

House Engrossed Senate Bill

~~insurance, fees, consent, limits~~

(now: insurance; fees; consent; medicare supplement)

State of Arizona
Senate
Fifty-fifth Legislature
Second Regular Session
2022

CHAPTER 342

SENATE BILL 1118

AN ACT

AMENDING SECTIONS 20-167, 20-239, 20-381, 20-1133, 20-1379, 20-1382,
20-1583 AND 20-2310, ARIZONA REVISED STATUTES; RELATING TO INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:
 2 Section 1. Section 20-167, Arizona Revised Statutes, is amended to
 3 read:

4 20-167. Fees; definition

5 A. The director shall collect in advance the following fees,
 6 determined by the director, which are nonrefundable on payment:

	Not Less Than:	Not More Than:
7		
8 1. For filing charter documents:		
9 (a) Original charter documents,		
10 articles of incorporation,		
11 bylaws, or record of		
12 organization of insurers,		
13 or certified copies thereof,		
14 required to be filed with		
15 the director and not also		
16 subject to filing in the		
17 office of the corporation		
18 commission	\$ 40.00	\$ 115.00
19 (b) Amended charter documents	15.00	45.00
20 (c) No charge or fee shall be		
21 required for filing with		
22 the director any of such		
23 documents also required		
24 by law to be filed in the		
25 office of the corporation		
26 commission		
27 2. Certificate of authority:		
28 (a) Issuance:		
29 Fraternal benefit societies	\$ 15.00	\$ 45.00
30 Medical or hospital service		
31 corporations, health care		
32 services organizations or		
33 prepaid dental plan		
34 organizations	40.00	115.00
35 Mechanical reimbursement		
36 reinsurers	150.00	450.00
37 All other insurers	100.00	295.00
38 (b) Renewal:		
39 Fraternal benefit societies	15.00	45.00
40 Medical or hospital service		
41 corporations, health care		
42 services organizations or		
43 prepaid dental plan		
44 organizations	40.00	115.00

1	Domestic stock life insurers,		
2	domestic stock disability		
3	insurers or domestic stock		
4	life and disability insurers	750.00	2,250.00
5	Domestic life reinsurers,		
6	domestic disability		
7	reinsurers or domestic		
8	life and disability		
9	reinsurers	2,250.00	5,500.00
10	Mechanical reimbursement		
11	reinsurers	2,250.00	5,500.00
12	All other insurers	70.00	205.00
13	3. Certificate of registration as an		
14	administrator or application for		
15	renewal under section 20-485.12	\$ 100.00	\$ 295.00
16	4. Authority to solicit applications		
17	for and issue policies by means		
18	of mechanical vending machines	\$ 30.00	\$ 90.00
19	5. Service company permit	\$ 150.00	\$ 450.00
20	6. Application for motor vehicle		
21	service contract program approval	\$ 150.00	\$ 450.00
22	7. Life care contract application		
23	or annual report	\$ 225.00	\$ 675.00
24	8. Filing annual statement	\$ 150.00	\$ 450.00
25	9. Annual statement filing for		
26	exempt insurer transacting life		
27	insurance, disability insurance		
28	or annuity business pursuant to		
29	section 20-401.05	\$ 65.00	\$ 100.00
30	10. Licenses and examinations:		
31	(a) Licenses:		
32	Surplus lines broker's license,		
33	quadrennially	\$ 600.00	\$1,000.00
34	All other licenses,		
35	quadrennially	60.00	180.00
36	(b) Examinations for license:		
37	Examination on laws and one kind		
38	of insurance	8.00	25.00
39	Examination on laws and two or		
40	more kinds of insurance	15.00	45.00
41	11. Miscellaneous:		
42	Fee accompanying service of		
43	process on director	\$ 8.00	\$ 25.00

1	Certificate of director,		
2	under seal	1.50 0.00	5.00
3	Copy of document filed in		
4	director's office, per page	0.50	0.75

5 B. Except as provided in section 20-1098.18, the director shall
6 deposit, pursuant to sections 35-146 and 35-147, all fees collected
7 pursuant to this section in the state general fund. A refund is not
8 allowed for any unused portion of a fee, and the director shall not
9 prorate fees.

10 C. The license fees prescribed by this section shall be payment in
11 full of all demands for all state, county, district and municipal license
12 fees, license taxes, business privilege taxes and business privilege fees
13 and charges of every kind.

