



STATE OF ARIZONA
DEPARTMENT OF INSURANCE

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REGULATORY BULLETIN 2002-07

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

From: Charles R. Cohen
Director of Insurance

Date: June 18, 2002

Re: **2002 Arizona Insurance Laws**

This Regulatory Bulletin summarizes the major pieces of newly enacted legislation affecting the Department, its licensees, and insurance consumers. This summary is not meant as an exhaustive list or a detailed legal 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 specific bills. Please do not regard this summary as a legal opinion or a binding interpretation 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 legislative web site at the following internet address: <http://www.azleg.state.az.us>. Please direct any questions regarding this bulletin to Vista Thompson Brown, Executive Assistant for Policy Affairs, 602/912-8456.

The 2002 Arizona Forty-fifth Legislature, Second Regular Session, adjourned *sine die* on May 23, 2002. Except as otherwise noted below, all insurance related legislation has a general effective date of August 22, 2002.

The Department initiated the following bills, which are described first: SB1016, SB1134, SB 1162, HB 2075, HB2135, and HB 2204.

DEPARTMENT BILLS

SB1016. Insurance adjuster; definition (Ch. 55)

This bill amends the definition of “adjuster” in A.R.S. § 20-321, as follows:

- Defines adjuster as a person who adjusts, investigates, or negotiates settlement of claims arising under an insurance contract, or who holds oneself out as performing such services.
- Adds the following exclusions to the definition of adjuster:
 - Political subdivision employees who adjust losses arising out of policies covering the political subdivision or its indemnitees; and
 - Independent contractors hired by a licensed adjuster solely to render technical assistance with a claim.
- Clarifies that the current exemption for “salaried employees of an insurer or managing general agent” means a person whose salary is not dependent on the outcome of a claim.

SB1134. Insurance; financial and accounting standards (Ch. 132)

Under current law, hospital, medical, dental and optometric service corporations (HMDOs), health care services organizations (HMOs), and prepaid dental plans (PDPs) are subject to standards for their financial accounting and reporting that differ in certain respects from each other and from the standards applicable to traditional insurers. This bill amends certain financial and accounting rules and procedures for regulatory oversight that are applicable to HMDOs, HMOs, and PDPs, in appropriate cases, to make them consistent with the rules and procedures applied to traditional insurers. The bill:

- Amends A.R.S. § 20-167 for the purpose of consolidating annual renewal fees for HMOs and PDPs into this section of law. Other changes to A.R.S. § 20-167 are included for the purpose of blending with other bills from both the 2001 and 2002 legislative sessions.

HMDOs

- Amends A.R.S. § 20-821, listing other sections of Title 20 applicable to HMDOs, to add: A.R.S. §§ 20-223 (annual financial statement); 20-234 (filing of financial information with the National Association of Insurance Commissioners (“NAIC”)); and 20-261 through 20-261.04 (authorized reinsurance transactions and credit for reinsurance), and any rules adopted pursuant to these or other sections listed in A.R.S. § 20-821.
- Enacts A.R.S. § 20-825.01 establishing \$25,000 as the minimum capital and surplus requirement for HMDOs exempt from statutory risk based capital requirements prescribed in A.R.S. § 20-488.08.

- Amends A.R.S. § 20-831:
 - Specifies that an HMDO shall file its annual financial statement as prescribed in A.R.S. §§ 20-223 and 20-234, showing its financial condition as of the preceding December 31st.
 - Enacts a new subsection requiring an HMDO to disclose other corporate information that the HMDO is required to file under Title 10, if the information is not otherwise filed with or available to the Director (this language is comparable to A.R.S. § 20-233 applicable to for-profit insurers.)
 - Enacts a new subsection that subjects an HMDO to the penalties prescribed in A.R.S. § 20-223 (fine of up to \$25.00/day, suspension, or revocation) for late filing of financial statements, fees and other required information.
- Enacts A.R.S. § 20-845 permitting the Director to suspend or revoke an HMDO's certificate of authority and to impose civil penalties, if the HMDO:
 - Is operating significantly in contravention of its organizational documents;
 - Has issued policies that do not comply with A.R.S. § 20-826 (listing requirements and mandates for a health insurance policy);
 - Cannot meet its obligations to its subscribers;
 - Has advertised or sold its services in an untrue, misleading or deceptive manner;
 - Has substantially failed to comply with applicable laws;
 - Is in an unsound or hazardous financial condition.

This new section prohibits the HMDO from accepting most new members and from marketing its products during a period of suspension. An HMDO must wind up its operations if its certificate is revoked. The section also specifies the HMDO's right to due process under Title 41, the Administrative Procedures Act, for any adverse action.

PDPs

- Amends A.R.S. § 20-1004 to repeal the subsection providing for annual expiration of a PDP's certificate of authority. The bill also strikes language about the annual renewal fee; comparable fee language is reinserted into A.R.S. § 20-1009(A) and A.R.S. § 20-167.
- Enacts A.R.S. § 20-1006.01 establishing \$25,000 as the minimum capital and surplus requirement for PDPs exempt from statutory risk based capital requirements prescribed in A.R.S. § 20-488.08.
- Amends A.R.S. § 20-1009.
 - Requires a PDP to file its annual financial statement as prescribed in A.R.S. §§ 20-223 and 20-234, showing its financial condition as of the preceding December 31st and to pay the annual renewal fee specified in A.R.S. § 20-167.
 - Subjects a PDP to the penalties prescribed in A.R.S. § 20-223 (fine of up to \$25.00/day, suspension, or revocation) for late filing of financial statements, fees and other required information.
- Amends A.R.S. § 20-1015 to add unsound or hazardous financial condition as an additional ground for suspension or revocation of a PDP's certificate of authority.

The bill also gives the Director an additional remedy (imposition of civil penalties) for violations of this section.

