

State of Arizona  
Senate  
Forty-fifth Legislature  
First Regular Session  
2001

CHAPTER 58

**SENATE BILL 1022**

AN ACT

AMENDING SECTIONS 20-108, 20-142, 20-167, 20-261, 20-441, 20-453, 20-454, 20-461, 20-488, 20-611 AND 20-708, ARIZONA REVISED STATUTES; REPEALING TITLE 20, CHAPTER 4, ARTICLES 5 AND 6, ARIZONA REVISED STATUTES; AMENDING SECTIONS 20-1133 AND 20-1134, ARIZONA REVISED STATUTES; AMENDING SECTION 20-1379, ARIZONA REVISED STATUTES, AS AMENDED BY LAWS 2000, CHAPTER 355, SECTION 10; AMENDING SECTIONS 20-2501, 20-3101, 36-125.07 AND 36-2906.01, ARIZONA REVISED STATUTES; AMENDING LAWS 2000, CHAPTER 37, SECTION 36; RELATING TO BENEFIT INSURERS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Section 20-108, Arizona Revised Statutes, is amended to  
3 read:

4 20-108. Types of insurers excepted

5 No provision of this title shall apply APPLIES with respect to:

6 1. Hospital and medical service corporations, except as stated in  
7 ~~article 3 of chapter 4, ARTICLE 3 of this title.~~

8 2. Fraternal benefit societies, except as stated in ~~article 4 of~~  
9 ~~chapter 4, ARTICLE 4 of this title.~~

10 ~~3. Domestic benefit insurers, except as stated in article 5 of chapter~~  
11 ~~4 of this title.~~

12 ~~4. Benefit stock insurers, except as stated in article 6 of chapter~~  
13 ~~4 of this title.~~

14 5. 3. Extended warranty insurers who comply with the bond  
15 requirements of section 20-108.01. For purposes of this paragraph "extended  
16 warranty insurer" means any insurer as otherwise defined by this title, ~~which~~  
17 THAT does not manufacture, sell or service radio, television or sound  
18 reproduction equipment, ~~and which~~ THAT:

19 (a) For a premium charged, not greater than twenty dollars per annum,  
20 nor greater than a three-year term, provides a nonrenewable warranty,  
21 guaranty or service contract on radio, television or sound reproduction  
22 equipment in addition to, or as an extension of, any warranty, guaranty or  
23 service provided by the manufacturer of such equipment.

24 (b) Is not otherwise authorized to transact property or casualty  
25 insurance business in this state or any other governmental jurisdiction.

26 (c) Is not owned or controlled in any degree nor to any extent by a  
27 person, persons or business otherwise authorized to transact property or  
28 casualty insurance business in this state or any other state or jurisdiction.

29 (d) Has gross sales in this state not exceeding one hundred thousand  
30 dollars annually.

31 (e) Has maximum contractual contingent liability not exceeding three  
32 hundred thousand dollars in this state.

33 Sec. 2. Section 20-142, Arizona Revised Statutes, is amended to read:

34 20-142. Powers and duties of director; payment of examination  
35 and investigation costs; home health services

36 A. The director shall enforce the provisions of this title.

37 B. The director shall have powers and authority expressly conferred  
38 by or reasonably implied from the provisions of this title.

39 C. The director may conduct examinations and investigations of  
40 insurance matters, including examinations and investigations of adjusters,  
41 agents and brokers and any other persons regulated under this title, in  
42 addition to examinations and investigations expressly authorized, as the  
43 director deems proper in determining whether a person has violated any  
44 provision of this title or for the purpose of securing information useful in  
45 the lawful administration of any provision of this title. The examined party

1 shall pay the cost of examinations conducted pursuant to this subsection  
2 except for examinations of adjusters, agents and brokers. The examined party  
3 shall pay the cost of examining adjusters, agents and brokers only if the  
4 party has violated any provision of this title. The state shall pay the cost  
5 of an investigation.

6 D. The director shall establish guidelines for insurers on home health  
7 services which THAT shall be used by the director pursuant to sections  
8 20-826, ~~20-934~~, 20-1342, 20-1402 and 20-1404. The director may use home  
9 health services as defined in section 36-151. Guidelines shall include but  
10 not be limited to:

- 11 1. Home health services which THAT are prescribed by a physician.
- 12 2. Home health services which THAT are determined to cost less if
- 13 provided in the home than the average length of in-hospital service for the
- 14 same service.
- 15 3. Skilled professional care in the home which THAT is comparable to
- 16 skilled professional care provided in-hospital and which THAT is reviewed and
- 17 approved at thirty day intervals by a physician.

18 E. Pursuant to section 41-1750, subsection G, the director may receive  
19 criminal history record information, in connection with the issuance,  
20 renewal, suspension or revocation of a license or certificate of authority  
21 or the consideration of a merger or acquisition. The director may require  
22 the submission of fingerprints of any person related to the issuance,  
23 renewal, suspension or revocation of a license or certificate of authority  
24 or the consideration of a merger or acquisition. The criminal identification  
25 section of the department of public safety shall provide such criminal  
26 history record information to the director pursuant to section 41-1750,  
27 subsection G.

