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REGULATORY BULLETIN 2006-05 [1]

To: Insurance Producers, Surplus Lines Brokers, Insurance Industry Representatives, Insurance Trade Associations, Life & Disability Insurers, Property & Casualty Insurers, and other interested parties

From: Christina Urias
Director of Insurance

Date: July 20, 2006

Re: **2006 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 legislative web site at http://www.azleg.state.az.us. Please direct any questions regarding this bulletin to Karlene Wenz, Executive Assistant for Policy Affairs, 602/364-3471.

Arizona's Forty-seventh Legislature, Second Regular Session, adjourned *sine die* on, June 22, 2006. Except as otherwise noted, all insurance related legislation has a general effective date of September 21, 2006.

[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 2006:

HB 2162: insurance annuities; protection (Ch. 172)

The bill establishes suitability standards for annuities transactions.

Enacts A.R.S. §20-1243:

- Defines "annuity" as "a fixed or variable annuity that is individually solicited, whether the product is classified as an individual or group annuity."
- Defines "recommendation" as "advice provided by an insurance producer, or an insurer if no producer is involved, to an individual consumer that results in a purchase or exchange of an annuity pursuant to the advice."
- References terms defined elsewhere in Title 20.

Enacts A.R.S. §20-1243.01:

- Applies provisions to any "recommendation" as defined above.
- Specifies that the provisions do not affect Title 44, chapters 12 and 13.

Enacts A.R.S. §20-1243.02:

- Provides that unless otherwise specified, the provisions do not apply to: 1) annuities recommendations involving direct response solicitations in which the recommendation is not based on information collected from the consumer, 2) contracts used to fund employee pension or welfare benefit plans, various retirement savings plans established or maintained by the employer, government or church plans, certain deferred compensation plans, liability settlements, or prepaid funeral contracts.

*****NOTE:** The enacted version of HB 2162 contained a typographical error in §20-1243.02 (2)(d), "a nonqualified deferred compensation arrangement established or maintained by an employee or plan sponsor." The proponents of this bill and the legislature intended the word "employee" in this clause to be "employer." The Department and the bill's proponents will pursue a technical correction in the next legislative session. Until then, the Department will treat the reference to "employee" in this clause to reference "employer" as intended.

Enacts A.R.S. §20-1243.03:

- Requires insurance producers or the insurer to have reasonable grounds to believe the recommendation is suitable for the consumer based on the facts disclosed by the consumer regarding the consumer's investments, other insurance products, financial situation and needs.
- Requires insurance producers or the insurer to make reasonable efforts to obtain information about the consumer's tax status, financial status, investment objectives, and other reasonable information prior to the purchase or exchange of an annuity.
- Specifies that the insurance producer or the insurer does not have any obligation to the consumer if the consumer: 1) refuses to provide relevant information requested by the producer or insurer, 2) decides to enter an insurance transaction not based on a recommendation of the producer or insurer, or 3) fails to provide complete or accurate information.
- Requires that an insurer's or a producer's recommendations be reasonable under all of the circumstances actually known to the insurer or the producer at the time of the recommendation.

Enacts A.R.S. §20-1243.04:

- Requires insurers to either establish and maintain a system to achieve compliance with the standards, or to hire a third party, such as a managing general agent or business entity, to establish and maintain the system.
- Specifies that the system shall include written procedures and periodic review of records designed to assist in finding and preventing violations.
- Requires third parties to either adopt a system established by the insurer, or to establish and maintain such a system.
- Requires insurers to ensure the third party is performing the necessary functions by annually obtaining certification from the third party that the third party is performing the required functions, and by periodically selecting third parties contracted for this purpose for a review to determine whether they are performing the required functions.
- States that an insurer that contracts with a third party fulfills its responsibilities by obtaining the certification and conducting the periodic review.
- Specifies that an insurer, managing general agent, or business entity is not required to review all insurance producer solicited transactions, or to include in the system a review of insurance producers' recommendations to consumers on products other than the annuities offered by the insurer, managing general agent, or business entity.
- Requires managing general agents or business entities to promptly provide the certification required above, or to provide a clear statement that they are unable to meet the certification criteria.
- Prohibits a person from providing the certification unless the person is a senior manager with responsibility for the delegated functions, and the person has a reasonable basis for making the certification.
- Allows compliance with the National Association of Securities Dealers conduct rules pertaining to suitability to satisfy the requirements of the section, but preserves the Director's authority to enforce the article.

