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REGULATORY BULLETIN 2013-02[1]

TO: Insurance Producers, Surplus Lines Brokers, Insurance Industry Representatives, Insurance Trade Associations, Life & Disability Insurers, Property & Casualty Insurers, and Other Interested Parties

FROM: Germaine L. Marks
Director

DATE: August 21, 2013

RE: 2013 Arizona Insurance Laws

This Regulatory Bulletin summarizes the major, newly enacted legislation affecting the Department, its licensees, and insurance consumers. This summary is not meant as an exhaustive list or a detailed analysis of all insurance-related bills. It generally describes the substantive content, but does not capture all details or necessarily cover all bills that may be of interest to a particular reader. The Department may follow this bulletin with other, more detailed bulletins related to implementation of the legislation. All interested persons are encouraged to obtain copies of the enacted bills by contacting the Arizona Secretary of State's Office at (602) 542-4086, or from the Arizona Legislature's website at http://www.azleg.gov. Please direct any questions regarding this bulletin to Andrew Carlson, Executive Assistant for Policy Affairs, (602) 364-3471.

Arizona's 51st Legislature, First Regular Session, adjourned *sine die* on June 14, 2013. Except as otherwise noted, all insurance-related legislation has a general effective date of September 13, 2013.

[1]This Substantive Policy Statement is advisory only. A Substantive Policy Statement does not include internal procedural documents that only affect the internal procedures of the Agency, and does not impose additional requirements or penalties on regulated parties or include confidential information or rules made in accordance with the Arizona Administrative Procedure Act. If you believe that this Substantive Policy Statement does impose additional requirements or penalties on regulated parties you may petition the agency under Arizona Revised Statutes Section 41-1033 for a review of the Statement.

INSURANCE-RELATED BILLS ENACTED IN 2013:

SB 1177: insurance; accreditation; receivership liquidation fund (Ch. 35)

This legislation makes several changes and additions to ARS Title 20 that align certain provisions of Arizona law with the National Association of Insurance Commissioners' ("NAIC") model acts for "Managing General Agents" (MGAs) and "Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition" (HFC). It also amends the Receivership Liquidation Fund (RLF) statute.

MGA provisions

Amends ARS § 20-311 by clarifying that a MGA is any person, firm, association or corporation that manages all or part of insurer's insurance business and that produces and underwrites a prescribed amount of gross direct premium and either engages in adjustment or payment of claims in excess of $10,000 or negotiates reinsurance on behalf of the insurer.

Amends ARS § 20-311.01:

- Prohibits a person from acting as a MGA in Arizona for an insurer licensed in Arizona with respect to risks located in Arizona unless the person is licensed as an insurance producer by ADOI.
- Prohibits a person from acting as a MGA for an insurer domiciled in Arizona with respect to risks located outside Arizona unless the person is licensed as an insurance producer by ADOI.
- Contains session law to require the Department to issue an insurance producer license to each person who holds a managing general agent license on the effective date of this act. The producer license shall be for the same kind of insurance as the existing license and maintain the same expiration date.

Amends ARS § 20-311.02:

- Revises the minimum insurer/MGA contractual requirements to include:
  - Monies collected by a MGA for an insurer must be held in a bank that is a FDIC insured institution.
  - A MGA may only use advertising material approved in writing by the insurer.
- Requires an insurer to require its MGA obtain and maintain a surety bond for the protection of the insurer that meets the following requirements:
  - The bond amount shall be 10% of the MGA's total annual written premium nationwide produced by the MGA for the insurer in the prior calendar year
  - The bond may not be less than $100,000 or more than $500,000
  - The bond must be available for ADOI's inspection.
- Requires an insurer to have its MGA file an independent audited financial statement or report for the two most recent fiscal years that prove the MGA has a positive net worth.
- Stipulates that if a MGA has been in existence less than two fiscal years, it must submit a financial statement or report for the prescribed period that is prepared in accordance with generally accepted accounting principles and certified by an officer of the MGA.
- Specifies that for a submitted audited financial report prepared on a consolidated basis, a MGA must provide an insurer a columnar consolidating worksheet with specific information.
- Requires an insurer to bear the examination costs of the MGA.

Repeals ARS § 20-311.03 to make conforming changes to Title 20.

Amends ARS §§ 20-229, 20-407, 20-411, 20-1098.04, 20-1243.05, 20-2102 and 20-2901 by making technical and/or conforming changes related to the new licensing requirements of MGAs as insurance producers.