28 Sec. 3. Section 20-167, Arizona Revised Statutes, is amended to read:  
29 20-167. Fees

30 A. The director shall collect in advance the following fees, which,  
31 subsequent to issuance of a receipt evidencing any payment, shall not be  
32 refunded by the director:

	Not Less Than:	Not More Than:
33		
34 1. For filing charter documents:		
35 (a) Original charter documents,		
36 articles of incorporation,		
37 bylaws, or record of organization		
38 of insurers, or certified copies		
39 thereof, required to be filed with		
40 the director and not also subject		
41 to filing in the office of the		
42 corporation commission	\$ 25.00	\$ 75.00
43 (b) Amended charter documents	10.00	30.00
44 (c) No charge or fee shall be required		
45 for filing with the director any		

1 of such documents also required  
 2 by law to be filed in the office  
 3 of the corporation commission.

4 2. Certificate of authority:

5 (a) Issuance:

6	Fraternal benefit societies	\$ 10.00	\$ 30.00
7	Medical or hospital service		
8	corporations, <del>or domestic</del>		
9	<del>benefit insurers</del>	25.00	75.00
10	All other insurers	65.00	195.00

11 (b) Renewal:

12	Fraternal benefit societies, <del>—</del>		
13	<del>or domestic benefit insurers</del>	10.00	30.00
14	Medical or hospital service		
15	corporations	25.00	75.00
16	Domestic stock life and disability		
17	insurers only or either	500.00	1,500.00
18	Domestic life and disability		
19	reinsurer only or either	\$1,500.00	\$4,500.00
20	All other insurers	45.00	135.00
21	3. Filing annual statement	100.00	300.00

22 4. Licenses and examinations:

23 (a) Licenses:

24	Surplus lines broker's license,		
25	biennially	200.00	600.00
26	All other licenses, biennially	20.00	60.00

27 (b) Examinations for license, agents  
 28 and brokers:

29	Examination on laws and one kind		
30	of insurance	5.00	15.00
31	Examination on laws and two or		
32	more kinds of insurance	10.00	30.00

33 5. Miscellaneous:

34	Fee accompanying service of		
35	process upon director	\$ 5.00	\$ 15.00
36	Certificate of director, under seal	1.00	3.00
37	Copy of document filed in director's		
38	office, per page	0.50	1.50

39 B. The director shall deposit, pursuant to sections 35-146 and 35-147,  
 40 all fees for licenses so collected in the state general fund. No refund  
 41 shall be allowed for any unused portion of a fee nor shall fees be prorated,  
 42 except that the fee for an initial license if applied for in the second half  
 43 of the biennial term shall not exceed one-half of the license fee.

44 C. The license fees prescribed by this section shall be payment in  
 45 full of all demands for any and all state, county, district and municipal

1 license fees, license taxes, business privilege taxes and business privilege  
2 fees and charges of every kind.

3 D. Each domestic stock life and disability insurer only or either,  
4 which pays the renewal fee required under the provisions of subsection A of  
5 this section, shall be entitled to a credit in the amount of four hundred  
6 fifty-five dollars to apply to the premium tax then owed by such company  
7 pursuant to the provisions of section 20-224, but such credit shall not be  
8 cumulative.

9 E. Each domestic life and disability reinsurer only or either, which  
10 pays the renewal fee required under the provisions of subsection A of this  
11 section, shall be entitled to a credit in the amount of fourteen hundred  
12 fifty-five dollars to apply to the premium tax then owed by such company  
13 pursuant to the provisions of section 20-224, but such credit shall not be  
14 cumulative.

15 F. The director may contract for the examination for the licensing of  
16 adjusters, agents, brokers and surplus lines brokers. When the director does  
17 so, the fee for examinations for licenses pursuant to this section shall be  
18 payable directly to the contractor by the applicant for examination. The  
19 director may agree to a reasonable examination fee to be charged by the  
20 contractor. Such fee may exceed the amounts prescribed in subsection A,  
21 paragraph 4, subdivision (b) of this section.

22 G. Beginning July 1, 1986 and every year thereafter, if the revenue  
23 collected from fees for the prior calendar year is less than ninety-five per  
24 cent or more than one hundred ten per cent of the appropriated budget for the  
25 beginning fiscal year, the director shall revise the fees within the limits  
26 prescribed by subsection A of this section on a uniform percentage basis  
27 among all fee categories and shall adjust the credits prescribed by  
28 subsections D and E of this section as necessary in order to retain any  
29 required uniformity. Fees shall be revised in such a manner that the revenue  
30 derived from the fees equals at least ninety-five per cent but not more than  
31 one hundred ten per cent of the appropriated budget for the beginning fiscal  
32 year, and such revised fee schedule shall be effective July 1 of the  
33 subsequent year.

34 H. The director may contract with a voluntary domestic organization  
35 of surplus lines brokers to perform any transaction prescribed in chapter 2,  
36 article 5 of this title, including the acceptance or maintenance of the  
37 reports required by section 20-408. The director may allow the contractor  
38 to charge a stamping fee. The surplus lines broker shall pay the stamping  
39 fee established pursuant to this section directly to the contractor.