Enacts A.R.S. §20-1243.05:

- Authorizes the Director to order appropriate corrective action by an insurer for a consumer harmed by the insurer's or the insurer's insurance producer's violation of the article.
- Authorizes the Director to order appropriate corrective action by an insurance producer, or a managing general agent that employs or contracts with an insurance producer to sell annuities, for any consumer harmed by the insurance producer's violation of the article.
- Permits the Director to reduce or eliminate applicable penalties in Title 20 if the above corrective action for the consumer was made promptly after discovery of the violation.

Enacts A.R.S. §20-1243.06:

- Requires insurers, insurance producers, managing general agents and business entities to be able to provide the Director with the records of the information collected from the consumer and used to make the recommendations, for at least five years, or until the next regular examination by the insurance regulator of the pertinent domicile, whichever is later.
- Allows an insurer to keep the records on behalf of the insurance producer.
- Permits records to be maintained in any form or process that accurately reproduces the actual document.

HB 2164: motorist coverage; claims; time limits (Ch. 107)

The legislation changes the statute of limitations for uninsured and underinsured motorist claims.

Amends A.R.S. §12-555:

- States that an insurer is not liable for uninsured motorist coverage benefits unless the person making the claim gives written notice to the insurer of their intent to pursue the claim against the uninsured motorist portion of a policy within three years after the date of the accident that caused the bodily injury.
- Provides for three exceptions to the above, stating that a person may make an uninsured motorist claim within three years after the earliest of the following:
  1) The date the person knew that the tortfeasor (other motorist) was uninsured.
  2) The date the person knows or should have known that the tortfeasor's insurer denied coverage.
  3) The date the person knows or should have known of the insolvency of the tortfeasor's insurer.
- Establishes a separate statute of limitations governing underinsured motorist benefits, requiring the person making the claim to give written notice to the insurer within three years of the date of the accident.
- Also requires the person to file a claim with the underinsured motorist's insurer, or to file an action against the underinsured motorist per A.R. S. §12-542, or within the time prescribed by law in the location where the accident occurred.
- Requires a person making an underinsured motorist claim to do so within three years after the date the person knows or should have known that the other person has insufficient liability insurance.
- Requires insurers to notify claimants in writing that the claimant must request arbitration or file suit pursuant to the term of the insurance contract within three years of providing the written notice of the claim, if the uninsured or underinsured motorist claim is not settled, or the insurer will not be liable.
- Requires claimants to request arbitration or file suit as described above, or the insurer is not liable for uninsured motorist or underinsured motorist coverage benefits.

The changes above apply only to losses that occur on or after the effective date of the act.

HB 2217: accountable health plans; filing rates (Ch. 109)

The bill requires accountable health plans to file with the Department the base premium rates and index rates for coverage sold to small employers.

Amends A.R.S. §20-2311:

- Clarifies that the annual actuarial certification required of each plan must include a review of the records, actuarial assumptions and methods used by the plan to establish base premium rates, index rates and premium rates.
- Requires accountable health plans to annually file their base premium rates and index rates with DOI for informational purposes.
- Requires the Director to make the rate filings available to the public upon request.

*****NOTE:** HB 2217 does not specify when the filing to the Department must take place or if the premium rates should be those in effect as of a specific date. The Department requests insurers to file the base premium rates and the index rates along with the annual actuarial certification required

by 20-2311(E) during the first quarter of each year. The base premium rates and index rates filed should be those in effect as of January 1st of the year in question.

Further, HB 2217 does not authorize the Department to review or institute a rate approval process for the rates filed.

HB 2177: health insurance premium tax credit (Ch. 378)

This bill establishes a health insurance premium subsidy for qualified individuals and small businesses via a premium tax credit for health insurers that reduce health insurance premiums by the amount of the subsidy.

