



STATE OF ARIZONA
DEPARTMENT OF INSURANCE

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REGULATORY BULLETIN 2003-08*

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

From: Charles R. Cohen
Director of Insurance

Date: July 1, 2003

Re: **2003 Arizona Insurance Laws**

This Regulatory Bulletin summarizes the major pieces of newly enacted legislation affecting the Department, its licensees, and insurance consumers. This summary is not meant as an exhaustive list or a detailed legal analysis of all insurance related bills. It generally describes the substantive content, but does not capture all details or necessarily cover all bills that may be of interest to a particular reader. The Department may follow this bulletin with other, more detailed bulletins related to implementation of specific bills. Please do not regard this summary as a legal opinion or a binding interpretation of the legislation. All interested persons are encouraged to obtain copies of the enacted bills by contacting the Arizona Secretary of State's Office at (602) 542-4086 or from the Arizona legislative web site at the following internet address: <http://www.azleg.state.az.us>. Please direct any questions regarding this bulletin to Vista Thompson Brown, Acting Deputy Director for Policy Affairs, 602/912-8456.

The 2003 Arizona Forty-sixth Legislature, First Regular Session, adjourned *sine die* on June 19, 2003. Except as otherwise noted below, all insurance related legislation has a general effective date of September 18, 2003.

The Department initiated the following bills, which are described first: HB2152, HB2153, and HB 2160.

* 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.

DEPARTMENT BILLS

HB2152. Captive insurers (Ch. 242)

This bill amends the captive insurance laws to allow more forms of captive insurers, with corresponding provisions for regulation of the new forms. The bill also establishes a funding mechanism for the program that may allow it to be self-supporting.

Amends A.R.S. § 20-1098 to add definitions for the new captive forms:

- Agency captive insurer: is owned by one or more businesses that are licensed as producers or managing general agents, and insures only risks on policies placed through its owners.
- Group captive insurer: insures only the risks of its group members and their affiliates. A group includes:
 - A risk retention group (“RRG”),
 - An industry group, or
 - An association.
- Protected cell captive insurer: insures the risks of separate participants through a participant contract, with each participant’s liability segregated into protected cells. Minimum capital and surplus is posted by sponsors who must satisfy certain requirements.

Amends A.R.S. § 20-1098.01 to specify the types of insurance that each form of captive may write.

- Group captives can insure only the risks of the group members and their affiliates.
- Agency captives can insure only risks placed through their owners and cannot directly write any life or disability insurance.
- Protected cell captives can insure only the risks of their participants.

Amends A.R.S. § 20-1098.01 to clarify the types of business that a captive insurer may directly write:

- A captive insurer cannot directly write:
 - Insurance provided by a service corporation licensed under A.R.S. § 20-821 et seq.
 - Insurance provided by a health care services organization licensed under A.R.S. § 20-1051 et seq. or a prepaid dental plan licensed under A.R.S. § 20-1001 et seq.
 - Prepaid legal insurance contracts (A.R.S. § 20-1097)
 - Title insurance business (A.R.S. § 20-1562)
 - Commercial motor vehicle insurance (except as a qualified self insurer); or
 - Worker’s compensation insurance (except as a qualified self insurer).
- A captive insurer may directly write commercial motor vehicle policies and workers compensation (“WC”) policies if the insured affiliate qualifies as a self insurer under applicable law.

Amends the list of captive insurer application requirements in A.R.S. § 20-1098.01 to add documentation for a captive insurer formed as a reciprocal insurer (e.g. certified

copy of the power of attorney of its attorney in fact) and for a protected cell captive insurer (e.g. a form for its participant contracts; its plan for equitable allocation of expenses to each cell).

Amends A.R.S. § 20-1098.03 to establish minimum capital requirements of at least the following amounts:

- Group captives: \$500,000
- Agency captives: \$500,000
- Protected cell captives: \$1,000,000
- Captives organized as reciprocal insurers: \$500,000 in free surplus

Amends A.R.S. § 20-1098.04 to:

- Permit captives to form as reciprocal insurers under Title 20, Ch. 4, Art. 2.
- Specify requirements for formation of reciprocal, agency, and protected cell captive insurers, and new requirements for existing forms:
 - Stock insurer captives: 1 Board member must be an Arizona resident.
 - Reciprocals: Authorized quorum may be 1/3 of the members of the subscribers' advisory committee ("SAC") and 1 member of the SAC must be an Arizona resident
 - Agency captive insurer:
 - Each owner must be licensed as a producer or an MGA.
- Permit a foreign or alien captive insurer to redomesticate as an Arizona captive insurer by complying with all Title 20 organizational and licensing requirements for domestic captives and with applicable requirements for corporate formation.