40 I. For the purposes of subsection H of this section, "stamping fee"  
41 means a reasonable filing fee charged by a contractor for any transaction  
42 prescribed in chapter 2, article 5 of this title, including the acceptance  
43 or maintenance of the reports required by section 20-408.

44 Sec. 4. Section 20-261, Arizona Revised Statutes, is amended to read:  
45 20-261. Authorized reinsurance

1           A. An insurer shall reinsure its risks, or any part of its risks, only  
2 in solvent insurers having surplus to policyholders not less in amount than  
3 the minimum required capital stock required under this title of a domestic  
4 stock insurer, other than a limited stock insurer or a domestic life and  
5 disability reinsurer, authorized to transact like kinds of insurance. A  
6 domestic limited stock life insurer or domestic life and disability reinsurer  
7 may accept reinsurance of the risks of other limited stock insurers ~~and of~~  
8 ~~domestic benefit insurers~~ or domestic life and disability reinsurers.

9           B. An insurer may reinsure in alien insurers if the alien insurers are  
10 authorized to transact insurance in at least one state of the United States  
11 or have in the United States a duly authorized attorney-in-fact to accept  
12 service of legal process against the insurer as to any liability that might  
13 arise on account of such reinsurance.

14           C. A credit shall not be allowed, as an admitted asset or as a  
15 deduction from liability, to any ceding insurer for reinsurance unless the  
16 reinsurance is payable by the reinsurer on the basis of the liability of the  
17 ceding insurer under the contracts reinsured without diminution because of  
18 the insolvency of the ceding insurer nor unless under the reinsurance  
19 contract the reinsurer assumes the liability for the reinsurance as of the  
20 same effective date. The reinsurer shall make payment directly to the ceding  
21 insurer or to its statutory successor by whatever name called for the purpose  
22 of liquidating or rehabilitating the business of the insurer unless either  
23 the reinsurance contract or the policies reinsured required the reinsurer to  
24 make payment to the payees under the policies reinsured in the event the  
25 ceding insurer becomes insolvent, or the reinsurer with the consent of the  
26 direct insured assumes the policy obligations of the ceding insurer to the  
27 payees under the policies reinsured in substitution for the obligations of  
28 the ceding insurer to those payees.

29           D. A domestic insurer shall not be a party to any agreement of  
30 reinsurance with an unauthorized insurer until the agreement is filed with  
31 and approved in writing by the director. The director shall approve the  
32 agreement within a reasonable time after filing unless in the director's  
33 opinion the effect of the agreement would be to reduce protection or service  
34 substantially either to policyholders resident of this state or to  
35 policyholders anywhere of the domestic insurer. If the director does not  
36 approve the agreement, the director shall notify the domestic insurer in  
37 writing specifying the reasons for not approving the agreement.

38           E. This section does not apply to insurance of ocean marine risks or  
39 marine protection and indemnity risks.

40           F. Unless the director requires the assuming insurer to file  
41 assumption reinsurance contracts, assumption reinsurance contracts are exempt  
42 from the filing requirements prescribed in subsection D if the assuming  
43 insurer has a surplus as to policyholders of at least fifty million dollars  
44 as shown in the most recent financial statement that is filed by the insurer  
45 with the department.



1           20-454. Programs for purchase by policyholders of securities of  
2                           companies not engaged in insurance

3           Notwithstanding the provisions of section 20-452 and notwithstanding  
4 any other provision of law, domestic life insurers, whether of the stock,  
5 mutual, fraternal, OR limited capital stock, ~~benefit stock or benefit type,~~  
6 ~~which,~~ THAT on January 1, 1955, are engaged pursuant to the requirements of  
7 TITLE 44, chapter 12 ~~of title 44,~~ in a program whereby the holders of their  
8 life insurance policies are offered the right from time to time to buy for  
9 cash or to exchange dividends on such policies or other policy values  
10 resulting therefrom for securities in domestic corporations neither engaged  
11 in nor organized to engage in the insurance business shall be permitted,  
12 subject to the requirements of TITLE 44, chapter 12 ~~of title 44,~~ to continue  
13 to engage in such program notwithstanding the adoption of this title, but no  
14 such insurer shall so engage unless the right to buy or the dividends or  
15 other policy values subject to exchange ~~results~~ RESULT from ownership of or  
16 ~~is~~ ARE payable on account of a policy ~~which~~ THAT from its inception is, or  
17 ~~which shall~~ THAT, within a period of not to exceed six years from its issue  
18 date, ~~become~~ BECOMES a life insurance policy on a permanent plan other than  
19 term. From and after being placed on such permanent plan, every such policy  
20 shall be in full compliance with sections 20-1231 and 20-1231.01 (standard  
21 nonforfeiture law), computed as from the date of being placed on such  
22 permanent plan. No such program shall be engaged in by the insurer  
23 subsequent to January 1, 1960, except that any such insurer may, subject to  
24 ~~chapter 12 of title 44,~~ CHAPTER 12, cause to be delivered stock in such  
25 corporation for an indefinite period subsequent to such limiting date if the  
26 right to acquire the stock arises as a result of a policy actually issued and  
27 delivered prior to such date.

