

REFERENCE TITLE: **contraception; cost sharing prohibition**

State of Arizona
House of Representatives
Fifty-sixth Legislature
First Regular Session
2023

HB 2126

Introduced by
Representatives Salman: De Los Santos, Ortiz, Stahl Hamilton

AN ACT

**AMENDING SECTIONS 20-826 AND 20-1057.08, ARIZONA REVISED STATUTES;
AMENDING TITLE 20, CHAPTER 6, ARTICLE 4, ARIZONA REVISED STATUTES, BY
ADDING SECTION 20-1376.11; AMENDING SECTIONS 20-1402 AND 20-1404, ARIZONA
REVISED STATUTES; RELATING TO HEALTH INSURANCE.**

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

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

4 20-826. Subscription contracts; definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 3. All preexisting conditions and other limitations have been met
9 by the insured.

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

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

26 L. The director may disapprove any contract if the benefits
27 provided in the form of such contract are unreasonable in relation to the
28 premium charged.

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

32 1. Conditions of eligibility.

33 2. Coverage of dependents.

34 3. Preexisting conditions.

35 4. Termination of insurance.

36 5. Probationary periods.

37 6. Limitations.

38 7. Exceptions.

39 8. Reductions.

40 9. Elimination periods.

41 10. Requirements for replacement.

42 11. Any other condition of subscription contracts.

43 N. Any contract that provides maternity benefits shall not restrict
44 benefits for any hospital length of stay in connection with childbirth for
45 the mother or the newborn child to less than forty-eight hours following a

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

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

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

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

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

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

24 0. ~~Nothing in~~ Subsection N of this section **DOES NOT**:

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

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

36 3. ~~Prevents~~ **PREVENT** a corporation from negotiating the level and
37 type of reimbursement with a provider for care provided in accordance with
38 subsection N of this section.

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

42 1. Blood glucose monitors.

43 2. Blood glucose monitors for the legally blind.

44 3. Test strips for glucose monitors and visual reading and urine
45 testing strips.

- 1 4. Insulin preparations and glucagon.
- 2 5. Insulin cartridges.
- 3 6. Drawing up devices and monitors for the visually impaired.
- 4 7. Injection aids.
- 5 8. Insulin cartridges for the legally blind.
- 6 9. Syringes and lancets, including automatic lancing devices.
- 7 10. Prescribed oral agents for controlling blood sugar that are
- 8 included on the plan formulary.
- 9 11. To the extent coverage is required under medicare, podiatric
- 10 appliances for prevention of complications associated with diabetes.
- 11 12. Any other device, medication, equipment or supply for which
- 12 coverage is required under medicare from and after January 1, 1999. The
- 13 coverage required in this paragraph is effective six months after the
- 14 coverage is required under medicare.
- 15 Q. ~~Nothing in~~ Subsection P of this section ~~prohibits~~ DOES NOT
- 16 PROHIBIT a medical service corporation, a hospital service corporation or
- 17 a hospital, medical, dental and optometric service corporation from
- 18 imposing deductibles, coinsurance or other cost sharing in relation to
- 19 benefits for equipment or supplies for the treatment of diabetes.
- 20 R. Any hospital or medical service contract that provides coverage
- 21 for prescription drugs shall not limit or exclude coverage for any
- 22 prescription drug prescribed for the treatment of cancer on the basis that
- 23 the prescription drug has not been approved by the United States food and
- 24 drug administration for the treatment of the specific type of cancer for
- 25 which the prescription drug has been prescribed, if the prescription drug
- 26 has been recognized as safe and effective for treatment of that specific
- 27 type of cancer in one or more of the standard medical reference compendia
- 28 prescribed in subsection S of this section or medical literature that
- 29 meets the criteria prescribed in subsection S of this section. The
- 30 coverage required under this subsection includes covered medically
- 31 necessary services associated with the administration of the prescription
- 32 drug. This subsection does not:
 - 33 1. Require coverage of any prescription drug used in the treatment
 - 34 of 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
 - 38 not approved for any indication by the United States food and drug
 - 39 administration.
 - 40 3. Alter any law with regard to provisions that limit the coverage
 - 41 of prescription drugs that have not been approved by the United States
 - 42 food and drug administration.
 - 43 4. Notwithstanding section 20-841.05, require reimbursement or
 - 44 coverage for any prescription drug that is not included in the drug
 - 45 formulary or list of covered prescription drugs specified in the contract.

