



Office of the Director

Arizona Department of Insurance and Financial Institutions

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REGULATORY BULLETIN 2020-05¹

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

From: Evan G. Daniels
Director of Insurance and Financial Institutions

Date: August 17, 2020

Re: 2020 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 or stephen.briggs@difi.az.gov.

Arizona's Fifty-fourth Legislature, Second Regular Session, adjourned *sine die* on May 26, 2020. Except as otherwise noted, all legislation has a general effective date of **August 25, 2020**.

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 2020

Laws 2020, Chapter 4 (S1523): Mental Health Omnibus

Amends ARS § 20-157.01, and creates ARS §§ 1138, 3501, 3502, 3503, 3504, and 3505 to require an insurer comply with certain reporting requirements and compliance standards consistent with mental health parity provisions. It requires that a member's health insurance identification card issued by a hospital and medical service corporation, health care service organization, or disability insurer display the letters "AZDOI" and a customer service telephone number for the health care insurer itself.

Section 3 defines classification of benefits, health care insurer, health plan, Mental Health Parity and Addition Equity Act, product network type and treatment limits. It further instructs a health care insurer to comply with the Act. The Director must specify a date after January 1, 2022 by which each health care insurer must submit a report to DOI for each insured product network type the insurer issues. The specified report must do the following:

- A) Describe the process that is used to develop the medical necessity criteria for mental health and substance use disorder benefits and the process to develop criteria for medical and surgical benefits;
- B) Identify nonquantitative treatment limits that are applied to mental health and substance use disorder benefits and to medical and surgical benefits within each benefit classification; and
- C) Demonstrate that for any nonquantitative treatment limit applied to mental health and substance use disorder benefits, any factor used in applying the limit is comparable to a factor used in applying a nonquantitative treatment limit for medical and surgical benefits in the same classification.

Insurers are required to file the above report every three years. In the years when a report is not required, the health insurer must file a summary of changes made to medical necessity criteria and nonquantitative treatment limits and a written attestation that states that the health care insurer is compliant with the Act. The department may require an insurer to answer additional questions related to the summary of changes or may request additional data from an insurer that is necessary to verify compliance with the Act. Three years after the original required report is submitted, a health insurer must either file an updated report or resubmit the currently filed report if the insurer also files a written attestation that there have been no changes. The department may not require an additional filing or report from a health care insurer if the insurer has provided the required information in an existing filing or report. The department may establish by rule the terms regarding required resubmittal of information. All reports and documents provided by an insurer to the Director are confidential.

Separately, the DOI must analyze insurer data to evaluate health plan compliance with financial requirements and treatment limits as part of its review of forms and rates, and may also require additional information from an insurer to determine compliance. The DOI may analyze an insurer's large group plans through a separate, consolidated report.

A health plan is generally prohibited from applying a financial requirement or quantitative treatment limit to mental health and substance use disorder benefits that is more restrictive than the financial requirement or quantitative treatment limit applied to medical and surgical benefits in the same classification. However, health plans may incorporate a benefit design using multi-tiered prescription drug benefits, multiple provider network tiers, or sub-classification of office visits and all other outpatient services, so long as the financial requirement or quantitative treatment limit applied to mental health or substance use disorder benefits within that tier or sub-classification is not more restrictive than the financial requirement or quantitative treatment limit applied to medical and surgical benefits in the same tier or sub-classification. ,

By January 1, 2021 the department shall provide the following information on its website:

- A) Information on the Act and the mental health parity requirements that apply to insurers;
- B) A step-by-step guide with supporting information that explains how consumers can file and appeal or complaint with the department; and
- C) A link to the U.S. Department of Labor website or a related site that provides information on consumer appeals or complaints.

By January 1, 2023, the department must post a summary of the reports filed by insurers, including conclusions about industry compliance with the Act. This information must not contain proprietary or confidential information of an insurer or allow a person to determine the identity of an insurer. The department's annual report must include a summary of all stakeholder outreach and regulatory activity.