28           Sec. 8. Section 20-461, Arizona Revised Statutes, is amended to read:

29           20-461. Unfair claim settlement practices

30           A. A person shall not commit or perform with such a frequency to  
31 indicate as a general business practice any of the following:

32           1. Misrepresenting pertinent facts or insurance policy provisions  
33 relating to coverages at issue.

34           2. Failing to acknowledge and act reasonably and promptly upon  
35 communications with respect to claims arising under an insurance policy.

36           3. Failing to adopt and implement reasonable standards for the prompt  
37 investigation of claims arising under an insurance policy.

38           4. Refusing to pay claims without conducting a reasonable  
39 investigation based upon all available information.

40           5. Failing to affirm or deny coverage of claims within a reasonable  
41 time after proof of loss statements have been completed.

42           6. Not attempting in good faith to effectuate prompt, fair and  
43 equitable settlements of claims in which liability has become reasonably  
44 clear.

1           7. Compelling insureds to institute litigation to recover amounts due  
2 under an insurance policy by offering substantially less than the amounts  
3 ultimately recovered in actions brought by the insureds.

4           8. Attempting to settle a claim for less than the amount to which a  
5 reasonable person would have believed he was entitled by reference to written  
6 or printed advertising material accompanying or made part of an application.

7           9. Attempting to settle claims on the basis of an application which  
8 was altered without notice to, or knowledge or consent of, the insured.

9           10. Making claims payments to insureds or beneficiaries not accompanied  
10 by a statement setting forth the coverage under which the payments are being  
11 made.

12           11. Making known to insureds or claimants a policy of appealing from  
13 arbitration awards in favor of insureds or claimants for the purpose of  
14 compelling them to accept settlements or compromises less than the amount  
15 awarded in arbitration.

16           12. Delaying the investigation or payment of claims by requiring an  
17 insured, a claimant or the physician of either to submit a preliminary claim  
18 report and then requiring the subsequent submission of formal proof of loss  
19 forms, both of which submissions contain substantially the same information.

20           13. Failing to promptly settle claims if liability has become  
21 reasonably clear under one portion of the insurance policy coverage in order  
22 to influence settlements under other portions of the insurance policy  
23 coverage.

24           14. Failing to promptly provide a reasonable explanation of the basis  
25 in the insurance policy relative to the facts or applicable law for denial  
26 of a claim or for the offer of a compromise settlement.

27           15. Attempting to settle claims for the replacement of any  
28 nonmechanical sheet metal or plastic part which generally constitutes the  
29 exterior of a motor vehicle, including inner and outer panels, with an  
30 aftermarket crash part which is not made by or for the manufacturer of an  
31 insured's motor vehicle unless the part meets the specifications of section  
32 44-1292 and unless the consumer is advised in a written notice attached to  
33 or printed on a repair estimate which:

34           (a) Clearly identifies each part.

35           (b) Contains the following information in ten point or larger type:

36           "This estimate has been prepared based on the use of replacement  
37 parts supplied by a source other than the manufacturer of your  
38 motor vehicle. Warranties applicable to these replacement parts  
39 are provided by the manufacturer or distributor of these parts  
40 rather than the manufacturer of your vehicle."

41           16. As an insurer subject to section 20-826, ~~20-934~~, 20-1342, 20-1402  
42 or 20-1404, or as an insurer of the same type as those subject to section  
43 20-826, ~~20-934~~, 20-1342, 20-1402 or 20-1404 that issues policies, contracts,  
44 plans, coverages or evidences of coverage for delivery in this state, failing  
45 to pay charges for reasonable and necessary services provided by any

1 physician licensed pursuant to title 32, chapter 8, 13 or 17, if the services  
2 are within the lawful scope of practice of the physician and the insurance  
3 coverage includes diagnosis and treatment of the condition or complaint,  
4 regardless of the nomenclature used to describe the condition, complaint or  
5 service.

6 17. Failing to comply with chapter 15 of this title.

7 B. Nothing in subsection A, paragraph 16 of this section shall be  
8 construed to prohibit the application of deductibles, coinsurance, preferred  
9 provider organization requirements, cost containment measures or quality  
10 assurance measures if they are equally applied to all types of physicians  
11 referred to in this section, and if any limitation or condition placed upon  
12 payment to or upon services, diagnosis or treatment by any physician covered  
13 by this section is equally applied to all physicians referred to in  
14 subsection A, paragraph 16 of this section, without discrimination to the  
15 usual and customary procedures of any type of physician.

16 C. In prescribing rules to implement this section, the director shall  
17 follow, to the extent appropriate, the national association of insurance  
18 commissioners unfair claims settlement practices model regulation.

19 D. Nothing contained in this section is intended to provide any  
20 private right or cause of action to or on behalf of any insured or uninsured  
21 resident or nonresident of this state. It is, however, the specific intent  
22 of this section to provide solely an administrative remedy to the director  
23 for any violation of this section or rule related thereto.

24 E. The director shall deposit, pursuant to sections 35-146 and 35-147,  
25 all civil penalties collected pursuant to this article in the state general  
26 fund.

27 Sec. 9. Section 20-488, Arizona Revised Statutes, is amended to read:  
28 20-488. Definitions

29 In this article, unless the context otherwise requires:

30 1. "Adjusted RBC report" means a report that has been adjusted by the  
31 director in accordance with section 20-488.01.

