REFERENCE TITLE: insurance; mental health coverage; parity.

State of Arizona
Senate
Forty-eighth Legislature
Second Regular Session
2008

SB 1242

Introduced by
Senators Burton Cahill, Rios

AN ACT

AMENDING TITLE 20, CHAPTER 4, ARTICLE 3, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-826.04; AMENDING SECTIONS 20-841 AND 20-1057, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 4, ARTICLE 9, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1057.11; AMENDING TITLE 20, CHAPTER 6, ARTICLE 5, ARIZONA REVISED STATUTES, BY ADDING SECTIONS 20-1402.03 AND 20-1404.03; AMENDING SECTION 20-1406, ARIZONA REVISED STATUTES; RELATING TO HEALTH INSURANCE COVERAGE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Title 20, chapter 4, article 3, Arizona Revised Statutes, is amended by adding section 20-826.04, to read:

20-826.04. Mental health coverage; parity; definitions

A. A CORPORATION THAT ISSUES A GROUP HEALTH CARE PLAN THAT PROVIDES BOTH MEDICAL AND SURGICAL BENEFITS AND MENTAL HEALTH BENEFITS TO A GROUP SHALL NOT IMPOSE ANY TREATMENT LIMITATIONS OR FINANCIAL REQUIREMENTS WITH RESPECT TO THE MENTAL HEALTH BENEFIT COVERAGE UNLESS COMPARABLE TREATMENT LIMITATIONS OR FINANCIAL REQUIREMENTS ARE IMPOSED ON MEDICAL AND SURGICAL BENEFITS.

B. THE DIRECTOR SHALL ADOPT RULES TO CARRY OUT THIS SECTION.

C. FOR THE PURPOSES OF THIS SECTION:

1. "FINANCIAL REQUIREMENTS" INCLUDES:

(a) DEDUCTIBLES.

(b) COINSURANCE.

(c) COPAYMENTS.

(d) OTHER COST SHARING REQUIREMENTS.

(e) LIMITATIONS ON THE TOTAL AMOUNT THAT MAY BE PAID BY A PARTICIPANT OR BENEFICIARY WITH RESPECT TO BENEFITS UNDER THE PLAN OR COVERAGE.

(f) THE APPLICATION OF AN ANNUAL AND LIFETIME LIMIT.

2. "MEDICAL AND SURGICAL BENEFITS" MEANS BENEFITS WITH RESPECT TO MEDICAL OR SURGICAL SERVICES, AS DEFINED UNDER THE TERMS OF THE PLAN OR COVERAGE, BUT DOES NOT INCLUDE MENTAL HEALTH BENEFITS.

3. "MENTAL HEALTH BENEFITS" MEANS BENEFITS WITH RESPECT TO SERVICES, AS DEFINED UNDER THE TERMS AND CONDITIONS OF THE PLAN OR COVERAGE, FOR ALL CATEGORIES OF MENTAL HEALTH DISORDERS OR CONDITIONS THAT INVOLVE MENTAL ILLNESS OR SUBSTANCE RELATED DISORDERS AND THAT FALL UNDER ANY OF THE DIAGNOSTIC CATEGORIES LISTED IN THE MENTAL DISORDERS SECTION OF THE INTERNATIONAL CLASSIFICATION OF DISEASE, IF THESE SERVICES ARE INCLUDED AS PART OF AN AUTHORIZED TREATMENT PLAN ACCORDING TO STANDARD PROTOCOLS AND MEET THE PLAN OR ISSUER'S MEDICAL NECESSITY CRITERIA.

4. "TREATMENT LIMITATIONS" MEANS LIMITATIONS ON THE FREQUENCY OF TREATMENT OR THE NUMBER OF VISITS OR DAYS OF COVERAGE OR OTHER SIMILAR LIMITS ON THE DURATION OR SCOPE OF TREATMENT UNDER THE PLAN OR COVERAGE.

Sec. 2. Section 20-841, Arizona Revised Statutes, is amended to read:

20-841. Prohibiting denial of certain contract benefits

A. Notwithstanding any provision of any subscription contract of a hospital and medical service corporation, benefits shall not be denied under the contract for any medical or surgical service performed by a holder of a license issued pursuant to title 32, chapter 7 or 11, if the service performed is within the lawful scope of ~~such~~ THE person's license, and if the service is surgical, ~~such~~ THE person is a member of the staff of an accredited hospital, and if ~~such~~ THE contract would have provided benefits if ~~such~~ THE service had been performed by a holder of a license issued pursuant to title 32, chapter 13.