An insurer that issues a health plan that includes mental health or substance use disorder benefits must not deny a claim for mental health or substance use disorder benefits for a minor solely on the grounds that the service was provided in an educational setting or ordered by a court if the service was provided by an in-network or out-of-network provider as allowed by the health plan that covers the insured. However, an insurer may reject a claim or refuse reimbursement for a service provided by an out-of-network provider. An insurer may require that mental health or substance use disorder service provided in an educational setting be provided in an appropriate location and in a manner compliant with applicable laws, including privacy and parental consent laws. Claims for covered services that are provided by an out-of-network provider and that are not covered by an insured's health plan must be paid from the Children's Behavioral Health Service Fund.

Finally, the bill creates the Mental Health Parity Advisory Committee under Title 20, to advise the Directors of the Department of Insurance and Financial Institutions (DIFI) and the Director of the Department of Health Services (DHS). It outlines the requirements for members appointed to the Committee and allows the Director of AHCCCS to serve in an advisory capacity at the request of the Director of DIFI or the Director of DHS. This committee ends on July 1, 2028.

Laws 2020, Chapter 9 (SB1038): Insurance Policies; Transfers; Affiliated Insurers

Amends ARS §§ 20-1652 and 20-1654 by stating that nonrenewal does not include the issuance and delivery of a new policy within the same insurer or an insurer under the same ownership or management as the original insurer. Allows an insurer to transfer any of its policies to an affiliated insurer, except that an insurer is prohibited from transferring a policyholder on the basis of the policyholder's location of residence, age, race, color, religion, sex, national origin or ancestry. The occurrence of a transfer, this insurer is not allowed to apply a new unrestricted 60-day period for cancellation or nonrenewal.

Laws 2020, Chapter 37 (SB1293): DOI; DFI; Omnibus

Amends multiple ARS Titles including 6, 9, 11, 12, 13, 15, 20, 23, 25, 28, 29, 33, 34, 35, 36, 38, 41, 42, 43, 44, and 48 making numerous technical and conforming changes. Establishes the Department of Insurance and Financial Institutions to be known as DIFI. Instructs the director of DIFI (Director) to appoint a deputy director of the financial institutions division of DIFI; an assistant director to perform the duties of the deputy director of the financial institutions division; and a deputy director of the insurance division of DIFI. The deputy directors of the financial institutions division and insurance division serve at the pleasure of the Director and report directly to the Director. The Director must have business experience and be well versed in financial institution matters, in addition to other prescribed requirements.

Requires DIFI to prepare detailed billing statements that provide reasonable specificity of the expenses and time billed in connection with an examination for an adjuster, producer or broker and that cite the rule or statute that authorizes the fees. Directs the party being examined to pay the costs allowed by this Act if the adjuster, producer or broker is found to have violated statute. Beginning January 1, 2021, a person being examined is only responsible for the direct costs of an examination that are supported by a billing statement that complies with statute. The guidelines for insurers on home health services used by the Director must include all statutorily prescribed requirements.

The Director must provide an insurer with a copy of any document related to insurer claims that the Director receives and believes supports a violation of statute or that justifies any regulatory or other action against the insurer. Maintains that a disclosure of such documents is not a waiver of any applicable privilege or claim of confidentiality in the disclosed document.

Requires the Director provide copies to an insurer being examined of all documents and other information that the Director intends to rely on as evidence of an alleged violation of statute or justifies an action against the insurer to allow them to review the findings and make any objections. It stipulates that such a disclosure is not a waiver of any applicable privilege or claim of confidentiality in the disclosed documents or other information.

Requires the Director to provide the captive insurer with a copy of any document they believe supports a violation of statute or that justifies any regulatory or other action against the captive insurer. Specifies that such a disclosure is not a waiver of any applicable privilege or claim of confidentiality in the document that was disclosed.

Requires the Director to provide copies to an insurer of all documents that the Director believes supports a violation of statute or that justify a regulatory or other action against the insurer.

Stipulates that such a disclosure is not a waiver of any applicable privilege or claim of confidentiality in the disclosed documents.

Repeals the insurance advisory board established in ARS § 20-400.10 and the continuing education review committee established in ARS § 20-2905.