32 2. "Authorized control level event" means any of the following events:

33 (a) The filing of an RBC report by the insurer indicating that the  
34 insurer's total adjusted capital is more than or equal to its mandatory  
35 control level RBC but less than its authorized control level RBC.

36 (b) The notification by the director to the insurer of an adjusted RBC  
37 report that indicates the event under subdivision (a) of this paragraph,  
38 unless the insurer challenges the adjusted RBC report under section  
39 20-488.06.

40 (c) If the insurer challenges an adjusted RBC report that indicates  
41 the event under subdivision (a) of this paragraph, the notification by the  
42 director to the insurer that the director, after a hearing, has rejected the  
43 insurer's challenge.

1 (d) The failure of the insurer to satisfactorily respond to a  
2 corrective order, unless the insurer has challenged the corrective order  
3 under section 20-488.06.

4 (e) If the insurer challenges a corrective order and, after a hearing,  
5 the director rejects the challenge or modifies the corrective order, the  
6 failure of the insurer to satisfactorily respond to the corrective order  
7 after its modification or the rejection of the challenge by the director.

8 3. "Authorized control level RBC" means the number determined under  
9 the risk-based capital formula in accordance with the RBC instructions.

10 4. "Company action level event" means any of the following:

11 (a) The filing of an RBC report by an insurer indicating either that:

12 (i) The insurer's total adjusted capital is more than or equal to its  
13 regulatory action level RBC but less than its company action level RBC.

14 (ii) If the insurer is a life or health insurer, the insurer's total  
15 adjusted capital is more than or equal to its company action level RBC but  
16 less than the product of its authorized control level RBC and 2.5 and has a  
17 negative trend.

18 (b) The notification by the director to the insurer of an adjusted RBC  
19 report that indicates either of the events under subdivision (a) of this  
20 paragraph, unless the insurer challenges the adjusted RBC report under  
21 section 20-488.06.

22 (c) If the insurer challenges an adjusted RBC report that indicates  
23 either of the events under subdivision (a) of this paragraph, the  
24 notification by the director to the insurer that the director, after a  
25 hearing, has rejected the insurer's challenge.

26 5. "Company action level RBC" means, with respect to any insurer, the  
27 product of 2.0 and its authorized control level RBC.

28 6. "Corrective order" means an order that is issued by the director  
29 and that specifies corrective actions that the director has determined are  
30 required.

31 7. "Domestic insurer" means a life or health insurer, property or  
32 casualty insurer or health organization that is authorized to transact  
33 insurance business in this state and that is organized in this state.

34 8. "Foreign insurer" means a life or health insurer, property or  
35 casualty insurer or health organization that is authorized to transact  
36 insurance business in this state but that is not domiciled in this state.

37 9. "Health organization" means a hospital service corporation, medical  
38 service corporation, dental service corporation or optometric service  
39 corporation or a hospital, medical, dental and optometric service corporation  
40 that has a certificate of authority pursuant to chapter 4, article 3 of this  
41 title, a prepaid dental plan organization that has a certificate of authority  
42 pursuant to chapter 4, article 7 of this title or a health care services  
43 organization that has a certificate of authority pursuant to chapter 4,  
44 article 9 of this title.

1           10. "Life or health insurer" means an insurer authorized to transact  
2 life insurance, annuities or accident and health insurance in this state, or  
3 an authorized property or casualty insurer writing only accident and health  
4 insurance, but does not include fraternal benefit societies, hospital,  
5 medical, dental and optometric service corporations, health care services  
6 organizations, OR prepaid dental plan organizations or benefit insurers.

7           11. "Mandatory control level event" means any of the following:

8           (a) The filing of an RBC report by the insurer indicating that the  
9 insurer's total adjusted capital is less than its mandatory control level  
10 RBC.

11           (b) The notification by the director to the insurer of an adjusted RBC  
12 report that indicates the event under subdivision (a) of this paragraph,  
13 unless the insurer challenges the adjusted RBC report under section  
14 20-488.06.

15           (c) If the insurer challenges an adjusted RBC report that indicates  
16 the event under subdivision (a) of this paragraph, the notification by the  
17 director to the insurer that the director, after a hearing, has rejected the  
18 insurer's challenge.

19           12. "Mandatory control level RBC" means the product of .70 and the  
20 authorized control level RBC.

21           13. "Negative trend" means, with respect to a life or health  
22 insurer, a negative trend over a period of time as determined in accordance  
23 with the trend test calculation included in the RBC instructions.

24           14. "Property or casualty insurer" means an insurer licensed to  
25 transact insurance as described in section 20-256 or 20-252, respectively,  
26 but does not include monoline mortgage guaranty insurers, financial guaranty  
27 insurers and title insurers.

28           15. "RBC" means risk-based capital.

29           16. "RBC instructions" means the RBC report, including risk-based  
30 capital instructions adopted by the national association of insurance  
31 commissioners.

32           17. "RBC level" means an insurer's company action level RBC, regulatory  
33 action level RBC, authorized control level RBC or mandatory control level  
34 RBC.

