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REGULATORY BULLETIN 2016-02[1]

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

From: Leslie Hess
Interim Director of Insurance

Date: July 5, 2016

Re: 2016 Arizona Insurance Laws

This regulatory bulletin summarizes the major, newly enacted legislation affecting the Department, its licensees, and insurance consumers. Legislation is presented in bill number order, with House Bills ("HB") described first and Senate Bills ("SB") described last. 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 specific legislation. All interested persons are encouraged to obtain copies of the enacted bills from the Arizona legislative web site at http://www.azleg.gov. Please direct any questions regarding this bulletin to Stephen Briggs, Legislative Liaison, at sbriggs@azinsurance.gov or (602) 364-3761.

In this Bulletin, "**Director**" means the director of the Arizona Department of Insurance, "**Department**" means the Arizona Department of Insurance, and **"ARS"** means Arizona Revised Statutes, unless otherwise noted.

Arizona's Fifty-second Legislature, Second Regular Session, adjourned *sine die* on May 7, 2016, at 5:45 a.m. Except as otherwise noted, the legislation referenced in this bulletin has a general effective date of August 6, 2016.

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[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 2016

HB 2002 (Laws 2016, Chapter 358): Insurance Premium Tax Reduction

Amends ARS § 20-224 relating to insurance premium tax rate by:

- Modifying the nominal insurance premium tax rate[2] as follows:
  - For Calendar Year (CY) 2016 from 1.99% to 1.95%;
  - For CY 2017 from 1.98% to 1.90%;
  - For CY 2018 from 1.95% to 1.85%;
  - For CY 2019 from 1.92% to 1.80%;
  - For CY 2020 from 1.89% to 1.75%; and,
  - For CY 2021 through CY 2025 from 1.86%, 1.83%, 1.80%, 1.77% and 1.74%, respectively, to 1.70%;
- Removing ARS § 20-224.02 (amount by which tax installment payments exceed tax liability) from the list of statutes for which the Director must provide a report to the Joint Legislative Budget Committee and Governor's Office of Strategic Planning and Budgeting;
- Clarifying that the calculation of fire insurance premium is partially based upon percentages of commercial multiple peril non-liability premium and farm-owners' multiple peril premiums.

HB 2129 (Laws 2016, Chapter 180): Uninsured and Underinsured Motorist Coverage

Amends ARS § 20-259.01 by specifying that:

- An insurance producer shall be considered to have taken reasonable care in explaining uninsured and underinsured motorist coverage to an insured if the producer:
  - uses a form approved by the Director in offering and explaining the nature and applicability of uninsured and underinsured motorist coverage, and
  - confirms the selection of limits or rejection of uninsured motorist coverage by a named insured or applicant using a form approved by the Director;
- A named insured's selection of limits or rejection of underinsured motorist coverage on a form approved by the Director constitutes final expression of the named insured's decision to purchase or reject underinsured motorist coverage.

HB 2144 (Laws 2016, Chapter 37): Genetic Testing; Informed Consent

Amends ARS § 20-448.02 to prohibit a person from ordering a genetic test without the written consent of the test subject (or the person legally authorized to consent for the prospective test subject), and to specify that results of a genetic test may be released to any party with the consent of the test subject.

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[2] The "nominal insurance premium tax rate" applies to premiums other than for fire insurance, disability insurance or health care service plans.

HB 2149 (Laws 2016, Chapter 38): Domestic Surplus Lines Insurance; Fees

Amends ARS § 20-401 to:

- Add a definition for "domestic surplus lines insurer," as being an insurer authorized to write surplus lines insurance in Arizona;
- Modify the definition of "unauthorized insurance" to add "surplus lines insurance" as an alternate term, and allows unauthorized insurance to be transacted by a domestic surplus lines insurer.

