



**Office of the Director**

**Arizona Department of Insurance**

2910 North 44<sup>th</sup> Street, Suite 210, Phoenix, Arizona 85018-7269

Phone: (602) 364-3471 | Web: <https://insurance.az.gov>

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**Douglas A. Ducey, Governor**

**Leslie R. Hess, Interim Director**

REGULATORY BULLETIN 2017-02<sup>1</sup>

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

From: Leslie Hess  
Interim Director of Insurance

Date: August 8, 2017

Re: 2017 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 more detailed bulletins related to the implementation of specific 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 <http://www.azleg.gov>. Please, direct any questions regarding this bulletin to Stephen Briggs, Legislative Liaison at (602) 364-3761.

Arizona's Fifty-third Legislature, First Regular Session, adjourned *sine die* on May 10, 2017 at 7:00 p.m. Except as otherwise noted, all insurance-related legislation has a general effective date of **August 9, 2017**.

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<sup>1</sup> 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 2017

### [Laws 2017, Chapter 88 \(HB 2052\): Limited Line Crop Insurance](#)

*Amends ARS § 20-281:*

- Adds limited line crop insurance to the definition of limited line insurance.

*Amends ARS § 20-286:*

- Adds crop insurance as a limited line of insurance.

*Amends ARS § 20-288:*

- Requires the applicant to take an examination to offer limited line crop insurance.

### [Laws 2017, Chapter 153 \(HB2069\): Insurance Taxes; Installments; Electronic Filing](#)

*Amends ARS § 20-224, 36-2905, and 36-2944.01:*

- Increases the amount of tax liability an insurer must have before being required to pay tax installments from \$2,000 to \$50,000.
- Allows the Director to require insurers and AHCCCS Medicaid contractors to report and pay insurance premium taxes electronically if the director posts to the Department's web site a list of one or more acceptable third-party services through which an insurer must submit reports and payments.

*Amends ARS § 20-225:*

- Makes a penalty inapplicable for a payment of tax or interest that was late due to delays caused by the third-party service.

Becomes effective on January 1, 2018.

### [Laws 2017, Chapter 150 \(HB2070\): Life Settlement Contracts; Broker Licenses](#)

*Amends ARS § 20-3202:*

- Provides that expiration date of broker authority shall coincide with expiration of life line of authority.

### [Laws 2017, Chapter 226 \(HB 2160\): Annuity Transaction; Training Requirements](#)

*Creates ARS § 20-1243.07:*

- Adds producer education requirements for annuities.
- Prohibits a producer from soliciting the sale of an annuity product unless he or she has adequate knowledge of the product to recommend the annuity and is in compliance with the insurer's standards for product training.
- Requires a producer to complete a one-time four credit hour training course that meets the continuing education (CE) requirements outlined under Title 20 before selling, soliciting or negotiating an annuity.
- Requires the length of the training course to be sufficient to qualify for at least four CE credit hours.
- Requires the CE training course to include information on the following topics:
  - Types of annuities and various classifications of annuities;
  - Identification of the parties to an annuity;
  - How product-specific annuity contract features affect consumers;

- The application of income taxation of qualified and nonqualified annuities;
- The primary use of annuities; and
- Appropriate sales practices, replacement requirements and disclosure requirements.
- Allows the completion of substantially similar training course requirements of another state to satisfy the CE training requirements of this state.
- Requires a CE training course provider to register as a CE provider and comply with statutory requirements regarding reporting and certification issuance.
- Requires an insurer to verify that a producer has completed the CE training course before allowing the producer to sell an annuity product.
- Allows an insurer to verify completion of the CE training course by obtaining certificates of completion or reports from the following:
  - Arizona Department of Insurance-sponsored database systems or vendors; or
  - A reliable commercial database vendor that has a reporting arrangement with approved insurance education providers

Becomes effective on January 1, 2018.

**Laws 2017, Chapter 31 (HB 2189): Disability Insurance; Service Coverage**

*Amends ARS §§ 20-1376.09 and 20-1406.09:*

- Excludes “disability income” from the requirement that a disability insurance policy provide coverage for provider services regardless of the provider’s familial relationship to the insured.

**Laws 2017, Chapter 195 (HB 2232): Commercial Insurance; Notice of Cancellation and Refund of Unearned Premium.**

*Amends ARS § 20-1674:*

- Allows the refund of premium, as a result of cancellation, to be mailed separately but within ten days.
- If premium has been financed, a refund shall be returned in accordance with ARS § 20-1416.