35           18. "RBC plan" means a comprehensive financial plan containing the  
36 elements specified in section 20-488.02, subsection A. If the director  
37 rejects the RBC plan and the insurer revises the plan, regardless of the  
38 director's recommendation, the plan shall be called the revised RBC plan.

39           19. "RBC report" means the report required under section 20-488.01.

40           20. "Regulatory action level event" means, with respect to any insurer,  
41 any of the following events:

42           (a) The filing of an RBC report by the insurer indicating that the  
43 insurer's total adjusted capital is more than or equal to its authorized  
44 control level RBC but less than its regulatory action level RBC.

1 (b) The notification by the director to the insurer of an adjusted RBC  
2 report that indicates the event under subdivision (a) of this paragraph,  
3 unless the insurer challenges the adjusted RBC report under section  
4 20-488.06.

5 (c) If the insurer challenges an adjusted RBC report that indicates  
6 the event under subdivision (a) of this paragraph, the notification by the  
7 director to the insurer that the director, after a hearing, has rejected the  
8 insurer's challenge.

9 (d) The failure by the insurer to file an RBC report by the filing  
10 date, unless the insurer provides the director with a satisfactory  
11 explanation for the failure and cures the failure within ten days after the  
12 filing date.

13 (e) The failure by the insurer to submit an RBC plan to the director  
14 within the time period prescribed in section 20-488.02, subsection B.

15 (f) Notification by the director to the insurer that both:

16 (i) The RBC plan or revised RBC plan that the insurer submitted is,  
17 in the judgment of the director, unsatisfactory.

18 (ii) If the insurer has not challenged a determination pursuant to  
19 section 20-488.06, the notification constitutes a regulatory action level  
20 event.

21 (g) If the insurer challenges pursuant to section 20-488.06 a  
22 determination made by the director pursuant to subdivision (f) of this  
23 paragraph, the notification by the director to the insurer that the director,  
24 after a hearing, has rejected the insurer's challenge.

25 (h) If the insurer has not challenged the determination pursuant to  
26 section 20-488.06, the notification by the director to the insurer that the  
27 insurer has failed to adhere to the insurer's RBC plan or revised RBC plan  
28 and that states that failure has a substantial adverse effect on the  
29 insurer's ability to eliminate the regulatory action level event in  
30 accordance with its RBC plan or revised RBC plan.

31 (i) If the insurer challenges pursuant to section 20-488.06 a  
32 determination made by the director pursuant to subdivision (h) of this  
33 paragraph, the notification by the director to the insurer that the director,  
34 after a hearing, has rejected the insurer's challenge, unless the insurer's  
35 failure to adhere to its RBC plan or revised RBC plan does not have a  
36 substantial adverse effect on the insurer's ability to eliminate the  
37 regulatory action level event.

38 21. "Regulatory action level RBC" means the product of 1.5 and an  
39 insurer's authorized control level RBC.

40 22. "Total adjusted capital" means the sum of:

41 (a) An insurer's statutory capital and surplus.

42 (b) Any other items that the RBC instructions may provide.

43 Sec. 10. Section 20-611, Arizona Revised Statutes, is amended to read:  
44 20-611. Definitions

45 For the purpose of this article:

1           1. "Ancillary state" means any state other than a domiciliary state.

2           2. "Court" means, unless the context otherwise requires, the judge of  
3 the superior court assigned to the delinquency proceeding.

4           3. "Delinquency proceeding" means any proceeding commenced against an  
5 insurer pursuant to this article for the purpose of liquidating,  
6 rehabilitating, reorganizing or conserving such insurer.

7           4. "Domiciliary state" means the state in which an insurer is  
8 incorporated or organized, or in the case of an insurer incorporated or  
9 organized in a foreign country, the state in which such insurer, having  
10 become authorized to do business in such state, has, at the commencement of  
11 delinquency proceedings, the largest amount of its assets held in trust and  
12 assets held on deposit for the benefit of its policyholders or policyholders  
13 and creditors in the United States, and any such insurer is deemed to be  
14 domiciled in such state.

15           5. "Foreign country" means territory not in any state.

16           6. "General assets" means all property, real, personal or otherwise,  
17 not specifically mortgaged, pledged, deposited or otherwise encumbered for  
18 the security or benefit of specified persons or a limited class or classes  
19 of persons, and as to such specifically encumbered property the term includes  
20 all such property or its proceeds in excess of the amount necessary to  
21 discharge the amount or amounts secured thereby. Assets held in trust and  
22 assets held on deposit for the security or benefit of all policyholders or  
23 all policyholders and creditors in the United States shall be deemed general  
24 assets.

25           7. "Impairment" or "insolvency" means that the capital of a stock  
26 insurer, ~~OR limited capital stock insurer or benefit stock insurer~~, or the  
27 surplus of a mutual or reciprocal insurer, shall be deemed to be impaired and  
28 the insurer shall be deemed to be insolvent, when such insurer is not  
29 possessed of assets at least equal to all liabilities and required reserves  
30 together with its total issued and outstanding capital stock if a stock  
31 insurer, or the minimum surplus if a mutual or reciprocal insurer, required  
32 by this title to be maintained for the kind or kinds of insurance it is then  
33 authorized to transact.