Enacts A.R.S. §20-224.05:

- Permits an annual premium tax credit, beginning January 1, 2007, against the tax owed by health insurers in Arizona in the amount equal to the premium subsidy due a qualified individual or small business, as determined by the Department of Revenue.
- Requires individuals and small businesses to purchase health insurance within 90 days after receiving a certificate of eligibility from the Department of Revenue.
- Limits the amount of annual tax credits allowed to the aggregate amount of the certificates approved by the Department of Revenue.
- Establishes that the amount of the tax credit allowed for coverage issued to an individual shall be the lesser of 50% of the health insurance premium, or, $1,000 for a single person, $500 for a child, and $3,000 for family coverage.
- Establishes that the amount of the tax credit allowed for coverage issued to a small business shall be the lesser of 50% of the health insurance premium, or, $1,000 for a single employee or $3,000 for an employee selecting family coverage.
- Permits a health insurer to carry forward unused tax credits and apply them to future years' premium tax liability for up to 5 years.
- Permits the Department of Insurance to adopt rules as necessary for the administration of this section.
- Specifies that a health insurer claiming this credit is not subject to additional retaliatory tax as a result of this section.
- Defines "family" as any of the following: 1) an adult and the adult's spouse; 2) an adult, the adult's spouse and all unmarried dependent children under age 19, or under age 25 if the child is a full-time student; 3) an adult and the adult's unmarried dependent children under age 19, or under age 25 if the child is a full-time student.
- Defines "health care insurer" as a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, medical service corporation or hospital, medical, dental and optometric service corporation that provides health insurance in Arizona.
- Defines "health insurance" as licensed health care plan or arrangement that pays for or furnishes medical or health care services and that is issued by a health care insurer.
- Specifies that "health insurance" does not include limited benefit coverage as defined in A.R.S. §20-1137.
- Defines "small business" as a business in existence in Arizona for at least one calendar year that has not provided health insurance to its employees for at least 6 months, and that had between 2 and 25 employees during the most recent calendar year.

Enacts A.R.S. §43-210:

- Requires the Department of Revenue to issue certificates of eligibility on a first-come, first-served basis, to persons and small businesses that complete an application prescribed by the Department of Revenue.
- Requires the Department of Revenue to determine whether program funds are still available prior to issuing the certificate, and to ensure that the person has not received a certificate previously.
- Requires recipients to either be a small business or an individual meeting all of the following requirements: earns less than 250% of the federal poverty level; has not had health insurance for at least 6 consecutive months prior to application; is not enrolled in the Arizona Health Care Cost Containment System, Medicare, or any other federal or state health insurance program.
- Requires a health care insurer that enrolls an individual or small business under this section to deduct the amount of the certificate from the premium charged.
- Establishes that the amount of the certificate issued to an individual shall be the lesser of 50% of the health insurance premium, or, $1,000 for a single person, $500 for a child, and $3,000 for family coverage.
- Establishes that the amount of the certificate issued to a small business shall be the lesser of 50% of the health insurance premium, or, $1,000 for a single employee or $3,000 for an employee selecting family coverage.
- Requires a health insurer enrolling an individual or small business pursuant to this section to notify the Department of Revenue of the enrollment and the amount of premium tax credit they intend to claim for the current calendar year no later than the 15th day of the month following the beginning of coverage.
- Prohibits the Department of Revenue from issuing certificates that exceed $5 million in the aggregate per calendar year.
- Establishes validity of the certificates for 30 days after issuance, and if the recipient applies for health insurance within this 30 days, the certificate is valid for one year from the commencement of coverage.
- Requires the Department of Revenue to review the status of certificate recipients 60 days before expiration of coverage, and if a recipient continues to meet the eligibility requirements, requires the Department of Revenue to reissue the certificate.
- Limits recipients to two reissued certificates of eligibility.
- States that this section does not guarantee health insurance coverage to an individual or small business.
- Requires the Department of Revenue to issue the certificates in the name of a specific individual, and specifies that the certificates are nontransferable.
- Establishes the sale, conveyance, transfer or assignment of the certificates to another person, or such attempts, as Class 2 misdemeanors.
- Defines “family,” “health care insurer,” “health insurance,” and “small business” as explained above in the description of A.R.S. § 20-224.05.
- Defines “federal poverty level” as the federal poverty guidelines published annually by the United States Department of Health and Humans Services.