HMOs

- Amends A.R.S. § 20-1053 to require an HMO to file its plan for risk of insolvency at the time it applies for a certificate of authority.
- Amends A.R.S. § 20-1054 to repeal the subsection providing for annual expiration of an HMO's certificate of authority.
- Amends A.R.S. § 20-1059.
 - Requires an HMO to file its annual financial statement as prescribed in A.R.S. §§ 20-223 and 20-234, showing its financial condition as of the preceding December 31st and to pay the annual renewal fee specified in A.R.S. § 20-167.
 - Subjects an HMO to the penalties prescribed in A.R.S. § 20-223 (fine of up to \$25.00/day, suspension, or revocation) for late filing of financial statements, fees and other required information.
- Amends A.R.S. § 20-1065 governing adverse action against an HMO to conform language to comparable laws for other insurers.
- Amends A.R.S. § 20-1068, listing other sections of Title 20 applicable to HMOs, to add: A.R.S. §§ 20-223 (annual financial statement); 20-234 (filing of financial information with the National Association of Insurance Commissioners); and 20-261 through 20-261.04 (authorized reinsurance transactions and credit for reinsurance).
- Amends A.R.S. § 20-1069 to clarify language regarding the plan for risk of insolvency.

SB1162. Insurance department; general fund recoupment (Ch. 214) **Effective May 15, 2002, on signature of the Governor**

This bill amends various provisions related to fees and assessments the Department charges to producers, insurers, reinsurers, and other fee payors.

- Amends A.R.S. § 20-167 to increase by 50% the allowable range of statutory fees, except:
 - Domestic life and disability reinsurers (caps top fee range at \$5500);
 - Mechanical reimbursement reinsurers (caps top fee range at \$5500); and
 - Copies of public records (reduced from top range of \$1.50/page to \$.75/page).
- Amends numerous sections to consolidate, into A.R.S. § 20-167(A), certain other fees scattered throughout Title 20, including:

- Issuance and renewal of a certificate of authority for prepaid dental plans (from A.R.S. §§ 20-1003 and 20-1004), and mechanical reimbursement reinsurers (from A.R.S. §§ 20-1096.04 and 20-1096.05);
 - Certification of registration as an administrator and registration renewal under A.R.S. § 20-485.12;
 - Service company permit (from A.R.S. § 20-1095.03);
 - Application for approval of a motor vehicle service contract (from A.R.S. § 20-1095.06)
 - Life care permits and annual statements (from A.R.S. §§ 20-1802 and 20-1807); and
 - Annual statement for certain insurers exempt under A.R.S. § 20-401.05.
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- Amends A.R.S. § 20-167(B) to clarify that all collected fees are deposited to the General Fund and that no fee may be prorated.
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- Amends A.R.S. § 20-167(D) and (E) to increase the allowable premium tax credit for domestic life and disability insurers consistent with changes to fees and the recoupment formula, and repeals the premium tax credit for domestic life and disability reinsurers.
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- Amends the recoupment formula in subsection (G) (now (F)) to change the time frames for comparison of revenues and appropriations and the adjustment of fees. Current law compares revenues for a prior calendar year against the Department's appropriation for an upcoming fiscal year. With the amendment, each December 1st, the Department will compare prior fiscal year revenues against the current fiscal year appropriation. Any required fee adjustments will be effective the next July 1st for the fiscal year beginning July 1st.
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- Amends A.R.S. § 20-224 to change (from March 31 to March 1) the date for authorized domestic insurers to file a premium tax report and pay premium taxes.
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- Amends A.R.S. § 20-466 to increase (from \$700 to \$1050) the allowable amount of the assessment for the fraud unit. (Any increase in the actual assessment will depend on the amount needed to recoup the unit's legislative appropriation.)
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- Requires Joint Legislative Budget Committee (JLBC) staff to analyze fees, assessments, and taxes listed in the bill and report to JLBC by October 1, 2002 on the relationship between fees and cost of services, and whether fees are equitable.
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- Makes conforming changes in numerous other sections.

The bill also includes language about the captive insurance program. This language passed last year; it was included in SB1162 because of technical statutory blending problems.

HB 2075. Small employer reinsurance program; repeal (Ch. 74)

This bill repeals the Small Employer Reinsurance Program (SERP), effective January 1, 2003. SERP was established in the early 1990's as part of a series of health insurance market reforms. A carrier that elects to participate in SERP may reinsure high-risk lives with SERP. SERP has been underutilized; currently, only 10 carriers participate in the program; only 3 of those carriers are ceding lives; and only 11 lives are reinsured.

The bill prohibits the program from accepting any new risks as of August 22, 2002, and directs the SERP Governing Board to wind up the program in accordance with its plan of operation.

The bill amends A.R.S. § 20-2201 to establish a new fund for voluntary plan assessments. Monies collected under this existing assessment authority, which is unrelated to SERP, are currently deposited into a SERP-related fund. With the repeal of SERP, the unrelated monies will be deposited into the newly created fund.

HB2135. Insurance; consumer credit; credit property (Ch. 236) Effective January 1, 2003

This bill updates current laws governing credit life insurance and credit disability insurance. The bill also establishes a regulatory scheme for credit property insurance and credit unemployment insurance.

Article 10. Consumer Credit Insurance

- Changes the name of Title 20, chapter 6, article 10 from "Credit Life Insurance and Credit Disability Insurance" to "Consumer Credit Insurance" and makes conforming changes throughout the article.
- Repeals A.R.S. § 20-1601, describing the purpose of the article, but enacts similar language as session law in section 23 of the bill.
- Amends A.R.S. § 20-1602 (Scope and repeal):
 - Clarifies that the article applies only to insurance for "personal, family, and household purposes";
 - Specifies that the article does not apply to insurance for which there is no identifiable charge, or to insurance written on a credit transaction secured by a first mortgage or deed of trust for the purchase of real property or construction of a dwelling; and
 - Consolidates all exclusions into one subsection.

- Amends A.R.S. § 20-1603 (Definitions):
 - Adds a definition of “consumer credit insurance” which means credit life, credit disability, or credit unemployment insurance”
 - Adds definitions for “credit property insurance,” “credit unemployment insurance,” “gross debt,” “identifiable charge,” and “net debt”; repeals the definition of “indebtedness”.