34           8. "Insurer" means any person, firm, corporation, association or  
35 aggregation of persons doing an insurance business and subject to the  
36 insurance supervisory authority of, or to liquidation, rehabilitation,  
37 reorganization or conservation by the director or the equivalent insurance  
38 supervisory official of another state.

39           9. "Preferred claim" means any claim with respect to which the law of  
40 the state or of the United States accords priority of payments from the  
41 general assets of the insurer.

42           10. "Receiver" means the director as receiver, liquidator,  
43 rehabilitator or conservator as the context may require.

44           11. "Reciprocal state" means any state other than this state in which  
45 in substance and effect the provisions of the uniform insurers liquidation

1 act, as defined in section 20-631, are in force, including the provisions  
2 requiring that the director of insurance or equivalent insurance supervisory  
3 official be the receiver of a delinquent insurer.

4 12. "Secured claim" means any claim secured by mortgage, trust deed,  
5 pledge, deposit as security, escrow or otherwise, including federal, state  
6 or local tax liens that are perfected before the commencement of a  
7 delinquency proceeding but not including a special deposit claim or claims  
8 against general assets. The term also includes claims which THAT more than  
9 four months prior to the commencement of delinquency proceedings in the state  
10 of the insurer's domicile have become liens upon ON specific assets by reason  
11 of judicial process.

12 13. "Special deposit claim" means any claim secured by a deposit made  
13 pursuant to statute for the security or benefit of a limited class or classes  
14 of persons, but not including any general assets.

15 14. "State" means any state of the United States, the District of  
16 Columbia and the territories and possessions of the United States.

17 Sec. 11. Section 20-708, Arizona Revised Statutes, is amended to read:  
18 20-708. Limited stock insurers

19 A. Domestic limited stock insurers may be formed, with capital and  
20 surplus as specified in sections 20-210 and 20-211, to transact life and  
21 disability insurance only or both, except as provided in subsection B of this  
22 section, but, such an insurer may not:

23 1. Issue any policy or policies or combination of policies of life or  
24 disability insurance whether individual or group as a direct writer.

25 2. Accept any risk as a reinsurer under which the maximum possible  
26 benefits payable on the death or on the disability of any one insured shall  
27 exceed five thousand dollars nor without reinsuring the excess over three  
28 thousand dollars by noncancellable reinsurance authorized under section  
29 20-261. Any risk accepted as a reinsurer under this paragraph shall be a  
30 risk under which the ceding life or disability insurer remains liable for the  
31 payment of all policyholder claims.

32 B. Prior to, but not after January 31, 1980, any domestic limited  
33 stock insurer which THAT on January 31, 1969 was the holder of a valid  
34 certificate of authority and which THAT on or before such date had policy  
35 forms approved as provided by this title and had sold and issued any such  
36 policies shall continue to have the right and privilege to issue life and  
37 disability policies direct without regard to the prohibition prescribed in  
38 subsection A of this section, but such company shall not:

39 1. Issue any policy or combination of life insurance policies or  
40 accept any risk direct under which the maximum possible benefits payable on  
41 the death of any one insured shall exceed five thousand dollars nor without  
42 reinsuring the excess over three thousand dollars by noncancellable  
43 reinsurance authorized under section 20-261.

44 2. Issue any policy or combination of disability insurance policies,  
45 or accept any disability risk direct under which the maximum possible

1 benefits payable to or on account of any one insured shall exceed five  
2 thousand dollars.

3 3. Issue pure endowment policies or annuity contracts, but this  
4 ~~provision shall~~ PARAGRAPH DOES not prohibit the insurer from issuing life  
5 insurance endowment policies, limited payment life and other standard plans  
6 of life insurance policies, nor from providing therein standard settlement  
7 options.

8 C. With appropriate powers in its articles of incorporation by  
9 increase of its authorized and paid-in capital and its surplus funds to the  
10 minimum amount required therefor by this title as for an insurer newly formed  
11 and upon ON application therefor to the director, a domestic limited stock  
12 insurer may become a domestic stock insurer free from the restrictions  
13 otherwise imposed by this section.

14 D. A domestic limited stock insurer may accept reinsurance of risks  
15 of life or disability stock insurers ~~or benefit insurers~~ or stock reinsurers,  
16 subject to limits as to amount of insurance as to anyone insured as set forth  
17 in this section.

18 Sec. 12. Repeal

19 Title 20, chapter 4, articles 5 and 6, Arizona Revised Statutes, are  
20 repealed.

21 Sec. 13. Section 20-1133, Arizona Revised Statutes, is amended to  
22 read:

23 20-1133. Medicare supplement insurance; applicability

24 A. The director shall adopt those rules as are necessary to comply  
25 with the requirements of the social security disability amendments of 1980  
26 (P.L. 96-265; 42 U.S.C. UNITED STATES CODE section 1395ss) and any federal  
27 laws or regulations pertaining to that section, so that this state may retain  
28 its full authority to regulate minimum standards for medicare supplement  
29 insurance.