Enacts new A.R.S. § 20-1098.05 (with current sections renumbered to conform) to allow formation of protected cell captive insurers, and to specify the requirements for formation:

- One or more sponsors may form the captive.
- The captive may establish protected cells to insure participants' risks.
- Only sponsors and participants can be stockholders.
- The insurer's books and records must separately account for each cell's financial condition and operations.
- The insurer's business liabilities cannot be satisfied from the assets of a protected cell.
- The insurer cannot transfer assets, issue dividends, or make distributions among protected cells without the written consent of all cells, and cannot do so as to sponsors and participants without the Director's approval.
- With its annual report, the insurer must also file an accounting of each cell's financial experience and any other information the Director specifies.
- The insurer must notify the Director of any cell's insolvency or financial impairment.
- The Director must approve each participant contract before it is effective.
- Any change in a protected cell's participants requires the Director's prior approval.
- For each cell, the insurance must be assumed from an authorized insurer, appropriately reinsured, and secured by a trust fund or irrevocable evergreen letter of credit.

Enacts new A.R.S. § 20-1098.06 (with current sections renumbered to conform) to specify the requirements for sponsors and participants in a protected cell captive insurer:

- Sponsors may be: a foreign or domestic insurer, an authorized or approved reinsurer, or an Arizona captive insurer; an RRG cannot be a sponsor or participant.
- Participants may be: an association, corporation, trust, limited liability company, partnership, or other recognized business entity.
- A sponsor may be a participant.
- A participant is not required to be a shareholder.
- A participant may insure only its own risks through the cell.

Amends A.R.S. § 20-1098.07 to specify that the annual audit of a captive insurer's financial statements must include an opinion as to the adequacy of the insurer's loss reserves and loss expense reserves.

Amends A.R.S. § 20-1098.10 to specify that agency and protected cell captives are subject to the same investment limitations applied to other captive forms.

Amends A.R.S. § 20-1098.15 to specify that:

- A captive formed as a corporation is subject to the applicable provisions of the general corporate laws in Title 10.
- General insurance laws governing mergers, consolidations, and other similar transactions apply to captive insurers, but the Director has discretion to waive or modify requirements as appropriate.

Enacts A.R.S. § 20-1098.18, which establishes the captive insurance regulatory and supervision fund within the Department of Insurance. The Department will deposit initial licensing and annual renewal fees collected from captive insurers into the fund and use fund monies to pay the costs of administering the captive insurance laws and promoting Arizona's captive insurance industry. All unencumbered monies in excess of \$100,000 at fiscal year end revert to the state general fund.

Makes conforming changes in other sections

HB2153. Long term care insurance (Ch. 133)

This bill amends Arizona's long term care (LTC) laws for closer conformity with the NAIC long term care model act. Although the bill has a general effective date, many of the provisions imposing new requirements or limitations on LTC policies are drafted to apply only to policies issued or renewed after the bill's effective date. Persons concerned about the effective date of a specific provision should carefully review the bill.

Amends A.R.S. § 20-1691 which has definitions used in the article:

- Repeals "activities of daily living".
- Clarifies "group" and "group long term care insurance".

- Clarifies that “long term care insurance” includes certain federally qualified LTC policies and policies that pay benefits based on cognitive impairment or loss of functional capacity.
- Enacts “maintenance or personal care services”.
- Expands “qualified long-term care insurance contract” to reflect changes to federal laws.

Repeals A.R.S. § 20-1691.06 entitled “Compliance”. (Similar provisions are included in new A.R.S. § 20-1691.01.)

Enacts A.R.S. § 20-1691.01 outlining the scope of the LTC article, and specifying that it applies to LTC policies marketed, delivered, or issued for delivery in this state, but does not apply to Medicare Supplement policies.

Amends A.R.S. § 20-1691.02 to expand and consolidate the Director’s rulemaking authority regarding LTC insurance. Expressly permits the Director to make rules:

- Setting standards for policy terms and conditions.
- To promote premium adequacy and protect policyholders that are subject to a substantial rate increase.
- To set standards for the manner, content, and required disclosures related to the sale of LTC policies.
- To prescribe a standard format for an outline of coverage.
- To specify the requirements for nonforfeiture benefits that must be offered as part of a LTC policy, and for contingent benefits on lapse.

Amends A.R.S. § 20-1691.03 by:

- Repealing requirements for specific types of group LTC insurance. (Note that similar provisions were enacted as new A.R.S. § 20-1691.04.)
- Prohibiting exclusions and provisions that limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions, beyond certain time periods.

Enacts A.R.S. § 20-1691.04 establishing requirements for LTC insurance marketed in this state to certain types of groups (new provisions were transferred from A.R.S. § 20-1691.03 (D)-(G)).