HB 2177 also requires the Department of Insurance and the Department of Revenue to provide information on the premium tax credit to the legislative council, and requires the legislative council to submit an annual report to the president of the senate and the speaker of the house semiannually through December 31, 2008. It also includes a continuing appropriation to the Department of Revenue for administrative costs.

HB 2364: eosinophilic esophagitas disorder (Ch. 233)

This bill requires health insurance that includes a prescription drug benefit to cover the medical food necessary for persons with eosinophilic gastrointestinal disorder.

Enacts A.R.S. §20-826.03:

- Requires a contract offered by a hospital service corporation or medical service corporation that includes a prescription drug benefit to cover amino acid-based formula ordered by a physician if the subscriber is diagnosed with an eosinophilic gastrointestinal disorder, is under the supervision of a licensed physician, and is at risk of a mental or physical impairment without the formula.
- Requires the hospital service corporation or medical service corporation to cover at least 75% of the cost of the formula, and allows a limit of coverage of $20,000 annually.
- Specifies that the above does not apply to limited benefit coverage.

Enacts A.R.S. §20-1057.10:

- Requires a contract or evidence of coverage offered by a health care services organization that includes a prescription drug benefit to cover amino acid-based formula ordered by a physician if the enrollee is diagnosed with an eosinophilic gastrointestinal disorder, is under the supervision of a licensed physician, and is at risk of a mental or physical impairment without the formula.
- Requires the health care services organization to cover at least 75% of the cost of the formula, and allows a limit of coverage of $20,000 annually.
- Specifies that the above does not apply to limited benefit coverage.

Enacts A.R.S. §20-1342.05:

- Requires a disability policy offered by a disability insurer that includes a prescription drug benefit to cover amino acid-based formula ordered by a physician if the insured is diagnosed with an eosinophilic gastrointestinal disorder, is under the supervision of a licensed physician, and is at risk of a mental or physical impairment without the formula.
- Requires the disability insurer to cover at least 75% of the cost of the formula, and allows a limit of coverage of $20,000 annually.
- Specifies that the above does not apply to limited benefit coverage.

Enacts A.R.S. §20-1402.02:

- Requires a group disability policy offered by a group disability insurer that includes a prescription drug benefit to cover amino acid-based formula ordered by a physician if the insured is diagnosed with an eosinophilic gastrointestinal disorder, is under the supervision of a licensed physician, and is at risk of a mental or physical impairment without the formula.
- Requires the group disability insurer to cover at least 75% of the cost of the formula, and allows a limit of coverage of $20,000 annually.
- Specifies that the above does not apply to limited benefit coverage.

Enacts A.R.S. §20-1404.02:

- Requires a policy or contract offered by a blanket disability insurer that includes a prescription drug benefit to cover amino acid-based formula ordered by a physician if the insured is diagnosed with an eosinophilic gastrointestinal disorder, is under the supervision of a licensed physician, and is at risk of a mental or physical impairment without the formula.
- Requires the blanket disability insurer to cover at least 75% of the cost of the formula, and allows a limit of coverage of $20,000 annually.

- Specifies that the above does not apply to limited benefit coverage.

Enacts A.R.S. §20-2332:
- Requires a health benefit plan offered by an accountable health plan includes a prescription drug benefit to cover amino acid-based formula ordered by a physician if the subscriber is diagnosed with an eosinophilic gastrointestinal disorder, is under the supervision of a licensed physician, and is at risk of a mental or physical impairment without the formula.
- Requires the accountable health plan to cover at least 75% of the cost of the formula, and allows a limit of coverage of $20,000 annually.
- Specifies that the above does not apply to limited benefit coverage.

HB 2698: small business health insurance plans (Ch. 229)

The bill permits the sale of health insurance coverage that is not subject to certain state requirements to a subset of small employers the bill refers to as "small businesses."