HFC provisions

Enacts ARS § 20-220.01:

- Permits the Director of Insurance, in determining whether the continued operation of an insurer transacting insurance in Arizona may be deemed to be hazardous to its policyholders, creditors or the general public, to consider 20 specifically enumerated standards.
- Permits the director, for the purposes of making a determination of an insurer's financial condition under this section, to:
    - Disregard any credit or amount receivable resulting from transactions with a reinsurer that is insolvent, impaired or otherwise subject to delinquency proceeding.
    - Make adjustments to asset values attributable to investments in or transactions with parents, subsidiaries or affiliates consistent with the NAIC "Accounting Practices and Procedures Manual", state laws and rules.
    - Refuse to recognize the stated value of accounts receivable if the ability to collect receivables is highly speculative in view of the age of the account or the debtor's financial condition.
    - Increase an insurer's liability in an amount equal to any contingent liability, pledge or guarantee not otherwise included if there is a substantial risk that the insurer will be called on to meet obligation undertaken with the next 12-month period.
- Permits the Director of Insurance, in determining whether the continued operation of an insurer transacting insurance in Arizona may be deemed to be hazardous to its policyholders, creditors or the general public, to issue an order requiring the insurer to:
    - Reduce its total amount of present and potential liability for policy benefits by reinsurance.
    - Reduce, suspend or limit the volume of business being accepted or renewed.
    - Reduce general insurance and commission expenses.
    - Increase the insurer's capital and surplus.
    - Suspend or limit the declaration and payment of dividends to its stockholders or policyholders.
    - File reports in a form acceptable to the Director concerning the market value of the insurer's assets.
    - Limit or withdraw from certain investments or discontinue certain investment practices.
    - Document the adequacy of premium rates in relation to the risks insured.
    - File interim financial reports (in addition to regular annual statements).
    - Correct corporate governance practice deficiencies and adopt and use acceptable governance practices.
    - Provide a business plan to the Director in order to continue to transact business in Arizona.
    - Adjust rates for any non-life insurance product written by the insurer that the director considers necessary to improve the financial condition of the insurer.
- Requires a hearing demanded by an insurer aggrieved by the director's order to be closed to the public unless otherwise requested by any principal party to the hearing.
- Specifies that this section (ARS § 20-220.01) does not limit or supersede any provision of ARS Title 20 or any other provision of law pertaining to the powers of the Director of Insurance or the regulation of the financial condition of insurers transacting insurance in Arizona.

Amends ARS § 20-481.19 by clarifying the methodology of an "extraordinary dividend or distribution" for non-life insurers to include "net income" instead of "net investment income".

Amends ARS § 20-488:

- Changes the definition of "company action level event" by making the adjusted capital calculation portion of the risk-based capital (RBC) report uniform among insurers.

- Expands the definitions of “Domestic Insurer” and “Foreign Insurer” to include a life **and** health insurer and a property **and** casualty insurer.
- Clarifies the definition of “Life or Health Insurer”.
- Includes all insurers in the definition of “Negative Trend”.

Amends ARS § 20-705 by removing the following incorporation requirements for a domestic stock or mutual insurers to accommodate the new provisions in ARS § 20-706:

- 5 or more individuals (18 years or older) may incorporate a stock insurer.
- 10 or more individuals (18 years or older) may incorporate a mutual insurer.
- At least 2/3 of the incorporators must be United States citizens residing in Arizona.
- The articles of incorporations must be signed and acknowledged by the incorporators.

Amends ARS § 20-706:

- Removes the requirement to record the articles of incorporation with a county where the corporation proposes to transact insurance.
- Requires articles of incorporation to be published as required by ARS Title 10 and removed the previous publication requirements.

Amends ARS § 20-709 by making technical/conforming changes.

Amends ARS § 20-1098.07:

- Requires a captive insurer’s audited financial statements to be in compliance with the “Audited Financial Reports” provisions of Title 20 (ARS Title 20, Ch. 3, Article 10).
- Removes previous annual report actuarial requirements and requires a captive insurer’s annual report to be based on the type of risks insured by the insurer and meet the applicable requirements of one or more of the following:
    1. The “Life and Health Actuarial Opinion and Memorandum Requirements” article (ARS Title 20, Ch. 3, Article 8)
    2. The “Property and Casualty Actuarial Opinion Requirements” article (ARS Title 20, Ch. 3, Article 9)
    3. The actuarial provisions of the NAIC “Health Annual Statement Instructions”.

Amends ARS § 20-1098.15:

- Applies the provisions of the Risk-Based Capital article (ARS Title 20, Ch. 2, Article 12) to Risk Retention Groups (RRGs).
- Permits the Director to use discretion when a RRG is subject to regulatory action under certain provisions of ARS Title 20.
- Applies the provisions of “Individual Risk Limitation” under ARS § 20-260(A) to RRGs unless otherwise prescribed by the Director.

RLF provisions

Amends ARS § 20-648 by requiring the Arizona State Treasurer to invest and divest monies in the RLF as provided by ARS § 35-313, on notice by the Arizona Director of Insurance. Monies earned from investment by the Treasurer are credited to the RLF.