Amends ARS § 20-407.01 to:

- Allow a domestic insurer that possesses minimum capital and surplus of at least $15 million, pursuant to a resolution by the insurer's board of directors and upon written approval of the Director, to be designated as a domestic surplus lines insurer and considered an unauthorized insurer for the purposes of writing surplus lines insurance;
- Restrict a domestic surplus lines insurer to only writing surplus lines insurance in Arizona and allow the insurer to write surplus lines in any other jurisdiction where the insurer complies with the jurisdiction's requirements;
- Specify that insurance written by a domestic surplus lines insurer is subject to the premium tax on surplus lines and exempt from the premium tax required under Title 20, Chapter 2, Article 1;
- Specify that a domestic surplus lines insurer shall be considered a nonadmitted insurer as referenced in 15 USC § 8206;
- Specify that surplus lines insurance policies issued by a domestic surplus lines insurer in this state are not subject to the protection of the Arizona Property and Casualty Insurance Guaranty Fund, and are exempt from statutory requirements relating to insurance rating and rating plans, policy forms, policy cancellation and nonrenewal in the same manner and extent as for policies from surplus lines insurers domiciled in another state.

Amends ARS § 20-410 to:

- Specify that domestic surplus lines insurers and other insurers transacting surplus lines insurance must include conspicuous verbiage in policies and on any evidence of surplus lines coverage stating that the insureds or claimants shall not be eligible for guaranty fund protection if the insurer becomes insolvent;
- Specify that fees charged by an insurance producer in connection with the transaction of surplus lines insurance are not subject to any premium taxes or stamping fees.

Amends ARS § 20-661, modifying the definition of a Property and Casualty Insurance Guaranty Fund member insurer to exclude insurers that only write surplus lines insurance.

HB 2152 (Laws 2016, Chapter 63): Consumer Lenders

Amends ARS § 6-636 to allow accidental death and dismemberment insurance and disability income protection insurance to be sold to a consumer in connection with a consumer lender loan.

Amends ARS § 6-638 to allow a disability insurance producer to sell and include in the principal amount of the consumer lender loan the insurance premium for accidental death and dismemberment insurance or disability income protection insurance if the insurance policy or certificate is approved by the Department, the purchase of insurance is not a condition of the consumer lender loan, the consumer signs an application for the insurance that is separate from

the consumer lender loan application and the insurance producer does not offer or discuss the insurance until after the consumer lender loan application is completed and the loan is approved.

HB 2188 (Laws 2016, Chapter 51): Insurance; Risk Management; Solvency Assessment (effective from and after December 31, 2016)

Adds Article 15 to Arizona Revised Statutes Title 20, Chapter 2 (ARS §§ 20-491 through 20-491.07). The Act:

Adds ARS §§ 20-491 through 20-491.03 and 20-491.05, requiring each insurer and each insurance group to:

- Maintain a risk management framework that enables the insurer to identify, assess, monitor, manage and report on material, relevant risks;
- Annually, and upon significant risk profile changes, conduct an "Own Risk and Solvency Assessment," or "ORSA," defined as a confidential internal assessment that an insurer or insurance group conducts to assess relevant risks associated with its current business plan and the sufficiency of capital resources to support those risks;
- Submit upon request of the Director an ORSA summary report consistent with the ORSA Guidance Manual, and to make supporting documentation available on examination or on request of the Director.

Adds ARS § 20-491.04, which:

- Exempts from ORSA requirements an insurer that has annual direct written and unaffiliated assumed premium (excluding premium reinsured by the Federal Crop Insurance Corporation or Federal Flood Program) of less than $500 million, and that is part of an insurance group that has annual direct written and unaffiliated assumed premium (excluding FCIC and Federal Flood Program reinsured premium) of less than $1 billion;
- Allows an insurer otherwise subject to ORSA requirements to petition the Director for a waiver;
- Allows the Director to require insurers that are exempt or waived from ORSA requirements to fulfill ORSA requirements based on unique circumstances involving the insurer or group, or if the insurer appears to be financially troubled;
- Requires an ORSA-exempt insurer that becomes subject to ORSA requirements due to changes in premium of the insurer or insurance group to fulfill ORSA requirements within one year of exceeding the premium threshold.

Adds ARS § 20-491.06, establishing that any ORSA-related document, material, summary report or other information disclosed to the Director by an insurer, insurer group, or other insurance regulator is confidential, is not subject to subpoena, public record request or admission as evidence in any private civil action, and may only be disclosed to another regulatory agency, the NAIC or other appropriate entity if the recipient has in place and agrees to follow protocols and procedures to maintain confidentiality and security of information.

Adds ARS § 20-491.07, which subjects an insurer that fails to timely file an ORSA summary report to a $500-per-day penalty, subject to a $100,000 maximum.