Enacts A.R.S. §20-2341:
- Defines "health care insurer" as "a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, medical service corporation or hospital and medical service corporation."
- Defines "small business" as "a business that employed at least two but not more than twenty-five persons at any time during the most recent calendar year and that has been uninsured for at least six months."
- Exempts health insurance coverage issued to small businesses as defined above from the following coverage requirements:
  - Minimum 12 chiropractic visits; provider choice
  - Claiming handicapped or disabled children as dependents beyond limiting age
  - Continuity of care for new HCSO enrollees and for those whose physician has been removed from an HCSO's network
  - Contraceptives, if plan covers prescriptions, and outpatient services related to contraceptives
  - Maternity benefits for the natural mother of adopted children
  - Medical foods for some metabolic disorders
  - Medical supplies from vendors reasonably accessible in hours of service and areas of coverage
  - Choice of care from nurse practitioner, if policy covers service within lawful scope of practice for nurse practitioner
  - Occupational and physical therapy provided out of network, despite lack of referral or prescription of specific services
  - Provider choice for covered eye care services as long as service is within scope of practice
  - Medical or surgical care provided by a podiatrist or dentist if service covered if performed by a physician, if service within provider's scope of practice, and if the service is surgical, the provider is on an accredited hospital's staff
  - Process for assuring access to medically necessary formulary and non-formulary drugs; approval of non-formulary drug if formulary drug ineffective or causes adverse reactions; coverage of prescription drugs removed from formulary for minimum of 60 days
  - Psychiatric, drug abuse or alcoholism services whether provided in psychiatric or general hospital
  - Choice of physician or psychologist care if coverage of psychologist services provided

    - Standing referral procedure
    - Surgery performed at any location if policy covers surgery.
- Specifies that § 20-2304(B), which requires insurers that offer more than one plan to small employers to offer all their plans to small employers, does not apply to small business health insurance plans issued under this article. In other words, an insurer that offers a "small business health insurance plan" as defined in this legislation, to qualified small businesses and offers another plan(s) to all small employers, does not have to offer the "small business health insurance plan" to small employers that are not qualified small businesses.

SB 1070: group life insurance; coverage requirement (Ch. 216)

The bill eliminates the participation requirement from the provisions governing several types of group life insurance.

Amends A.R.S. §20-1251.01:

- Removes the requirement that 75% of eligible persons participate in a group life insurance policy from the provision governing credit union groups.

Amends A.R.S. §20-1252:

- Removes the requirement that 75% of eligible persons participate in a group life insurance policy from the provision governing employee groups.

Amends A.R.S. §20-1254:

- Removes the requirement that 75% of eligible persons participate in a group life insurance policy from the provision governing labor union groups.

Amends A.R.S. §20-1255:

- Removes the requirement that 75% of eligible persons participate in a group life insurance policy from the provision governing trustee groups.

Amends A.R.S. §20-1257:

- Removes the requirement that in order for coverage under a group life insurance policy to be extended to dependents, 75% of eligible persons insured under the policy must elect to do so.

SB 1154: chiropractic care: medical necessity review (Ch. 293)

The bill adds permissive language to the statute governing medical necessity review.

Amends A.R.S. §20-2510:

- Permits health care insurers to use a chiropractor licensed in Arizona or another state to conduct a medical necessity review of a direct denial of prior authorization of chiropractic service requested by a chiropractor.

SB 1188: bail bond agent prohibitions (Ch. 255)

The bill provides an exception to the restrictions governing who may be licensed as a bail bond agent or work for a bail bond agent.

Amends A.R.S. §20-340.03:

- Permits persons whose felony conviction has been set aside, or whose civil rights have been restored, to be licensed as bail bond agents or to be employed by bail bond agents, provided the conviction was not for theft or for a crime involving the carrying or possession of a deadly weapon or dangerous instrument.
- Effective May 1, 2006.

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. Any person may view this bulletin on the Department's web site at www.id.state.az.us. For questions about this bulletin, please contact Karlene Wenz, Executive Assistant for Policy Affairs, at 602/364-3471, or kwenz@id.state.az.us.