Throughout the article, sections are amended to substitute the new defined terms.

- Repeals A.R.S. § 20-1604 (Permissible transactions) and enacts new A.R.S. § 20-1604 (Types of consumer credit insurance), which provides that the three types of consumer credit insurance may be written separately or in combination, for both group and individual policies, and allows the Director of Insurance to adopt rules limiting or prohibiting any combination.
- Amends A.R.S. § 20-1606 (Maximum amount of credit disability insurance and credit unemployment insurance).
 - Places limits on the allowable amount of credit unemployment insurance identical to limits for credit disability insurance.
 - Specifies the allowable amount of indemnity on open-end credit agreements and for policies where no single indemnity exceeds the net debt.
- Enacts A.R.S. § 20-1606.01 specifying requirements for credit unemployment insurance policies.
 - Lists the allowable exclusions; the policy need not cover unemployment due to: voluntary forfeiture of income; resignation; retirement; general strike; illegal walk-out; war; separation from the military; misconduct or unlawful behavior; and disability resulting from injury, sickness, or pregnancy.
 - Monthly benefits must start after a waiting period of no more than 30 days, need not be retroactive, and must have a maximum period of at least 6 months.
 - The following persons may be excluded from qualifying for coverage: (a) self-employed individuals; (b) seasonal and temporary workers (jobs of less than 6 months); and (c) persons with written notice of imminent layoff or termination (within 60 days of coverage commencement). However, there can be no employment requirement more restrictive than requiring a debtor to be employed full time (at least a 30 hour regular work week) on the date of coverage and for the 6 months preceding the date of coverage.
- Repeals A.R.S. § 20-1608 (Provisions of policies and certificates) and enacts new A.R.S. § 20-1608 (Policy provisions and disclosures).
 - Requires the following presale disclosures (which may be combined with other state or federally mandated disclosures):
 - (1) That purchase of credit insurance is optional, is not a condition of loan approval, and is potentially unnecessary for a person with other life or disability insurance;
 - (2) A statement as to whether a debtor may separately purchase particular types of credit insurance or must purchase multiple coverages as a package;

- (3) That a debtor may cancel the insurance and receive a full refund during the first 30 days of coverage;
 - (4) The conditions of eligibility and a description of the amount, term, and rate for coverage; and
 - (5) That financed premiums and charges are subject to the same financing rates as the credit transaction.
- Requires that disclosures be made as follows:
 - For offers made at the time of the credit extension, or via direct mail, disclosure must be clear, conspicuous, and in writing
 - For offers other than direct mail offers, made after the extension of credit, only certain of the listed disclosures are required, and may be given orally if: a specific warning using language detailed in the statute is given at the same time, and all disclosures are provided in writing within 10 days.
 - Requires that all coverage be evidenced by a policy or certificate that is delivered to the debtor, and includes the following information:
 - The insurer's name and home office address;
 - The debtor's name;
 - A description of each type of coverage, with applicable limitations and exclusions, and the premium charged for each coverage, or, for open-end accounts, the basis for the charges;
 - A statement that policy benefits are payable to the creditor, and that any excess over the amount needed to extinguish the debt is payable to the debtor or a named beneficiary; and
 - If applicable, a statement in at least 10 point bold typeface indicating that the term of the insurance is less than the term of the loan.
 - Requires that the debtor receive a copy of the signed insurance application if a copy of the policy or certificate is not delivered to the debtor when the debt is incurred or coverage is purchased. The application shall:
 - Contain most of the same basic information listed above for the policy;
 - Be separate from the loan documents unless the required information is prominently set forth in such documents, and
 - State that the insurance is effective upon the insurer's acceptance.On accepting the insurance, and no later than 30 days after the debt is incurred or insurance is purchased, the insurer shall deliver the policy or certificate to the debtor.
 - Allows an insurer to combine required disclosures with an application or certificate so long as all required information is incorporated into the document.
 - Gives the debtor a 30-day free look period, running from the date the debtor receives the policy or certificate of coverage. If the debtor cancels, the insurer may require the debtor to provide written notice of the cancellation and to return the policy or certificate. Within 30 days of receiving a cancellation, the insurer shall refund or credit the debtor all insurance premiums and charges.

- If an insurer declines to insure a particular risk, a substitute insurer may accept the risk. The substitute insurer shall provide the debtor with a policy or certificate containing the insurer's name and home office address and the amount of premium to be charged. If the substitute insurer has a lower premium, the debtor must receive a refund or credit of the premium difference within 30 days, and of all premiums and charges if no insurer accepts the risk.
- For insurance on open end credit agreements:
 - The policy or certificate is deemed delivered when the debt is incurred or the debtor elects to purchase coverage if the actual delivery occurs within 30 days of the date insurance is effective; and
 - Coverage continues from the effective date through the term of the credit agreement unless earlier terminated.
- Amends A.R.S. §§ 20-1609 and 20-1610, respectively regarding form and rate review.
 - Prohibits use of any form or rate unless it is filed with and approved by the Director. A form or rate is deemed approved unless the director disapproves it within 30 days of filing. On written notice to the filer given within the 30-day review period, the Director may extend the review period for up to 15 additional days.
 - Adds "ambiguity" as a reason for form disapproval.
 - Subjects credit unemployment insurance rates to determination and review pursuant to the same standards applied to credit property insurance rates under A.R.S. § 20-1621.05.
- Amends A.R.S. § 20-1611 to increase the minimum threshold for an insurer's refund obligation from \$1.00 to \$5.00.
- Amends A.R.S. § 20-1613 to allow for payment of claims by electronic funds transfer.
- Repeals A.R.S. § 20-1616 (Penalties) and enacts new A.R.S. § 20-1616 and 20-1616.01. Allows the Director to issue a cease and desist order to any person violating this article or any implementing rules. A person subject to an order may request a hearing pursuant to the Administrative Procedures Act. Also allows the Director to impose civil penalties on an insurer who violates an order issued under this article or any implementing rules, following notice and hearing. Penalties range from up to \$1000/violation, (subject to an aggregate limit of \$100,000,) and up to \$25,000/violation (aggregate of \$250,000) for flagrant violations.

