STATE OF ARIZONA
OFFICE OF THE GOVERNOR

DOUGLAS A. DUCEY
GOVERNOR

EXECUTIVE OFFICE

March 11, 2019

The Honorable Katie Hobbs
Secretary of State
1700 W. Washington, 7th Floor
Phoenix, AZ 85007

Dear Secretary Hobbs:

I am transmitting to you the following bills from the Fifty-fourth Legislature, 1st Regular Session, which I signed on March 11th, 2019:

SB 1109 short-term limited duration insurance; notice. (Livingston)

Sincerely,

Douglas A. Ducey
Governor
State of Arizona

cc: Senate Secretary
Chief Clerk of the House of Representatives
Arizona News Service

Senate Engrossed

FILED
KATIE HOBBS
SECRETARY OF STATE

State of Arizona
Senate
Fifty-fourth Legislature
First Regular Session
2019

CHAPTER 8

SENATE BILL 1109

AN ACT

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

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

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

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

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

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

2. Impose any preexisting condition exclusion for that coverage.

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

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

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

2. The offer includes at least either:

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

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

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

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

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

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

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

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

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

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

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

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

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

I. Nothing in this section:

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

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

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

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

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

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

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

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

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

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

1. The date that the certificate is issued.

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

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

4. The telephone number to call for further information regarding the certificate.

5. One of the following:

(a) A statement that the individual has at least eighteen months of creditable coverage. For the purposes of this subdivision, "eighteen months" means five hundred forty-six days.

(b) Both the date that the individual first sought coverage, as evidenced by a substantially complete application, and the date that creditable coverage began.

6. The date creditable coverage ended, unless the certificate indicates that creditable coverage is continuing from the date of the certificate.

7. The consumer assistance telephone number for the department.

8. The following statement in at least fourteen point type:

Important Notice!

Keep this certificate with your important personal records to protect your rights under the health insurance portability and accountability act of 1996 ("HIPAA"). This certificate is proof of your prior health insurance coverage. You may need to show this certificate to have a guaranteed right to buy new health insurance ("Guaranteed issue"). This certificate may also help you avoid waiting periods or exclusions for preexisting conditions. Under HIPAA, these rights are guaranteed only for a very short time period. After your group coverage ends, you must apply for new coverage within 63 days to be protected by HIPAA. If you have questions, call the Arizona department of insurance.

M. A health care insurer has satisfied the certification requirement under this section if the insurer offering the health benefits plan provides the certificate of creditable coverage in accordance with this section within thirty days after the event that triggered the issuance of the certificate.

N. Periods of creditable coverage for an individual are established by the presentation of the certificate described in this section and section 20-2310. In addition to the written certificate of creditable coverage as described in this section, individuals may establish creditable coverage through the presentation of documents or other means. In order to make a determination that is based on the relevant facts and circumstances of the amount of creditable coverage that an individual has, a health care insurer shall take into account all information that the insurer obtains or that is presented to the insurer on behalf of the individual.

O. A health care insurer shall calculate creditable coverage according to the following rules:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. The individual is not eligible for coverage under:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. "Health care insurer" means a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, medical service corporation or ~~a~~ hospital, medical, dental and optometric service corporation.

8. "Health status-related factor" means any factor in relation to the health of the individual or a dependent of the individual enrolled or to be enrolled in a health care services organization including:

(a) Health status.

(b) Medical condition, including physical and mental illness.

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

(g) Evidence of insurability, including conditions arising out of acts of domestic violence as defined in section 20-448.

(h) The existence of a physical or mental disability.

9. "Higher level of coverage" means a policy form for which the actuarial value of the benefits under the health insurance coverage offered by a health care insurer is at least fifteen ~~per cent~~ PERCENT more than the actuarial value of the health insurance coverage offered by the health care insurer as a lower level of coverage in this state but not more than one hundred twenty ~~per cent~~ PERCENT of a policy form weighted average.

10. "Individual health insurance coverage" means health insurance coverage offered by a health care insurer to individuals in the individual market but does not include limited benefit coverage or short-term limited duration insurance. A health care insurer that offers limited benefit coverage or short-term limited duration insurance to individuals and no other coverage to individuals in the individual market is not a health care insurer that offers health insurance coverage in the individual market.

11. "Limited benefit coverage" has the same meaning prescribed in section 20-1137.

12. "Lower level of coverage" means a policy form offered by a health care insurer for which the actuarial value of the benefits under the health insurance coverage is at least eighty-five ~~per cent~~ PERCENT but not more than one hundred ~~per cent~~ PERCENT of the policy form weighted average.

13. "Network plan" means a health care plan provided by a health care insurer under which the financing and delivery of health care services are provided, in whole or in part, through a defined set of providers either under contract with a health care insurer licensed pursuant to chapter 4, article 3 of this title or under contract with a health care insurer in accordance with the determination made by the

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

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

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

16. "Preexisting condition limitation" or "preexisting condition exclusion" means a limitation or exclusion of benefits for a preexisting condition under a health insurance policy or other contract that provides health coverage benefits.

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

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

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

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

NOTICE

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

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

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

C. FOR THE PURPOSES OF THIS SECTION:

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

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

APPROVED BY THE GOVERNOR MARCH 11, 2019.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MARCH 11, 2019.

Passed the House March 4, 2019,

by the following vote: 28 Ayes,

30 Nays, 2 Not Voting

FAILED

Speaker of the House

Jim Drake

Chief Clerk of the House

Passed the Senate February 13, 2019,

by the following vote: 18 Ayes,

12 Nays, 0 Not Voting

Karen Fann

President of the Senate

Susan Accevos

Secretary of the Senate

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF GOVERNOR

This Bill was received by the Governor this

_____ day of _____, 20____,

at _____ o'clock _____ M.

_____

Secretary to the Governor

Approved this _____ day of

_____, 20_____,

at _____ o'clock _____ M.

_____

Governor of Arizona

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF SECRETARY OF STATE

This Bill was received by the Secretary of State

this _____ day of _____, 20____,

at _____ o'clock _____ M.

_____

Secretary of State

S.B. 1109

Passed the House March 4, 2019

by the following vote: 31 Ayes,

28 Nays, 1 Not Voting

Speaker of the House

☑ Pro Tempore

Chief Clerk of the House

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF GOVERNOR

This Bill received by the Governor this

5th day of March, 2019

at 1:51 o'clock P M.

Secretary to the Governor

Approved this 11th day of

March 2019

at 2:44 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 11 day of March, 2019

at 4:01 o'clock P. M.

Secretary of State

ON RECONSIDERATION
S.B. 1109