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

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

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

9 1. The acceptable standard medical reference compendia are the
10 following:

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

13 (b) The national comprehensive cancer network drugs and biologics
14 compendium.

15 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

37 T. A corporation shall not issue or deliver any advertising matter
38 or sales material to any person in this state until the corporation files
39 the advertising matter or sales material with the director. This
40 subsection does not require a corporation to have the prior approval of
41 the director to issue or deliver the advertising matter or sales material.
42 If the director finds that the advertising matter or sales material, in
43 whole or in part, is false, deceptive or misleading, the director may
44 issue an order disapproving the advertising matter or sales material,
45 directing the corporation to cease and desist from issuing, circulating,

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

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

23 V. The metabolic disorders triggering medical foods coverage under
 24 this section shall:

25 1. Be part of the newborn screening program prescribed in section
 26 36-694.

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

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

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

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

41 X. A hospital service corporation or medical service corporation
 42 shall cover at least fifty ~~percent~~ PERCENT of the cost of medical foods
 43 prescribed to treat inherited metabolic disorders and covered pursuant to
 44 this section. A hospital service corporation or medical service
 45 corporation may limit the maximum annual benefit for medical foods under

1 this section to ~~five thousand dollars~~ \$5,000, which applies to the cost of
2 all prescribed modified low protein foods and metabolic formula.

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

5 1. If the contract provides coverage for prescription drugs, the
6 contract shall provide coverage for any prescribed drug or device that is
7 approved by the United States food and drug administration for use as a
8 contraceptive. A corporation may use a drug formulary, multitiered drug
9 formulary or list but that formulary or list shall include oral, implant
10 and injectable contraceptive drugs, intrauterine devices and prescription
11 barrier methods. ~~if~~ The corporation ~~does~~ MAY not impose deductibles,
12 coinsurance, copayments or other cost containment measures for
13 contraceptive drugs, ~~that are greater than the deductibles, coinsurance,~~
14 ~~copayments or other cost containment measures for other drugs on the same~~
15 ~~level of the formulary or list~~ INTRAUTERINE DEVICES, PRESCRIPTION BARRIER
16 METHODS OR MALE STERILIZATION.

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

24 3. This subsection does not apply to contracts issued to
25 individuals on a nongroup basis.

26 ~~Z. Notwithstanding subsection Y of this section, a religiously~~
27 ~~affiliated employer may require that the corporation provide a contract~~
28 ~~without coverage for specific items or services required under subsection~~
29 ~~Y of this section because providing or paying for coverage of the specific~~
30 ~~items or services is contrary to the religious beliefs of the religiously~~
31 ~~affiliated employer offering the plan. If a religiously affiliated~~
32 ~~employer objects to providing coverage for specific items or services~~
33 ~~required under subsection Y of this section, a written affidavit shall be~~
34 ~~filed with the corporation stating the objection. On receipt of the~~
35 ~~affidavit, the corporation shall issue to the religiously affiliated~~
36 ~~employer a contract that excludes coverage for specific items or services~~
37 ~~required under subsection Y of this section. The corporation shall retain~~
38 ~~the affidavit for the duration of the contract and any renewals of the~~
39 ~~contract. This subsection shall not exclude coverage for prescription~~
40 ~~contraceptive methods ordered by a health care provider with prescriptive~~
41 ~~authority for medical indications other than for contraceptive,~~
42 ~~abortifacient, abortion or sterilization purposes. A religiously~~
43 ~~affiliated employer offering the plan may state religious beliefs in its~~
44 ~~affidavit and may require the subscriber to first pay for the prescription~~
45 ~~and then submit a claim to the hospital service corporation, medical~~

1 ~~service corporation or hospital, medical, dental and optometric service~~
2 ~~corporation along with evidence that the prescription is not for a purpose~~
3 ~~covered by the objection. A hospital service corporation, medical service~~
4 ~~corporation or hospital, medical, dental and optometric service~~
5 ~~corporation may charge an administrative fee for handling these claims.~~

