

State of Arizona
House of Representatives
Fifty-second Legislature
First Regular Session
2015

CHAPTER 116

House Engrossed
FILED
MICHELE REAGAN
SECRETARY OF STATE

HOUSE BILL 2332

AN ACT

AMENDING SECTION 20-1057.02, ARIZONA REVISED STATUTES; REPEALING SECTION 20-1076, ARIZONA REVISED STATUTES; AMENDING SECTION 20-2304, ARIZONA REVISED STATUTES; REPEALING SECTION 20-2323, ARIZONA REVISED STATUTES; RELATING TO ACCOUNTABLE HEALTH PLANS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

2 Section 1. Section 20-1057.02, Arizona Revised Statutes, is amended to
3 read:

4 20-1057.02. Prescription drug formulary; definitions

5 A. A health care services organization with a prescription drug
6 benefit that uses a drug formulary as a component of the evidence of coverage
7 shall provide to its enrollees notice in the evidence of coverage ~~and the~~
8 ~~disclosure form prescribed in section 20-1076~~ regarding the applicable drug
9 formulary. The health care services organization shall write the notice so
10 that the language and format are easy to understand. The notice shall
11 include an explanation of what a drug formulary is, how the health care
12 services organization determines which prescription drugs are included or
13 excluded and how often the health care services organization reviews the
14 contents of the drug formulary.

15 B. A health care services organization described in subsection A of
16 this section shall:

17 1. Develop and maintain a process by which health care professionals
18 may request authorization for a medically necessary formulary or nonformulary
19 prescription drug during nonbusiness hours. If the health care services
20 organization does not maintain that process, the health care services
21 organization shall reimburse an enrollee for the enrollee's out-of-pocket
22 expense minus any deductible or copayment for a prescription drug that was
23 purchased by the enrollee without preauthorization but that was later
24 approved by the health care services organization.

25 2. Develop and maintain a process by which health care professionals
26 may request authorization for medically necessary nonformulary prescription
27 drugs. The health care services organization shall approve an alternative
28 prescription drug when either of the following conditions is met:

29 (a) The equivalent prescription drug on the formulary has been
30 ineffective in the treatment of the enrollee's disease or condition.

31 (b) The equivalent prescription drug on the formulary has caused an
32 adverse or harmful reaction in the enrollee.

33 C. If the health care services organization's pharmacy benefit plan
34 does not require authorization, subsection B, paragraph 2 of this section
35 does not apply.

36 D. If the enrollee's treating health care professional makes a
37 determination that the enrollee meets any of the conditions described in
38 subsection B of this section, any denial to cover the nonformulary
39 prescription drug by the health care services organization shall be made in
40 writing by a licensed pharmacist or medical director. The written denial
41 shall contain an explanation of the denial, including the medical or
42 pharmacological reasons why the authorization was denied, and the licensed
43 pharmacist or medical director who made the denial shall sign it. The health
44 care services organization shall send a copy of the written denial to the
45 enrollee's treating health care professional who requested the authorization.

1 The health care services organization shall maintain copies of all written
2 denials and shall make the copies available to the department for inspection
3 during regular business hours.

4 E. Any evidence of coverage that is issued, amended or renewed by a
5 health care services organization and that includes prescription drug
6 benefits shall not limit or exclude coverage for at least sixty days after
7 the health care services organization's notice or the pharmacy's notice
8 pursuant to subsection F of this section to the enrollee, whichever occurs
9 first, for a prescription drug for an enrollee to refill a previously
10 prescribed drug if the prescription drug was previously approved for coverage
11 under the drug formulary or pharmacy benefit plan for the enrollee's medical
12 condition and the health care professional continues to prescribe the
13 prescription drug for the same medical condition. The limitation or
14 exclusion prohibited by this subsection applies if the prescription drug is
15 appropriately prescribed and is considered safe and effective for treating
16 the enrollee's medical condition. This subsection does not prohibit the
17 health care professional from prescribing another prescription drug that is
18 covered by the drug formulary and that is medically appropriate for the
19 enrollee, including generic drug substitutions.