Article 10.1. Credit property insurance.

This new article is based on the NAIC Credit Property Insurance model law.

- Enacts A.R.S. § 20-1621 defining the applicable scope of the article. The article applies to the transaction of credit property insurance written in connection with

loans for personal, family, and household purposes, including consumer loans governed by A.R.S. Title 6, chapter 5. The article does not apply to insurance on the following:

- loans for business or commercial purposes,
 - mobile homes,
 - loans secured by a real estate mortgage or deed of trust,
 - creditor placed insurance
 - title insurance
 - nonrecording insurance; or
 - creditor purchased insurance following a repossession action.
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- Enacts A.R.S. § 20-1621.01 containing definitions of the following terms: “closed–end credit,” “collateral,” “compensation,” “consumer credit insurance,” “credit agreement,” “credit property insurance,” credit transaction,” “creditor-placed insurance,” “debtor”, “dual interest insurance”, “experience”, “experience period”, “finance charge”, “gross debt”, “incurred losses”, “loss ratio”, “net debt”, “nonrecording insurance”, “open-end credit”, “personal property”, “policy”, “producer”, and “single interest insurance.”
 - Enacts A.R.S. § 20-1621.02 establishing terms, conditions and limitations for credit property insurance. Insurance cannot be sold on a closed-end loan unless the amount financed is over \$100. The amount and term of insurance cannot exceed the amount and term of the underlying loan. At minimum, the coverage must be comparable to the coverage under a standard fire policy and endorsement, and shall cover the possibility of an actual and substantial risk of loss or damage to the underlying property. An insurer cannot require a debtor to purchase credit property insurance bundled with other credit insurance coverage, and must allow for separate purchase. An insurer cannot use gross debt as an exposure rating base in setting premiums.
 - Enacts A.R.S. § 20-1621.03 establishing required disclosure obligations to debtors. The requirements for the form and method of disclosure, as well as the obligation to provide a copy of the policy or certificate, are very similar to those specified in A.R.S. § 20-1608 for consumer credit insurance described above. Please refer to the bill for precise details. Special disclosures, as detailed in the statute, are required at offering and annually, for credit property insurance coverage on an open-end credit transaction. The special disclosure is designed to advise the debtor that the insurance may duplicate existing residential property coverage and that the premium may be based on things for which coverage cannot be claimed, such as services.
 - Enacts A.R.S. § 20-1621.04 requiring insurers to file policy forms and rates with the Director for the Director’s approval. Provides for deemed approval after 30 days if the Director does not earlier approve or disapprove the filing. Allows the Director to extend the 30-day review period for up to 15 days on written notice to the filer. The bill specifies grounds for disapproval of rates and forms including: (1) the rate is inadequate, unfairly discriminatory, excessive, or not reasonable in relation to coverage provided; (2) the policy has terms that encourage misrepresentation or are

unjust, unfair, inequitable, ambiguous, misleading, deceptive, or contrary to law. The bill also specifies the procedures the Director must follow to disapprove or withdraw approval of a rate or form, and the process for challenging the Director's action.

- Enacts A.R.S. § 20-1621.05 requiring that insurance premium rates be reasonable in relation to the benefits provided. The bill requires the Director to establish, by order, a loss ratio standard at least once every three years. In setting the standard, the Director must consider actual and expected experience and numerous rating components. The Director must also establish prima facie rates; prima facie rates are presumed to be not excessive. Insurers charging the prima facie rates are not required to file rates with the Director, but must annually certify that the rates do not exceed prima facie rates, and are not inadequate or unfairly discriminatory. The certification must include the insurer's rates then in effect. The Director retains discretion to require the insurer to make a rate filing.
- Enacts A.R.S. § 20-1621.06 requiring insurers to file annual reports on credit property insurance business, and specifying requirements for the form of the report.
- Enacts A.R.S. § 20-1621.08 requiring a premium refund to debtors, calculated on a daily pro rata basis, on cancellation of the insurance, other than refunds of less than \$5.00.
- Enacts A.R.S. § 20-1621.09 specifying the requirements for handling of claims and the form for claims payments. Creditors must promptly report claims to insurers. The bill places limits on an insurer's ability to designate creditors as claims representatives, and to deny claims on the basis of debtor ineligibility more than 90 days after coverage begins.
- Enacts A.R.S. §§ 20-1621.10 and 20-1621.12, respectively allowing the Director to issue a cease and desist order and to impose civil penalties against a person who violates the laws applicable to credit property insurance, and allowing the person to challenge the Director's action pursuant to the laws governing administrative hearings.
- Enacts A.R.S. § 20-1621.11 giving the Director authority to adopt rules to implement the article.

HB2204. Insurer rates; forms; review (Ch. 41)

This bill contains several provisions to standardize the Department's process for review of insurers' rate and form filings, and to improve the efficiency of that process.

- Amends A.R.S. §§ 20-357 and 20-359 to require that a workers' compensation rating system and any insurer deviations to that system be on file with the Director for at least 30 days before the effective date. (Prior law required a 15-day waiting period.)

