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FILED
Jane Dee Hull
Secretary of State

CHAPTER 148

SENATE BILL 1359

AN ACT

AMENDING SECTIONS 20-282, 20-283, 20-286, 20-291 AND 36-2912, ARIZONA REVISED STATUTES; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

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

Section 1. Section 20-282, Arizona Revised Statutes, is amended to read:

20-282. Agent defined; exception

A. An "agent" is an individual, firm or corporation authorized by an insurer to solicit applications for insurance or annuities or to negotiate insurance on its behalf and, if authorized by the insurer, to effectuate and countersign insurance contracts. Notwithstanding any statement in the application or policy to the contrary, in the event of any controversy between the insured or the insured's beneficiary and the company, an agent who acts within the scope of his authority or within the scope of his apparent authority or whose actions have been previously authorized or are subsequently ratified by the company is the agent of the company which issued the insurance.

B. A regular salaried officer or employee of a life insurer shall not be deemed to be an agent by reason of rendering assistance to or on behalf of a licensed life insurance agent, if such officer or employee devotes substantially all of his time to activities other than the solicitation of applications for life or disability insurance or annuity contracts and receives no commission or other compensation directly dependent upon the amount of business obtained.

C. As used in this title, "agent" includes a bail bond agent AND A PERSON AUTHORIZED TO ACT AS AN AGENT FOR A HEALTH PLAN CONTRACTED TO PROVIDE COVERAGE TO PERSONS DEFINED AS ELIGIBLE PURSUANT TO SECTION 36-2901, PARAGRAPH 4, SUBDIVISION (d), (e), (f) OR (g).

Sec. 2. Section 20-283, Arizona Revised Statutes, is amended to read:

20-283. "Broker" defined

A "broker" is an individual, firm or corporation who for compensation as an independent contractor in any manner solicits, negotiates or procures insurance OR COVERAGE FROM A HEALTH PLAN CONTRACTED TO PROVIDE COVERAGE TO PERSONS DEFINED AS ELIGIBLE PURSUANT TO SECTION 36-2901, PARAGRAPH 4, SUBDIVISION (d), (e), (f) OR (g) or the renewal or continuance thereof, on behalf of PERSONS, insureds or prospective insureds other than himself, and not on behalf of an insurer or agent.

Sec. 3. Section 20-286, Arizona Revised Statutes, is amended to read:

20-286. "Solicitor" defined

A "solicitor" is an individual appointed and authorized by an agent or broker to solicit applications for insurance OR COVERAGE FROM A HEALTH PLAN CONTRACTED TO PROVIDE COVERAGE TO PERSONS DEFINED AS ELIGIBLE PURSUANT TO SECTION 36-2901, PARAGRAPH 4, SUBDIVISION (d), (e), (f) OR (g) as a representative of such agent or broker, and who offices with such agent or broker. An individual employed on salary only by, and devoting full time to clerical work with incidental taking of insurance applications in the office of, the agent or broker, is not deemed to be a solicitor if his employment or compensation is not contingent upon or related to the volume of such applications, insurance or premiums.

Sec. 4. Section 20-291, Arizona Revised Statutes, is amended to read:

20-291. Application for license

A. Application for an agent, broker or solicitor license shall be made to the director by the applicant. As part of or in connection with the application the applicant shall furnish information concerning his identity, personal history, business record, experience in insurance, purposes for which the license is to be used and other pertinent facts the director requires.

B. The application shall also show whether:

1. The applicant was ever previously licensed to transact any kind of insurance in this state or elsewhere.

2. Any license was ever refused, suspended or revoked.

3. Any insurer or general agent claims the applicant is indebted to it, and if so the details thereof.

4. The applicant ever had an agency contract cancelled, and the facts thereof.

5. The applicant received a passing score on the required licensing examination.

C. If a firm or corporation applies for an agent or broker license, the application shall set forth the information required by subsections A and B with respect to the firm or corporation, and in addition shall set forth the names of all members, officers and directors of the firm or corporation and the name of each person who is to exercise the agent or broker powers conferred upon the firm or corporation by the license. Each person so named in the application shall furnish the information required for a license as an individual.