20 F. A health care services organization shall provide written notice of
21 the removal of any prescription drug from the health care services
22 organization's drug formulary to each pharmacy vendor with which the health
23 care services organization has a contract. On notice from the health care
24 services organization, the contracted pharmacy vendor at the point of
25 dispensing a prescription drug that has been removed from the drug formulary
26 shall notify the enrollee by means of a verbal consultation or other direct
27 communication with an enrollee that the enrollee may be required to consult
28 with a health care professional to obtain a new prescription for a
29 replacement drug after the sixty day period prescribed in subsection E of
30 this section. The notice prescribed in this subsection is not required if the
31 pharmacy vendor is a pharmacy that is owned by a health care services
32 organization or a corporate affiliate of that health care services
33 organization.

34 G. This section does not:

35 1. Prohibit a health care services organization from applying
36 deductibles, coinsurance or other cost containment or quality assurance
37 measures.

38 2. Apply to a health care services organization that provides a
39 multitiered benefit plan that allows access to prescription drugs without
40 authorization by the health care services organization.

41 H. For the purposes of this section:

42 1. "Health care professional" means a person who has an active
43 nonrestricted license pursuant to title 32 and WHO is authorized to write
44 drug prescriptions to treat medical conditions.

1 2. "Prescription drug" means any prescription medication as defined in
2 section 32-1901 that is prescribed by a health care professional to an
3 enrollee to treat the enrollee's condition.

4 Sec. 2. Repeal

5 Section 20-1076, Arizona Revised Statutes, is repealed.

6 Sec. 3. Section 20-2304, Arizona Revised Statutes, is amended to read:
7 20-2304. Availability of insurance; premium tax exemption

8 A. As a condition of doing business in this state, each accountable
9 health plan shall offer at least one health benefits plan on a guaranteed
10 issuance basis to small employers as required by this section. All small
11 employers qualify for this guaranteed offer of coverage. The accountable
12 health plan shall provide a health benefits plan to each small employer
13 without regard to health status-related factors if the small employer agrees
14 to make the premium payments and to satisfy any other reasonable provisions
15 of the plan that are not inconsistent with this chapter.

16 B. If an accountable health plan offers more than one health benefits
17 plan to small employers, the accountable health plan shall offer a choice of
18 all health benefits plans that the accountable health plan offers to small
19 employers and shall accept any small employer that applies for any of those
20 plans.

21 C. ~~In addition to the requirements prescribed in section 20-2323,~~ For
22 any offering of any health benefits plan to a small employer, as part of the
23 accountable health plan's solicitation and sales materials, an accountable
24 health plan shall make a reasonable disclosure to the employer of the
25 availability of the information described in this subsection and, on request
26 of the employer, shall provide that information to the employer. The
27 accountable health plan shall provide information concerning the following:

28 1. Provisions of coverage relating to the following, if applicable:

29 (a) The accountable health plan's right to change premium rates and
30 the factors that may affect changes in premium rates.

31 (b) Renewability of coverage.

32 (c) Any preexisting condition exclusion.

33 (d) Any affiliation period applied by a health care services
34 organization.

35 (e) The geographic areas served by health care services organizations.

36 2. The benefits and premiums available under all health benefits plans
37 for which the employer is qualified.

38 D. The accountable health plan shall describe the information required
39 by subsection C of this section in language that is understandable by the
40 average small employer and with a level of detail that is sufficient to
41 reasonably inform a small employer of the employer's rights and obligations
42 under the health benefits plan. This requirement is satisfied if the
43 accountable health plan provides each of the following for each product the
44 accountable health plan offers:

45 1. An outline of coverage that describes the benefits in summary form.

1 2. The rate or rating schedule that applies to the product,
2 preexisting condition exclusion or affiliation period.

3 3. The minimum employer contribution and group participation rules
4 that apply to any particular type of coverage.

5 4. In the case of a network plan, a map or listing of the areas
6 served.

7 E. An accountable health plan is not required to disclose any
8 information that is proprietary and protected trade secret information under
9 applicable law.

10 F. An accountable health plan that issues a health benefits plan
11 through a network plan may limit the employers that may apply for any health
12 benefits plan offered by the accountable health plan to those eligible
13 individuals who live, work or reside in the service area for the network plan
14 of the accountable health plan.