SB 1047: mortgage insurance; repeal coverage limitation (Ch. 30)

Repeals ARS § 20-1546, which required a mortgage guaranty insurance company to either limit its coverage net of reinsurance ceded to a maximum of 25% of the entire indebtedness to the insured or elect to pay the entire indebtedness to the insured and acquire title to the authorized real estate security.

SB 1149: insurance; principle-based valuation; reserves (Ch. 42)

This legislation makes several changes and additions to ARS Title 20 that aligns certain provisions of Arizona law with the National Association of Insurance Commissioners' ("NAIC") model acts for the "Standard Valuation Law" (SVL) and "Standard Nonforfeiture Law for Life Insurance" (SNL) model acts.

SVL provisions

Amends ARS § 20-510:

- Makes several changes and additions to the SVL regulations that certain insurers must adhere to both before and after the operative date of the valuation manual.
- Provides statutory guidelines for the Director to enforce the SVL both before and after the operative date of the valuation manual.
- Provides that certain documents, materials and other information are confidential and privileged and are not subject to public records or judicial requests except under specific circumstances as outlined in the bill.
- For policies issued on or after the operative date of the valuation manual, defines the "Operative Date" as January 1st of the first calendar year following the first July 1st as of which all of the following have occurred:
    1. The valuation manual has been adopted by the NAIC by an affirmative vote of at least 42 members, or three-fourths of the members voting, whichever is greater.
    2. The SVL, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing greater than 75% of the direct premiums written as reported in the following annual statements submitted for 2008:
        - Life, Accident and Health Annual Statements;
        - Health Annual Statements; or
        - Fraternal Annual Statements.
    3. The SVL, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least 42 states of the following 55 jurisdictions:
        - The 50 states of the USA
        - American Samoa
        - The American Virgin Islands
        - The District of Columbia
        - Guam
        - Puerto Rico.
- Outlines the applicability and various requirements of the valuation manual for policies issued on or after the operative date.
- Provides confidentiality guidelines and requirements for information obtained by or disclosed to specified entities.
- For the purposes of ARS § 20-510 (V), defines "Confidential Information".
- For the purposes of ARS § 20-510 and applicable on or after the operative date of the valuation manual, defines "Accident and Health Insurance", "Appointed Actuary", "Company", "Deposit-Type Contract", "Life Insurance", "Policyholder Behavior", "Principle-Based Valuation", "Qualified Actuary", "Reserves", "Tail Risk", and "Valuation Manual".

- Amends ARS §§ 20-696.01, 20-696.02 and 20-696.04 by making conforming changes based on the amended provisions of ARS § 20-510.

SNL provisions

Amends ARS § 20-1231.01:

- Specifies which mortality tables may be used to determine the minimum nonforfeiture standard for policies issued before, after and on the operative date of the valuation manual.
- Provides the methods to determine the nonforfeiture interest rate for policies issued before, after and on the operative date of the valuation manual.

SB 1243 exemption; insurance regulation (Ch. 181)

Amends ARS § 20-108 by including certain "associations or orders" in the list of entities exempt from Title 20 regulation.

Amends ARS § 20-861 by defining "association or order" as *any association or order that is a non-profit military mutual aid association, whose members are officers or enlisted, regular or reserve, active, retired or honorably discharged members of the armed forces or sea services of the United States, and whose principal purpose is to provide life insurance and annuities to its members and their dependents or beneficiaries*.

Amends ARS § 20-893:

- Exempts an association or order from the insurance laws of this state, with respect to the sale of life insurance or annuities, if the association or order meets the following criteria:
    - Each policy or contract issued under the exemption provides notice to the consumer that the issuing association or order does not possess a certificate of authority from ADOI and the policy or contract issued is not eligible for insurance guaranty fund protection pursuant to Title 20.
    - Requires an unlicensed association or order intending on doing business in Arizona to provide to the Director of Insurance all of the following:
        - Satisfactory proof of the association's or order's nonprofit status and exemption from taxation under section 501(c) of the Internal Revenue Code.
        - A true and complete statement of its statutory financial condition that is audited by an independent CPA and an actuarial memorandum issued by a qualified actuary (pursuant to ARS §20-696.04).
            - The statement and memorandum are approved 30-days after filing unless directorial action occurs within the 30-day period.
            - An association or order shall pay the filing fee determined by the Director.
    - Permits the Director to require an association or order to file quarterly financial statements with the ADOI.
    - Authorizes the Director to require an association or order to file financial statements on an alternate schedule due to factors or trends impacting insurers writing a particular class(es) of business or because of changes to an association's or order's managerial, financial, or operational condition.
    - Permits the Director to order an association or order to increase its capital and/or surplus to a sufficient amount if the Director determines the association or order will not be able to meet its liabilities. If an association or order that fails to comply with this order, the Director may order it to cease and desist from assuming additional liabilities in this state until it complies with the previous order.
    - Prohibits an exempt association or order from giving or allowing any person any compensation for procuring new members.
    - Authorizes the Director to examine an association or order to determine if the association or order is exempt from ARS Title 20, Chapter 4, Article 4.