14 D. The director may contract for the examination for licensing
15 adjusters, insurance producers, bail bond agents, risk management
16 consultants and surplus lines brokers. If the director does so, the fee
17 for examinations for licenses pursuant to this section is payable directly
18 to the contractor by the applicant for examination. The director may
19 agree to a reasonable examination fee to be charged by the contractor.
20 The fee may exceed the amounts prescribed in this section.

21 E. The director may contract with a voluntary domestic organization
22 of surplus lines brokers to perform any transaction prescribed in chapter
23 2, article 5 of this title, including the acceptance or maintenance of the
24 reports required by section 20-408. The director may allow the contractor
25 to charge a stamping fee. The surplus lines broker shall pay the stamping
26 fee established pursuant to this section directly to the contractor.

27 F. Captive insurers shall pay certificate of authority issuance and
28 renewal fees as prescribed by the director.

29 G. For the purposes of this section, "stamping fee" means a
30 reasonable filing fee charged by a contractor for any transaction
31 prescribed in chapter 2, article 5 of this title, including the acceptance
32 or maintenance of the reports required by section 20-408.

33 Sec. 2. Section 20-239, Arizona Revised Statutes, is amended to
34 read:

35 20-239. Electronic communications and records; applicability;
36 definitions

37 A. Any notice to a party or any other document that is required
38 under this title in an insurance transaction or that is to serve as
39 evidence of insurance coverage may be delivered, stored and presented by
40 electronic means if it meets the requirements of title 44, chapter 26,
41 article 1. If an insurer uploads a document or notice to a portal or
42 secure website, the insurer shall send a separate notice to the party that
43 specifies that the document or notice has been uploaded and that includes
44 a description of the document or notice that has been uploaded.

1 B. An insurer may deliver a notice or document by electronic means
2 to a party pursuant to this section if the party electronically consents
3 to that method of electronic delivery and has not withdrawn consent. A
4 named insured that effectuates insurance transactions by electronic means
5 shall be deemed to have consented to receive notices and documents by
6 electronic means in accordance with this section unless the named insured
7 opts out of electronic delivery and elects delivery by hard copy.

8 C. EITHER an oral communication WITH A CONTEMPORANEOUS WRITTEN
9 RECORD MADE OF THE COMMUNICATION or ~~a~~ AN ARCHIVED recording of an oral
10 communication SUBJECT TO THE INSURER'S WRITTEN RECORD RETENTION POLICY
11 ~~does not~~ SHALL qualify as consent for the purposes of this section. THE
12 ORAL CONSENT PRESCRIBED IN THIS SUBSECTION APPLIES ONLY TO AN AGREEMENT TO
13 THE USE OF ELECTRONIC COMMUNICATION WITH THE INSURER AND IS NOT AN
14 AGREEMENT BY THE INSURED TO ANY SPECIFIC INSURANCE POLICY OR COVERAGE OR
15 ANY OTHER INSURANCE MATTER.

16 D. Notwithstanding subsection A of this section, an insurer sending
17 a notice pursuant to section 20-1632, subsection A, for a period of five
18 years after the date of the notice, shall maintain in its files
19 verification that the notice was sent by electronic means with a United
20 States postal service electronic postmark or another email delivery
21 service that provides electronic postmarks substantially similar to a
22 United States postal service electronic postmark. The verification must
23 contain sufficient information from which the department may determine
24 that the notice was properly sent.

25 E. An insurer providing notice to an insured pursuant to section
26 20-1632 by electronic means shall also send that notice to the named
27 insured by United States postal service certified mail, certificate of
28 mailing or first class mail using intelligent mail barcode or another
29 similar tracking method used or approved by the United States postal
30 service pursuant to section 20-1632 if either of the following applies:

31 1. The notice being electronically delivered is rejected for
32 delivery or returned to the insurer.

33 2. The insurer becomes aware that the email address provided by the
34 party is no longer valid.

35 F. Delivery of a notice or document pursuant to this section is
36 equivalent to any delivery method required or allowed under this title,
37 including delivery by the United States postal service by first class
38 mail, postage prepaid, certified mail, certificate of mailing or first
39 class mail using intelligent mail barcode or another similar tracking
40 method used or approved by the United States postal service.

41 G. After the party elects to receive notices and documents by
42 electronic means, if a change in the hardware or software requirements
43 needed to access or retain a notice or document delivered by electronic
44 means creates a material risk that the party will not be able to access or

1 retain a subsequent notice or document to which the consent applies, the
2 insurer must inform the party of:

3 1. The revised hardware and software requirements for access to and
4 retention of a notice or document delivered by electronic means.