HB 2238 (Laws 2016, Chapter 65): Identity Theft Group Policies; Insurance

Adds Article 18 to Arizona Revised Statutes Title 20, Chapter 6 (ARS §§ 20-1694 through 20-1694.02), and provides the Director authority to adopt rules and to be exempt from rulemaking requirements for one year after the effective date of the Act. The Act:

Adds ARS § 20-1694, which adds definitions for "certificate holder," "conditional renewal," "identity theft group insurance," "identity theft insurance" and "stolen identity event," the latter defined as theft, accidental release, publication or misappropriation of information related to personal identification or social security number.

Adds ARS § 20-1694.01, which:

- Permits authorized insurers or unauthorized insurers to issue identity theft group policies in Arizona to cover losses incurred due to a stolen identity event. Before issuing policies, authorized insurers must file and gain approval for the policy to be issued to the group policyholder and certificates to be issued to individual group members in accordance with ARS § 20-398.
- Restricts insurers to issuing group identity theft policies to groups that consist only of natural persons that are either:
    - Businesses that sell products or services designed to prevent or minimize the effects of stolen identity events; or
    - Entities determined by Department rule to consist of members engaged in a common enterprise or social affinity and for whom policy issuance would not be contrary to the best interest of the public.
- Requires insurers to treat all eligible groups of the same class in a like manner.

Adds ARS § 20-1694.02, which:

- Provides that policy premiums can be wholly paid by the policyholder, the group members or jointly by the policyholder and group members;
- Requires that policies be issued or renewed for a period of at least one year, and restricts cancellation to one of the following causes: nonpayment of premium; conviction of a criminal offense for acts increasing the hazard against the insured; discovery of fraud or misrepresentation in obtaining the policy or presenting a claim; discovery of an act, omission or violation of any policy condition subsequent to the current policy period inception that substantially increases the hazard covered under the policy; material changes to the extent or nature of risk substantially increasing the risk of loss beyond that contemplated when the policy was issued or last renewed; or, the Director's determination that continuation of the insurer's present premium volume would jeopardize the insurer's solvency and threaten the interests of policyholders, creditors or the public;
- Provides that coverage for an individual group member is terminated upon termination of the member's affiliation with the group policyholder;
- Specifies that an act or omission by a group member does not constitute a basis for cancelling the entire group policy;
- Requires insurers to set forth specific reasons for cancellation, nonrenewal or conditional renewal of a group policy or any certificate issued under the policy, and that cancellation, nonrenewal or conditional renewal does not become effective until at least 20 days after

delivery of a written cancellation notice in the event of nonpayment, or at least 45 days for any other cause;

- Allows group policyholders to cancel policies for any reason upon 30 days' written notice to the insurer. Group policyholders must provide 30 days' written notice to members unless a similar policy has been acquired by the policyholder without a lapse in coverage;
- Requires an insurer to cover identity theft losses on canceled, nonrenewed or conditionally renewed policies/certificates for losses occurring before policy/certificate cancellation/nonrenewal/conditional renewal.

HB 2239 (Laws 2016, Chapter 360): Premium Tax Credit; Reciprocal Insurer

Amends ARS §20-224.03 **retroactive to taxable years beginning from and after December 31, 2015**, by removing the sunset date for the credit (causing credit eligibility to be applied under ARS § 41-1525), and by regarding a reciprocal insurer and its attorney-in-fact as the same entity for the purposes of calculating the premium tax credit for new employment.

HB 2264 (Laws 2016, Chapter 42): Insurance; Prescription Eye Drops; Refills

Adds identical provisions as *ARS §§ 20-841.11* (health corporation), *20-1057.16* (health care service organization), *20-1376.08* (disability insurer), and *20-1406.08* (group or blanket disability insurer). *[Cited sections of statute are subject to renumbering.]* The Act holds that **beginning January 1, 2018**, a health corporation, health care service organization, disability insurer or a group or blanket disability insurer is prohibited from denying insurance coverage for refills of prescription eye drops that treat either glaucoma or ocular hypertension if all of the following apply:

- For a 30 day supply, the prescription refill is requested between 23 and 30 days after the original date of distribution or most recent refill date;
- For a 60 day supply, the prescription refill is requested between 45 and 60 days after the original date of distribution or most recent refill date;
- For a 90 day supply, the prescription refill is requested between 68 and 90 days after the original date of distribution or most recent refill date;
- The prescription eye drops are a covered benefit under the subscriber's health care provider;
- The health care provider indicates on the original prescription that additional quantities of the prescription are needed;
- The requested refill does not exceed the number of additional quantities subscribed.