A regulated person who is being inspected or audited is only responsible for the direct and reasonable costs of the inspection or audit and is entitled to receive a detailed billing statement and requires a detailed billing statement to provide reasonable specificity of the inspection or audit fees imposed and cite the rule or statute that authorizes the fees being charged. The department is required to adopt rules to establish fees relating to direct and indirect costs in connection with examinations.

The manner in which the fees in ARS § 20-167 are adjusted are changed and are now determined by the director.

Directs the Director to appoint an individual to operate both the fraud unit and the automobile theft authority. The requirement for the Director to revise the assessment amount every year is removed as well. The monies appropriated to DIFI for the fraud unit must be included as a separate line item in the general appropriations act and used exclusively to operate the fraud unit.

An administrator may collect charges according to the written agreement between the administrator and insurer. It provides that the written agreement must outline the applicable standards for the permissible collection of charge by the administrator. It also prohibits an administrator from collecting charges that remain unpaid on an account that has been inactive for more than 12 months, unless the administrator is licensed as a collection agency. A person licensed to act as an administrator for an insurer and that collects charges pursuant to Title 32 are exempt from the collection agency requirements outlined in statute.

Contains a retroactivity clause of July 1, 2020.

[Laws 2020, Chapter 38 \(SB1294\)](#): Insurance and Financial Institutions; Continuation

Creates ARS § 41-3025.02 that continues the Department of Insurance and Financial Institutions (DIFI) until July 1, 2025. If the voters approve a constitutional amendment repealing the authority for the Department of Insurance, the Department terminates on July 1, 2025 and Title 6, Title 20, Title 32, Chapters 9 and 36, Title 41, Chapter 31 and Title 44, Chapter 2.1 and this section are repealed on January 1, 2026. The law contains a retroactivity clause of July 1, 2020.

[Laws 2020, Chapter 42 \(SB1331\)](#): Self-Insured Employers; Deviation Continuation

Continues the deviation rate found in Sec. 22, for calculating taxes or assessments paid by self-insured employers, for two more years. [Laws 2011, Chapter 157](#) established a 10% deviation rate for calculating any tax or assessment to be paid by an authorized self-insured employer, including workers' compensation pools, for calendar years 2013, 2014, 2015. [Laws 2014, Chapter 35](#) continued the deviation rate through calendar year 2020.

Laws 2020, Chapter 61 (SB1040): Insurers; Notice; Methods of Delivery

Creates ARS § 20-123 and amends ARS §§ 20-117, 20-239, 20-240, 20-259.01, 20-367.01, 20-866, 20-1108, 20-1241.03, 20-1241.05, 20-1631, 20-1632, 20-1632.01, 20-1653, 20-1654, 20-1656, 20-1674, 20-1676, 20-1677, 20-1678, 20-1694.02, 20-2110, 20-2209, 20-2533, 20-2534, 20-2535, 20-2536, 20-2537, 20-2609, and 20-2637 to allow an insurer to send certain notices, documents or correspondence by means other than mail consistent with the requirements of ARS § 20-239. It is important that insurers read these laws in conjunction with one another in order to glean the full ramifications of these changes.

ARS §§ 20-117 and 20-123 apply to all types of insurance where the word “send, sending or sent” is used, including health insurance. While the scope of ARS § 20-239(P) only applies to life, property and casualty insurance, the definition of “sent” in ARS § 20-117 states that any notice, document or correspondence that is sent by electronic means to an Arizona insured must comply with ARS § 20-239. If warranted, the Department may issue a separate bulletin at a later date to further clarify the impact on various lines of insurance.

Generally, the new law defines send, sending, or sent as delivery by the US. Mail, personal delivery, fax or electronic means. If a notice or correspondence is sent by mail or electronic means, the insurer must send the notice or correspondence to the recipient's last known mailing address or email address. As a result, communication, notice or correspondence may now be *sent* rather than mailed.

However, an insurer must still comply with the requirement to mail a notice if an insured refuses to accept receipt of notices electronically, or if the electronic notice delivered is rejected or returned to the insurer, or if the insurer becomes aware that the email address is no longer valid. When a notice is mailed, insurers must continue to meet the mailing requirements for the specified type of insurance.