5 2. The party's right to withdraw consent without the imposition of
6 any fee, condition or consequence.

7 H. This section does not affect the requirements related to content
8 or timing of any notice or document required under this title.

9 I. If a provision of this title expressly requires verification or
10 acknowledgment of receipt of a notice or document, the notice or document
11 may be delivered by electronic means only if the method used provides for
12 verification or acknowledgment of receipt.

13 J. The legal effectiveness, validity or enforceability of any
14 insurance contract or policy executed by a party may not be denied solely
15 because the insurer failed to obtain electronic consent or confirmation of
16 consent.

17 K. A party's withdrawal of consent:

18 1. Does not affect the legal effectiveness, validity or
19 enforceability of a notice or document delivered by electronic means to
20 the party before the withdrawal of consent is effective.

21 2. Is effective within seven days after the insurer receives the
22 withdrawal.

23 L. If an insurer fails to comply with subsection G of this section,
24 the party may treat that failure as a withdrawal of consent for the
25 purposes of this section.

26 M. This section does not apply to a notice or document delivered by
27 an insurer in an electronic format before July 24, 2014 to a party who,
28 before that date, has consented to receive a notice or document in an
29 electronic format as otherwise provided by law.

30 N. If a party's consent to receive certain notices or documents in
31 an electronic format is on file with an insurer before July 24, 2014 and
32 the insurer intends to deliver additional notices or documents to that
33 party in an electronic format pursuant to this section, before delivering
34 the additional notices or documents electronically the insurer must notify
35 the party of both of the following:

36 1. The notices or documents that may be delivered by electronic
37 means under this section that were not previously delivered
38 electronically.

39 2. The party's right to withdraw consent to have notices or
40 documents delivered by electronic means.

41 O. An insurer may not charge a fee to a party who does not consent
42 to receive notices or documents by electronic means and who chooses to
43 receive the notices or documents in hard copy.

1 P. This section applies only to property, casualty, disability,
2 marine and transportation, surety, prepaid legal, prepaid dental, title,
3 identity theft, workers' compensation and life insurance policies and
4 annuities that are subject to this title, including policies and contracts
5 issued by health care services organizations and hospital, medical, dental
6 and optometric service corporations.

7 Q. This section does not modify, limit or supersede the electronic
8 signatures in global and national commerce act (P.L. 106-229; 15 United
9 States Code sections 7001 through 7031).

10 R. For the purposes of this section:

11 1. "Delivered by electronic means" includes either:

12 (a) The delivery to an email address at which a party has consented
13 to receive notices or documents.

14 (b) The posting on an electronic network or site accessible via the
15 internet or a mobile application, computer, mobile device, tablet or other
16 electronic device, together with a separate notice of the posting that
17 includes a description of the document or notice that has been posted and
18 that is provided by email to the email address at which the party has
19 consented to receive notice or by any other delivery method that has been
20 consented to by the party.

21 2. "Party" means a recipient of any notice or document as part of
22 an insurance transaction, including an applicant, an insured or a
23 policyholder.

24 Sec. 3. Section 20-381, Arizona Revised Statutes, is amended to
25 read:

26 20-381. Definitions

27 In this article, unless the context otherwise requires:

28 1. "Advisory organization":

29 (a) Means any person other than a single insurer who assists **TWO OR**
30 **MORE** insurers or rate service organizations in the making of rates by
31 compiling and furnishing loss or expense statistics or other statistical
32 information and data, or by the submission of recommendations as to rates,
33 forms or supplementary rate information. ~~Advisory organization~~

34 (b) Does not include a joint underwriting association, any
35 actuarial or legal consultant, any employee of an insurer or insurers
36 under common control or management or their employees or manager.

37 2. "Loss cost adjustment":

38 (a) Means that portion of a rate filed by an insurer with the
39 director that includes the insurer's general expenses, total product
40 expenses, taxes, licenses and fee expenses and underwriting profit and
41 contingencies. ~~loss cost adjustment~~

42 (b) Does not include loss adjustment expenses or prospective loss
43 costs.

1 3. "Loss cost modification factor" means that rating factor filed
2 by an insurer with the director for the purpose of modifying the rate
3 service organization's prospective loss cost filing.

4 4. "Prospective loss costs" means the historical aggregate losses
5 and loss adjustment expenses filed by a rate service organization with the
6 director on which a portion of a rate is based, adjusted through actuarial
7 trending to a future point in time and developed to their ultimate values.