Coverage may be limited to the remainder of the dosage initially approved for coverage.

HB 2306 (Laws 2016, Chapter 100): Healthcare Providers, Family Members, Coverage

Adds identical provisions in *ARS §§ 20-841.11* (health corporation), *20-1057.16* (health care service organization), *20-1376.08* (disability insurer), and *20-1406.08* (group or blanket disability insurer). *[Cited sections of statute are subject to renumbering.]* Requires policies, contracts, and evidence of coverage issued, delivered or renewed **on or after July 1, 2017**, to provide coverage for in-network, lawful health care services provided by a health care provider to a subscriber, enrollee or insured, regardless of the familial relationship of the health care provider to the

subscriber, enrollee or insured, if the health care services would be covered were they provided to a subscriber, enrollee or insured who was not related to the health care provider.

HB 2342 (Laws 2016, Chapter 101): Insurance; Licensed Entities

Amends ARS § 20-229 by replacing the requirement for a policy or countersignature endorsement to be signed by a licensed producer or bail bond agent with a requirement for the name of the licensed producer to be identified on the policy declaration page or endorsement.

Amends ARS § 20-286 by requiring an insurance licensee to notify the Director of a change in e-mail address within 30 days.

Amends ARS § 20-1693 by specifying that a portable electronics vendor is a business entity.

Repeals ARS § 20-2405, which had required policies issued to risk retention groups to include a countersignature, which the Act eliminated from ARS § 20-229.

HB 2445 (Laws 2016, Chapter 363: Motor Vehicle Insurance; Nonrenewal

Amends ARS § 20-1631 to allow an insurer to refuse to renew a motor vehicle insurance policy for any reason other than the location of residence, age, race, color, religion, sex, national origin or ancestry of an insured except that an insurer may refuse to renew a policy if the named insured establishes primary residency outside Arizona. Prior to the Act, an insurer could only "fail to renew" a policy for specific reasons identified in the statute.

The section was also amended to allow an insurer to transfer any of its policies to an affiliated insurer, and to prohibit an insurer or insurance producer from asking an applicant for motor vehicle insurance whether the applicant or any person in the applicant's household was nonrenewed by an insurer.

Amends ARS § 20-1632 by requiring an insurer to mail a notice of nonrenewal for reasons other than nonpayment of the premium at least 45 days prior to the effective date of nonrenewal; requiring any such nonrenewal notice to specify facts underlying the nonrenewal reason; and, allowing an insurer to refund unearned premium by electronic means.

Amends ARS § 20-1633, allowing a person who believes nonrenewal was unlawful to file a written objection with the Director.

HB 2553 (Laws 2016, Chapter 201: Insurance; Risk Retention Groups

Amends ARS § 20-2402, as follows:

- Requires a board of directors of a risk retention group ("RRG") to consist of a majority of individuals independent of the RRG; requires the attorney-in-fact of a reciprocal RRG to be independent from the RRG; and, as permitted by law, requires a reciprocal RRG's service providers to contract with the RRG and not the attorney-in-fact;
- Requires a RRG's board of directors to affirmatively determine a board member has no material relationship with the RRG to qualify as independent, and, to disclose determinations of director independence to the RRG's domestic regulator at least annually;
- Provides that a RRG's direct or indirect owner or subscriber, or an officer, director or employee of an owner and insured of the RRG, is regarded as independent unless another position constitutes a material relationship;