6 ~~AA. Subsection Z of this section does not authorize a religiously~~
7 ~~affiliated employer to obtain an employee's protected health information~~
8 ~~or to violate the health insurance portability and accountability act of~~
9 ~~1996 (P.L. 104-191, 110 Stat. 1936) or any federal regulations adopted~~
10 ~~pursuant to that act.~~

11 ~~BB. Subsection Z of this section shall not be construed to restrict~~
12 ~~or limit any protections against employment discrimination that are~~
13 ~~prescribed in federal or state law.~~

14 ~~CC.~~ Z. For the purposes of:

15 1. This section:

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

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

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

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

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

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

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

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

35 (i) Formulated to be consumed or administered enterally under the
36 supervision of a physician who is licensed pursuant to title 32, chapter
37 13 or 17.

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

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

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

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

7 ~~3. Subsections Z and AA of this section, "religiously affiliated~~
8 ~~employer" means either:~~

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

10 ~~(i) The entity primarily employs persons who share the religious~~
11 ~~tenets of the entity.~~

12 ~~(ii) The entity primarily serves persons who share the religious~~
13 ~~tenets of the entity.~~

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

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

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

22 20-1057.08. Prescription contraceptive drugs and devices

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

25 1. Prescription drugs, the evidence of coverage shall provide
26 coverage for any prescribed drug or device that is approved by the United
27 States food and drug administration for use as a contraceptive. A health
28 care services organization may use a drug formulary, multitiered drug
29 formulary or list but that formulary or list shall include oral, implant
30 and injectable contraceptive drugs, intrauterine devices and prescription
31 barrier methods. ~~if~~ The health care services organization ~~does~~ MAY not
32 impose deductibles, coinsurance, copayments or other cost containment
33 measures for contraceptive drugs, ~~that are greater than the deductibles,~~
34 ~~coinsurance, copayments or other cost containment measures for other drugs~~
35 ~~on the same level of the formulary or list~~ INTRAUTERINE DEVICES,
36 PRESCRIPTION BARRIER METHODS OR MALE STERILIZATION.

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

44 ~~B. Notwithstanding subsection A of this section, a religiously~~
45 ~~affiliated employer may require that the health care services organization~~

1 ~~provide an evidence of coverage without coverage for specific items or~~
2 ~~services required under subsection A of this section because providing or~~
3 ~~paying for coverage of the specific items or services is contrary to the~~
4 ~~religious beliefs of the religiously affiliated employer offering the~~
5 ~~plan. If a religiously affiliated employer objects to providing coverage~~
6 ~~for specific items or services required under subsection A of this~~
7 ~~section, a written affidavit shall be filed with the health care services~~
8 ~~organization stating the objection. On receipt of the affidavit, the~~
9 ~~health care services organization shall issue to the religiously~~
10 ~~affiliated employer an evidence of coverage that excludes coverage for~~
11 ~~specific items or services required under subsection A of this section.~~
12 ~~The health care services organization shall retain the affidavit for the~~
13 ~~duration of the coverage and any renewals of the coverage.~~

14 ~~C. Subsection B of this section does not exclude coverage for~~
15 ~~prescription contraceptive methods ordered by a health care provider with~~
16 ~~prescriptive authority for medical indications other than for~~
17 ~~contraceptive, abortifacient, abortion or sterilization purposes. A~~
18 ~~religiously affiliated employer offering the plan may state religious~~
19 ~~beliefs in its affidavit and may require the enrollee to first pay for the~~
20 ~~prescription and then submit a claim to the health care services~~
21 ~~organization along with evidence that the prescription is not for a~~
22 ~~purpose covered by the objection. A health care services organization may~~
23 ~~charge an administrative fee for handling claims under this subsection.~~

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

29 ~~E. Subsections B and C of this section shall not be construed to~~
30 ~~restrict or limit any protections against employment discrimination that~~
31 ~~are prescribed in federal or state law.~~

32 ~~F. B. This section does not apply to evidences of coverage issued~~
33 ~~to individuals on a nongroup basis.~~