8 5. "Rate":

9 (a) Means that cost of insurance per exposure unit whether
10 expressed as a single number or as a prospective loss cost with an
11 adjustment to account for the treatment of expenses, profit and individual
12 insurer variation in loss experience before any application of individual
13 risk variations based on loss or expense considerations. ~~Rate~~

14 (b) Does not include the minimum premium.

15 6. "Rate service organization":

16 (a) Means any person other than a single insurer who assists
17 insurers by compiling and furnishing loss or expense statistics and
18 recommending, making or filing rates, forms or supplementary rate
19 information. ~~Rate service organization~~

20 (b) Does not include a joint underwriting association, any
21 actuarial or legal consultant, any employee of an insurer or insurers
22 under common control or management, or their employees or manager.

23 7. "Supplementary rate information":

24 (a) Means any manual or plan of rates, statistical plan,
25 classification, rating schedule, minimum premium, schedule of fees,
26 including membership fees charged by a reciprocal or mutual insurer,
27 rating rule, rate related underwriting rule and ~~any~~ other information used
28 by an insurer in making rates. ~~Supplementary rate information~~

29 (b) Does not include the final rate pages that combine the
30 prospective loss costs with the loss cost adjustments.

31 Sec. 4. Section 20-1133, Arizona Revised Statutes, is amended to
32 read:

33 20-1133. Medicare supplement insurance; early enrollment
34 discounts; applicability

35 A. The director shall adopt ~~those~~ rules ~~as are~~ necessary to comply
36 with the requirements of the social security disability amendments of 1980
37 (P.L. 96-265; 42 United States Code section 1395ss) and any federal laws
38 or regulations pertaining to that section, so that this state may retain
39 its full authority to regulate minimum standards for medicare supplement
40 insurance.

41 B. FOR THE PURPOSES OF THIS SECTION, AN INSURER MAY FILE FOR
42 MEDICARE SUPPLEMENT RATES THAT INCLUDE AN EARLY ENROLLMENT DISCOUNT THAT
43 WILL NOT BE CONSIDERED AN ATTAINED AGE RATING STRUCTURE. AN EARLY
44 ENROLLMENT DISCOUNT SHALL DIMINISH OVER A PERIOD OF TIME AND IS ONLY

1 AVAILABLE TO ENROLLEES WHO PURCHASE THE PLAN WITHIN THE EARLY ENROLLMENT
2 PERIOD DESIGNATED BY THE INSURER. INSURERS SHALL DISCLOSE TO ALL
3 APPLICANTS HOW THE EARLY ENROLLMENT DISCOUNT WILL DIMINISH OVER TIME.

4 ~~B.~~ C. Subject to the other limitations provided in this
5 subsection, ~~no~~ A benefit mandated in this title for health insurance
6 policies ~~shall~~ DOES NOT apply to medicare supplement insurance policies
7 unless ~~such~~ THE mandated policy ~~benefits are~~ BENEFIT IS set forth in rules
8 adopted pursuant to this section or unless the statute mandating THE
9 policy ~~benefits~~ BENEFIT expressly states that it is made specifically
10 applicable to medicare supplement insurance policies. ~~No~~ A medicare
11 supplement insurance policy ~~shall~~ MAY NOT contain any exclusion for
12 services provided by any type of properly licensed health care provider if
13 the provider's services are eligible for medicare reimbursement and if the
14 specific services in question would be covered by medicare. ~~In no event~~
15 ~~shall~~ The scope of benefits of a medicare supplement policy MAY NOT be
16 less than the minimum level of benefits established by federal law.

17 ~~C.~~ D. Notwithstanding any other provision of this title, rules
18 adopted pursuant to this section apply to insurance ~~furnished~~ PROVIDED
19 under disability insurance policies, under subscription contracts of
20 hospital, medical, dental or optometric service corporations, under
21 certificates of fraternal benefit societies, under evidences of coverage
22 of health care services organizations and under coverages issued by any
23 other insurer, which policies, contracts, certificates, membership
24 coverages, evidences of coverage and coverages are delivered or issued for
25 delivery in this state on or after the effective date of rules adopted
26 pursuant to subsection A OF THIS SECTION. In adopting the rules required
27 by subsection A OF THIS SECTION, the director shall prescribe an effective
28 date of the rules that will allow insurers sufficient time to bring their
29 forms and practices into compliance with the requirements of the rule.

30 Sec. 5. Section 20-1379, Arizona Revised Statutes, is amended to
31 read:

32 20-1379. Guaranteed availability of individual health
33 insurance coverage; prior group coverage;
34 definitions

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

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

41 2. Impose any preexisting condition exclusion for that coverage.