Amends A.R.S. § 20-1691.05 to:

- Prohibit newly issued policies from conditioning eligibility for:
 - Benefits in an institutional care setting on prior receipt of a higher level of care, or
 - Any benefits (other than postconfinement, recuperative-type benefits) on prior institutionalization.
- Require that any policy with postconfinement or recuperative type benefits shall separate out and clearly label any limitations or conditions on those benefits.
- Provide that a policy which limits noninstitutional benefits based on prior receipt of institutional care cannot require a stay of longer than 30 days.

- Provide that a policy that issues benefits only after institutionalization cannot require that the insured have been admitted to a facility for the same or related conditions within a period of less than 30 days after discharge from the institution.

Amends A.R.S. § 20-1691.06 governing the outline of coverage:

- Expands (from just individual policies to also include group policies) the requirement to provide the outline at initial solicitation, although for certain groups, an insurer may satisfy the requirement by including the same information in group enrollment materials.
- Requires that the outline include references to any conversion or continuation provisions, a description of the terms under which the policy may be returned and premium refunded, a description of the relationship of cost of care and benefits.
- Requires that the policy summary include a specific statement if the policy lacks a LTC inflation protection option.
- Permits the policy summary to be included with any required life insurance illustration.¹
- Requires an insurer to deliver a LTC policy within 30 days of approving an application.
- Requires an insurer to notify a claimant whether a LTC claim is accepted or denied within 15 work days of receiving an adequately documented claim, or alternatively, to notify the claimant within the 15 day period if the insurer requires more time for a determination.² A determination cannot exceed 60 days.
- Requires the insurer to provide a written explanation of the reasons for denial of a claim, and to make available information about the denial.

Enacts A.R.S. § 20-1621.08 which clarifies the existing process for review and approval of LTC policy forms³ and establishes new authority to review and disapprove LTC rates.

- Rates and forms are deemed approved 30 days after filing unless the Director affirmatively disapproves the filing. The Director may extend the 30-day review period for 15 days, by giving notice to the insurer within the 30-day period.
- The Director may disapprove a rate that does not comply with the LTC article or any implementing rules.
- The Director may disapprove a policy form that is ambiguous, misleading, deceptive, or contrary to law.
- The Director must notify the insurer of any disapproval. The insurer has the right to appeal the disapproval order as an appealable agency action under the Administrative Procedure Act.
- By order, the Director may withdraw approval of any form or rate; this is also an appealable agency action.
- The Director has discretion to exempt any form or rate from the filing requirements.

¹ Arizona has not enacted the NAIC life illustration model act.

² This requirement is not included in the NAIC model, but has been previously applied to LTC insurers pursuant to A.A.C. R20-6-801(G).

³ The Department has historically treated LTC as a form of disability insurance and has reviewed forms under the authority of A.R.S. § 20-1110.

Amends A.R.S. § 20-1691.10 regarding contestability periods to specify that the contestability provision in a LTC policy does not apply to the remaining death benefit of a life insurance policy that accelerates LTC benefits on death of the insured. Contestability is governed by A.R.S. § 20-1204.

Enacts A.R.S. § 20-1691.11 requiring LTC insurers to include an optional nonforfeiture benefit. The insurer must provide a contingent benefit upon lapse to any policyholder who declines the nonforfeiture benefit, and who is subject to a substantial rate increase. In the case of group coverage, the insurer is generally required to extend the offer to the group policyholder.

HB2160. Health insurer reporting (Ch. 55)

Repeals the December 31, 2003 sunset date for two laws related to Arizona's implementation of the Health Insurance Portability and Accountability Act (HIPAA):

- A.R.S. § 20-1381 (Suspension of health care insurer obligation to issue coverage on a guaranteed issuance basis to eligible individuals); and
- 20-1382 (health care insurers; reporting requirements).

Amends health insurers' annual reporting requirements in A.R.S. § 20-1382 to add a requirement that insurers report on the total number of outstanding HIPAA policies, and to excuse insurers from annually filing certain information if there has been no change since the insurer's last report.

OTHER INSURANCE-RELATED BILLS

HB2015. Reviser's technical corrections: 2003 (Ch. 188)

Each year, Legislative Council produces a comprehensive technical corrections bill. This year's bill includes amendments to A.R.S. §§ 20-1003 and 20-1004 to fix errors that resulted from past legislation which amended incorrect versions of these sections. The corrections are retroactive to June 30, 2002.

HB2032. Adverse underwriting decision; credit history (Ch. 151)
(Delayed effective date of September 1, 2004)

Amends A.R.S. § 20-2110(E) governing the notice obligations of an insurer and producer towards an applicant/insured who is the subject of an adverse underwriting decision based on credit related information:

- Repeals the obligation to provide the individual with a list of factors that typically affect a consumer credit report.⁴
- Requires a description of up to four factors that were the primary reason for the adverse action taken against the particular applicant/insured.