34 ~~G. For the purposes of this section, "religiously affiliated~~
35 ~~employer" means either:~~

36 ~~1. An entity for which all of the following apply:~~

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

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

41 ~~(c) The entity is a nonprofit organization as described in section~~
42 ~~6033(a)(3)(A)(i) or (iii) of the internal revenue code of 1986, as~~
43 ~~amended.~~

1 ~~2. An entity whose articles of incorporation clearly state that it~~
2 ~~is a religiously motivated organization and whose religious beliefs are~~
3 ~~central to the organization's operating principles.~~

4 Sec. 3. Title 20, chapter 6, article 4, Arizona Revised Statutes,
5 is amended by adding section 20-1376.11, to read:

6 20-1376.11. Contraceptive coverage; prescriptions; male
7 sterilization; cost sharing prohibited

8 A DISABILITY INSURANCE POLICY THAT INCLUDES PRESCRIPTION DRUG
9 COVERAGE SHALL PROVIDE COVERAGE FOR ANY PRESCRIBED DRUG OR DEVICE THAT IS
10 APPROVED BY THE UNITED STATES FOOD AND DRUG ADMINISTRATION FOR USE AS A
11 CONTRACEPTIVE. A DISABILITY INSURANCE POLICY MAY NOT INCLUDE ANY COST
12 SHARING REQUIREMENTS FOR CONTRACEPTIVE DRUGS, INTRAUTERINE DEVICES,
13 PRESCRIPTION BARRIER METHODS OR MALE STERILIZATION.

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

16 20-1402. Provisions of group disability policies; definitions

17 A. Each group disability policy shall contain in substance the
18 following provisions:

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

26 2. A provision that the insurer will furnish to the policyholder,
27 for delivery to each employee or member of the insured group, an
28 individual certificate setting forth in summary form a statement of the
29 essential features of the insurance coverage of the employee or member and
30 to whom benefits are payable. If dependents or family members are
31 included in the coverage additional certificates need not be issued for
32 delivery to the dependents or family members. Any policy, except
33 accidental death and dismemberment, applied for that provides family
34 coverage, as to such coverage of family members, shall also provide that
35 the benefits applicable for children shall be payable with respect to a
36 newly born child of the insured from the instant of such child's birth, to
37 a child adopted by the insured, regardless of the age at which the child
38 was adopted, and to a child who has been placed for adoption with the
39 insured and for whom the application and approval procedures for adoption
40 pursuant to section 8-105 or 8-108 have been completed to the same extent
41 that such coverage applies to other members of the family. The coverage
42 for newly born or adopted children or children placed for adoption shall
43 include coverage of injury or sickness including the necessary care and
44 treatment of medically diagnosed congenital defects and birth
45 abnormalities. If payment of a specific premium is required to provide

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

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

9 4. Each contract shall be so written that the corporation shall pay
10 benefits:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25 B. Any policy that provides maternity benefits shall not restrict
26 benefits for any hospital length of stay in connection with childbirth for
27 the mother or the newborn child to less than forty-eight hours following a
28 normal vaginal delivery or ninety-six hours following a cesarean section.
29 The policy shall not require the provider to obtain authorization from the
30 insurer for prescribing the minimum length of stay required by this
31 subsection. The policy may provide that an attending provider in
32 consultation with the mother may discharge the mother or the newborn child
33 before the expiration of the minimum length of stay required by this
34 subsection. The insurer shall not:

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

38 2. Provide monetary payments or rebates to mothers to encourage
39 those mothers to accept less than the minimum protections available
40 pursuant to this subsection.

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

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

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

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

9 1. ~~Requires~~ **REQUIRE** a mother to give birth in a hospital or to stay
10 in the hospital for a fixed period of time following the birth of the
11 child.

12 2. ~~Prevents~~ **PREVENT** an insurer from imposing deductibles,
13 coinsurance or other cost sharing in relation to benefits for hospital
14 lengths of stay in connection with childbirth for a mother or a newborn
15 child under the policy, except that any coinsurance or other cost sharing
16 for any portion of a period within a hospital length of stay required
17 pursuant to subsection B of this section shall not be greater than the
18 coinsurance or cost sharing for any preceding portion of that stay.