SB 1310 special fund; workers' compensation (Ch. 183)

Section One

- Directs the Industrial Commission of Arizona (ICA) to publish a report showing the amount of cash and assets held by the Special Fund (ARS § 23-1065) that are attributable or allocated to the payment of claims of insolvent insurers as of June 30, 2013.
- Specifies that the amount of attributed cash and assets shown in the report must include the total amount of monies that are held by the Special Fund from any assessments, recoveries and released deposits.
- Requires the report to:
    - Include all insurers that have had claims assigned to the Special Fund
    - Be accompanied by a statement of actuarial opinion by an actuary confirming the adequacy of the reserves reported. The actuary must be a member in good standing of the American Academy of Actuaries.
    - Published by the ICA at the ICA's final 2013 meeting.
    - Include an explanation of the methodology and all of the data relied on to produce the report.
    - Include an opinion from an independent Certified Public Accountant on whether the employed methodology fairly presents the attribution of cash and assets to the payment of claims of insolvent insurers.

Section Two

- States that Laws 2013, Chapter 34 (SB 1148: workers' compensation; reciprocity) *applies to any claim that has not been accepted as compensable or adjudicated as compensable as of the effective date of Laws 2013, Chapter 34*.

SB 1353: health insurance; telemedicine (Ch. 70)

This legislation is applicable to insurers licensed by ADOI as a "Hospital, Medical, Dental and Optometric Service Corporation" (ARS § 20-841.09), a "Health Care Services Organization" (ARS § 20-1057.13), an Disability Insurer for individuals (ARS § 20-1376.05), or a Group or Blanket Disability Insurer (ARS § 20-1406.05)

Adds ARS §§ 20-841.09, 20-1057.13, 20-1376.05 and 20-1406.05:

- Requires all policies, contracts and evidences of coverage issued, delivered or renewed on after January 1, 2015 to provide coverage for specified health care services that are provided through telemedicine and received by an individual in a rural region of Arizona.
- Permits an insurer to limit telemedicine coverage to health care providers who are members of the insurer's provider network.
- Stipulates that an insurer may impose deductible, copayment or coinsurance requirements if the costs do not exceed and are applied the same as an in-person consultation.
- Requires services provided through telemedicine to comply with Arizona licensing requirements, accreditation standards and any applicable practice guidelines.
- Excludes telemedicine coverage requirements from Limited Benefit Coverage as defined in ARS § 20-1137.
- For the purposes §§ 20-841.09, 20-1057.13, 20-1376.05 and 20-1406.05, defines:
    - "Health Care Services" as *services provided for the following conditions or in the following settings:*
        - *Trauma.*
        - *Burn.*

        - *Cardiology.*
        - *Infectious Diseases.*
        - *Mental Health Disorders.*
        - *Neurologic Diseases including strokes.*
        - *Dermatology.*
    - "Rural Region" as either:
        - *An area that is located in a county with a population of less than 900,000 persons.*
        - *A city or town that is located in a county with a population of 900,000 or more and whose nearest boundary is more than 30 miles from the boundary of a city that has a population of 500,000 persons of more.*
    - "Telemedicine" as t*he interactive use of audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. Telemedicine does not include the sole use of an audio-only telephone, a video-only system, a fax machine, instant messages or email.*

HB 2356: insurance; prohibited inducements (Ch. 57)

Amends ARS § 20-452 by increasing from $10 to $25 the permitted total aggregate value of any prizes, goods, wares, merchandise or tangible property used as an inducement to insurance.

HB 2357: insurance; fees; exception (Ch. 96)

Amends ARS § 20-465:

- Exempts insurers and insurance producers transacting "commercial insurance" from filing requirements for fees and services not customarily required in an insurance transaction.
- For the purposes of ARS § 20-465, defines "commercial insurance" as *insurance that insures against the risks resulting from the responsibilities or activities of one or more businesses, including motor vehicle insurance policies insuring seven or more motor vehicles*.

HB 2358: insurance; licensees; continuing education requirements (Ch. 160)

This legislation makes several changes to the continuing education requirements for insurance producers. Unless otherwise exempted, Arizona resident-only insurance producers, who have never held a nonresident license, now will be required to complete continuing education.