42 B. Every health care insurer that offers individual health
43 insurance coverage in the individual market in this state shall offer all
44 policy forms of health insurance coverage that are designed for, that are

1 made generally available and actively marketed to and that enroll both
2 eligible or other individuals. A health care insurer that offers only one
3 policy form in the individual market complies with this section by
4 offering that form to eligible individuals. A health care insurer also
5 may comply with the requirements of this section by electing to offer at
6 least two different policy forms to eligible individuals as provided by
7 subsection C of this section.

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

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

13 2. The offer includes at least either:

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

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

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

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

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

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

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

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

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

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

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

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

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

22 I. ~~Nothing in~~ This section **DOES NOT**:

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

26 2. ~~Prevents~~ **PREVENT** a health care insurer that offers health
27 insurance coverage in the individual market from establishing premium
28 rates or modifying otherwise applicable copayments or deductibles in
29 return for adherence to programs of health promotion and disease
30 prevention.

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

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

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

42 1. Ceases to be covered under a policy offered by a health care
43 insurer. An individual who is covered by a policy that is issued on a
44 group basis by a health care insurer, that is terminated or not renewed at

1 the choice of the sponsor of the group and where the replacement of the
2 coverage is without a break in coverage is not entitled to receive the
3 certification prescribed in this paragraph but is instead entitled to
4 receive the certification prescribed in paragraph 2 of this subsection.

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

8 K. The certificate of creditable coverage provided by a health care
9 insurer is a written certification of the period of creditable coverage of
10 the individual under the health insurance coverage offered by the health
11 care insurer. The department may enforce and monitor the issuance and
12 delivery of the notices and certificates by health care insurers as
13 required by this section, section 20-1380, the health insurance
14 portability and accountability act of 1996 (P.L. 104-191; 110 Stat. 1936)
15 and any federal regulations adopted to implement the health insurance
16 portability and accountability act of 1996. **NOTWITHSTANDING ANY OTHER
17 LAW, AN INSURER IS NOT REQUIRED TO PROVIDE A CERTIFICATE OF CREDITABLE
18 COVERAGE IF THE FEDERAL LAWS THAT REQUIRE PROVIDING A CERTIFICATE OF
19 CREDITABLE COVERAGE ARE SUPERSEDED BY THE PROHIBITION ON PREEXISTING
20 CONDITION EXCLUSIONS.**

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

25 1. The date that the certificate is issued.

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

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

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

36 5. One of the following:

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

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

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

4 7. The consumer assistance telephone number for the department.

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

6 Important Notice!

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

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

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

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

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

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

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

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

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

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

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

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

33 (a) An employee welfare benefit plan that provides medical care to
34 employees or the employees' dependents directly or through insurance,
35 reimbursement or otherwise pursuant to the employee retirement income
36 security act of 1974 (P.L. 93-406; 88 Stat. 829; 29 United States Code
37 sections 1001 through 1461).

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

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

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

1 2. The individual is not eligible for coverage under:
2 (a) An employee welfare benefit plan that provides medical care to
3 employees or the employees' dependents directly or through insurance,
4 reimbursement or otherwise pursuant to the employee retirement income
5 security act of 1974.
6 (b) A health benefits plan issued by an accountable health plan as
7 defined in section 20-2301.
8 (c) Part A or part B of title XVIII of the social security act.
9 (d) Title 36, chapter 29 or any other plan established under title
10 XIX of the social security act, and the individual does not have other
11 health insurance coverage.
12 3. The most recent coverage within the coverage period was not
13 terminated based on any factor described in section 20-2309, subsection B,
14 paragraph 1 or 2 relating to nonpayment of premiums or fraud.
15 4. The individual was offered and elected the option of
16 continuation coverage under a COBRA continuation provision pursuant to the
17 consolidated omnibus budget reconciliation act of 1985 (P.L. 99-272; 100
18 Stat. 82) or a similar state program.
19 5. The individual exhausted the continuation coverage pursuant to
20 the consolidated omnibus budget reconciliation act of 1985.
21 Q. Notwithstanding subsection P of this section, an individual is
22 an eligible individual if:
23 1. The individual is an individual enrollee in a health care
24 services organization that is domiciled in this state on the date that the
25 health care services organization is declared insolvent, including any
26 health care services organization that is not an accountable health plan
27 as defined in section 20-2301.
28 2. The individual's coverage terminates during the delinquency
29 proceeding, after the health care services organization is declared
30 insolvent.
31 3. The individual satisfies the requirements of an eligible
32 individual as prescribed in this section other than the required period of
33 creditable coverage.
34 R. Notwithstanding subsection P of this section, a newborn child,
35 adopted child or child placed for adoption is an eligible individual if
36 the child was timely enrolled and otherwise would have met the definition
37 of an eligible individual as prescribed in this section other than the
38 required period of creditable coverage and the child is not subject to any
39 preexisting condition exclusion or limitation if the child has been
40 continuously covered under health insurance coverage or a health benefits
41 plan offered by an accountable health plan since birth, adoption or
42 placement for adoption.
43 S. If a health care insurer imposes a waiting period for coverage
44 of preexisting conditions, within a reasonable period of time after