⁴ The Department publishes a consumer information brochure on use of credit history; the brochure lists typical factors.

Enacts A.R.S. § 20-2110(F) limiting an insurer's ability to use the types of credit history listed below to calculate an insurance score to determine premiums on property and casualty insurance for personal, family, or household use.

- Lack of credit history*
- Inability to determine credit history*
- Collection accounts identified with a medical code
- Bankruptcy or lien satisfaction more than 7 years old
- Consumer's use of a particular credit, charge, or debit card*
- Consumer's total available line of credit (except the insurer may consider total outstanding debt in relation to available credit).

Prohibits use of an insurance score that is calculated using a consumer's income, gender, address, zip code, ethnic group, religion, marital status, or nationality, even though an insurer may still use zip code, address, gender, and marital status for insurance underwriting purposes.

*Indicates information that may be used if the insurer can actuarially justify the use of a different premium for persons with such credit history.

HB 2049. State agency reports; repeal (Ch. 104)

Section 12 of the bill repeals the Department's obligation to publish three reports:

- A.R.S. § 20-154.01. The motor vehicle annual report;
- A.R.S. § 20-466.05. The Fraud Unit report; and
- A.R.S. § 20-2319. The triennial accountable health plan report.

HB2148. Mortgage guaranty; insurance (Ch. 28)

- Amends A.R.S. § 20-382 to specify that A.R.S. Title 20, Chapter 2, Article 4.1 (open competition) applies to mortgage guaranty insurance.
- Amends A.R.S. § 20-1549 to specify that policy forms and rates for mortgage guaranty insurance must be filed with the Department pursuant to Article 4.1.
- Repeals language requiring that a rate filing be on file for 15 days before becoming effective, and a policy form on file for 30 days before it becomes effective.
- Makes conforming changes to other sections.

HB2150. Insurance producers; continuing education; extension (Ch. 216)

Extends the sunset date for Title 20, Chapter 18 (A.R.S. § 20-2901 et seq.), "continuing education" requirements for insurance producers, from July 1, 2004 to July 1, 2010.

HB2151. Vehicles uninsured coverage; limits; notice (Ch. 86)

Amends A.R.S. § 20-259.01 to excuse insurers from having to complete and maintain a form indicating that UM/UIM coverage was offered to a prospective insured if the insured purchases UM/UIM coverage in an amount equal to the insured's policy limits for insurance covering bodily injury and death.

HB2154. Insurance holding company systems (Ch. 143)

Conforms Arizona's holding company act provisions governing insurers' investments in subsidiaries, to the NAIC model act.

Amends A.R.S. § 20-481.01(B)(1) which currently allows a domestic insurer to invest in the stock of its subsidiaries up to certain limits, to exclude from the calculation of the limits, investments in domestic and foreign insurance subsidiaries and health care services organizations (HMOs).

Amends A.R.S. § 20-481.01(B)(2) to specify that insurers' unrestricted investments in subsidiaries that have agreed to certain investment limitations, apply only to subsidiaries whose business is limited to ownership and management of the insurer's authorized investments.

Repeals unnecessary outdated language in A.R.S. § 20-481.01(B)(2) and (B)(5).

Amends A.R.S. § 20-481.25(C) to corrects an erroneous cross-reference.

HB2156. Vehicle claims; lienholders; notice (Ch. 243)

Enacts new section 20-270⁵ requiring an insured/claimant to provide an insurer with information about any liens or encumbrances against a vehicle when filing a claim for loss related to the vehicle, if the loss exceeds \$2500. The insurer may rely on the information and is not liable for the insured/claimant's failure to provide accurate information. The insured or claimant is liable for any damages that may arise from providing inaccurate information.

This section does not apply to an insurer that either issues a release and makes payment in the joint names of the insured/claimant and the lienholder, or that directly pays the vehicle repairer after verification of repair.

HB2186. Life insurance; annuities; replacement (Ch. 224)

(Delayed effective date of January 1, 2004, except changes to A.R.S. § 20-1233.)

This bill codifies two NAIC model regulations: Life Insurance and Annuities Replacement and Annuity Disclosure. The old NAIC Life Insurance Replacement model regulation is currently codified in Department rule at A.A.C. R20-6-215 and Exhibits A and B to that rule. The Department will initiate rulemaking activity to repeal the rule. If that activity is not completed by the effective date of the bill, the statute will, as a matter of law, supersede the rule.

Amends A.R.S. § 20-1233 to extend the free look period for annuity contracts, from 10 days to 30 days, for persons who are age 65 or older on the date of application.