Amends ARS § 20-2901:

- For the purposes of Title 20, Chapter 18, Article 1:
    - Defines "continuously licensed" as licensee who has maintained a license without the license being terminated for any reason.
    - Stipulates that "continuously licensed" does not include:
        - An expired license under ARS § 20-289(E) if the late fee is timely paid and the license is renewed
        - A license placed on inactive status for licensee ordered to military service.
    - Defines "ethics training" as a *continuing education course content regarding the ethical responsibilities insurance producers own to insurers, applicants, policyholders, regulators, insurance professionals and the public.*
    - Redefines "licensee" to mean an individual licensed by ADOI to sell, solicit or negotiate major line insurance (life insurance, accident and health or sickness insurance, property insurance, casualty insurance, personal lines insurance and variable insurance contracts). "Licensee" does not include any business entity.
    - Renames "nonresident applicant" as "nonresident licensee" and defines "nonresident licensee" to mean a licensee who is applying to renew a nonresident license in Arizona.

Amends ARS § 20-2902:

- To qualify for the renewal of an ADOI resident producer license prior to January 1, 2014, a non-exempted licensee must complete 40 hours of continuing education, if the licensee held a nonresident license in another state during the preceding licensing period.
- To qualify for the renewal of an ADOI resident producer license on or after January 1, 2014, a non-exempted licensee must complete 48 hours of continuing education, including at least 6 hours of ethics training. This requirement is applicable only if the current license term began on or after January 1, 2014.
- Establishes an exemption from the continuing education requirements for licensees who meet all the following criteria as of January 1, 2014:
    - The licensee has been continuously licensed as an insurance agent, broker or producer in Arizona prior to January 1, 1995.
    - The licensee has not at any time since January 1, 1995, held a nonresident insurance producer license in another state.
    - The licensee has not been the subject of an order issued by the Director finding that the licensee violated any provision of ARS Title 20 in which the Director ordered any of the following:
        - The suspension, revocation or denial or renewal of the licensee's agent, broker or producer license.
        - A licensee to cease and desist from the conduct constituting the violation
        - The licensee to pay restitution or a civil penalty.
- Permits a licensee, who instructs an approved continuing education course on behalf of an approved provider, to receive two times the credit hours assigned to the approved course.
- Restricts a licensee to receive credit for a particular approved continuing education course one time during a single license period.
- In addition to current requirements, a licensee's continuing education "certificate of compliance" must include:
    - The total number of ethics training credit hours completed by the licensee in an approved continuing education course.
    - The total number of credit hours completed by the licensee in an approved continuing education course.
- Prohibits the Director of Insurance from renewing a licensee's resident license unless the licensee has provided evidence that he or she has completed the applicable continuing education credit hours.
- Stipulates that if a nonresident licensee's home state does not have a continuing education requirement, the licensee is subject to the same continuing education requirements as an Arizona resident-only licensee (see first two bullet points above).
- Makes technical and/or conforming changes related to the new continuing education requirements as outlined in this summary.

Amends ARS § 20-2903 by making technical and conforming changes related to the new continuing education requirements as outlined in this summary.

HB 2490: utilization review; requirements. (Ch. 60)

Amends ARS § 20-2508 by requiring a non-exempt utilization review agent to have a licensed chiropractor supervise or conduct utilization review activities for health care services that are performed by a chiropractor and within the chiropractor's scope of practice (pursuant to ARS Title 32, Chapter 8).

Amends ARS § 20-2510 to require health care insurers to use a licensed chiropractor to review any direct denial of prior authorization of a chiropractic service requested by a chiropractor on the basis of medical necessity.

HB 2534: insurance; form filing (Ch. 152)

Amends ARS § 20-1110 to include contracts and policy forms filed under ARS § 20-826 (A) by a corporation holding a certificate of authority under ARS Title 20, Chapter 4, Article 3, under the statutory guidelines for the Department's approval of forms. This legislation is retroactively effective from and after March 31, 2013.

HB 2546: insurance; guaranty fund (Ch. 214)

Amends ARS § 20-681:

- Defines "authorized", "called", "contractual obligation", "covered policy", "insolvent insurer", "Moody's Corporation bond Yield Average", "owner", "structured settlement annuity", "supplemental contract", and "unallocated annuity contract".
- Redefines *premiums* and *resident.*
- Redefines "impaired insurer" to mean *a member insurer that is not an insolvent insurer and that is placed under an order of rehabilitation or conservation by a court of competent jurisdiction*.
- Clarifies the definition of "member insurer" to mean an insurer that holds a certificate of authority to transact insurance in Arizona and includes an insurer whose license/certificate of authority in Arizona may have been suspended, revoked, not renewed or voluntarily withdrawn.
- Excludes from the definition of "member insurer" the following:
    - A licensed Fraternal Benefit Society.
    - A licensed Hospital, Medical, Dental or Optometric Service Corporation.
    - A licensed Prepaid Dental Plan Organization.
    - A licensed Health Care Services Organization.
    - A mandatory state pooling plan.
    - A mutual assessment company or other person that operates on an assessment basis.
    - A licensed reciprocal insurance exchange.
    - An entity that is similar to any of the above, listed entities.

Repeals ARS § 20-682 in order to enact new provisions for the same section.