1 B. If a subscription contract of a hospital and medical service
2 corporation provides for or offers eye care services, the subscriber shall
3 have freedom of choice to select either an optometrist or a physician and
4 surgeon skilled in diseases of the eye to provide the examination, care, or
5 treatment for which the subscriber is eligible and which THAT falls within
6 the scope of practice of the optometrist or physician and surgeon. Unless
7 such A subscription contract otherwise provides, there shall be no
8 reimbursement SHALL NOT BE MADE for ophthalmic materials, lenses,
9 spectacles, OR eyeglasses, or appurtenances thereto TO OPHTHALMIC
10 MATERIALS, LENSES, SPECTACLES OR EYEGLASSES.
11 C. SUBJECT TO SECTION 20-826.04, if any subscription contract of a
12 hospital and medical service corporation is written to provide coverage for
13 psychiatric, drug abuse or alcoholism services, reimbursement for such THOSE
14 services shall be made in accordance with the terms of the contract without
15 regard to whether the covered services are rendered in a psychiatric special
16 hospital or general hospital. Reimbursement for the cost of the service may
17 be made directly to the person licensed or certified pursuant to title 32,
18 chapter 13 or 19.1 or to the subscriber if the cost of the service has not
19 been reimbursed to another provider or health care institution.
20 Sec. 3. Section 20-1057, Arizona Revised Statutes, is amended to read:
21 20-1057. Evidence of coverage by health care services
22 organizations; renewability; definitions
23 A. Every enrollee in a health care plan shall be issued an evidence of
24 coverage by the responsible health care services organization.
25 B. Any contract, except accidental death and dismemberment, applied
26 for that provides family coverage shall also provide, as to such coverage of
27 family members, that the benefits applicable for children shall be payable
28 with respect to a newly born child of the enrollee from the instant of such
29 child's birth, to a child adopted by the enrollee, regardless of the age at
30 which the child was adopted, and to a child who has been placed for adoption
31 with the enrollee and for whom the application and approval procedures for
32 adoption pursuant to section 8-105 or 8-108 have been completed to the same
33 extent that such coverage applies to other members of the family. The
34 coverage for newly born or adopted children or children placed for adoption
35 shall include coverage of injury or sickness including necessary care and
36 treatment of medically diagnosed congenital defects and birth abnormalities.
37 If payment of a specific premium is required to provide coverage for a child,
38 the contract may require that notification of birth, adoption or adoption
39 placement of the child and payment of the required premium must be furnished
40 to the insurer within thirty-one days after the date of birth, adoption or
41 adoption placement in order to have the coverage continue beyond the
42 thirty-one day period.
43 C. SUBJECT TO SECTION 20-1057.11, any contract, except accidental
44 death and dismemberment, that provides coverage for psychiatric, drug abuse
45 or alcoholism services shall require the health care services organization to

1 provide reimbursement for such services in accordance with the terms of the
2 contract without regard to whether the covered services are rendered in a
3 psychiatric special hospital or general hospital.
4 D. No evidence of coverage or amendment to the coverage shall be
5 issued or delivered to any person in this state until a copy of the form of
6 the evidence of coverage or amendment to the coverage has been filed with and
7 approved by the director.
8 E. An evidence of coverage shall contain a clear and complete
9 statement if a contract, or a reasonably complete summary if a certificate of
10 contract, of:
11 1. The health care services and the insurance or other benefits, if
12 any, to which the enrollee is entitled under the health care plan.
13 2. Any limitations of the services, kind of services, benefits or kind
14 of benefits to be provided, including any deductible or copayment feature.
15 3. Where and in what manner information is available as to how
16 services may be obtained.
17 4. The enrollee's obligation, if any, respecting charges for the
18 health care plan.
19 F. An evidence of coverage shall not contain provisions or statements
20 that are unjust, unfair, inequitable, misleading or deceptive, that encourage
21 misrepresentation or that are untrue.
22 G. The director shall approve any form of evidence of coverage if the
23 requirements of subsections E and F of this section are met. It is unlawful
24 to issue such form until approved. If the director does not disapprove any
25 such form within forty-five days after the filing of the form, it is deemed
26 approved. If the director disapproves a form of evidence of coverage, the
27 director shall notify the health care services organization. In the notice,
28 the director shall specify the reasons for the director's disapproval. The
29 director shall grant a hearing on such disapproval within fifteen days after
30 a request for a hearing in writing is received from the health care services
31 organization.
32 H. A health care services organization shall not cancel or refuse to
33 renew an enrollee's evidence of coverage that was issued on a group basis
34 without giving notice of the cancellation or nonrenewal to the enrollee and,
35 on request of the director, to the department of insurance. A notice by the
36 organization to the enrollee of cancellation or nonrenewal of the enrollee's
37 evidence of coverage shall be mailed to the enrollee at least sixty days
38 before the effective date of such cancellation or nonrenewal. The notice
39 shall include or be accompanied by a statement in writing of the reasons as
40 stated in the contract for such action by the organization. Failure of the
41 organization to comply with this subsection shall invalidate any cancellation
42 or nonrenewal except a cancellation or nonrenewal for nonpayment of premium,
43 for fraud or misrepresentation in the application or other enrollment
44 documents or for loss of eligibility as defined in the evidence of coverage.
45 A health care services organization shall not cancel an enrollee's evidence