1 receiving an individual's proof of creditable coverage and not later than
2 the date by which the individual must select an insurance plan, the health
3 care insurer shall give the individual written disclosure of the insurer's
4 determination regarding any preexisting condition exclusion period that
5 applies to that individual. The disclosure shall include all of the
6 following information:

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

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

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

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

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

21 1. "Affiliation period" has the same meaning prescribed in section
22 20-2301.

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

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

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

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

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

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

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

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

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

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

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

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

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

7 (l) A policy or contract, including short-term limited duration
8 insurance, issued on an individual basis by an insurer, a health care
9 services organization, a hospital service corporation, a medical service
10 corporation or a hospital, medical, dental and optometric service
11 corporation.

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

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

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

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

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

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

32 (a) Health status.

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

34 (c) Claims experience.

35 (d) Receipt of health care.

36 (e) Medical history.

37 (f) Genetic information.

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

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

41 9. "Higher level of coverage" means a policy form for which the
42 actuarial value of the benefits under the health insurance coverage
43 offered by a health care insurer is at least fifteen percent more than the
44 actuarial value of the health insurance coverage offered by the health

1 care insurer as a lower level of coverage in this state but not more than
2 one hundred twenty percent of a policy form weighted average.

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

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

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

17 13. "Network plan" means a health care plan provided by a health
18 care insurer under which the financing and delivery of health care
19 services are provided, in whole or in part, through a defined set of
20 providers either under contract with a health care insurer licensed
21 pursuant to chapter 4, article 3 of this title or under contract with a
22 health care insurer in accordance with the determination made by the
23 director pursuant to section 20-1053 regarding the geographic or service
24 area in which a health care insurer may operate.

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

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

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

1 17. "Short-term limited duration insurance" has the same meaning
2 prescribed in section 20-1384 and is not intended or marketed as health
3 insurance coverage subject to guaranteed issuance or guaranteed renewal
4 provisions of the laws of this state but is creditable coverage within the
5 meaning of this section and section 20-2301.

6 Sec. 6. Section 20-1382, Arizona Revised Statutes, is amended to
7 read:

8 20-1382. Health care insurers; reporting requirements

9 A. On or before March 1 of each year, each health care insurer
10 shall submit to the director a written report that contains the following
11 information:

12 1. The number of eligible individuals covered by policies that were
13 written by that health care insurer in the individual market during the
14 previous calendar year.

15 2. The number of individuals covered by policies that were issued
16 other than to eligible individuals during the previous calendar year.

17 3. The earned premium for each category of individual policy for
18 the previous calendar year.

19 4. The total number of eligible individuals covered by policies
20 that were issued by the health care insurer as of the end of the previous
21 calendar year.

22 B. Each health care insurer shall submit the following information
23 to the department, if applicable, to demonstrate compliance with sections
24 20-1379, 20-1380 and 20-1381:

25 1. The health care insurer's name and address.

26 2. The identification, form number and summary of all products that
27 the health care insurer offers in the individual market.

28 3. If the health care insurer elects the option prescribed in
29 section 20-1379, subsection C, paragraph 2, subdivision (a) the data on
30 premium volumes of all policy forms that the health care insurer offers in
31 the individual market and the number of individuals who are covered under
32 each form during the preceding calendar year.

33 4. If the health care insurer elects the option prescribed in
34 section 20-1379, subsection C, paragraph 2, subdivision (b) the data,
35 assumptions and methods used to calculate the actuarial values of the two
36 representative policy forms.

37 5. An explanation of how the health care insurer is complying with
38 sections 20-1379, 20-1380 and 20-1381.