**Laws 2017, Chapter 281 (HB 2267): Captive Insurance; Fund**

*Amends ARS § 20-1098.18:*

- Increases the threshold amount above which unencumbered monies in the Fund revert to the State General Fund at the close of the fiscal year from \$100,000 to \$200,000.

**Laws 2017, Chapter 251 (HB 2279): Insurance; Fees; Insurance Producers**

*Amends ARS § 20-265:*

- Requires the Department’s compilation and publication of information comparing automobile insurance premiums to include fees charged at policy inception.

*Amends ARS § 20-381:*

- Modifies the definition of “supplementary rate information” to include a schedule of fees, including membership fees charged by a reciprocal or mutual insurer.

*Amends ARS § 20-465:*

- Eliminates some restrictions on insurers being able to charge fees to an insured.
- Except as to life insurance, annuities, long-term care insurance or Medicare supplement insurance, allows insurance producers to charge a fee or service charge in addition to premium when the fee or service charge does not duplicate or increase any fee or service charge in the insurer’s rate filing disclosed and the insured agrees in writing to the fee or service charge.
- Preserves an insurance producer’s ability to charging and collecting fees the insurer included in its rate filing.
- Modifies the definition of “commercial insurance” (to which ARS § 20-465 does not apply) to exclude insurance maintained by a transportation network company driver under a private passenger automobile insurance policy.
- Excludes from the restrictions of ARS § 20-465 surplus lines brokers transacting surplus lines insurance.

**Laws 2017, Chapter 323 (HB 2372): Public Benefits; Fee Waivers; Requirements**

*Creates ARS § 41-1080.01:*

- Requires an agency to waive any fee charged for an initial license for any individual applicant whose family income does not exceed 200 percent of the Federal Poverty Line guidelines if the individual is applying for that specific license in this state for the first time.

**Laws 2017, Chapter 152 (HB 2386): Insurance; Advertising; Filing Requirements**

*Amends ARS § 20-1110:*

- With respect to Sections 20-826, 20-1018, 20-1057 and 20-1110, exempts the following from classification as advertising matter and sales material that is subject to filing with the Director:
  - Materials designed solely to increase public awareness of an insurer’s name, trademarks, service marks, slogan or brand and not referencing specific products or benefits offered by the insurer;
  - Materials designed for and distributed only to large group benefit administrators and their brokers and that are not intended for distribution to group members;
  - Webpages and other materials published exclusively to guide current members about use of already purchased products;
  - Social media sites and content that do not reference products or benefits offered by the insurer or include a call to action;
  - Web-banner advertisements, paid social media posts and online search engine advertisements not linked to advertising matter and sales material or, if linked to such content, linked only to content that meets one of the following criteria:

- Not referencing specific products offered by the insurer; or
  - Being less than 100 characters;
- Educational materials designed to increase consumer health insurance literacy and not including a call to action or reference to a specific insurer, other than as the source or author of the materials; and
- Other materials and advertisements specified by the Department in rule or by exemption order.
- Defines “insurer” as a disability insurer, group disability insurer, blanket disability insurer, fraternal benefit society, prepaid dental plan organization, hospital service corporation, medical service corporation, dental service corporation, optometric service corporation and health care service organization.
- Defines “call to action” as a statement or other content that invites a consumer to respond by contacting the insurer by phone, letter, email or other electronic communication or attending an event so that the insurer can attempt to sell the individual a product or service.

**Laws 2017, Chapter 326 (HB 2498): Prepaid Legal Insurance; Capital Requirements**

*Amends ARS §20-1097.10:*

- Reduces the unimpaired surplus requirement from \$600,000 to \$50,000 for applicants seeking authorization to sell prepaid legal insurance contracts that only provide legal service plans related to the lawful use of firearms.

**Laws 2017, Chapter 299 (HB 2528): Index Exemptions; Unused Tax Credits**

*Amends ARS § 20-167:*

- Eliminates the domestic stock life or disability insurer premium tax credit.

*Repeals ARS 20-224.04*

Becomes effective January 1, 2018.

**Laws 2017, Chapter 9 (SB 1081): Mutual Holding Company Reorganization**

*Amends Title 20, Chapter 2, Arizona Revised Statutes, by adding Article 8.1; Creates ARS § 20-713.01:*

- Adds Article 8.1 and Section 20-731.01 to provide requirements for mutual holding company reorganizations (See Sections 20-482 through 20-482.07, and 20-731.01)

**Laws 2017, Chapter 70 (SB 1215): Insurance; Definition; Fire Protection Services**

*Amends ARS § 20-398:*

- Adds an exclusion for the wildfire protection services portion of a property insurance policy from being filed and approved by the Director.
- Requires a property insurance policy containing wildfire protection services, including wildfire mitigation and wildfire suppression services, conducted by a private entity, to contain a conspicuously stamped or written notice that states the **wildfire fire protection services** are not subject to review by the Department.