Enacts ARS § 20-682:

- Outlines who is covered by ARS Title 20, Chapter 3, Article 7 (Administration of Life and Disability Insurance Insolvencies) for specified life, disability or annuity policies and contracts that are issued by member insurers.
- Outlines the persons, policies and contracts that are excluded from coverage by ARS Title 20, Chapter 3, Article 7 (Administration of Life and Disability Insurance Insolvencies).
- Specifies that the benefits that the Life and Disability Insurance Guaranty Fund may be obligated to cover shall not exceed the lesser of:
    1. The contractual obligations for which the impaired or insolvent insurer is liable (or would have been liable if it were not an impaired or insolvent insurer).
    2. With respect to one life:
        - $300,000 in life insurance death benefits but not more than $100,000 in net cash surrender and net cash withdrawal values for life insurance.
        - $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values.
    3. With respect to one life in disability insurance benefits:
        - $100,000 for coverages not defined as disability income insurance or basic hospital, medical and surgical insurance or major medical insurance or long-term care insurance.
        - $300,000 for disability income insurance.

        - $300,000 for long-term care insurance.
        - $500,000 for basic hospital, medical and surgical insurance or major medical insurance.
    4. With respect to each payee of a structured settlement annuity (or beneficiary), an aggregate of $250,000 in present value annuity benefits, including net cash surrender and new cash withdrawals.
- Permits the Life and Disability Insurance Guaranty Fund to limit its obligation to not cover more than either:
    1. An aggregate of $300,000 in benefits with respect to any one individual as outlined in the previous bullet point except with respect to benefits for basic hospital, medical and surgical insurance and major medical insurance, in which case the aggregate may not exceed $500,000 with respect to any one individual.
    2. $5,000,000 in benefits for one owner of multiple nongroup life insurance policies, regardless of the number of policies/contract held by the owner.
- Provides that the Life and Disability Insurance Guaranty Fund, in determining the benefits payable to policyholders, may take into account the amount of estate assets attributable to covered policies.

Amends ARS § 20-685:

- Removes the distinction between “domestic”, “foreign” and “alien” insurers for Fund purposes and consolidates them under the term “member” insurers.
- Allows the Life and Disability Insurance Guaranty Fund, under certain circumstances and with approval of the Director of Insurance, to:
    - Guarantee, assume or reinsure, or cause to be guaranteed, assumed or reinsured, any or all of the policies or contracts of an impaired insurer.
    - Provide monies, pledges, loans, notes, guarantees or other means to guarantee, assume or reinsure any or all of the impaired insurer’s policies or contracts and to assure payment of the impaired insurer’s contractual obligations.
- Allows the Life and Disability Insurance Guaranty Fund with approval of the Director of Insurance to either:
    - Guarantee, assume or reinsure, or cause to be guaranteed, assumed or reinsured, the policies or contracts of an insolvent insurer or assure payment of the contractual obligations of the insolvent insurer, and provide monies, pledges, loans, notes, guarantees or other means reasonably necessary to discharge the Fund’s obligations.
    - Provide specified obligations, benefits and coverages to the policies and contracts covered by the Life and Disability Insurance Guaranty Fund.
- Specifies the term of coverage provided by the Life and Disability Insurance Guaranty Fund, provides for notice of termination of coverage, and specifies the terms of any substitute coverage offered by the Fund.
- Entitles the Life and Disability Insurance Guaranty Fund to have standing to appear or intervene before any court with jurisdiction over an impaired or insolvent insurer concerning certain matters and obligations.
- Outlines the legal standings, remedies, rights and assignment of rights of the fund and covered beneficiaries of the Life and Disability Insurance Guaranty Fund.
- Permits the Life and Disability Insurance Guaranty Fund to join an organization comprised of one or more other state funds in order to further the administration of the fund’s powers and duties.
- Allows the Life and Disability Insurance Guaranty Fund, under specific circumstances/guidelines and with written notice to the affected reinsurers, to assume a ceding member insurer’s rights and obligations that relate to policies or annuities covered by the Fund under any reinsurance contracts entered into by the insolvent insurer.
- Provides that the Life and Disability Insurance Guaranty Fund has no additional obligations to a covered person if that person opts out of the benefits offered by the Fund.
- Requires the venue in a suit against Life and Disability Insurance Guaranty Fund arising under ARS Title 20, Chapter 3, Article 7, to be in the Superior Court of Maricopa County.

- States that the Life and Disability Insurance Guaranty Fund is not required to give a bond in an appeal that relates to a cause of action.
- Makes other technical and conforming changes.

Amends ARS § 20-686:

- Prescribes a timeframe by which member insurer must pay required assessments.
- Caps a member insurer's total calendar year assessments at 2% (for each account) of the member insurer's average annual premiums received in Arizona on policies and contracts covered by the account in the three years preceding the year an insurer became impaired or insolvent.
- Provides a method to determine a member insurer's aggregate assessment when two or more assessments are authorized in one calendar year with respect to insurers that become impaired or insolvent in different calendar years.
- Grants the fund discretion on whether the amount of an abated or deferred assessment against a member insurer is assessed against the other member insurers. Currently, this provision is mandatory.