1 of coverage issued on a group basis because of the enrollee's or dependent's
2 age, except for loss of eligibility as defined in the evidence of coverage,
3 sex, health status-related factor, national origin or frequency of
4 utilization of health care services of the enrollee. An evidence of coverage
5 issued on a group basis shall clearly delineate all terms under which the
6 health care services organization may cancel or refuse to renew an evidence
7 of coverage for an enrollee or dependent. Nothing in this subsection
8 prohibits the cancellation or nonrenewal of a health benefits plan contract
9 issued on a group basis for any of the reasons allowed in section 20-2309. A
10 health care services organization may cancel or nonrenew an evidence of
11 coverage issued to an individual on a nongroup basis only for the reasons
12 allowed by subsection N of this section.
13 I. A health care plan that provides coverage for surgical services for
14 a mastectomy shall also provide coverage incidental to the patient's covered
15 mastectomy for surgical services for reconstruction of the breast on which
16 the mastectomy was performed, surgery and reconstruction of the other breast
17 to produce a symmetrical appearance, prostheses, treatment of physical
18 complications for all stages of the mastectomy, including lymphedemas, and at
19 least two external postoperative prostheses subject to all of the terms and
20 conditions of the policy.
21 J. A contract that provides coverage for surgical services for a
22 mastectomy shall also provide coverage for mammography screening performed on
23 dedicated equipment for diagnostic purposes on referral by a patient's
24 physician, subject to all of the terms and conditions of the policy and
25 according to the following guidelines:
26 1. A baseline mammogram for a woman from age thirty-five to
27 thirty-nine.
28 2. A mammogram for a woman from age forty to forty-nine every two
29 years or more frequently based on the recommendation of the woman's
30 physician.
31 3. A mammogram every year for a woman fifty years of age and over.
32 K. Any contract that is issued to the enrollee and that provides
33 coverage for maternity benefits shall also provide that the maternity
34 benefits apply to the costs of the birth of any child legally adopted by the
35 enrollee if all the following are true:
36 1. The child is adopted within one year of birth.
37 2. The enrollee is legally obligated to pay the costs of birth.
38 3. All preexisting conditions and other limitations have been met and
39 all deductibles and copayments have been paid by the enrollee.
40 4. The enrollee has notified the insurer of the enrollee's
41 acceptability to adopt children pursuant to section 8-105 within sixty days
42 after such approval or within sixty days after a change in insurance
43 policies, plans or companies.
44 L. The coverage prescribed by subsection K of this section is excess
45 to any other coverage the natural mother may have for maternity benefits