**Laws 2017, Chapter 267 (SB 1331): Workers' Compensation; Rates; Deviations**

*Amends ARS § 20-359:*

- Expands the exception for an insurer filing a deviation with the Director from one deviation to up to six uniform percentage deviations that decrease or increase the statewide portion of the rating organization's rate filing.
  - Requires that if more than one deviation is filed by an insurer, each deviation must be established consistent with underwriting rules that are based on criteria that would lead to a logical distinction of potential risk.

**Laws 2017, Chapter 287 (SB 1332): Workers' Compensation; Unemployment Insurance**

*Amends ARS § 23-722.04; Repeals ARS § 23-941.01; Creates ARS § 23-941.01; Amends ARS § 23-1062:*

- Allows DES or Office of Economic Opportunity to disclose unemployment insurance information to the ICA, Department of Insurance or Attorney General for use by the agency, their agents or their contractors in the investigation and prosecution of workers' compensation fraud.
- Repeals existing requirements of a final settlement agreement in a workers' compensation case.
- Provides new requirements for the final settlement of a workers' compensation claim.
- Effective November 1, 2017, allows, in compliance with the requirements of the Section, an interested party in a workers' compensation claim to:
  - Settle and release all or part of an accepted claim for compensation, benefits, penalties or interest.
  - If the period of disability is terminated by a carrier, negotiate a full and final settlement agreement.

**Laws 2017, Chapter 163 (SB 1341): Foster Children; Motor Vehicle Insurance**

*Amends ARS § 20-1106:*

- Allows a foster child who is at least 16 years old and who has completed a driver training program to contract, notwithstanding the minor's minority status, for motor vehicle liability insurance that satisfies the requirements of Section 28-4009 and that covers the minor.

**Laws 2017, Chapter 190 (SB 1441): Health Insurers; Surprise Billings; Arbitration**

*Amends ARS § 20-3101 and 20-3102; Amends ARS Title 20, Chapter 20 by adding Article 2:*

- Lists general exceptions to qualification under this section. Lists requirements for a bill to qualify as a surprise out-of-network bill for purposes of this section. Allows an enrollee who has received a bill that meets the criteria of this section and who disputes the amount of the bill to seek dispute resolution in accordance with this section, if all of the following apply:

- The enrollee has resolved any health care appeal that the enrollee may have had against the insurer following the insurer's initial adjudication of the claim;
  - The amount of the bill for which the enrollee is responsible after deduction of the enrollee's cost sharing requirements and the insurer's allowable reimbursement is at least \$1,000; and
  - The enrollee received the bill.
- Sets forth the framework for a dispute resolution procedure for surprise bills which includes the following:
  - Requires the enrollee to participate in the teleconference and allows the enrollee the option of participating in the arbitration.
  - Requires the insurer and provider (or their representative) to participate in both the teleconference and the arbitration.
  - Prohibits an enrollee from seeking arbitration of a bill if the enrollee signed certain disclosures set forth in the section and the surprise bill is less or equal to the amount presented in the disclosure.
- Requires the Arizona Department of Insurance to develop a simple, fair, efficient and cost-effective arbitration procedure for bill disputes and specify time frames, standards and other details of the arbitration proceeding.
- Allows the Department to contract with one or more entities to provide qualified arbitrators for the purpose of the arbitration process. Department staff may not serve as arbitrators.
- Allows the enrollee to request arbitration of a bill by submitting a request for arbitration to the Department on a Department-prescribed form (form).
- Requires the Department to notify the insurer and provider of arbitration requests.
- Requires the Department to arrange an informal settlement teleconference within 30 days of receiving request for arbitration. Department is not a participant in teleconference.
- Requires the insurer to provide the other parties with the enrollee's cost sharing requirements under the enrollee's health plan based on the adjudicated claim.
- Requires the parties involved to notify the Department of the results of the teleconference.
- Specifies that if either the insurer or provider or their representative fails to participate in the teleconference, then the other party may notify the Department to immediately initiate arbitration with the nonparticipating party being required to pay the total cost of the arbitration.
- Requires the Department, upon receipt of notice that the dispute has not been settled or that a party has failed to participate in the teleconference, to appoint an arbitrator and to notify the parties of the arbitration and the appointed arbitrator.