15 G. On approval of the director, an accountable health plan may refuse
16 to enroll a qualified small employer in a health benefits plan or in a
17 geographic area served by the plan if the accountable health plan
18 demonstrates that its financial or administrative capacity to serve
19 previously enrolled groups and individuals would be impaired. An accountable
20 health plan that refuses to enroll a qualified small employer may not enroll
21 an employer of the same or larger size until the earlier of:

22 1. The date on which the director determines that the accountable
23 health plan has the capacity to enroll a qualified small employer.

24 2. The date on which the accountable health plan enrolls a qualified
25 small employer.

26 H. An accountable health plan that offers coverage to a qualified
27 small employer shall offer coverage to all of the eligible employees of the
28 qualified small employer and their eligible dependents.

29 I. An accountable health plan may request health screening and
30 underwriting information on prospective enrollees to evaluate the risks
31 associated with a qualified small employer who applies for coverage. The
32 accountable health plan may use this information for the purposes of setting
33 premiums, evaluating plan offerings and making reinsurance decisions. An
34 accountable health plan shall not use this information to deny coverage to a
35 qualified small employer or to an eligible employee or to an eligible
36 dependent, except a late enrollee who attempts to enroll outside an open
37 enrollment period.

38 J. Accountable health plans are exempt from the premium taxes that are
39 required by section 20-224, subsection B and sections 20-837, 20-1010 and
40 20-1060 for the net premiums received for health benefits plans issued to
41 small employers, including the net premiums collected from coverage issued
42 pursuant to section 20-2313, subsection C. Each accountable health plan
43 shall notify the small employers to whom it provides coverage of the
44 reductions in the premium tax as specified in this subsection.

1 K. The director may use independent contractor examiners pursuant to
2 sections 20-148 and 20-159 to review the higher level of coverage and lower
3 level of coverage health benefits plans offered by an accountable health plan
4 insurer in compliance with this section. All examination and examination
5 related expenses shall be borne by the insurer and shall be paid by the
6 insurance examiners' revolving fund pursuant to section 20-159.

7 Sec. 4. Repeal

8 Section 20-2323, Arizona Revised Statutes, is repealed.

APPROVED BY THE GOVERNOR MARCH 30, 2015.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MARCH 31, 2015.

Passed the House February 19, 20 15

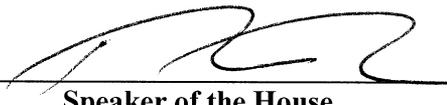
Passed the Senate March 24, 20 15

by the following vote: 57 Ayes,

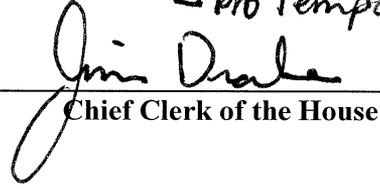
by the following vote: 28 Ayes,

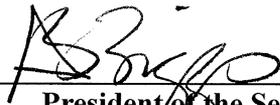
0 Nays, 3 Not Voting

0 Nays, 2 Not Voting

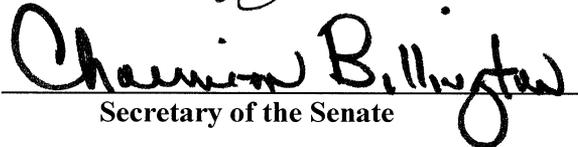


Speaker of the House
Pro Tempore


Chief Clerk of the House



President of the Senate

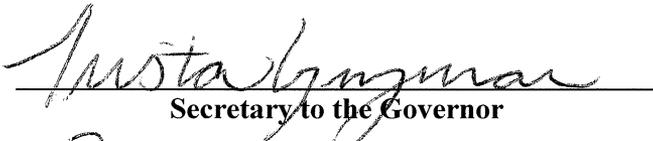

Secretary of the Senate

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF GOVERNOR

This Bill received by the Governor this

25th day of March, 20 15

at 3:31 o'clock P. M.


Secretary to the Governor

Approved this 30th day of

March

at 12:57 o'clock P. M.


Governor of Arizona

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF SECRETARY OF STATE

This Bill received by the Secretary of State

this 31st day of March, 20 15

at 10:00 o'clock A M.


Secretary of State