1 except coverage made available to persons pursuant to title 36, chapter 29
2 but not including coverage made available to persons defined as eligible
3 under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e). If
4 such other coverage exists the agency, attorney or individual arranging the
5 adoption shall make arrangements for the insurance to pay those costs that
6 may be covered under that policy and shall advise the adopting parent in
7 writing of the existence and extent of the coverage without disclosing any
8 confidential information such as the identity of the natural parent. The
9 enrollee adopting parents shall notify their health care services
10 organization of the existence and extent of the other coverage. A health
11 care services organization is not required to pay any costs in excess of the
12 amounts it would have been obligated to pay to its hospitals and providers if
13 the natural mother and child had received the maternity and newborn care
14 directly from or through that health care services organization.
15 M. Each health care services organization shall offer membership to
16 the following in a conversion plan that provides the basic health care
17 benefits required by the director:
18 1. Each enrollee including the enrollee's enrolled dependents leaving
19 a group.
20 2. Each enrollee and the enrollee's dependents who would otherwise
21 cease to be eligible for membership because of the age of the enrollee or the
22 enrollee's dependents or the death or the dissolution of marriage of an
23 enrollee.
24 N. A health care services organization shall not cancel or nonrenew an
25 evidence of coverage issued to an individual on a nongroup basis, including a
26 conversion plan, except for any of the following reasons and in compliance
27 with the notice and disclosure requirements contained in subsection H of this
28 section:
29 1. The individual has failed to pay premiums or contributions in
30 accordance with the terms of the evidence of coverage or the health care
31 services organization has not received premium payments in a timely manner.
32 2. The individual has performed an act or practice that constitutes
33 fraud or the individual made an intentional misrepresentation of material
34 fact under the terms of the evidence of coverage.
35 3. The health care services organization has ceased to offer coverage
36 to individuals that is consistent with the requirements of sections 20-1379
37 and 20-1380.
38 4. If the health care services organization offers a health care plan
39 in this state through a network plan, the individual no longer resides, lives
40 or works in the service area served by the network plan or in an area for
41 which the health care services organization is authorized to transact
42 business but only if the coverage is terminated uniformly without regard to
43 any health status-related factor of the covered individual.
44 5. If the health care services organization offers health coverage in
45 this state in the individual market only through one or more bona fide

associations, the membership of the individual in the association has ceased but only if that coverage is terminated uniformly without regard to any health status-related factor of any covered individual.

O. A conversion plan may be modified if the modification complies with the notice and disclosure provisions for cancellation and nonrenewal under subsection H of this section. A modification of a conversion plan that has already been issued shall not result in the effective elimination of any benefit originally included in the conversion plan.

P. Any person who is a United States armed forces reservist, who is ordered to active military duty on or after August 22, 1990 and who was enrolled in a health care plan shall have the right to reinstate such coverage upon release from active military duty subject to the following conditions:

1. The reservist shall make written application to the health plan within ninety days of discharge from active military duty or within one year of hospitalization continuing after discharge. Coverage shall be effective upon receipt of the application by the health plan.

2. The health plan may exclude from such coverage any health or physical condition arising during and occurring as a direct result of active military duty.

Q. The director shall adopt emergency rules THAT ARE applicable to persons who are leaving active service in the armed forces of the United States and returning to civilian status consistent with subsection P of this section ~~including~~ AND THAT INCLUDE:

1. Conditions of eligibility.

2. Coverage of dependents.

3. Preexisting conditions.

4. Termination of insurance.

5. Probationary periods.

6. Limitations.

7. Exceptions.

8. Reductions.

9. Elimination periods.

10. Requirements for replacement.

11. Any other conditions of evidences of coverage.

R. Any contract that provides maternity benefits shall not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than forty-eight hours following a normal vaginal delivery or ninety-six hours following a cesarean section. The contract shall not require the provider to obtain authorization from the health care services organization for prescribing the minimum length of stay required by this subsection. The contract may provide that an attending provider in consultation with the mother may discharge the mother or the newborn child before the expiration of the minimum length of stay required by this subsection. The health care services organization shall not:

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

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

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

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

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

S. Nothing in subsection R of this section:

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

2. Prevents a health care services organization from imposing deductibles, coinsurance or other cost sharing in relation to benefits for hospital lengths of stay in connection with childbirth for a mother or a newborn child under the contract, except that any coinsurance or other cost sharing for any portion of a period within a hospital length of stay required pursuant to subsection R of this section shall not be greater than the coinsurance or cost sharing for any preceding portion of that stay.

3. Prevents a health care services organization from negotiating the level and type of reimbursement with a provider for care provided in accordance with subsection R of this section.

T. Any contract or evidence of coverage that provides coverage for diabetes shall also provide coverage for equipment and supplies that are medically necessary and that are prescribed by a health care provider including:

1. Blood glucose monitors.

2. Blood glucose monitors for the legally blind.

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

4. Insulin preparations and glucagon.

5. Insulin cartridges.

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

7. Injection aids.

8. Insulin cartridges for the legally blind.

9. Syringes and lancets including automatic lancing devices.

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

1 11. To the extent coverage is required under medicare, podiatric
2 appliances for prevention of complications associated with diabetes.
3 12. Any other device, medication, equipment or supply for which
4 coverage is required under medicare from and after January 1, 1999. The
5 coverage required in this paragraph is effective six months after the
6 coverage is required under medicare.
7 U. Nothing in subsection T of this section:
8 1. Entitles a member or enrollee of a health care services
9 organization to equipment or supplies for the treatment of diabetes that are
10 not medically necessary as determined by the health care services
11 organization medical director or the medical director's designee.
12 2. Provides coverage for diabetic supplies obtained by a member or
13 enrollee of a health care services organization without a prescription unless
14 otherwise permitted pursuant to the terms of the health care plan.
15 3. Prohibits a health care services organization from imposing
16 deductibles, coinsurance or other cost sharing in relation to benefits for
17 equipment or supplies for the treatment of diabetes.
18 V. Any contract or evidence of coverage that provides coverage for
19 prescription drugs shall not limit or exclude coverage for any prescription
20 drug prescribed for the treatment of cancer on the basis that the
21 prescription drug has not been approved by the United States food and drug
22 administration for the treatment of the specific type of cancer for which the
23 prescription drug has been prescribed, if the prescription drug has been
24 recognized as safe and effective for treatment of that specific type of
25 cancer in one or more of the standard medical reference compendia prescribed
26 in subsection W of this section or medical literature that meets the criteria
27 prescribed in subsection W of this section. The coverage required under this
28 subsection includes covered medically necessary services associated with the
29 administration of the prescription drug. This subsection does not:
30 1. Require coverage of any prescription drug used in the treatment of
31 a type of cancer if the United States food and drug administration has
32 determined that the prescription drug is contraindicated for that type of
33 cancer.
34 2. Require coverage for any experimental prescription drug that is not
35 approved for any indication by the United States food and drug
36 administration.
37 3. Alter any law with regard to provisions that limit the coverage of
38 prescription drugs that have not been approved by the United States food and
39 drug administration.
40 4. Notwithstanding section 20-1057.02, require reimbursement or
41 coverage for any prescription drug that is not included in the drug formulary
42 or list of covered prescription drugs specified in the contract or evidence
43 of coverage.

5. Notwithstanding section 20-1057.02, prohibit a contract or evidence of coverage from limiting or excluding coverage of a prescription drug, if the decision to limit or exclude coverage of the prescription drug is not based primarily on the coverage of prescription drugs required by this section.

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

W. For the purposes of subsection V of this section:

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

(a) The American medical association drug evaluations, a publication of the American medical association.

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

(c) Drug information for the health care provider, a publication of the United States pharmacopoeia convention.

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

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

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

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

X. A health care services organization shall not issue or deliver any advertising matter or sales material to any person in this state until the health care services organization files the advertising matter or sales material with the director. This subsection does not require a health care services organization to have the prior approval of the director to issue or deliver the advertising matter or sales material. If the director finds that the advertising matter or sales material, in whole or in part, is false, deceptive or misleading, the director may issue an order disapproving the advertising matter or sales material, directing the health care services organization to cease and desist from issuing, circulating, displaying or using the advertising matter or sales material within a period of time specified by the director but not less than ten days and imposing any

1 penalties prescribed in this title. At least five days before issuing an
2 order pursuant to this subsection, the director shall provide the health care
3 services organization with a written notice of the basis of the order to
4 provide the health care services organization with an opportunity to cure the
5 alleged deficiency in the advertising matter or sales material within a
6 single five day period for the particular advertising matter or sales
7 material at issue. The health care services organization may appeal the
8 director's order pursuant to title 41, chapter 6, article 10. Except as
9 otherwise provided in this subsection, a health care services organization
10 may obtain a stay of the effectiveness of the order as prescribed in section
11 20-162. If the director certifies in the order and provides a detailed
12 explanation of the reasons in support of the certification that continued use
13 of the advertising matter or sales material poses a threat to the health,
14 safety or welfare of the public, the order may be entered immediately without
15 opportunity for cure and the effectiveness of the order is not stayed pending
16 the hearing on the notice of appeal but the hearing shall be promptly
17 instituted and determined.
18 Y. Any contract or evidence of coverage that is offered by a health
19 care services organization and that contains a prescription drug benefit
20 shall provide coverage of medical foods to treat inherited metabolic
21 disorders as provided by this section.
22 Z. The metabolic disorders triggering medical foods coverage under
23 this section shall:
24 1. Be part of the newborn screening program prescribed in section
25 36-694.
26 2. Involve amino acid, carbohydrate or fat metabolism.
27 3. Have medically standard methods of diagnosis, treatment and
28 monitoring including quantification of metabolites in blood, urine or spinal
29 fluid or enzyme or DNA confirmation in tissues.
30 4. Require specially processed or treated medical foods that are
31 generally available only under the supervision and direction of a physician
32 who is licensed pursuant to title 32, chapter 13 or 17 or a registered nurse
33 practitioner who is licensed pursuant to title 32, chapter 15, that must be
34 consumed throughout life and without which the person may suffer serious
35 mental or physical impairment.
36 AA. Medical foods eligible for coverage under this section shall be
37 prescribed or ordered under the supervision of a physician licensed pursuant
38 to title 32, chapter 13 or 17 or a registered nurse practitioner who is
39 licensed pursuant to title 32, chapter 15 as medically necessary for the
40 therapeutic treatment of an inherited metabolic disease.
41 BB. A health care services organization shall cover at least fifty per
42 cent of the cost of medical foods prescribed to treat inherited metabolic
43 disorders and covered pursuant to this section. An organization may limit
44 the maximum annual benefit for medical foods under this section to five