19 3. ~~Prevents~~ **PREVENT** an insurer from negotiating the level and type
20 of reimbursement with a provider for care provided in accordance with
21 subsection B of this section.

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

25 1. Blood glucose monitors.

26 2. Blood glucose monitors for the legally blind.

27 3. Test strips for glucose monitors and visual reading and urine
28 testing strips.

29 4. Insulin preparations and glucagon.

30 5. Insulin cartridges.

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

32 7. Injection aids.

33 8. Insulin cartridges for the legally blind.

34 9. Syringes and lancets including automatic lancing devices.

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

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

39 12. Any other device, medication, equipment or supply for which
40 coverage is required under medicare from and after January 1, 1999. The
41 coverage required in this paragraph is effective six months after the
42 coverage is required under medicare.

43 E. ~~Nothing in~~ Subsection D of this section ~~prohibits~~ **DOES NOT**
44 **PROHIBIT** a group disability insurer from imposing deductibles, coinsurance

1 or other cost sharing in relation to benefits for equipment or supplies
2 for the treatment of diabetes.

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

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

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

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

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

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

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

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

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

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

40 (b) The national comprehensive cancer network drugs and biologics
41 compendium.

42 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

23 I. The metabolic disorders triggering medical foods coverage under
24 this section shall:

25 1. Be part of the newborn screening program prescribed in section
26 36-694.

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

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

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

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

42 K. An insurer shall cover at least fifty ~~per cent~~ PERCENT of the
43 cost of medical foods prescribed to treat inherited metabolic disorders
44 and covered pursuant to this section. An insurer may limit the maximum
45 annual benefit for medical foods under this section to ~~five thousand~~

1 ~~dollars~~ \$5,000, which applies to the cost of all prescribed modified low
2 protein foods and metabolic formula.

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

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

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

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

1 ~~N. Subsection M of this section does not authorize a religiously~~
2 ~~affiliated employer to obtain an employee's protected health information~~
3 ~~or to violate the health insurance portability and accountability act of~~
4 ~~1996 (P.L. 104-191; 110 Stat. 1936) or any federal regulations adopted~~
5 ~~pursuant to that act.~~

6 ~~O. Subsection M of this section shall not be construed to restrict~~
7 ~~or limit any protections against employment discrimination that are~~
8 ~~prescribed in federal or state law.~~

9 ~~P.~~ M. For the purposes of:

10 1. This section:

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

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

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

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

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

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

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

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

31 (i) Formulated to be consumed or administered enterally under the
32 supervision of a physician who is licensed pursuant to title 32, chapter
33 13 or 17 or a registered nurse practitioner who is licensed pursuant to
34 title 32, chapter 15.

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

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

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

44 2. Subsection A of this section, the term "child", for purposes of
45 initial coverage of an adopted child or a child placed for adoption but

1 not for purposes of termination of coverage of such child, means a person
2 WHO IS under ~~the age of~~ eighteen years OF AGE.

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

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

6 ~~(i) The entity primarily employs persons who share the religious~~
7 ~~tenets of the entity.~~

8 ~~(ii) The entity serves primarily persons who share the religious~~
9 ~~tenets of the entity.~~

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

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

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

18 20-1404. Blanket disability insurance; definitions

19 A. Blanket disability insurance is that form of disability
20 insurance covering special groups of persons as enumerated in one of the
21 following paragraphs:

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

26 2. Under a policy or contract issued to an employer, who shall be
27 deemed the policyholder, covering all employees or any group of employees
28 defined by reference to hazards incident to an activity or activities or
29 operations of the policyholder. Dependents of the employees and guests of
30 the employer or employees may also be included where exposed to the same
31 hazards.

32 3. Under a policy or contract issued to a college, school or other
33 institution of learning or to the head or principal thereof, who or which
34 shall be deemed the policyholder, covering students, teachers, employees
35 or volunteers.

36 4. Under a policy or contract issued in the name of any volunteer
37 fire department or any first aid, civil defense or other such volunteer
38 group, or agency having jurisdiction thereof, which shall be deemed the
39 policyholder, covering all or any group of the members, participants or
40 volunteers of the fire department or first aid, civil defense or other
41 group.