D. The director may require any application to be in the applicant's handwriting and under the applicant's oath.

E. If for an agent's license, the application shall show:

1. The kinds of insurance to be transacted and the name of the authorized insurer the applicant is authorized to represent subject to issuance of the license.

2. IF AUTHORIZED TO REPRESENT A HEALTH PLAN CONTRACTED TO PROVIDE COVERAGE TO PERSONS DEFINED AS ELIGIBLE PURSUANT TO SECTION 36-2901, PARAGRAPH 4, SUBDIVISION (d), (e), (f) OR (g), THE NAME OF THE HEALTH PLAN THE APPLICANT IS AUTHORIZED TO REPRESENT SUBJECT TO ISSUANCE OF THE LICENSE.

F. If for a solicitor's license, the application shall be accompanied by written appointment of the applicant as solicitor by a licensed agent or broker.

G. Wilful misrepresentation of any fact required to be disclosed in any such application or accompanying statement is a violation of this title.

Sec. 5. Section 36-2912, Arizona Revised Statutes, is amended to read:

36-2912. Coverage; requirements for small businesses and public employers; related requirements; definitions

A. The administration shall establish a separate organization to coordinate, administer and regulate the delivery of health care services to persons defined as eligible pursuant to section 36-2901, paragraph 4, subdivisions (d), (e), (f) and (g).

B. An employer of eligible persons defined by section 36-2901, paragraph 4, subdivision (d), (e), (f) or (g) shall not, subject to subsection C of this section:

1. Offer coverage available pursuant to this section as the exclusive health benefits coverage for eligible employees.

2. Allot a larger contribution for coverage available pursuant to this section than contributions applicable under any other plan.

C. Employers with forty or fewer eligible employees under section 36-2901, paragraph 4, subdivision (f):

1. May contract for and offer coverage available pursuant to this section as the exclusive health benefits plan if the employer determines that no other health benefits plan is available at affordable rates. If an employer's health ~~benefit~~ BENEFITS plan has been terminated or discontinued by a health ~~benefit~~ BENEFITS carrier, the organization established pursuant

to subsection A of this section shall, subsequent to a contract with the employer, allow coverage to begin immediately.

2. Shall have a minimum of one and a maximum of forty full-time employees at the effective date of their first contract with the organization.

3. Shall, as a condition for contracting for coverage made available pursuant to this section, have a minimum of fifty per cent of ~~its~~ THEIR eligible employees enroll for system coverage. Employees with proof of other medical coverage who do not wish to enroll shall not be considered in determining the percentage.

D. An employer shall not offer coverage made available pursuant to this section to ~~employees~~ PERSONS defined as eligible pursuant to section 36-2901, paragraph 4, subdivision (d), (e), (f) or (g) as a substitute for a federally designated plan.

E. An employee or dependent defined as eligible pursuant to section 36-2901, paragraph 4, subdivision (d), (e), (f) or (g) may participate in the system on a voluntary basis only.

F. Notwithstanding subsection C, paragraph 2 of this section, the administration shall adopt rules to allow a business that offers system coverage pursuant to this section to continue coverage if it expands its employment to include more than forty employees.

G. The director shall:

1. Ensure that any organization developed to provide services to persons defined as eligible pursuant to section 36-2901, paragraph 4, subdivision (d), (e), (f) or (g) operates separately from the administration and that the full cost of any function performed by the administration on behalf of that organization is reimbursed by the organization or its contracted health plans, whichever is applicable.

2. Require that any health plan contracted to provide system covered services to persons defined as eligible pursuant to section 36-2901, paragraph 4, subdivisions (a), (b), (c), (h) and (j) provide separate audited reports on the assets, liabilities and financial status of any corporate activity involving providing coverage pursuant to this section to persons defined as eligible pursuant to section 36-2901, paragraph 4, subdivision (d), (e), (f) or (g).