ARS § 20-259.01 requires an insurer to offer UM/UIM coverage on a form approved by the director. SB 1040 removed the requirement that the offer form must be provided at the time of the application.

SB 1040 also amends ARS § 20-2533 to eliminate the requirement that a health care insurer mail a copy of a healthcare appeals packet within 5 days after the date an appeal is initiated or upon request of the member or treating provider. Instead, a health care insurer shall provide access to a copy of the information packet on its website.

Laws 2020, Chapter 62 (SB 1041): Travel Insurance

Amends ARS §§ 20-281 and 20-3503 and creates ARS §§ 20-3501, 20-3502, 20-3504, 20-3505, 20-3506, 20-3507, 20-3508 and states that this act may be cited as the “Travel Insurance Model Act”. This law contains a purpose and applicability clause and defines applicable terms.

20-3504 Requires a travel insurer to pay premium tax on travel insurance premiums paid by 1) an individual primary policy holder who is an Arizona resident; 2) a primary certificate holder who is an Arizona resident and who elects coverage under a group travel insurance policy; and 3) a blanket travel insurance policy holder that meets certain specified conditions. It further requires a travel insurer to document the state of residence or principal place of business of the policy or certificate holder and report as premium only the amount allocable to travel insurance and not the amounts received for travel assistance services or cancellation fee waivers.

20-3505 Allows a travel protection plan to be offered for one price for the combined features of travel insurance, travel assistance services and cancellation fee waivers if the plan, at or before the time of purchase, provides information and opportunity for the consumer to obtain additional information regarding the features and pricing of each. The fulfillment materials that describe and delineate the combined features must include the travel insurance disclosures and contact information for persons providing travel assistance services and cancellation fee waivers.

20-3506 Travel protection plans can be offered for one price for the combined features the plan offers in this state if certain conditions are met. Anyone offering travel insurance in Arizona is subject to the unfair trade practice and fraud statutes of the state. Offering or selling travel insurance that could never result in any claim payment for any insured under the policy is an unfair trade practice under this law. Any documents provided to the consumer before the purchase of a travel insurance policy, including sales advertising and marketing materials must be consistent with the policy and rate filings. Any policies that contain an exclusion for preexisting conditions shall provide information and an opportunity to learn more about the exclusion before the time of purchase and in the coverage's fulfillment materials. Unless a covered trip has started or the insured has filed a claim under the policy, a travel policy may be canceled for a full refund within 15 days if the travel protection plans fulfillment materials were delivered by postal mail or 10 days if delivered by means other than postal mail. The policy shall disclose whether the travel insurance is primary or secondary to other applicable coverage. If the travel policy is marketed directly on an insurer's website or through an aggregator website, it is not a violation of unfair trade practice if an accurate summary or description of the coverage is provided and the full provisions of the policy are available through electronic means. A person may not offer a travel policy by using a negative or opt out option that requires a consumer to take an affirmative action to deselect coverage, such as unchecking a box on an electronic form, when the consumer purchases a trip. It is an unfair trade practice to market blanket travel insurance coverage as free. If a consumer's destination requires insurance coverage, it is not an unfair trade practice to require a consumer to purchase coverage or obtain and provide proof of coverage that meets the destination's requirements before departure.

20-3507 Prohibits a person from acting as a travel administrator unless the person is either a licensed property and casualty insurance producer for activities allowed under that license or holds a valid managing general agent license in this state. A travel administrator and its employees are exempt from the adjuster licensing requirements for the travel insurance it administers. An insurer that underwrites travel insurance is responsible for the acts of the travel administrator and for ensuring that all relevant books and records are maintained by the travel administrator and made available to the director on request.

20-3508 Travel insurance is classified as an inland marine line of insurance for purposes of rate and forms. However, travel insurance that provides coverage for sickness, accident, disability or death occurring during travel may be filed under an accident and health line of insurance. The eligibility and underwriting standards may be developed based on Plans that are designed for individual or identified marketing or distribution channels, if those standards also met the state's underwriting standards for inland marine.