- Amends A.R.S. § 20-376 to require that a title insurance rate filing be on file with the Director for at least 30 days before the effective date. (Prior law required a 15-day waiting period.)
- Amends A.R.S. § 20-398 governing property and casualty forms to clarify that a form is deemed approved 30 days after filing unless the Director affirmatively disapproves the form. Adds a new provision allowing the Director to extend the 30-day review period by up to 15 days, upon notice to the filer, given within the 30-day period.
- Amends A.R.S. § 20-401.07 to revise the definition of an “industrial insured”, which is an entity that may purchase insurance products that are exempt from rate and form filing and certain other regulatory provisions. To qualify as an industrial insured under the revised definition, an insured must procure insurance through a “risk manager,” as defined in the statute, and satisfy at least two of the following criteria:
 - Aggregate annual gross P&C premiums of \$100,000 (previously \$500,000);
 - Net worth over \$10 million (previously \$50 million);
 - Net revenues or sales over \$25 million (previously \$100 million);
 - More than 80 full time equivalent employees (FTEs) or 100 FTEs in a holding company system (previously 500 FTEs and 1000 FTEs, respectively)
- Amends A.R.S. § 20-1110 governing life and disability forms:
 - Clarifies that a form is deemed approved 30 days after filing unless the Director affirmatively disapproves the form.
 - Reduces the period of time by which the Director may extend the 30-day review period, from an additional 30 days to 15 days.
- Amends A.R.S. § 20-1591 governing title insurance forms:
 - Clarifies that a form is deemed approved 30 days after filing unless the Director affirmatively disapproves the form.
 - Adds a new provision allowing the Director to extend the 30-day review period by up to 15 days, upon notice to the filer, given within the 30-day period.
- Amends A.R.S. §§ 20-1609 and 20-1610 governing credit life and disability insurance forms and rates:
 - Clarifies that a form or rate is deemed approved 30 days after filing unless the Director affirmatively disapproves the form or rate.
 - Adds a new provision allowing the Director to extend the 30-day review period by up to 15 days, upon notice to the filer, given within the 30-day period.
 - Adds ambiguity as a new reason for form disapproval
 - Repeals outdated subsection related to policies issued before and after June 23, 1961.

OTHER INSURANCE-RELATED BILLS

SB1015. Surplus lines brokers (Ch.93)

- Amends A.R.S. § 20-408, which lists the information required for a surplus lines broker's report. The report no longer requires the insurer's address, but will require its NAIC identification number. The explanation of the diligent effort is no longer required on the 408 form; the broker must attach, to the 408 form, an affidavit attesting to compliance with A.R.S. § 20-407, and maintain evidence of diligent search efforts in the broker's office for 6 years following policy expiration.
- Amends A.R.S. § 20-411.01 to clarify that either a resident or a nonresident licensed insurance producer may obtain a license as a Mexican insurance surplus lines broker.

SB1098. Annuity contracts; free look (Ch. 131)

Amends A.R.S. § 20-1233 to provide that the 10-day "free look" period normally applicable to annuity purchases does not apply to an annuity contract that is:

- Supplemental to a settled annuity contract that provides for payments in consideration of accumulations from the original annuity contract; and
- Issued only to holders of the original annuity contract.

SB1107. Corporation commission; securities enforcement (Ch. 157)

This bill contains many changes in the securities laws. This bulletin discusses only those changes related to insurance products.

- Amends A.R.S. § 44-1848 to require that securities dealers and salesman who engage in transactions involving variable contracts that are exempt from registration requirements under A.R.S. § 44-1843(A)(4) register with the Arizona Corporation Commission. (A.R.S. § 44-1843(A)(4) exempts: insurance or endowment policies, annuity contracts, and optional annuity contracts.)
- Amends A.R.S. § 44-1850(A). This section previously exempted viatical and life settlement contracts from A.R.S. § 44-1842, which makes it unlawful for unregistered dealers and salesman to transact in these types of products. The effect of this provision is to require a person who regularly transacts in these products to register as a securities dealer or salesperson.
- Amends A.R.S. § 44-1850(A)(2)(a)(i) to clarify the accounting requirements for maintenance of an exemption from securities registration requirements under A.R.S. § 44-1841 for a viatical or life settlement contract.

SB1161. Mortgage guaranty; insurance (Ch. 98)

- Amends A.R.S. § 20-342 to specify that A.R.S. Title 20, Chapter 2, Article 4.0 does not apply to mortgage guaranty insurance.
- Amends the definition of “authorized real estate security” in A.R.S. § 20-1541 so as to increase, from 100% to 103%, the authorized loan to value ratio on which mortgage guaranty insurance can be written, so long as the additional 3% is used to finance fees and closing costs on the indebtedness.
- Amends A.R.S. § 20-1549 to eliminate the requirement of prior approval for rates and policy forms for mortgage guaranty insurance. New language requires that a rate filing shall be on file for 15 days before becoming effective, and a policy form on file for 30 days before it becomes effective.

SB1164. Licensure; registration; applicants; fingerprint requirements (Ch. 99)
(Effective April 29, 2002, on signature of Governor)

Makes parallel changes to A.R.S. § 20-142, 20-285, 20-289, 20-340.04 to adopt language required by the federal law, to permit the Department’s continued access to state and federal criminal records, via submission of fingerprints to the Department of Public Safety.

SB1196. Insurance producer licensing; conforming changes (Ch. 71)

Last year, Arizona adopted the Uniform Producer Licensing Model Act (Laws 2001, Ch. 205). Section 44 of that bill required Legislative Council staff to prepare conforming legislation for the 2002 session. SB1196 amends numerous sections of the Insurance Code by changing the terms “insurance agent”, “agent”, “insurance broker”, and “broker” to “insurance producer” or producer”.

The bill also amends A.R.S. § 20-832 to eliminate the prohibition on payment of a bonus, commission, or dividend to an officer or employee of a hospital, medical, dental or optometric service corporation.

SB1229. Physical therapists; insurance (Ch. 166)
(Applies only to policies issued or renewed on or after January 1, 2003).

Parallel enactments in A.R.S. § 20-841 (nonprofit service corporations), 20-1376.04 (individual insurance), and A.R.S. § 20-1406.04 (group and blanket disability insurance). This bill establishes a new requirement for health insurance policies that provide both in-network and out-of-network physical therapy benefits. Insurers subject to the law cannot deny coverage for out-of-network physical therapy services solely because the physician did not refer the insured to the physical therapist or prescribe specific physical therapy services. Insurers may continue to impose coinsurance, deductibles, and other similar cost containment measures as a condition of coverage for physical therapy benefits.