Amends ARS § 20-690:

- Prohibits distribution of an impaired or insolvent insurer's assets to stockholders until and unless the total amount of valid claims of the Life and Disability Insurance Guaranty Fund with interest thereon the monies expended in carrying out the fund's powers and duties with respect to such insurer is fully recovered by the fund.

Amends ARS §§ 20-687, 20-688, 20-689 and 20-694 by making technical and conforming changes related to the other provisions of this legislation.

HB 2550: health insurance; policies; rating areas (Ch. 215)

Adds ARS § 20-238:

- Requires the Director of Insurance, through the adoption of rules or other regulatory and administrative actions, to ensure that Arizona retains its full authority to regulate health insurance contracts issued by health insurers taking into consideration the enactment of The Patient Protection and Affordable Care Act ("act").
- Prohibits a health insurer from issuing a health insurance contract if the coverage and benefits provided in the contract are inconsistent with applicable provisions of the "act".
- Establishes and requires the use of the following rating areas for health insurers issuing individual and small group health insurance contracts (except for grandfathered individual and small group health insurance contracts):
    1. Mohave, Coconino, Apache and Navajo Counties.
    2. Yavapai County.
    3. La Paz and Yuma Counties.
    4. Maricopa County.
    5. Pinal and Gila Counties.
    6. Pima and Santa Cruz Counties.
    7. Graham, Greenlee and Cochise Counties.
- Defines "act" as the "Patient Protection and Affordable Care Act" (Public Laws 111-148) as amended by the "Health Care and Education Reconciliation Act" (Public Laws 111-152) or any rules adopted pursuant to those acts.
- Defines "health insurer" to mean a disability insurer, group disability insurer, blanket disability insurer, "health care services organization", hospital service corporation, medical service corporation, dental service corporation, prepaid dental plan organization or "hospital, medical, dental and optometric" service corporation.

- Defines “rating area” to mean an area within which a health insurer shall not vary rates based on geography.

Amends ARS § 20-2537:

- Expands the time period – from 30 days to 4 months – a member may request an external independent review of an adverse decision made by a health care insurer.
- Reduces the expedited external independent review time period – from 5 business days to 72 hours – that an independent review organization must evaluate, analyze and render a decision about whether a service or claim for service is covered. The 72 hours begins once the case is received from ADOI.

Contains session law that exempts the Director of Insurance from rule making requirements for three years for the purposes of adopting rules pursuant to ARS § 20-238. Under this exemption, the Director must provide public notice and an opportunity for public comment on a proposed rule at least 30 days before a rule is adopted or amended.

Contains session law that repeals the provisions of this legislation and any adopted rules if the “act” is declared unconstitutional by the US Supreme Court or repealed by the US Congress. The repeal date is effective as of the date Title 1 of the “act” is repealed or declared unconstitutional. The Director of Insurance must notify in writing the Director of the Arizona Legislative Council of the repeal date.

HB 2565: insurance; website posting of policies (Ch. 156)

Adds ARS § 20-398.01:

- Permits an insurer to post certain property and casualty insurance policy and endorsement forms on the insurer’s website instead of mailing or delivering the documents to the insured, if all of the following conditions are met:
    1. The policy and endorsement forms posted by the insurer on its website do not contain personal or privileged information.
    2. The insurer makes each policy and endorsement form accessible on the insurer’s website while each form remains in use and for 5 years after the form is discontinued by the insurer.
    3. The insurer posts its policy and endorsement forms on the insurer’s website in a manner that enables an insured to print and save a copy of the documents using programs/applications that are widely available on the internet and free to use.
    4. Upon request, the insurer agrees to provide a method by which an insured may obtain:
        - A paper or electronic copy of the insured’s policy or endorsement form including any changes to the form.
        - The insurer’s specific website address and instructions on how to access the appropriate policy and endorsement forms on the website.

       The insurer must respond to an insured’s request in a timely manner and to provide the documents without charge.
    5. The insurer provides notice to the insured of:
        - Any changes to the policy or endorsement forms and the insured’s right to obtain a free paper or electronic copy of the documents.
        - The insurer’s specific website address and instructions on how to access the policy and endorsement forms on the website.
    6. On each declarations page delivered to an insured, the insurer indentifies the exact policy and endorsement forms purchased by the insured.
- States that “personal information” and “privileged information” have the same meanings prescribed in ARS § 20-2102 for the purposes of ARS § 20-398.01.