Laws 2020, Chapter 65 (SB 1062): Insurance Transactions; Discrimination; Exceptions

Amends ARS § 20-450 to allow the payment of implementation credits an insurer makes to offset expenses that a group policyholder or employer incurs when the insurer changes new or existing group coverage to either 1) include implementation credits in the premium and then reimburse the policyholder; or 2) pay for the implementation credits and provide appropriate disclosure in the group policy. The life insurer must disclose to the policy holder whether implementation credits were included in the premium. The list of products and services is not prohibited from including those that enhance the financial wellness of the insured. Clarifies that the term life insurance includes disability income and supplemental benefit policies.

Laws 2020, Chapter 67 (SB 1090): Insurance Adjusters; Claims Certificate

Amends ARS §§ 20-321 and 20-321.01 by excluding from the definition of an adjuster an employee of a third-party administrator or self-insured employer who adjusts, investigates or negotiates settlement of only workers' compensations claims. It also removes the requirement for an adjuster license applicant to take and pass a Department examination if the applicant holds a certification from a national or state-based claims association whose certification program consists of at least 40 hours of pre-examination course work and a proctored examination of sufficient length to adequately determine the competency of the applicant and who requires at least 24 hours of continuing education on a biennial basis for certification renewals.

Laws 2020, Chapter 68 (SB 1091): Insurance Producer Licensing; Surrender; Application

Amends ARS § 20-289 to allow a person who surrenders a line of authority or a license to obtain the same authority or licensee if the person complies with the requirements that apply to a person who has not previously held the authority or license. Prior to passage of this law, a person was prohibited from reapplying for the same license or authority for one year from the date of surrender.

Laws 2020, Chapter 80 (SB 1397): Insurance; Preexisting Condition Exclusions; Prohibition

Creates ARS § 20-123 which **CONDITIONALLY ENACTS** this Act based on the court of competent jurisdiction ruling that the PPACA is unconstitutional and the judgment of that ruling becomes final and definitive by June 30, 2023. It requires health care insurers who offer individual health plans to provide guaranteed availability of coverage to eligible individuals and prohibits them from:

- A) Declining to offer that coverage to, or deny enrollment of, that individual; and
- B) Imposing any preexisting condition exclusions with respect to the issuance, renewal or scope of benefits.

Permits health care insurers to restrict enrollment in individual health plans to open enrollment and special enrollment periods to the extent the periods are not inconsistent with applicable federal law. The department is required to adopt rules establishing minimum open enrollment dates and criteria for special enrollment periods. Grandfathered health plan coverage and limited benefit coverage are exempt. By August 1, 2023, the Attorney General must notify the Director of the Arizona Legislative Council of the date on which the condition was met or was not met.

Laws 2020, Chapter 90 (SB 1557): Annuity Transactions; Requirements

Replaces ARS § 20-1243.03 and amends ARS §§ 20-2324, 20-1243.01 20-1243.05, 20-1243.06, 20-1243.07, to include definitions of pertinent terms in the article. The provisions do not create or imply a private cause of action for a violation or subject a producer to civil liability under the best interest standard of care or under standards of a fiduciary or fiduciary relationship. When a producer recommends an annuity, the producer must act in the interest of the consumer under the circumstances known at the time the recommendation is made and without placing the Producer's financial interest ahead of the consumers. The producer will have acted in the best interest of the consumer if the producer has satisfied the obligation regarding care, disclosure, conflict of interest and documentation. To satisfy the care obligation in making a recommendation, the producer must exercise reasonable diligence and skill to do all of the following:

- A) Know the consumer's financial situation, insurance needs and financial objectives;
- B) Understand the available recommended options;
- C) Have a reasonable basis to believe the recommended options effectively address the consumer's situation over the life of the product and that the consumer would benefit from the features of an annuity, such as annuitization, death or living benefits or other features.
- D) Communicate the basis of the recommendation;
- E) Make a reasonable effort to obtain consumer profile information from the consumer before recommending an annuity;
- F) Consider the types of products the producer is authorized and licensed to recommend or sell that address the consumer's situation. The producer is not required to consider any products outside the producer's license and must be held to standards that apply to other producers with the same authority.
- G) In the case of an exchange or replacement of an annuity the producer must consider whether:
 - a. The consumer will incur a surrender charge, be subject to a new surrender period, lose existing benefits or be subject to increased fees;
 - b. The replacement product would substantially benefit the consumer in comparison to the current product over the life of the product;
 - c. The consumer has had another exchange or replacement of an annuity, in particular, within the proceeding sixty (60) months.