3. Ensure that any health plan not contracted to provide system covered services to persons defined as eligible pursuant to section 36-2901, paragraph 4, subdivisions (a), (b), (c), (h) and (j) has complied with any applicable provisions of section 36-2906.01. The director may make requests of the director of the department of insurance on behalf of the organization pursuant to section 36-2906.01.

4. Not distribute any appropriated funds, unless specifically authorized by the legislature, to the organization or to any of the organization's contracted health plans.

5. Ensure that the organization's contracted health plans are required to meet contract terms as are necessary in the judgment of the director to ensure adequate performance by the health plan. Contract provisions shall include, but are not limited to, the maintenance of deposits, performance bonds, financial reserves or other financial security. The organization, upon approval of the director, may waive requirements for the posting of bonds or security for health plans which have posted other security, equal to or greater than that required by the organization, with the administration or the department of insurance for the performance of health service contracts if funds would be available to the organization from the other security upon the health plan's default. In waiving, or approving waivers of, any requirements established pursuant to this section, the organization and the director shall ensure that it has taken into account all the obligations to which a health plan's security is associated. The director may also, on behalf of the organization, adopt rules which provide for the withholding or forfeiture of payments to be made to a contracted health plan for the failure of the health plan to comply with provisions of its contract or with provisions of adopted rules.

6. ~~Promulgate~~ ADOPT separate rules on behalf of the organization. These rules shall stand alone and not be dependent upon any reference to rules adopted by the administration for health plans providing system covered services to persons defined as eligible pursuant to section 36-2901, paragraph 4, subdivisions (a), (b), (c), (h) and (j).

H. With respect to services provided by contracted health plans to persons defined as eligible pursuant to section 36-2901, paragraph 4, subdivision (d), (e), (f) or (g), the contracted health plan shall not be considered as payor of last resort and does not possess lien or subrogation rights beyond those held by health care services organizations licensed pursuant to title 20, chapter 4, article 9.

I. Health plans contracted to provide coverage to persons defined as eligible pursuant to section 36-2901, paragraph 4, subdivision (d), (e), (f) or (g) may exclude inpatient coverage for preexisting conditions, as defined in section 20-2301, for a period of not more than twelve months. The exclusion of coverage does not apply to newborns who were otherwise covered from the time of their birth or to persons who satisfy the portability requirements of section 20-2308. Credit of one month shall be given for each month of continuous coverage that the individual had under another health plan contracted to provide coverage to persons defined as eligible pursuant to section 36-2901, paragraph 4, subdivision (d), (e), (f) or (g) or a health benefits plan issued by an accountable health plan as defined in section 20-2301. Upon request, a contracted health plan or an accountable health plan which had provided continuous coverage to an individual shall promptly disclose the coverage provided, the period of coverage and the benefits provided under the coverage.

J. HEALTH PLANS CONTRACTED TO PROVIDE COVERAGE TO PERSONS DEFINED AS ELIGIBLE PURSUANT TO SECTION 36-2901, PARAGRAPH 4, SUBDIVISION (d), (e), (f) OR (g) SHALL ENSURE THAT THE PERSONNEL EMPLOYED OR CONTRACTED TO INTERACT WITH EMPLOYER GROUPS AS AGENTS, BROKERS OR SOLICITORS ARE LICENSED PURSUANT TO TITLE 20, CHAPTER 2, ARTICLE 3.

~~J.~~ K. For purposes of this section:

1. "Continuous coverage" means, with respect to particular services, the period beginning on the date an individual is enrolled under a health plan and ending on the date the individual is no longer enrolled for a continuous period of more than sixty days.

2. "Organization" means an entity developed by the administration pursuant to subsection A of this section.

Sec. 6. Emergency

This act is an emergency measure that is necessary to preserve the public peace, health or safety and is operative immediately as provided by law.

APPROVED BY THE GOVERNOR APRIL 10, 1996

FILED IN THE OFFICE OF THE SECRETARY OF STATE APRIL 11, 1996