- Restricts to five years the term of a RRG's "material service provider contract" (with a contract cost at or greater than the greater of 5% of the RRG's annual gross premium or 2% of the RRG's surplus), and requires board approval for any contract or its renewal;
- Allows the board of directors to terminate any service provider, audit, or actuarial contract after providing notice set forth in the contract;
- Requires the board of directors to notify the Director at least 30 days in advance of executing a contract that would create a material relationship with a service provider, and prevents the board of directors from executing the contract if disapproved by the Director;
- Requires the board of directors to adopt in its plan of operation a written policy that requires the board of directors to:
  - Ensure all of the RRG owners or insureds receive evidence of ownership interest;
  - Develop a set of governance standards;
  - Oversee the evaluation of the RRG's management;
  - Approve the amount to be paid for all material services providers;
  - For the RRG's officers and service providers, annually review and approve the compensation goals and objectives, assess performance, and determine whether to continue engagement;
- Requires each RRG to maintain an audit committee composed of at least three independent board members unless the Director determines it impracticable and the RRG's board of director can fulfill the audit committee responsibilities; allows a non-independent board member invited by the members to participate in audit committee activities but not as a committee member;
- Requires the audit committee to have a written charter that defines the committee's purpose, which shall include all the following:
  - Helping oversee the integrity of financial statements, legal and regulatory requirements, as well as qualifications, independence and performance of the independent auditor and actuary;
  - Discussing annual and quarterly audited financial statements with management, and its independent auditor;
  - Discussing policies with respect to risk assessment and management;
  - Meeting separately and periodically, either directly or indirectly, with management and independent auditors;
  - Reviewing any audit problem with the independent auditor;
  - Establishing clear hiring policies involving employees or former employees of the independent auditor;
  - Requiring the external auditor to rotate both the lead/coordinating audit partner who has primary responsibility for the RRG audit and the audit partner responsible for reviewing the RRG audit, so that neither individual performs auditing and audit-review responsibilities for the RRG for more than five consecutive fiscal years;
- Requires a RRG to make the following information available electronically, and upon request to members and insureds:
  - The process by which the board of directors are elected;

  - Board director qualification standards, responsibilities, access to management and independent advisors, and compensation;
  - Information about board director orientation and continuing education;
  - The policies and procedures for management succession;
  - The policies and procedures for annual performance evaluation of the board;
- Requires the board of directors to adopt and disclose a code of business conduct that:
  - Addresses conflicts of interest, the Corporate Opportunity Doctrine under the state of domicile, confidentiality, fair dealing, protection and proper use of the RRG's assets, and compliance with applicable laws, rules and regulations;
  - Requires reporting illegal or unethical behavior affecting the RRG's operation;
- Requires a RRG captive manager, president or chief executive officer to notify the domestic regulator of any material noncompliance with any of the RRG's governance standards;
- Defines "board director," "board of directors," "board," "material relationship" and "service providers."

Adds ARS § 20-2414, which requires the Director, beginning on or before December 31, 2017, to annually report the following to the President of the Senate and the Speaker of the House of Representatives:

- The number of RRGs licensed in Arizona since the effective date of this Act;
- Any regulatory action taken against a RRG for noncompliance with statute;
- The number of private passenger automobile insurance policies that were nonrenewed during the previous calendar year;
- The number of private passenger automobile insurance policies in force at the end of the previous calendar year;
- The number of private passenger automobile insurance policies in force within Arizona's assigned risk plan at the end of the previous calendar year.

HB 2692 (Laws 2016, Chapter 303): Insurance; Pharmacy Benefits; Audits

Adds Chapter 25, Article 1 to Arizona Revised Statutes Title 20, applying to all contracts entered into, amended, extended or renewed, and audits initiated **from and after December 31, 2016**, as follows:

Adds ARS § 20-3321, which defines "Auditing Entity," "Clerical Errors," "Desktop Audit," "In-Pharmacy Audit," "Insurer," and "Pharmacy Benefits Manager."

Adds ARS § 20-3322, establishing procedures and requirements that apply to an auditing entity's audit of a pharmacy, which includes:

- Requiring an auditing entity conducting an in-pharmacy audit to give the pharmacy at least 14 days' written notice; refraining from conducting an audit during the first five days of the month unless the pharmacy otherwise consents; and, providing the pharmacy a list of items to be audited that includes prescription numbers or a date range;
- Limiting audits to claims adjudicated by the pharmacy benefits manager within the preceding two years;

- Requiring audits that involve clinical or professional judgment to be conducted by or in consultation with a pharmacist;
- Allowing a pharmacy to validate its records using hospital or other authorized practitioner records;
- Requiring each pharmacy to be audited under the same standards and parameters as other similarly situated pharmacies in Arizona;
- Restricting an auditing entity's finding that a pharmacy was overpaid or underpaid to actual, and not projected, overpayment or underpayment, unless otherwise required by federal or state law; and, requiring exclusion of a dispensing fee amount from the calculation of an overpayment unless the patient or designee did not receive the prescription, the prescriber denied authorization, the prescription was dispensed in error or the overpayment was based solely on an extra dispensing fee;
- Prohibiting an audit entity from recouping monies from a pharmacy for clerical errors identified in the audit, and prohibiting interest from accruing during the audit period.