⁵ Note: SB1266 also enacted a new section 20-270. The Department expects that Legislative Council will renumber one of the new sections as 20-271.

Article 1.1. Replacement of Life Insurance Policies and Annuity Contracts

Enacts A.R.S. § 20-1241 establishing definitions for “contract”, “direct response solicitation”, “direct solicitation”, “existing insurer”, “existing policy or contract”, “financed purchase”, “illustration”, “insurance producer”, “policy summary”, “registered contract”, “replaced or replacement”, “replacing insurer”, and “sales material”.

Enacts A.R.S. § 20-1241.01 defining the scope of the article. The article applies to replacement of life insurance policies and annuity contracts except:

- Credit life insurance.
- Group policies and contracts that do not involve direct solicitation of individuals.
- Prearranged funeral agreements as defined in A.R.S. § 32-1301.
- Certain ERISA qualified pension and welfare plans.
- Certain governmental and church plans.
- Nonqualified deferred compensation arrangements.
- Certain applications made to an existing insurer, including replacement of insurance issued under a binder.
- Nonrenewable and nonconvertible term life insurance that expires in less than 5 years.
- Immediate annuities bought with proceeds from an existing contract.
- Structured settlements as defined in A.R.S. § 12-2901.

Enacts A.R.S. § 20-1241.02 establishing requirements for policy summaries:

- The summary must be in writing.
- A summary (for other than a universal life policy) shall have, as applicable:
 - Current death benefit,
 - Annual contract premium,
 - Current cash surrender value,
 - Current dividend, and its application, and
 - Amount of outstanding loan.
- A summary of a universal life policy shall have:
 - Beginning and end date of current report period,
 - Policy values at end of prior and current report periods,
 - Total amounts credited and debited to policy value during reporting period,
 - Current death benefit on each life,
 - Net cash surrender value, and
 - Amount of any outstanding loans.

Enacts A.R.S. § 20-1241.03 establishing duties for insurance producers. A producer must give the insurer a statement signed by both the producer and the applicant as to whether the applicant has an existing policy or contract. If yes, the producer must read the applicant a prescribed notice about replacement, unless the applicant affirmatively declines the reading. The producer and applicant must sign the notice and the applicant must get a copy. The notice must include prescribed information about the policy/contract proposed for replacement. If the applicant completes the application, the producer must also give the applicant a copy of all sales materials. The producer is also required to send the insurer copies of the notices and sales materials, unless the

producer uses only the insurer's approved materials – in which case a statement to this effect is sufficient.

Enacts A.R.S. § 20-1241.04 establishing requirements for insurers that use producers. The insurer must have a system for supervision and control of producers to ensure compliance with replacement laws. The insurer and its system must:

- Educate producers about the laws and how to comply with them, and the insurer's policies on acceptability and appropriateness of replacement,
- Provide for detection of unreported replacements and review of replacements to ensure conformity with insurer's policy and the laws;
- Be able to monitor producer's replacement transactions and to provide detailed records on individual producer's transactions, including replacements and lapsed policies as percentages of total annual sales, for both annuity contracts and life insurance policies, and number of unreported replacements;
- Require submission of and be able to produce copies of the statements and notices required by other sections;
- For applicants with existing policies/contracts, be able to produce copies of sales materials and illustrations, for 5 years after termination of the existing policy/contract, and monitor the information for legal compliance and accuracy.

An insurer may maintain the required information in any form that can accurately reproduce the document.

Enacts A.R.S. § 20-1241.05 prescribing duties for replacing insurers that use producers. For each replacement transaction, a replacing insurer must:

- Verify receipt of all required forms and verify that the forms are legally compliant;
- Promptly notify any existing insurer affected by a proposed replacement and provide certain information on request;
- Be able to produce copies of replacement notices for up to 5 years after replacement;
- Provide the buyer notice of the right to return the policy/contract within the first 30 days for a refund of all consideration, less certain allowable charges;
- If the replacing insurer is the same as or affiliated with the existing insurer, credit the applicant for incontestability and suicide periods already fulfilled under the existing policy/contract up to the amount of that policy/contract.

If the insurer prohibits insurers from using nonapproved sales materials, the insurer may (in lieu of getting copies of the materials from producers) have the producer file a signed statement to this effect. An insurer that relies on a signed statement must also send the applicant notice to ensure that the producer left the sales materials with the applicant, with a toll free number to contact the insurer, and must stress the importance of keeping the materials for future reference. The insurer must be able to produce a copy of this notice for up to 5 years.

Enacts A.R.S. § 20-1241.06 prescribing the duties of an existing insurer. The insurer must:

- Be able to provide copies of replacement notices, indexed by replacing insurer, for up to 5 years;

- Within 5 days of receiving a replacement notice, send the insured notice of the right to get information on the policy/contract being replaced, and provide the information within 5 days of the insured's request;
- Upon receipt of a request to use policy/contract values, send the insured a notice explaining the potential consequences of the release. This notice must be separate from the check if the check goes to anyone besides the insured.