39 6. A list of all products, including all marketing material, that
40 the health care insurer is making or will make available to eligible
41 individuals and an explanation of how the health care insurer will inform
42 individuals of these policy forms.

43 7. A description of the risk spreading and financial subsidization
44 mechanism.

1 C. The health care insurer shall submit the information described
2 in subsection B of this section to the department by March 1 of each year.

3 D. If all or part of the information required by subsection B,
4 paragraph 5, 6 or 7 of this section has not changed since the health care
5 insurer's last previous submission, instead of refiling the information
6 the health care insurer may indicate the information that has not changed.

7 E. NOTWITHSTANDING ANY OTHER LAW, AN INSURER IS NOT REQUIRED TO
8 COMPLY WITH THE REPORTING REQUIREMENTS OF THIS SECTION IF THE FEDERAL LAWS
9 THAT REQUIRE PROVIDING A CERTIFICATE OF CREDITABLE COVERAGE ARE SUPERSEDED
10 BY THE PROHIBITION ON PREEXISTING CONDITION EXCLUSIONS.

11 Sec. 7. Section 20-1583, Arizona Revised Statutes, is amended to
12 read:

13 20-1583. Title insurance agencies; use of corporate names

14 ~~A. An agent for a title insurer shall not adopt a corporate or~~
15 ~~business name containing the words "title insurance", "title guaranty" or~~
16 ~~"title guarantee" or other words indicating that the agent is in the~~
17 ~~business of title insurance, unless those words are followed by the words~~
18 ~~"agent" or "agency". In any stationery, sign, advertising, brochure,~~
19 ~~literature or similar writing issued or used by the agent, the words~~
20 ~~"agent" or "agency" shall be in the same size and type as the words~~
21 ~~preceding them. This section does not apply to a title insurer acting as~~
22 ~~agent for another title insurer.~~

23 ~~B. A title insurer may authorize the use of its corporate name or a~~
24 ~~portion of the name to a title insurance agency if the name of the title~~
25 ~~insurance agency complies with subsection A.~~

26 ~~C. For purposes of this section only, a title insurer is not~~
27 ~~responsible for a violation of this section by an agent for the title~~
28 ~~insurer and is not liable for a civil penalty that is imposed on a title~~
29 ~~insurance agent.~~

30 Sec. 8. Section 20-2310, Arizona Revised Statutes, is amended to
31 read:

32 20-2310. Discrimination prohibited; preexisting conditions;
33 wellness programs

34 A. Except as provided in subsection B of this section, a health
35 benefits plan may not deny, limit or condition the coverage or benefits
36 based on a person's health status-related factors or a lack of evidence of
37 insurability.

38 B. A health benefits plan shall not exclude coverage for
39 preexisting conditions, except that:

40 1. A health benefits plan may exclude coverage for preexisting
41 conditions for a period of not more than twelve months or, in the case of
42 a late enrollee, eighteen months. The exclusion of coverage does not
43 apply to services that are furnished to newborns who were otherwise

1 covered from the time of their birth or to persons who satisfy the
2 portability requirements under section 20-2308.

3 2. The accountable health plan shall reduce the period of any
4 applicable preexisting condition exclusion by the aggregate of the periods
5 of creditable coverage that apply to the individual.

6 C. A health benefits plan shall not include an affiliation period
7 in a policy unless the affiliation period satisfies the requirements
8 prescribed in 45 Code of Federal Regulations section 146.119(b).

9 D. On request of a health benefits plan, a person who provides
10 coverage during a period of continuous coverage with respect to a covered
11 individual shall promptly disclose the coverage provided to the covered
12 individual, the period of the coverage and the benefits provided under the
13 coverage.

14 E. The accountable health plan shall calculate creditable coverage
15 according to the following rules:

16 1. The accountable health plan shall give an individual credit for
17 each day the individual was covered by creditable coverage.

18 2. The accountable health plan shall not count a period of
19 creditable coverage for an individual enrolled in a health benefits plan
20 if after the period of coverage and before the enrollment date there were
21 sixty-three consecutive days during which the individual was not covered
22 under any creditable coverage.

23 3. The accountable health plan shall give credit in the calculation
24 of creditable coverage for any period that an individual is in a waiting
25 period or an affiliation period for any health coverage.

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

37 5. In determining the extent to which an individual has satisfied
38 any portion of any applicable preexisting condition period the accountable
39 health plan shall count a period of creditable coverage without regard to
40 the specific benefits covered during that period.

41 6. An accountable health plan shall not impose any preexisting
42 condition exclusion in the case of an individual who is covered under
43 creditable coverage thirty-one days after the individual's date of birth.