Adds ARS § 20-3323, which:

- Requires the auditing entity to deliver a preliminary audit report to the pharmacy within 60 days of completion;
- Allows a pharmacy at least 30 days after receiving the preliminary report to address discrepancies;
- Requires the auditing entity to make available to network pharmacies, and to include in all contracts between a pharmacy benefits manager and a pharmacy, a written appeals process that allows a pharmacy at least 30 days from delivery of the final audit findings to appeal an unfavorable audit finding;
- Requires the auditing entity to provide a network pharmacy the telephone number for the person responsible for processing appeals for the pharmacy benefits manager;
- Requires the auditing entity to deliver a final audit report to the pharmacy within 90 days after receiving the preliminary audit report or final appeal, whichever is later;
- Prevents chargebacks, recoupment or other penalties from being assessed until the appeals process has been exhausted and the final audit report has been issued;
- Prevents audit information from being shared with any entity other than the insurer on whose behalf the audit was conducted, unless required by federal or state law, and restricts access to a pharmacy's previously conducted audits to the auditing entity that conducted those audits.

Adds ARS § 20-3324, which:

- Restricts Act applicability to audits conducted for pharmacies located in Arizona;
- Excludes from Act applicability claims reviews initiated within three days after a claim is submitted if no chargeback or recoupment is demanded;
- Excludes from Act applicability an audit arising from fraudulent activity or intentional and willful misrepresentation evidenced by physical review, review of claims data, statements or other investigative methods, for which the audit reason is documented and available upon request.

HB 2708 (Laws 2016, Chapter 125): Appropriating Monies; Revenue Budget Reconciliation

Section 7 of the Act provides session law that disallows the Director from revising fees or assessments in fiscal year 2017 for the purpose of meeting the requirement to recover at least 95% but not more than 110% of the Department's appropriated budget.

SB 1363 (Laws 2016, Chapter 278): Insurance Coverage; Telemedicine

Identically modifies *ARS §§ 20-841.09, 20-1057.13, 20-1376.05 and 20-1406.05* to require that insurance contracts issued, delivered or renewed **on or after January 1, 2018**, include pulmonology in the list of health care services for which delivery via telemedicine will be covered, and to expand telemedicine insurance coverage requirements to all areas within Arizona rather than only in rural regions.

SB 1441 (Laws 2016, Chapter 280): Long-Term Care; Rates; Premiums

In session law enacted with an emergency clause and signed into law **May 17, 2016**, requires the Department to adopt rules relating to long-term care insurance that substantially conform to those adopted in model regulations adopted by the National Association of Insurance Commissioners, including the 2014 revisions, and exempts the Department from rulemaking requirements for one year after the effective date of the Act except that the Department must provide public notice and an opportunity for public comment on the proposed rules at least 60 days before the rules are amended or adopted.

SB 1494 (Laws 2016, Chapter 113): Insurance; Prohibited Inducements; Exceptions

Adds identical provisions in ARS §§ 20-449, 20-451 and 20-452 allowing an insurer to have an independent third party obtain customer feedback on the insurer's products or services, and to offer each customer up to $200 for providing feedback.

SB 1516 (Laws 2016, Chapter 79): Campaign Contributions and Expenses

Repeals several sections of ARS §§ 16-901 through 16-925;

Adds a new ARS § 16-901, which in part, provides definitions for "exclusive insurance contract," and "insurance producer" as they relate to ARS Title 16, Chapter 6;

Adds a new § 16-916, which allows an insurer or a separate segregated fund that the insurer registers as a political action committee to solicit political contributions to the separate segregated fund from an insurance producer's employees, members, executives, stockholders and retirees and their families.