SB1377. Insurance pooling; educational institutions (Ch. 134) (See also, HB2198)

Amends A.R.S. § 11-952.01 governing public agency insurance pools to permit the pool to accept a private nonprofit educational institution into the pool. Any such institution that joins a pool shall post a bond, cash deposit, or other comparable financial security in an amount equal to at least one and one-half times the institution's annual premium to ensure payment of legal liabilities and other obligations in the event of the pool's insolvency or inability to discharge obligations.

HB2026. Insurance license; inactive status; military (Ch. 33)

Enacts A.R.S. § 20-289.01 permitting an insurance producer who is called to active military service to place his or her insurance license on inactive status for the period of active military service. The time periods for license renewal and completion of continuing education requirements are extended by the number of days the licensee is in active military service. Active military service is defined to exclude periodic and routine service as a military reservist.

The bill specifies the information that the licensee needs to send the Department when requesting inactive status; prohibits the licensee from selling, soliciting or negotiating insurance while on inactive status; and permits the licensee to collect renewal or other deferred commissions while inactive.

HB 2027. Domestic insurers; investments in subsidiaries (Ch. 34)

- Amends A.R.S. § 20-481.01 under the holding company act to raise (from 5% to 10%) the percentage of its assets that a domestic insurer may invest in its subsidiaries.
- Amends A.R.S. § 20-481.21 to specify that documents, records, and information gathered pursuant to A.R.S. § 20-481.19 (extraordinary dividends or distribution) are confidential and not subject to release under public records laws.

HB2137. Services; health care services organizations (Ch. 139)

This bill clarifies the Department's rulemaking authority regarding the aspects of HMO regulatory oversight transferred to the Department under SB1330 (Laws 2000, Ch. 355).

- Amends A.R.S. § 20-1051 to repeal the definition of "basic health care services" "as determined by the Director of Insurance." Amends other sections to remove all references to "basic health care services."
- Amends the definition of "health care plan" in A.R.S. § 20-1051(6) (now (5)) to clarify that it includes "contractually covered" health care services; also adds services required by statute or rule.
- Amends A.R.S. § 20-1054 to specify that the Director shall determine whether an HMO is an appropriate mechanism to achieve an effective health care plan, based on the HMO article and any rules adopted pursuant to the article. Also amends

A.R.S. § 20-1065 to provide that failure to achieve an effective health care plan (rather than failure to provide basic health care services as determined by the director) is a basis for suspension or revocation of a certificate of authority.

- Enacts A.R.S. § 20-1078 giving the Director authority to adopt rules needed to carry out the HMO article.

HB2181. Enterprise; military reuse; tax credits (Ch. 237)

The bill makes numerous changes to Arizona's tax credit scheme for employers operating in enterprise zones and military reuse zones. Only the changes related to insurer-employers claiming a premium tax credit are discussed here.

- Makes numerous amendments to A.R.S. § 20-224.03 regarding various requirements that an insurer-employer must satisfy in order to claim a premium tax credit for conducting business operations in an enterprise zone, including:
 - (1) Clarifies the requirements as to employees who reside in the enterprise zone area, but who move out in subsequent years; permits substitution of new resident employees;
 - (2) Allows a qualified employee who performs job functions within an enterprise zone, but is shifted to another such zone, to continue as a qualified employee;
 - (3) Clarifies the employee health insurance coverage that a self-insured employer must maintain for employees in the zone;
 - (4) Provides that a qualified position filled during the last 90 days of the year is deemed a new qualified position in the next year;
 - (5) Clarifies that credit is available in the second and third years only on positions for which credit was allowed in the first year;
 - (6) Establishes a new formula for determining net increases in positions;
 - (7) Limits employers to claiming credit under only one section (A.R.S. § 20-224.03 or 20-224.04) for the same employees;
 - (8) Sets guidelines for claiming credits when the insurer-employer merges or otherwise changes corporate ownership; and
 - (9) Requires insurers to provide the Department of Insurance with proof that the insurer-employer has timely filed its reports with the Department of Commerce.
- Makes conforming changes in A.R.S. § 20-224.04.
- Amends A.R.S. § 41-1525 to include detailed reporting obligations for employers claiming an enterprise or military reuse zone tax credit.

HB2192. Structured settlements (Ch. 239)

This bill creates a new article addressing sales and transfers of structured settlements, which are defined as "an arrangement for periodic payment of damages for personal injuries or sickness that is established by settlement or judgment in resolution of a tort claim or for periodic payments in settlement of a workers' compensation claim."

Enacts A.R.S. § 12-2901, a comprehensive set of definitions.

Enacts A.R.S. § 12-2902 prohibiting sale or transfer of a structured settlement that has not been prior authorized by the court pursuant to the provisions of this article. Prior to authorizing the transaction, the court must make certain detailed findings about the value and benefits of the transaction, and ensure that the original recipient of the settlement has had an opportunity to seek independent advice about the proposed transaction. The bill also establishes the legal rights of the parties to the transaction following approval.

Enacts A.R.S. § 12-2903 giving the Superior Court jurisdiction over these matters, and establishing procedures for seeking judicial approval.

Enacts A.R.S. § 12-2904 prohibiting waiver of this article and imposition of any penalties, fees, or liability against a payee if the transferee fails to satisfy the article's requirements for transfer.

HB2198. Insurance pools (Ch. 240) (See also, SB1377)

This bill amends A.R.S. § 11-952.01 governing public agency insurance pools. The bill has provisions identical to the provisions of SB1377 regarding participation by private nonprofit schools, but, unlike SB1377, prohibits such schools from participating in worker's compensation pools.

- Eliminates the requirement that a worker's compensation pool must be separate from pools for other types of insurance, but adds language allowing the Industrial Commission to adopt requirements for administration of a worker's compensation pool, including separation or commingling of funds, accounting, auditing, reporting, actuarial standards and procedures. The bill clarifies that the pools may purchase disability or accident insurance, and certain coverage for the public agency and its officials and employees.
- Amends A.R.S. § 15-213 to excuse school districts from engaging in competitive bidding when seeking the services necessary to administer a self-insurance program or an insurance pool.
- Amends A.R.S. § 41-621.01 governing insurance pools for state contractors and subcontractors to expand the types of insurance the pools may provide, and to more closely mirror the provisions of A.R.S. § 11-952.01, as amended, regarding allowable forms of insurance coverage.