thousand dollars, which applies to the cost of all prescribed modified low protein foods and metabolic formula.

CC. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization.

DD. For the purposes of:

1. This section:

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

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

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

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

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

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

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

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

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

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

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

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

2. Subsection B of this section, "child", for purposes of initial coverage of an adopted child or a child placed for adoption but not for purposes of termination of coverage of such child, means a person under ~~the age of~~ eighteen years OF AGE.

1 Sec. 4. Title 20, chapter 4, article 9, Arizona Revised Statutes, is
2 amended by adding section 20-1057.11, to read:
3 20-1057.11. Mental health coverage; parity; definitions
4 A. A HEALTH CARE SERVICES ORGANIZATION THAT ISSUES A GROUP HEALTH CARE
5 PLAN THAT PROVIDES BOTH MEDICAL AND SURGICAL BENEFITS AND MENTAL HEALTH
6 BENEFITS TO A GROUP SHALL NOT IMPOSE ANY TREATMENT LIMITATIONS OR FINANCIAL
7 REQUIREMENTS WITH RESPECT TO THE MENTAL HEALTH BENEFIT COVERAGE UNLESS
8 COMPARABLE TREATMENT LIMITATIONS OR FINANCIAL REQUIREMENTS ARE IMPOSED ON
9 MEDICAL AND SURGICAL BENEFITS.
10 B. THE DIRECTOR SHALL ADOPT RULES TO CARRY OUT THIS SECTION.
11 C. FOR THE PURPOSES OF THIS SECTION:
12 1. "FINANCIAL REQUIREMENTS" INCLUDES:
13 (a) DEDUCTIBLES.
14 (b) COINSURANCE.
15 (c) COPAYMENTS.
16 (d) OTHER COST SHARING REQUIREMENTS.
17 (e) LIMITATIONS ON THE TOTAL AMOUNT THAT MAY BE PAID BY A PARTICIPANT
18 OR BENEFICIARY WITH RESPECT TO BENEFITS UNDER THE PLAN OR COVERAGE.
19 (f) THE APPLICATION OF AN ANNUAL AND LIFETIME LIMIT.
20 2. "MEDICAL AND SURGICAL BENEFITS" MEANS BENEFITS WITH RESPECT TO
21 MEDICAL OR SURGICAL SERVICES, AS DEFINED UNDER THE TERMS OF THE PLAN OR
22 COVERAGE, BUT DOES NOT INCLUDE MENTAL HEALTH BENEFITS.
23 3. "MENTAL HEALTH BENEFITS" MEANS BENEFITS WITH RESPECT TO SERVICES,
24 AS DEFINED UNDER THE TERMS AND CONDITIONS OF THE PLAN OR COVERAGE, FOR ALL
25 CATEGORIES OF MENTAL HEALTH DISORDERS OR CONDITIONS THAT INVOLVE MENTAL
26 ILLNESS OR SUBSTANCE RELATED DISORDERS THAT FALL UNDER ANY OF THE DIAGNOSTIC
27 CATEGORIES LISTED IN THE MENTAL DISORDERS SECTION OF THE INTERNATIONAL
28 CLASSIFICATION OF DISEASE, IF THESE SERVICES ARE INCLUDED AS PART OF AN
29 AUTHORIZED TREATMENT PLAN ACCORDING TO STANDARD PROTOCOLS AND MEET THE PLAN
30 OR ISSUER'S MEDICAL NECESSITY CRITERIA.
31 4. "TREATMENT LIMITATIONS" MEANS LIMITATIONS ON THE FREQUENCY OF
32 TREATMENT OR THE NUMBER OF VISITS OR DAYS OF COVERAGE OR OTHER SIMILAR LIMITS
33 ON THE DURATION OR SCOPE OF TREATMENT UNDER THE PLAN OR COVERAGE.
34 Sec. 5. Title 20, chapter 6, article 5, Arizona Revised Statutes, is
35 amended by adding sections 20-1402.03 and 20-1404.03, to read:
36 20-1402.03. Mental health coverage; parity; definitions
37 A. A GROUP DISABILITY INSURER THAT ISSUES A GROUP HEALTH CARE PLAN
38 THAT PROVIDES BOTH MEDICAL AND SURGICAL BENEFITS AND MENTAL HEALTH BENEFITS
39 TO A GROUP SHALL NOT IMPOSE ANY TREATMENT LIMITATIONS OR FINANCIAL
40 REQUIREMENTS WITH RESPECT TO THE MENTAL HEALTH BENEFIT COVERAGE UNLESS
41 COMPARABLE TREATMENT LIMITATIONS OR FINANCIAL REQUIREMENTS ARE IMPOSED ON
42 MEDICAL AND SURGICAL BENEFITS.
43 B. THE DIRECTOR SHALL ADOPT RULES TO CARRY OUT THIS SECTION.
44 C. FOR THE PURPOSES OF THIS SECTION:
45 1. "FINANCIAL REQUIREMENTS" INCLUDES:

1 (a) DEDUCTIBLES.
2 (b) COINSURANCE.
3 (c) COPAYMENTS.
4 (d) OTHER COST SHARING REQUIREMENTS.
5 (e) LIMITATIONS ON THE TOTAL AMOUNT THAT MAY BE PAID BY A PARTICIPANT
6 OR BENEFICIARY WITH RESPECT TO BENEFITS UNDER THE PLAN OR COVERAGE.
7 (f) THE APPLICATION OF AN ANNUAL AND LIFETIME LIMIT.
8 2. "MEDICAL AND SURGICAL BENEFITS" MEANS BENEFITS WITH RESPECT TO
9 MEDICAL OR SURGICAL SERVICES, AS DEFINED UNDER THE TERMS OF THE PLAN OR
10 COVERAGE, BUT DOES NOT INCLUDE MENTAL HEALTH BENEFITS.
11 3. "MENTAL HEALTH BENEFITS" MEANS BENEFITS WITH RESPECT TO SERVICES,
12 AS DEFINED UNDER THE TERMS AND CONDITIONS OF THE PLAN OR COVERAGE, FOR ALL
13 CATEGORIES OF MENTAL HEALTH DISORDERS OR CONDITIONS THAT INVOLVE MENTAL
14 ILLNESS OR SUBSTANCE RELATED DISORDERS AND THAT FALL UNDER ANY OF THE
15 DIAGNOSTIC CATEGORIES LISTED IN THE MENTAL DISORDERS SECTION OF THE
16 INTERNATIONAL CLASSIFICATION OF DISEASE, IF THESE SERVICES ARE INCLUDED AS
17 PART OF AN AUTHORIZED TREATMENT PLAN ACCORDING TO STANDARD PROTOCOLS AND MEET
18 THE PLAN OR ISSUER'S MEDICAL NECESSITY CRITERIA.
19 4. "TREATMENT LIMITATIONS" MEANS LIMITATIONS ON THE FREQUENCY OF
20 TREATMENT OR THE NUMBER OF VISITS OR DAYS OF COVERAGE OR OTHER SIMILAR LIMITS
21 ON THE DURATION OR SCOPE OF TREATMENT UNDER THE PLAN OR COVERAGE.
22 20-1404.03. Mental health coverage; parity; definitions
23 A. A BLANKET DISABILITY INSURER THAT ISSUES A GROUP HEALTH CARE PLAN
24 THAT PROVIDES BOTH MEDICAL AND SURGICAL BENEFITS AND MENTAL HEALTH BENEFITS
25 TO A GROUP SHALL NOT IMPOSE ANY TREATMENT LIMITATIONS OR FINANCIAL
26 REQUIREMENTS WITH RESPECT TO THE MENTAL HEALTH BENEFIT COVERAGE UNLESS
27 COMPARABLE TREATMENT LIMITATIONS OR FINANCIAL REQUIREMENTS ARE IMPOSED ON
28 MEDICAL AND SURGICAL BENEFITS.
29 B. THE DIRECTOR SHALL ADOPT RULES TO CARRY OUT THIS SECTION.
30 C. FOR THE PURPOSES OF THIS SECTION:
31 1. "FINANCIAL REQUIREMENTS" INCLUDES:
32 (a) DEDUCTIBLES.
33 (b) COINSURANCE.
34 (c) COPAYMENTS.
35 (d) OTHER COST SHARING REQUIREMENTS.
36 (e) LIMITATIONS ON THE TOTAL AMOUNT THAT MAY BE PAID BY A PARTICIPANT
37 OR BENEFICIARY WITH RESPECT TO BENEFITS UNDER THE PLAN OR HEALTH INSURANCE
38 COVERAGE.
39 (f) THE APPLICATION OF AN ANNUAL AND LIFETIME LIMIT.
40 2. "MEDICAL AND SURGICAL BENEFITS" MEANS BENEFITS WITH RESPECT TO
41 MEDICAL OR SURGICAL SERVICES, AS DEFINED UNDER THE TERMS OF THE PLAN OR
42 COVERAGE, BUT DOES NOT INCLUDE MENTAL HEALTH BENEFITS.
43 3. "MENTAL HEALTH BENEFITS" MEANS BENEFITS WITH RESPECT TO SERVICES,
44 AS DEFINED UNDER THE TERMS AND CONDITIONS OF THE PLAN OR COVERAGE FOR ALL
45 CATEGORIES OF MENTAL HEALTH DISORDERS OR CONDITIONS THAT INVOLVE MENTAL