Enacts A.R.S. § 20-1241.07 prescribing the duties of insurers as to direct response solicitations. The insurer must ask a responding applicant whether the applicant will be replacing an existing policy/contract, and send the applicant a notice if the applicant fails to respond or denies replacement. For identified replacement transactions, the insurer must comply with A.R.S. § 20-1241.05(C) and (D) if the applicant identifies the existing insurer and with A.R.S. § 20-1241.05 (E) and (F).

Enacts A.R.S. § 20-1241.08 prescribing the penalties listed in A.R.S. § 20-220, 20-295, and 20-456, for violations of the replacement article. The Director may also revoke or suspend a producer or insurer's license; assess civil monetary penalties, order forfeiture of commissions, and require restitution, restoration of value, and interest. Violations include:

- Deceptive or misleading information in sales materials
- At application, failing to make pertinent inquiries as to replacement and financing
- Intentional incorrect recording of an answer;
- Advising an applicant to answer that replacement is not intended or to take actions that obscure the identity of the replacing insurer.

If a policy/contract owner applies for new coverage, indicates that replacement is not intended, and does replace existing coverage, it is deemed prima facie evidence of a producer's knowledge of replacement and intent to violate the law.

If the requirements of this article are not met, the replacing insurer must send the applicant certain information on the replacement policy, including available illustrations, a policy summary, and notices.

Article 1.2. Annuity Disclosure

This new Article mirrors the NAIC model regulation for Annuity Disclosure.

Enacts A.R.S. § 20-1242 establishing definitions for "contract owner," "determinable elements," "generic name," "guaranteed elements," "insurance producer," "nonguaranteed elements," and "structured settlement annuity."

Enacts A.R.S. § 20-1242.01 making the annuity disclosure article applicable to all annuity contracts, including annuities funded solely by employee contributions to a plan if the insurer knows that employees have a choice among fixed annuity providers, and the employees are directly solicited. The article does not apply to:

- Registered or nonregistered variable annuities and registered products;
- Immediate and deferred annuities that do not have nonguaranteed elements;

- Annuities used to fund ERISA qualified plans, governmental and church plans, certain nonqualified deferred compensation arrangements; or
- Structured settlement annuities.

Enacts A.R.S. § 20-1242.02 establishing standards for disclosure documents and buyer's guides related to the purchase of an annuity.

- The applicant must receive the disclosure and guide at the time of application in any face to face meeting, and no later than 5 work days after the insurer receives an application taken by some other means, subject to the following:
 - For applications received from a direct mail solicitation, the insurer may include the buyer's guide and disclosure with the solicitation.
 - For applications received through the internet, the insurer may provide the guide and disclosure by making it readily available for viewing on and printing from the internet site.
- Any solicitation other than in a face to face meeting must include a statement that the applicant can get a free buyer's guide from the insurer.
- If the disclosure and guide are not provided on or before the application date, the buyer has a free look period of at least 15 days, which can run concurrently with other such periods.
- The Director specifies the form of the guide and disclosure which must include certain information such as generic name of contract, company product name, form number, insurer identification, contract and benefits description, guaranteed, nonguaranteed, and determinable elements, any limitations, and how they function; explanation of initial crediting rate, and how it can vary over time, periodic income options on guaranteed and nonguaranteed basis, value reductions caused by withdrawals or surrender; how to access contract values, death benefits, a statement of federal tax status; riders, fees and charges, current guaranteed rates.

Enacts A.R.S. § 20-1242.03 which requires that for annuities in certain status, the insurer must provide the contract owner with at least an annual report that must include: the reporting period dates, the accumulation and cash surrender values, total amounts credited and charged, and amount of any outstanding loans.

Enacts A.R.S. § 20-1242.04 subjecting insurers and producers to the penalties prescribed in A.R.S. § 20-220, 20-295 and 20-456 for violations of the article.

Rulemaking: Enacts A.R.S. § 20-1241.09 and A.R.S. § 20-1242.05 granting the Director express authority to adopt implementing rules for, respectively, the replacement article and the annuity disclosure article, with an exemption from the rulemaking process for the purpose of adopting rules to establish the form and content of notices and other required forms, summaries, and guides, all of which must substantially conform to NAIC models.

HB2211. Hospital emergency services; study committee (Ch. 111)

Establishes an interim study committee on community access to hospital emergency services and patient safety. Committee membership must include, among others, a

representative of a health care insurance plan to be appointed by the Speaker of the House. The committee is to report and make recommendations by November 15, 2003.