The requirements under the best interest and care obligations do not create a fiduciary obligation or relationship. Only a regulatory obligation is created and the bill outlines the circumstances in which care obligation requirements are applicable.

Under the care obligation, the consumer profile information, characteristics of the insurer and product costs, rates, benefits are the relevant factors in deciding whether an annuity addresses the consumer's situation. However the importance of factors may vary by case and each factor may not be considered in isolation. It provides an outline for the information required to satisfy the disclosure obligation that the producer must provide to a consumer on a form before making a recommendation. The form must be substantially similar to the “insurance Agent Disclosure for annuities” from the 2020 NAIC Suitability in Annuity transactions Model Regulation. Under this disclosure obligation the producer must have a reasonable basis to believe that the consumer has been informed of the specified features, potential charges or tax penalties, fees, interest returns and market risk of the annuity. The producer must identify and avoid or reasonably manage and disclose material conflicts of interest, including ownership interest.

Sets additional requirements to satisfy the documentation obligation that must be completed by the producer at the time of the recommendation or sale. The provisions apply to every producer who has exercised material control or influence in the making of a recommendation and has received direct compensation as a result of the recommendation, regardless of whether the producer has had any direct contact with the consumer. It sets the activities that do not constitute material control or influence. An insurer's issuance of an annuity must be reasonable under all the known circumstances at the time.

A producer has no other obligation under the prior provisions to a consumer relating to an annuity transaction if:

- A) No recommendation is made;
- B) A recommendation was made based on materially inaccurate information provided by the consumer;
- C) The consumer refuses to provide relevant profile information and the annuity transaction is not recommended; or
- D) The consumer decides to enter into an annuity transaction that is not based on a recommendation.

Provides an outline for the requirements of each insurer to establish and maintain a supervision system that is designed to achieve the insurers and its producer's compliance with the previous provisions.

An insurer may contract for performance of a function, including maintenance of procedures, but is responsible for taking appropriate corrective action and may be subject to sanctions and penalties pursuant to specified statute.

Outlines what an insurers system must and must not include for supervision of contractual performance.

A producer or an insurer, cannot dissuade, or attempt to dissuade, a consumer from:

- A) Truthfully responding to an insurer's request for confirmation of the consumer profile information;
- B) Filing a complaint; or
- C) Cooperating in the investigation of a complaint.

The recommendations and sales of annuities made by financial professionals that comply with comparable standards satisfy the requirements of these provisions. Further, the recommendations and sales of annuities made by financial professionals does not limit the Director's ability to enforce pertinent statutes. An insurer can base its analysis on a consumer's situation in the information received from either a financial professional or the entity supervising a financial professional. It establishes the criteria insurers must follow to comply with recommendations and sales of annuities made by financial professionals.

Section 5 says that an insurer is responsible for compliance and if a violation occurs, either because of the action or inaction of the insurer or its producer, the director can order:

- A) The insurer to contract an entity to perform the insurer's supervisory duties;
- B) A general agency or independent agency to take reasonably appropriate corrective action; and
- C) Appropriate penalties and sanctions.

Removes a business entity that employs or contracts with a producer for annuities sales from taking reasonably appropriate corrective action.

Authorizes the Director to reduce or eliminate any applicable penalty if the violation was not part of a pattern or practice and states that the authority to enforce compliance is vested exclusively with the Director.

Independent agencies are added to the list of entities that are able to make recommendation records available to the Director.

The completion of any course or courses with components that are substantially similar satisfy the producer training requirements.

Finally, it requires a producer who has completed an annuity training course, to complete the following within six months after the effective date:

- A) A new four credit hour annuity training course approved by the Director; and
- B) An additional one credit hour annuity training course approved by the DIFI on appropriate sales practices, replacement and disclosure requirements.

Contains a delayed effective date of January 1, 2021.