The following bills neither enact new, nor amend existing, provisions of Title 20; however, these bills may also impact the Department, its licensees and insurance consumers:

HB 2231: exoneration; appearance bonds (Ch. 133)

Amends ARS § 13-3974:

A. Requires a surety to be relieved from liability on an appearance bond (on which a defendant is released), if one of the following applies:
    1. The surety surrenders the defendant into the custody of the sheriff of the county in which the prosecution is pending on or before the defendant is ordered to appear in court and the sheriff reports the surrender to the court.
    2. The defendant is in the custody of the sheriff of the county in which prosecution is pending on or before the defendant is ordered to appear in court and the sheriff receives, processes and reports to the court an affidavit of surrender of the appearance bond from the surety.
    3. Before the defendant is released to the custody of the surety, the defendant is released or transferred to another government agency, preventing the defendant from appearing in court on the date and time the defendant is order to appear, and the surety establishes both of the following:
        - The surety did not know and could not have reasonably known of the release or transfer or that a release or transfer was likely to occur.
        - The defendant's failure to appear was a direct result of the release or transfer.

- Requires a surety to return the premium and collateral to the guarantors of the appearance bond, if the surety is relieved of liability pursuant ARS § 13-3974 (A)(3).
- Requires the clerk of the court to return any money deposited, if the surety is relieved of liability pursuant ARS § 13-3974 (A)(3).
- Specifies that the provisions of ARS § 13-3974 (A)(3) do not apply if either:
    - A detainer was placed on the defendant before the appearance bond was posted.
    - The release or transfer to another government agency is for a period of 24 hours or less.

HB 2462 bail bond agents; lists; loitering (Ch. 21)

Amends ARS § 13-2905:

- Modifies the definition of criminal loitering to include the solicitation of bail bond business inside a court building or immediately around or near the entrance of a county or city jail. A violation of this statute is class 3 misdemeanor.
- Defines "solicit" to include *handing out business cards or any printed material or displaying any electronic devices related to bail bonds, verbally asking a person if the person needs a bail bond and recruiting another person to solicit bail bond business.*

Amends ARS §13-3969:

- Requires a county or city jail to update the list of authorized persons who may post bail bonds each month.
- Requires the clerk of the court to rotate the order of the list of authorized persons who may post bail bonds and electronically transmit to the list to county and city jails each month.
- Prohibits a sheriff or keeper of a county or city jail from recommending any bail bond agent, private person or private company to a person charged with a bailable offense.
- Requires the sheriff or keeper of a county or city jail to:
    - Accept a secured appearance bond from an employee of a bail bond agent if the employee has proper identification.
    - Accept money orders, cashier's checks, cash or a secured appearance bond for the release of a person in the custody of the sheriff or keeper, if bail is authorized by the court.

- Be open 24-hours a day, every day, including holidays, to accept secured appearance bonds, money orders, cashier's checks or cash.

SB 1148 workers' compensation; reciprocity (Ch. 34)*

Repeals ARS § 23-904 in order to enact new provisions for the same section.

Enacts ARS § 23-904:

- Entitles an injured worker, who was hired or is regularly employed in Arizona, to receive compensation according to the laws of this state if the worker received a personal injury by accident arising out of and in the course of the worker's employment – even if the injury was received outside this state.
- Entitles a worker, who is employed in Arizona and temporarily leaves Arizona incidental to the worker's employment and receives an injury arising out of and in the course of employment, to the benefits of ARS Title 23, Chapter 6 (the workers' compensation statutes).
- Exempts a worker from another state and the worker's employer in that other state from Arizona's workers' comp. statutes while the worker is temporarily in Arizona doing work for the employer if all of the following are true:
    1. The employer has furnished workers' compensation insurance coverage under the laws of another state so as to cover that worker's employment while in Arizona.
    2. The extraterritorial provisions of ARS Title 23, Chapter 6 are recognized in the other state.
    3. Employers and workers who are covered in Arizona are likewise exempted from the application of the workers' compensation insurance act or similar laws of the other state.
    4. The benefits under the workers' compensation insurance act or similar laws of the other state, or other remedies under a similar act or laws, are the exclusive remedy against the employer for any injury, whether resulting in death or not, received by the worker while temporarily working for that employer in Arizona.
- States that a certificate from a duly recognized officer of the Industrial Commission of Arizona, ADOI or a similar department of another state certifying that the employer in the other state is insured in that state is prima facie evidence that the employer carries that workers' compensation insurance.
- Requires the courts to take judicial notice of the laws of another state, if in any appeal or other litigation the construction of the laws of another state is required.
- Specifies how a worker is deemed to be temporarily working in a state.
- Specifies the method by which an injured worker will receive benefits when both Arizona and another government are involved for the same injury.
- States that claims made after September 13, 2013, are subject to the new ARS § 23-904 regardless of the date of injury.

*Pursuant to Laws 2013, Chapter 183, Section 2, this legislation *applies to any claim that has not been accepted as compensable or adjudicated as compensable as of the effective date of* this act.