HB2267. Towed vehicle retrieval; insurance companies (Ch. 153)

Enacts A.R.S. § 28-4847 which requires a towing company to release a towed vehicle to an insurer or its designated representative on payment of reasonable charges. To obtain release, the insurer must provide certain information in writing (identifying information on the insurer and the claimant). A towing company cannot charge additional storage fees after receiving a request that complies with this section.

HB2273. Structural pest control commission (Ch.146)
(Delayed effective date of July 1, 2004)

Amends A.R.S. § 32-2313 governing the financial security requirements for structural pest control company applicants to clarify that the applicant may obtain insurance from either an admitted carrier holding a certificate of authority in Arizona or from a surplus lines carrier. (Note: identical language appears in another bill: HB2341. Structural pest and fungi control (Ch. 115).)

HB2283. Taxis, limousines, and sedans; regulations (Ch. 168)

This is a comprehensive bill that establishes new regulatory requirements for taxis, limousines, and sedans, including financial responsibility requirements specific to such vehicles. The bill amends A.R.S. § 28-4033 to require, for transportation of passengers, minimum uninsured motorist coverage of \$750,000, in addition to liability coverage of \$300,000, and to specify that insurance coverage must be obtained from either an admitted carrier holding a certificate of authority in Arizona or from a surplus lines carrier.

HB2294. Vehicle title; registration (Ch. 258)

This is an omnibus bill dealing with numerous motor vehicle issues, including issues involving title to salvage or total loss vehicles. The bill includes an amendment to A.R.S. § 28-2091(A). Under the amendment, when an insurer acquires a salvage vehicle, the insurer must apply to DMV for the salvage title within 30 days after the vehicle owner properly assigns title to the insurer, with a release of all liens. The bill also amends the definition of salvage vehicle in A.R.S. § 28-2091(T)(4) to clarify that an insurer liable for paying a third party claim may also declare a vehicle to be a total loss or a salvage vehicle, in addition to the first party insurer.

HB2306. Employer drug policy (Ch. 185)

Amends A.R.S. § 23-1021 by repealing the requirement that an employer with a drug/alcohol screening policy file an annual written certification of the policy with the Industrial Commission.

HB2340. Insurers; credit life and disability (Ch. 81)

Amends A.R.S. § 20-1094.01 governing the reserve requirements for unaffiliated credit life and disability reinsurers by allowing such reinsurers to secure liabilities assumed under a reinsurance agreement with a clean, irrevocable letter or credit, in addition to existing methods.

HB 2358. Health coverage impact (Ch. 232)

Amends A.R.S. § 20-181 to require that reports on the impact of proposed new health insurance coverage mandates be submitted to JLBC prior to consideration by the assigned standing legislative committee, for proposals submitted by individuals as well as groups.

Amends A.R.S. § 20-182 to require that an actuary who is a member of the American Academy of Actuaries prepare and certify to the financial impact analysis included in the report. The report must address the specific mandate under consideration and that reports on similar proposals from other jurisdictions are insufficient.

HB2391. Removal of Medicaid special exemption (Ch. 136)
(Emergency effective date of May 1, 2003)

Enacts A.R.S. § 36-2905 and A.R.S. § 36-2944.01 requiring AHCCCS contractors and LTC program contractors to pay 2% "premium" tax based on capitation payments and other contractor reimbursement, beginning October 1, 2003. Contractors are required to make quarterly filings and estimated payments with the Department, on a Department specified form. The Department will deposit all collections to the General Fund. The Department will use information provided by AHCCCS, and will work with AHCCCS to reconcile tax payments with the amount of contractor reimbursements, and will refund any overpayments and collect underpayments. Civil penalties are imposed on any contractor who fails to make quarterly filings or pay taxes due.

HB2429. Social security numbers (Ch. 137)

(Delayed effective date. Applies to new policies issued on or after January 1, 2005. For policies in existence on January 1, 2005, applies on policy renewal date, but no later than January 1, 2006.)

Enacts A.R.S. § 44-1376 establishing confidentiality safeguards for social security numbers (SSN). Prohibits persons from:

- Publicizing or communicating an individual's SSN to the public.
- Printing an individual's SSN on identity cards used to procure services or products.
- Requiring internet transmission of an SSN unless it is encrypted or transmitted over a secure connection.
- Requiring an SSN to access a web site, unless a unique password, PIN, or identifier is also required.
- Printing an SSN on mailed materials unless required by other applicable law, or certain limited purposes, such as to confirm accuracy of an SSN.

The bill contains a grandfather provision allowing a person to continue use of an SSN in one of the ways listed above, if:

- The nonconforming use was in effect prior to January 1, 2005;
- The nonconforming use is continuous;
- The user advises the individual of the nonconforming use and gives the individual the right to stop the use; and
- The individual does not make a written request to stop the use.