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

44 6. Under a policy or contract issued to a sports team or to a camp
45 or sponsor thereof, which team or camp or sponsor thereof shall be deemed

1 the policyholder, covering members, campers, employees, officials,
2 supervisors or volunteers.

3 7. Under a policy or contract issued to an incorporated or
4 unincorporated religious, charitable, recreational, educational or civic
5 organization, or branch thereof, which organization shall be deemed the
6 policyholder, covering any group of members, participants or volunteers
7 defined by reference to hazards incident to an activity or activities or
8 operations sponsored or supervised by or on the premises of the
9 policyholder.

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

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

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

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

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

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

33 14. Under a policy or contract issued to a qualified marketplace
34 platform, which is deemed the policyholder, covering qualified marketplace
35 contractors that have executed a written contract with the qualified
36 marketplace platform. For the purposes of this paragraph, "qualified
37 marketplace contractor" and "qualified marketplace platform" have the same
38 meanings prescribed in section 20-485.

39 15. Under a policy or contract that is issued to any other
40 substantially similar group and that, in the discretion of the director,
41 may be subject to the issuance of a blanket disability policy or
42 contract. The director may exercise discretion on an individual risk
43 basis or class of risks, or both.

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

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

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

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

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

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

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

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

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

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

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

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

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

26 3. A mammogram every year for a woman WHO IS fifty years of age and
27 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
31 the 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
35 by the insured.

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

40 J. The coverage prescribed by subsection I of this section is
41 excess to any other coverage the natural mother may have for maternity
42 benefits except coverage made available to persons pursuant to title 36,
43 chapter 29. If such other coverage exists the agency, attorney or
44 individual arranging the adoption shall make arrangements for the
45 insurance to pay those costs that may be covered under that policy and

1 shall advise the adopting parent in writing of the existence and extent of
2 the coverage without disclosing any confidential information such as the
3 identity of the natural parent. The insured adopting parents shall notify
4 their insurer of the existence and extent of the other coverage.

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

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

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

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

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

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

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

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

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

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

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

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

22 N. ~~Nothing in~~ Subsection M of this section ~~prohibits~~ DOES NOT
23 PROHIBIT a blanket disability insurer from imposing deductibles,
24 coinsurance or other cost sharing in relation to benefits for equipment or
25 supplies for the treatment of diabetes.

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

- 38 1. Require coverage of any prescription drug used in the treatment
39 of a type of cancer if the United States food and drug administration has
40 determined that the prescription drug is contraindicated for that type of
41 cancer.
- 42 2. Require coverage for any experimental prescription drug that is
43 not approved for any indication by the United States food and drug
44 administration.

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

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

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

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

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

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

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

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

21 (c) Thomson Micromedex compendium DrugDex.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

41 2. Outpatient health care services shall also provide coverage for
42 outpatient contraceptive services. For the purposes of this paragraph,
43 "outpatient contraceptive services" means consultations, examinations,
44 procedures and medical services provided on an outpatient basis and

1 related to the use of approved United States food and drug administration
2 prescription contraceptive methods to prevent unintended pregnancies.

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

26 ~~W. Subsection V of this section does not authorize a religiously
27 affiliated employer to obtain an employee's protected health information
28 or to violate the health insurance portability and accountability act of
29 1996 (P.L. 104-191; 110 Stat. 1936) or any federal regulations adopted
30 pursuant to that act.~~

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

34 ~~Y.~~ V. For the purposes of:

35 1. This section:

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

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

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

42 (i) Formulated to be consumed or administered enterally under the
43 supervision of a physician who is licensed pursuant to title 32, chapter
44 13 or 17 or a registered nurse practitioner who is licensed pursuant to
45 title 32, chapter 15.

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

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

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

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

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

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

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

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

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

28 ~~3. Subsections V and W of this section, "religiously affiliated~~
29 ~~employer" means either:~~

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

31 ~~(i) The entity primarily employs persons who share the religious~~
32 ~~tenets of the entity.~~

33 ~~(ii) The entity serves primarily persons who share the religious~~
34 ~~tenets of the entity.~~

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

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