HB2234. Health care insurance; contraceptive coverage (Ch. 57) (Applies to policies issued or renewed on or after January 1, 2003)

This bill contains parallel enactments mandating contraceptive coverage (as described below) in the following sections of the Insurance Code:

- A.R.S. § 20-826 (requirements for subscription contracts for hospital, medical, and dental service corporations);
 - A.R.S. § 20-1057.08 (health care services organizations (HMOs));
 - A.R.S. § 20-1402 (requirements for group disability (health) policies);
 - A.R.S. § 20-1404 (requirements for blanket disability (health) insurance policies);
 - A.R.S. § 20-2329 (accountable health plans).
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- If an insurer listed above provides coverage for prescription drugs, the insurer must also provide coverage for any prescribed drug or device that is FDA approved as a contraceptive. The insurer may use a formulary and other cost containment measures (e.g. deductibles and copays,) so long as the formulary includes oral, implant, and injectable contraceptive drugs, intrauterine devices, and prescription barrier methods, and the cost containment measures are no greater than those applied to other comparable drugs.
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- The insurer is also required to cover contraceptive outpatient services, defined as outpatient “consultations, exams, procedures, and other medical services,” related to use of contraceptives designed to prevent unintended pregnancies.
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- The bill gives “religious employers” whose religious tenets prohibit use of prescribed contraceptives, the right to opt out of purchasing insurance with contraceptive coverage, except for coverage of contraceptives that are prescribed for medical indications other than pregnancy prevention.
 - A “religious employer” is defined as an entity that meets all of the following 3 criteria: (1) & (2) primarily employs and serves persons who share the entity’s religious tenets, and (3) qualifies as a nonprofit organization under Internal Revenue Code § 6033(a)(2)(A)(i) or (iii).
 - To opt out, the religious employer must:
 - Provide the insurer with a written affidavit attesting that it satisfies the statutory criteria for a religious employer; and
 - Provide written notice to all prospective insureds that it is invoking the right to opt out of contraceptive coverage.
 - A religious employer that opts out cannot discriminate against an employee who independently obtains insurance coverage for or purchases contraceptives from another source.
 - If the religious entity opts out, the insurer:
 - Must keep the affidavit on file for the term of the policy and any renewals;
 - May require an insured to first pay for contraceptives prescribed for medical indications other than pregnancy prevention, and then to submit a claim with evidence of the other medical indications (“special claims”); and
 - May charge an administrative fee for handling special claims.

HB2276. Workers' compensation; loss adjustment expenses (Ch. 43)

Amends A.R.S. § 23-963.01, which permits a worker's compensation insurer to offer deductible coverage. The amendment requires that any deductible endorsement specify whether loss adjustment expenses are treated as part of the employer's deductible.

HB2277. Insurance; third party intermediary; bond (Ch. 82)

Amends A.R.S. § 20-120, a section requiring third party intermediaries (TPIs) (entities that contract with HMOs and other insurers) to post a bond or other financial security ensuring payment to providers. The amendment repeals an exemption from the financial security requirements that was enacted last session. The repealed exemption applied to TPIs to which an insurer or HMO had delegated responsibility to process and pay provider claims, if the TPI's provider contracts required providers to hold harmless the insurer or HMO and its policyholders and enrollees if the TPI failed to pay the claims.

The bill includes a grandfathering provision for TPIs that were acting under the now repealed exemption so long as the TPI:

- continues to have the hold harmless provision in its provider contracts; and
- sends the Department and its contracted insurers a written notice that it is availing itself of the grandfather exception, advising of the insurers for which it acts as a TPI, and attesting that its provider contracts have the required, hold harmless provision.

HB2280. Health insurers; HIPAA preemption; privacy (Ch. 142)

Enacts A.R.S. § 20-2122 providing that an insurer is deemed to be in compliance with the following sections of the Insurance Information and Privacy Protection Act if the insurer complies with 45 C.F.R. Part 164, subparts A and E: A.R.S. §§ 20-2101 (scope); 20-2102 (definitions); 20-2104 (privacy notice); 20-2105 (marketing and research surveys); 20-2106 (content of disclosure form); 20-2108 (access to recorded personal information); 20-2109 (correction of recorded personal information); and 20-2113 (disclosure limitations, conditions and exceptions)

HB2286. Health insurance task force (Ch. 265)

This bill continues the statewide health care system task force established by Laws 200, Ch. 320 (HB2050). The bill specifies the task force members, who shall include the chairs of the House and Senate Health and Insurance committees (or designees), among others. The bill establishes the task force guiding principles: health care shall be available, accessible, affordable, and properly financed; provided through a seamless system; achieved in collaboration and cooperation with various stakeholders from the public and private sectors. The task force is required to annually report its findings by November 15th.

HB2386. Insurance; credit scoring (Ch. 292)

- Amends A.R.S. § 20-2102 to expand the definition of “adverse underwriting decision” under Arizona’s Insurance Information and Privacy Protection Act¹. For property or casualty insurance, an adverse underwriting decision now includes the following actions, if those actions were based on any credit related information derived from an applicant or policyholder’s consumer report, insurance score, or lack of credit history: (1) assigning an applicant or policyholder to a higher rating tier; or (2) failing to apply a premium discount or credit. The bill also adds a definition of “insurance score.”
- Amends A.R.S. § 20-2109 governing an insurer’s obligations after an individual has exercised the right to correct or supplement personal information that the individual believes is erroneous. New language requires an insurer to reconsider its underwriting decision in light of the new information, if the applicant or policyholder so requests.
- Amends A.R.S. § 20-2110 governing an insurer or agent’s obligation to provide an individual with the specific reason for an adverse underwriting decision. If the decision is based on credit related information, or the absence of such information, new language requires the insurer/agent to provide at least the following information:
 - (1) that the decision was based on credit related information, or the lack thereof;
 - (2) the source of the consumer report and how to obtain it;
 - (3) the credit history items that can typically have a negative impact, including: numerous revolving accounts or new accounts, a large revolving credit balance, past due balances, collection accounts, and derogatory public records.

