 to the use of approved United States food and drug administration
20 prescription contraceptive methods to prevent unintended pregnancies.

21 V. Notwithstanding subsection U of this section, ~~a religious employer~~
22 ~~whose religious tenets prohibit the use of prescribed contraceptive methods~~
23 ~~may require that the insurer provide a blanket disability policy without~~
24 ~~coverage for all United States food and drug administration approved~~
25 ~~contraceptive methods. A religious employer shall submit a written affidavit~~
26 ~~to the insurer stating that it is a religious employer. On receipt of the~~
27 ~~affidavit, the insurer shall issue to the religious employer a blanket~~
28 ~~disability policy that excludes coverage of prescription contraceptive~~
29 ~~methods.~~ A BLANKET DISABILITY POLICY DOES NOT FAIL TO MEET THE REQUIREMENTS
30 OF SUBSECTION U OF THIS SECTION IF THE POLICY'S FAILURE TO PROVIDE COVERAGE
31 OF SPECIFIC ITEMS OR SERVICES REQUIRED UNDER SUBSECTION U OF THIS SECTION IS
32 BECAUSE PROVIDING OR PAYING FOR COVERAGE OF THE SPECIFIC ITEMS OR SERVICES IS
33 CONTRARY TO THE RELIGIOUS BELIEFS OF THE EMPLOYER, SPONSOR, ISSUER, INSURER
34 OR OTHER ENTITY OFFERING THE PLAN OR IS BECAUSE THE COVERAGE IS CONTRARY TO
35 THE RELIGIOUS BELIEFS OF THE PURCHASER OR BENEFICIARY OF THE COVERAGE. IF AN
36 OBJECTION TRIGGERS THIS SUBSECTION, A WRITTEN AFFIDAVIT SHALL BE FILED WITH
37 THE INSURER STATING THE OBJECTION. The insurer shall retain the affidavit
38 for the duration of the blanket disability policy and any renewals of the
39 policy. ~~Before a policy is issued, every religious employer that invokes~~
40 ~~this exemption shall provide prospective insureds written notice that the~~

~~religious employer refuses to cover all United States food and drug administration approved contraceptive methods for religious reasons.~~ This subsection shall not exclude coverage for prescription contraceptive methods ordered by a health care provider with prescriptive authority for medical indications other than ~~to prevent an unintended pregnancy~~ FOR CONTRACEPTIVE, ABORTIFACIENT, ABORTION OR STERILIZATION PURPOSES. An insurer, EMPLOYER, SPONSOR, ISSUER OR OTHER ENTITY OFFERING THE POLICY may STATE RELIGIOUS BELIEFS IN ITS AFFIDAVIT THAT require the insured to first pay for the prescription and then submit a claim to the insurer along with evidence that the prescription is ~~for a noncontraceptive purpose~~ NOT IN WHOLE OR IN PART FOR A PURPOSE COVERED BY THE OBJECTION. An insurer may charge an administrative fee for handling these claims under this subsection. ~~A religious employer shall not discriminate against an employee who independently chooses to obtain insurance coverage or prescriptions for contraceptives from another source.~~

W. For the purposes of:

1. This section:

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

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

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

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

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

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

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

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

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

1 or 17 or a registered nurse practitioner who is licensed pursuant to title
2 32, chapter 15.

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

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

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

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

16 ~~3. Subsection V of this section, "religious employer" means an entity
17 for which all of the following apply:~~

18 ~~(a) The entity primarily employs persons who share the religious
19 tenets of the entity.~~

20 ~~(b) The entity serves primarily persons who share the religious tenets
21 of the entity.~~

22 ~~(c) The entity is a nonprofit organization as described in section
23 6033(a)(2)(A)(i) or (iii) of the internal revenue code of 1986, as amended.~~

24 Sec. 5. Section 20-2329, Arizona Revised Statutes, is amended to read:
25 20-2329. Prescription contraceptive drugs and devices

26 A. An accountable health plan that provides a health benefits plan
27 that provides coverage for:

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

38 2. Outpatient health care services shall also provide coverage for
39 outpatient contraceptive services. For the purposes of this paragraph,
40 "outpatient contraceptive services" means consultations, examinations,

1 procedures and medical services provided on an outpatient basis and related
2 to the use of United States food and drug prescription contraceptive methods
3 to prevent unintended pregnancies.