SB1010. Elder abuse; medical malpractice (Ch. 129)

Amends A.R.S. § 12-562 to provide that a medical malpractice action cannot be based on neglect, abuse, or exploitation of an incapacitated or vulnerable adult, except as explicitly provided under the elder abuse law (A.R.S. § 46-455).

Amends A.R.S. § 46-455 (the elder abuse law) to:

- Prohibit a civil cause of action under this law against an M.D., D.O., podiatrist, registered nurse practitioner, or physician assistant, who is acting within the licensed scope of practice, except under the following circumstances: At the time of the events giving rise to the civil action:
 - The adult care facility* housing the incapacitated/vulnerable adult employed, retained, or designated the person being sued as its medical director; or
 - The person being sued was the primary medical provider for the incapacitated/vulnerable person, but the person serving as the primary medical provider in the two years preceding admission to the adult care facility is expressly exempted from liability
- Shorten the statute of limitations on elder abuse claims from 7 to 2 years.

*Adult care facility includes: a nursing care institution; a skilled nursing or nursing facility; an assisted living center, facility, or home; an adult day health care facility; a residential care institution; and an adult care home.

SB1048. Professional employer services (Ch. 180)

Amends A.R.S. § 23-901 to enact new definitions for “professional employer agreement”, “professional employer organization”, “professional employer services”, and “client”. Amends the definition of “employee” to include a person employed under a professional employer (PE) agreement. (Note special delayed effective date for changes made to this section in 2002 legislation.)

Enacts A.R.S. § 23-901.08 which:

- Subjects a person providing PE services to state workers’ compensation (WC) requirements in Title 23, Chapter 6.
- Designates the PEO and the client as an employee’s co-employers while the PE agreement is in effect, with both parties responsible for WC coverage and for compliance with certain WC laws, and entitled to the exclusive remedy protections of A.R.S. § 23-1022.

- Requires a PEO to notify its WC carrier and the Industrial Commission when the PEO enters into a PE agreement with a client and when an agreement terminates.
- Requires a PEO to notify a client of the client's obligation to secure WC coverage for any employees not covered under the PE agreement.

A.R.S. § 23-901.08 further requires that notice about entry into a PE agreement must be on an IC approved form with the following information:

- Identifying information on the client,
- The extent of the client's workforce covered under the PE agreement, and
- The name of the client's WC carrier if its entire workforce is not covered under the PE agreement.

Makes conforming changes in other sections: A.R.S. § 23-401, 23-901.01, 23-901.05, 23-901.06, and 23-961.

Amends A.R.S. § 23-907 governing the liability of an employer that fails to obtain WC insurance and payment of claims from the special fund, to:

- Provide that an employer who protests payment by the special fund on the grounds that the employer has complied with WC laws, must provide a copy of the WC insurance declaration page, or proof of compliance as a self-insured.
- Permit the Special Fund to pay benefits on claims by employees of an employer who lacks WC insurance pending a final determination on an employer's protest; filing of a protest cannot interrupt ongoing claim payments unless the Special Fund acts to do so.
- Permit the Industrial Commission to spend special fund monies on, and include as an employer liability, certain claims-related expenses, including consultants, experts, and examiners.
- Raise the fixed penalty for a violation from \$500 to \$1000, with new penalties for repeat violations, and factors for the Industrial Commission to consider when assessing penalties.

Amends A.R.S. § 23-1065 related to the special fund by enacting a new subsection permitting the Industrial Commission to spend special fund monies on expenses necessary to process, pay, or determine liability of the fund, including travel, discovery, experts, consultants, and examiners.

SB1265. Insurance policy; grounds for cancellation (Ch. 120)
(Delayed effective date. Applies to applications submitted on or after January 1, 2004.)

Amends A.R.S. § 20-1652 by enacting new provisions that limit an insurer's ability to cancel homeowners' insurance based on information from consumer reports and other computerized databases. If an insurer uses database information (such as CLUE) for underwriting purposes, the insurer must obtain the information as soon as possible after receiving an application and before issuing a binder. An insurer that fails to timely obtain the database information on the prospective residence or insured cannot use the information as grounds to decline coverage or terminate a binder on new business. In

addition, 30 days after the application, the insurer cannot decline or terminate coverage based on database information. An insurer may still decline or terminate coverage based on the condition of the premises, as determined by a physical inspection.

SB1266. Residential property insurance; prohibited acts (Ch. 131)

Enacts A.R.S. § 20-270 which prohibits an insurer from charging a higher premium to insure property that has had a single, below-deductible claim of less than \$500 during the prior three years. An insured with a claim cannot be charged more than an insured with no such claim.

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