ILLNESS OR SUBSTANCE RELATED DISORDERS AND THAT FALL UNDER ANY OF THE DIAGNOSTIC CATEGORIES LISTED IN THE MENTAL DISORDERS SECTION OF THE INTERNATIONAL CLASSIFICATION OF DISEASE, IF THESE SERVICES ARE INCLUDED AS PART OF AN AUTHORIZED TREATMENT PLAN ACCORDING TO STANDARD PROTOCOLS AND MEET THE PLAN OR ISSUER'S MEDICAL NECESSITY CRITERIA.

4. "TREATMENT LIMITATIONS" MEANS LIMITATIONS ON THE FREQUENCY OF TREATMENT OR THE NUMBER OF VISITS OR DAYS OF COVERAGE OR OTHER SIMILAR LIMITS ON THE DURATION OR SCOPE OF TREATMENT UNDER THE PLAN OR COVERAGE.

Sec. 6. Section 20-1406, Arizona Revised Statutes, is amended to read:

20-1406. Prohibiting denial of certain contract benefits

A. Notwithstanding any provision of any group disability insurance contract or blanket disability insurance contract, benefits shall not be denied under the contract for any medical or surgical service performed by a holder of a license issued pursuant to title 32, chapter 7 or 11 or BY a registered nurse practitioner who is licensed pursuant to title 32, chapter 15, if the service performed is within the lawful scope of ~~such~~ THE person's license, and if the service is surgical, ~~such~~ THE person is a member of the staff of an accredited hospital, and if ~~such~~ THE contract would have provided benefits if ~~such~~ THE service had been performed by a holder of a license issued pursuant to title 32, chapter 13.

B. If any group disability insurance contract or blanket disability insurance contract provides for or offers eye care services, the subscriber shall have freedom of choice to select either an optometrist or a physician and surgeon skilled in diseases of the eye to provide the examination, care, or treatment for which the subscriber is eligible and ~~which~~ THAT falls within the scope of practice of the optometrist or physician and surgeon. Unless ~~such~~ A group disability insurance contract or blanket disability insurance contract otherwise provides, ~~there shall be no~~ reimbursement SHALL NOT BE MADE for ophthalmic materials, lenses, spectacles~~,~~ OR eyeglasses~~,~~ or appurtenances ~~thereto~~ TO OPHTHALMIC MATERIALS, LENSES, SPECTACLES OR EYEGLASSES.

C. SUBJECT TO SECTIONS 20-1402.03 AND 20-1404.03, if any group disability insurance contract is written to provide coverage for psychiatric, drug abuse or alcoholism services, reimbursement for ~~such~~ THOSE services shall be made in accordance with the terms of the contract without regard to whether the covered services are rendered in a psychiatric special hospital or general hospital. Reimbursement for the cost of the service may be made directly to the person licensed or certified pursuant to title 32, chapter 13 or 19.1 or to the subscriber if the cost of the service has not been reimbursed to another provider or health care institution.

Sec. 7. Applicability

This act applies to policies, contracts and plans that are issued or renewed on or after January 1, 2009.