4 B. Notwithstanding subsection A OF THIS SECTION, ~~a religious employer~~
5 ~~whose religious tenets prohibit the use of prescribed contraceptive methods~~
6 ~~may require that the accountable health plan provide a health benefits plan~~
7 ~~without coverage for all federal food and drug administration approved~~
8 ~~contraceptive methods. A religious employer shall submit a written affidavit~~
9 ~~to the accountable health plan stating that it is a religious employer. On~~
10 ~~receipt of the affidavit, the accountable health plan shall issue to the~~
11 ~~religious employer a health benefits plan that excludes coverage of~~
12 ~~prescription contraceptive methods.~~ AN ACCOUNTABLE HEALTH PLAN DOES NOT FAIL
13 TO MEET THE REQUIREMENTS OF SUBSECTION A OF THIS SECTION IF THE PLAN'S
14 FAILURE TO PROVIDE COVERAGE OF SPECIFIC ITEMS OR SERVICES REQUIRED UNDER
15 SUBSECTION A OF THIS SECTION IS BECAUSE PROVIDING OR PAYING FOR COVERAGE OF
16 THE SPECIFIC ITEMS OR SERVICES IS CONTRARY TO THE RELIGIOUS BELIEFS OF THE
17 EMPLOYER, SPONSOR, ISSUER, ACCOUNTABLE HEALTH PLAN OR OTHER ENTITY OFFERING
18 THE PLAN OR IS BECAUSE THE COVERAGE IS CONTRARY TO THE RELIGIOUS BELIEFS OF
19 THE PURCHASER OR BENEFICIARY OF THE COVERAGE. IF AN OBJECTION TRIGGERS THIS
20 SUBSECTION, A WRITTEN AFFIDAVIT SHALL BE FILED WITH THE ACCOUNTABLE HEALTH
21 PLAN STATING THE OBJECTION. The accountable health plan shall retain the
22 affidavit for the duration of the health benefits plan and any renewals of
23 the plan.

24 ~~C. Before enrollment in the plan, every religious employer that~~
25 ~~invokes this exemption shall provide prospective enrollees written notice~~
26 ~~that the religious employer refuses to cover all federal food and drug~~
27 ~~administration approved contraceptive methods for religious reasons.~~

28 ~~D.~~ C. Subsection B OF THIS SECTION shall not exclude coverage for
29 prescription contraceptive methods ordered by a health care provider with
30 prescriptive authority for medical indications other than ~~to prevent an~~
31 ~~unintended pregnancy~~ FOR CONTRACEPTIVE, ABORTIFACIENT, ABORTION OR
32 STERILIZATION PURPOSES. An accountable health plan, EMPLOYER, SPONSOR,
33 ISSUER OR OTHER ENTITY OFFERING THE PLAN may STATE RELIGIOUS BELIEFS IN ITS
34 AFFIDAVIT THAT require the enrollee to first pay for the prescription and
35 then submit a claim to the accountable health plan along with evidence that
36 the prescription is ~~for a noncontraceptive purpose~~ NOT IN WHOLE OR IN PART
37 FOR A PURPOSE COVERED BY THE OBJECTION. An accountable health plan may charge
38 an administrative fee for handling claims under this subsection.

1 ~~E. A religious employer shall not discriminate against an employee who~~
2 ~~independently chooses to obtain insurance coverage or prescriptions for~~
3 ~~contraceptives from another source.~~

4 ~~F. For the purposes of this section, "religious employer" means an~~
5 ~~entity for which all of the following apply:~~

6 ~~1. The entity primarily employs persons who share the religious tenets~~
7 ~~of the entity.~~

8 ~~2. The entity serves primarily persons who share the religious tenets~~
9 ~~of the entity.~~

10 ~~3. The entity is a nonprofit organization as described in section~~
11 ~~6033(a)(2)(A)i or iii of the internal revenue code of 1986, as amended."~~

12 Amend title to conform

and, as so amended, it do pass

EDWIN W. FARNSWORTH
Chairman

2625-se-jud
2/16/12
H:lae

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02/14/2012
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