- Specifies that the insurer and provider agree to the arbitrator and provides appointment procedure if objection to appointed arbitrator.
- Requires the following to occur before arbitration:
  - The enrollee pays or makes arrangements in writing to pay to the provider the total amount of the enrollee's cost sharing due for the services contained in the bill;
  - The enrollee pays any amount received from the enrollee's insurer as payment for the out-of-network services that were rendered by the provider; and
  - If the insurer pays for out-of-network services directly to a provider, then the insurer that has not remitted its payment for such services remits the amount due to the provider.
- Requires arbitration of any bill to be conducted in the county in which the health care services giving rise to the bill were rendered and allows the arbitration to be conducted telephonically on the agreement of all of the participants.
- Requires the arbitration of the bill to take place with or without the enrollee's participation.
- Requires the arbitrator to determine the amount the provider is entitled to receive as payment for the health care services, laboratory services or durable medical equipment.
- Requires the arbitrator to allow each party to provide information the arbitrator reasonably determines to be relevant in evaluating the bill, including the following:
  - The average contracted amount that the insurer pays for the health care services at issue in the county where the services were performed;
  - The average amount that the provider has contracted to accept for the health care services at issue in the county where the service were performed;
  - The amount that Medicare and Medicaid pay for the health care services at issue;
  - The provider's direct pay rate, if any;
  - Any information that would be evaluated in determining whether a fee is reasonable and not excessive for the health care services at issue, including the usual and customary charges for health care services at issue that were:
    - Performed by a provider in the same or similar specialty; and
    - Provided in the same geographical area; and
  - Any other reliable databases or sources of information on the amount paid for the health care services at issue in the county where the services were performed.
- Requires the arbitration to be conducted within 120 days after the Department's notice of arbitration, except on the agreement of the parties participating in the arbitration.

- Prohibits the arbitration from lasting more than four hours, except on the agreement of the parties participating in the arbitration.
- Requires the arbitrator to issue a final written decision within 10 business days following the arbitration hearing.
- Requires the arbitrator to provide a copy of the decision to the enrollee, the insurer and the provider or its billing company or authorized representative.
- Specifies that all pricing information provided by insurers and providers in connection with the arbitration of a bill is confidential and may not be disclosed by the arbitrator or any other party participating in the arbitration.
- Exempts a claim that is the subject of an arbitration request from being subject to A.R.S. Title 20, Chapter 20, Article 1, pertaining to the timely payment of health care provider claims, while the arbitration is pending.
- Requires an insurer to remit its portion of the payment resulting from the teleconference or the amount awarded by the arbitrator within 30 days of resolution of the claim.
- Stipulates that the enrollee, notwithstanding any informal settlement of the arbitrator's decision with respect to the bill, is responsible for only the amount of the enrollee's cost sharing requirements and any amount received by the enrollee from the enrollee's insurer as payment for out-of-network services that were rendered by the provider.
- Prohibits a provider from issuing, either directly or through its billing company, any additional balance bill to the enrollee related to the health care service, laboratory service or durable medical equipment that was the subject of the teleconference or arbitration.
- Requires the insurer and provider to share the costs of the arbitration equally, unless all parties otherwise agree.
- Specifies that the enrollee is not responsible for any portion of the cost of the arbitration.
- Requires a person to do the following in order to qualify as an arbitrator:
  - Have at least three years of experience in health care services claims; and
  - Comply with any other qualifications established by the Department.
- Requires the Department, in conjunction with the appropriate health care boards, to prescribe a notice that outlines an enrollee's rights to dispute a bill.
- Requires insurers to include the above notice in each explanation of benefits or other similar claim adjudication notice that is:
  - Issued to enrollees; and
  - Involves covered services rendered by a non-contracted provider.
- Requires a provider, their representative or billing company, upon being contacted by the enrollee, to provide written notice as prescribed by the Department to the enrollee, informing them of the dispute resolution process.
- Requires the Department to post information on its website for health care consumers regarding:
  - What constitutes a bill;

- How to try to avoid a bill; and
- How the dispute resolution process may be used to resolve a bill.
- Requires the Department, beginning on or before December 31, 2019 and by each December 31 thereafter, to report on the resolution of disputed bills to the Governor, President of the Senate and Speaker of the House of Representatives, with a copy to the Secretary of State. Specifies the information required in the report.