HB2435. Insurance; confidential information; fraud unit (Ch. 108)

- Amends A.R.S. § 20-466 governing information submitted to the Department in connection with a fraud unit referral. Requires that the Director:
 - Keep confidential the name of a fraud informant and any information that would identify the informant; and
 - Notify an insurer of any public records request or subpoena for information the insurer has referred to the fraud unit so the insurer may assert any applicable privileges.

These new provisions do not apply if a law enforcement or prosecutorial agency requests the information for a criminal investigation or prosecution.

HB2437. Nonforfeiture; deferred annuities (Ch. 180)

Amends A.R.S. § 20-1232 to lower the required minimum nonforfeiture amount on an annuity from 3% to 1.5%.

¹ This Act is limited in scope. It applies to insurers that “in the case of property or casualty insurance...engage in insurance transactions...in this state.” A.R.S. § 20-2101. “Insurance transactions” involve insurance that is primarily for personal, family or household use. Thus the Department does not view these new requirements about credit scoring as applicable to commercial insurance policies.

HB2541. Holocaust victims; insurance policies (Ch. 147)

Creates new provisions to limit insurers' ability to assert a statute of limitations defense against insurance claims of Holocaust survivors.

- Enacts A.R.S. § 20-490 containing the following definitions applicable to the article: "Holocaust victim," "insurance policy" and "insurer."
- Enacts A.R.S. § 20-490.01 expressly permitting Holocaust victims to bring (in an Arizona court) a claim against an insurer on an insurance policy that was purchased or in effect in Europe prior to 1946. Through December 31, 2012, prohibits the court from dismissing the claim on the basis of statute of limitations.
- Enacts A.R.S. § 20-490.02 making it unlawful for an insurer to deny Holocaust survivors' claims on the basis of statute of limitations or untimeliness. Permits the Director to examine any insurer asserting such defenses, to issue a cease and desist order against the insurer, to assess a civil penalty against the insurer, or to refer the matter to the Attorney General.

HB2620. Purchaser Dwelling Actions (Ch. 281)

This bill establishes a new process for claims related to construction defects for certain residential dwellings. The bill does not amend any sections of the Insurance Code, but may be of interest to property and casualty insurers.

OTHER BILLS OF GENERAL APPLICATION TO STATE AGENCIES

SB1415. Public records; inspection; mail (Ch. 211)

Amends A.R.S. § 39-121.01 to permit a person seeking a public record not otherwise available on an agency's web site, to request that the agency mail the record. The agency may require the requesting party to pay in advance for copying and postage charges. If an agency does not promptly respond to a request, it is deemed a denial of access under the public records laws.

SB1339. State agencies; administrative procedures; rules (Ch. 334)

- Amends the definition of "preamble" in A.R.S. § 41-1001 to require that the preamble also include a reference to any study that is relevant to a rulemaking and which the agency reviewed, but did not rely on, as support for the rulemaking. An amendment to A.R.S. § 41-1052 prohibits GRRC from approving a rule if the agency fails to appropriately disclose such studies in the preamble. Also amends the definition to require the preamble to include a summary of all comments made regarding the rule, not merely "principal" comments.
- Enacts A.R.S. § 41-1021.02 requiring agencies to publish an annual regulatory and rulemaking agenda; specifying the information that must be included on the agenda;

and providing that agencies may pursue rulemaking activities not listed on the agenda.

- Amends A.R.S. § 41-1024 to clarify that an agency must consider all comments submitted about information in a preamble, as well as the rule.
- Amends A.R.S. §§ 41-1024, 41-1029, 41-1031, 41-1036, and 41-1052 to eliminate the requirement for and all references to the concise explanatory statement (CES).
- Amends A.R.S. § 41-1032 to delay the normal effective date of rules from the date filed with the Secretary of State's office to a date 60 days thereafter, unless the agency has announced and demonstrated one of five specified statutory reasons warranting an immediate effective date. Also clarifies an agency's right to set an even later effective date. Amends A.R.S. § 41-1044 and A.R.S. § 41-1052 to prohibit the Attorney General and GRRC, respectively, from approving any rule with an immediate effective date unless the rule complies with the new requirements listed in A.R.S. § 41-1032. Amends A.R.S. § 41-1052 to require that a two-thirds voting quorum of GRRC members approve an immediate effective date.
- Amends A.R.S. § 41-1091 to require agencies to include certain specific disclaimer language on all substantive policy statements.
- Continues the Regulatory Reform and Enforcement Committee.

HB2414. Agency reports; web site posting (Ch. 116)

Enacts A.R.S. § 41-4153, which applies to state agencies that already maintain a web site. These agencies:

- Shall post copies of any annual agency reports on the agency web site;
- Shall not distribute printed copies of the report except to the Governor, Senate President, Speaker of the House, and the Department of Library, Archives, and Public Records (DLAPR), or pursuant to a public records request;
- Shall provide DLAPR with enough copies of the report to send out to public libraries on interlibrary loan;
- Shall notify the Governor, the members of the Legislature, and the DLAPR Director that a report has been posted on the web.

State agencies must report on the cost savings generated by this legislation.

Note re HB2414: *the Department of Insurance already makes its annual report and numerous other publications available on its web site. Persons who may previously have received informational copies of certain reports will now be required to make a formal public records request for a photocopy of the report.*

Any person may view this bulletin on the Department's web site at www.state.az.us/id. For questions regarding this bulletin, please contact Vista Thompson Brown, Executive Assistant for Policy Affairs at 602/912-8456 or vbrown@id.state.az.us.