1 7. An accountable health plan shall not impose any preexisting
2 condition exclusion in the case of a child who is adopted or placed for
3 adoption before age eighteen and who is covered under creditable coverage
4 thirty-one days after the adoption or placement for adoption.

5 F. An accountable health plan shall provide the certificate of
6 creditable coverage described in subsection G of this section without
7 charge for creditable coverage occurring after June 30, 1996 if the
8 individual:

9 1. Ceases to be covered under a health benefits plan offered by an
10 accountable health plan or otherwise becomes covered under a COBRA
11 continuation provision. An individual who is covered by a health benefits
12 plan that is offered by an accountable health plan, that is terminated or
13 not renewed at the choice of the employer and where the replacement of the
14 health benefits plan is without a break in coverage is not entitled to
15 receive the certification prescribed in this paragraph but is instead
16 entitled to receive the certifications prescribed in paragraphs 2 and 3 of
17 this subsection.

18 2. Who was covered under a COBRA continuation provision ceases to
19 be covered under the COBRA continuation provision.

20 3. Requests certification from the accountable health plan within
21 twenty-four months after the coverage under a health benefits plan offered
22 by an accountable health plan ceases.

23 G. The certificate of creditable coverage provided by an
24 accountable health plan is a written certification of:

25 1. The period of creditable coverage of the individual under the
26 accountable health plan and any applicable coverage under a COBRA
27 continuation provision.

28 2. Any applicable waiting period or affiliation period imposed on
29 an individual for any coverage under the accountable health plan.

30 H. Any accountable health plan that issues health benefits plans in
31 this state, as applicable, shall issue and accept a written certificate of
32 creditable coverage of the individual that contains at least the following
33 information:

34 1. The date that the certificate is issued.

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

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

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

1 5. One of the following:

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

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

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

11 7. The consumer assistance telephone number for the department.

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

13 Important notice!

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

26 I. An accountable health plan may provide any certification
27 pursuant to subsection F, paragraph 1 of this section at the same time the
28 accountable health plan sends the notice required by the applicable COBRA
29 continuation provision.

30 J. An accountable health plan has satisfied the certification
31 requirement under this section if the accountable health plan offering the
32 health benefits plan provides the prescribed certificate in accordance
33 with this section within thirty days after the event that triggered the
34 issuance of the certification.

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

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

1 2. The basis for the accountable health plan's determination and
2 the source and substance of any information on which the accountable
3 health plan has relied.

4 3. A statement of any right the individual may have to present
5 additional evidence of creditable coverage and to appeal the accountable
6 health plan's determination, including an explanation of any procedures
7 for submission and appeal.

8 L. Periods of creditable coverage for an individual are established
9 by presentation of the written certifications described in this section
10 and section 20-1379. In addition to written certification of the period
11 of creditable coverage as described in this section, individuals may
12 establish creditable coverage through the presentation of documents or
13 other means. In order to make a determination that is based on the
14 relevant facts and circumstances of the amount of creditable coverage that
15 an individual has, an accountable health plan shall take into account all
16 information that the plan obtains or that is presented to the plan on
17 behalf of the individual.

18 M. The department may enforce and monitor the issuance and delivery
19 of the notices and certificates by accountable health plans and insurers
20 as required by this section, the health insurance portability and
21 accountability act of 1996 (P.L. 104-191; 110 Stat. 1936) and any federal
22 regulations adopted to implement the health insurance portability and
23 accountability act of 1996.

24 N. This section does not prohibit any health benefits plan from
25 providing or offering to provide rewards or incentives under a wellness
26 program that satisfies the requirements for an exception from the general
27 prohibition against discrimination based on a health factor under the
28 health insurance portability and accountability act of 1996 (P.L. 104-191;
29 110 stat. 1936), including any federal regulations that are adopted
30 pursuant to that act.

31 O. NOTWITHSTANDING ANY OTHER LAW, AN INSURER IS NOT REQUIRED TO
32 PROVIDE A CERTIFICATE OF CREDITABLE COVERAGE IF THE FEDERAL LAWS THAT
33 REQUIRE PROVIDING A CERTIFICATE OF CREDITABLE COVERAGE ARE SUPERSEDED BY
34 THE PROHIBITION ON PREEXISTING CONDITION EXCLUSIONS.

APPROVED BY THE GOVERNOR JULY 6, 2022.

FILED IN THE OFFICE OF THE SECRETARY OF STATE JULY 6, 2022.