30 B. Subject to the other limitations provided in this subsection, no  
31 benefit mandated in this title for health insurance policies shall apply to  
32 medicare supplement insurance policies unless such mandated policy benefits  
33 are set forth in rules adopted pursuant to this section or unless the statute  
34 mandating policy benefits expressly states that it is made specifically  
35 applicable to medicare supplement insurance policies. No medicare supplement  
36 insurance policy shall contain any exclusion for services provided by any  
37 type of properly licensed health care provider if the provider's services are  
38 eligible for medicare reimbursement and if the specific services in question  
39 would be covered by medicare. In no event shall the scope of benefits of a  
40 medicare supplement policy be less than the minimum level of benefits  
41 established by federal law.

42 C. Notwithstanding any other provision of this title, rules adopted  
43 pursuant to this section apply to insurance furnished under disability  
44 insurance policies, under subscription contracts of hospital, medical, dental  
45 or optometric service corporations, under certificates of fraternal benefit

1 ~~societies, under policies of benefit insurers or benefit stock insurers,~~  
2 ~~under evidences of coverage of health care services organizations and under~~  
3 ~~coverages issued by any other insurer, which policies, contracts,~~  
4 ~~certificates, membership coverages, evidences of coverage and coverages are~~  
5 ~~delivered or issued for delivery in this state on or after the effective date~~  
6 ~~of rules adopted pursuant to subsection A. In adopting the rules required~~  
7 ~~by subsection A, the director shall prescribe an effective date of the rules~~  
8 ~~which THAT will allow insurers sufficient time to bring their forms and~~  
9 ~~practices into compliance with the requirements of the rule.~~

10 Sec. 14. Section 20-1134, Arizona Revised Statutes, is amended to  
11 read:

12 20-1134. Coordination of benefits

13 The director shall adopt rules relating to coordination of benefits  
14 provisions in group disability insurance policies. This section shall apply  
15 to hospital and medical service corporations, ~~AND health care service~~  
16 ~~SERVICES organizations, and benefit insurers.~~

17 Sec. 15. Section 20-1379, Arizona Revised Statutes, as amended by Laws  
18 2000, chapter 355, section 10, is amended to read:

19 20-1379. Guaranteed availability of individual health insurance  
20 coverage; prior group coverage; definitions

21 A. Every health care insurer that offers individual health insurance  
22 coverage in the individual market in this state shall provide guaranteed  
23 availability of coverage to an eligible individual who desires to enroll in  
24 individual health insurance coverage and shall not:

25 1. Decline to offer that coverage to, or deny enrollment of, that  
26 individual.

27 2. Impose any preexisting condition exclusion for that coverage.

28 B. Every health care insurer that offers individual health insurance  
29 coverage in the individual market in this state shall offer all policy forms  
30 of health insurance coverage that are designed for, are made generally  
31 available and actively marketed to and enroll both eligible or other  
32 individuals. A health care insurer that offers only one policy form in the  
33 individual market complies with this section by offering that form to  
34 eligible individuals. A health care insurer also may comply with the  
35 requirements of this section by electing to offer at least two different  
36 policy forms to eligible individuals as provided by subsection C of this  
37 section.

38 C. A health care insurer shall meet the requirements prescribed in  
39 subsection B of this section if:

40 1. The health care insurer offers at least two different policy forms,  
41 both of which are designed for, made generally available and actively  
42 marketed to and enroll both eligible and other individuals.

43 2. The offer includes at least either:

44 (a) The policy forms with the largest and next to the largest earned  
45 premium volume of all policy forms offered by the health care insurer in this

1 state in the individual market during a period not to exceed the preceding  
2 two calendar years.

3 (b) A choice of two policy forms with representative coverage,  
4 consisting of a lower level of coverage policy form and a higher level of  
5 coverage policy form, each of which includes benefits that are substantially  
6 similar to other individual health insurance coverage offered by the health  
7 care insurer in this state and each of which is covered by a method that  
8 provides for risk adjustment, risk spreading or a risk spreading mechanism  
9 among the health care insurer's policies.

10 D. The health care insurer's election pursuant to subsection C of this  
11 section is effective for policies offered during a period of at least two  
12 years.

13 E. If a health care insurer offers individual health insurance  
14 coverage in the individual market through a network plan, the health care  
15 insurer may do both of the following:

16 1. Limit the individuals who may be enrolled under health insurance  
17 coverage to those who live, reside or work within the service area for a  
18 network plan.

19 2. Within the service area of a network plan, deny health insurance  
20 coverage to individuals if the health care insurer has demonstrated, if  
21 required, to the director that both:

22 (a) The health care insurer will not have the capacity to deliver  
23 services adequately to additional individual enrollees because of the health  
24 care insurer's obligations to existing group contract holders and enrollees  
25 and individual enrollees.

26 (b) The health care insurer is applying this paragraph uniformly to  
27 individuals without regard to any health status-related factor of the  
28 individuals and without regard to whether the individuals are eligible  
29 individuals.

30 F. A health care insurer may deny individual health insurance coverage  
31 in the individual market to an eligible individual if the health care insurer  
32 demonstrates to the director that the health care insurer:

33 1. Does not have the financial reserves necessary to underwrite  
34 additional coverage.

35 2. Is denying coverage uniformly to all individuals in the individual  
36 market in this state pursuant to state law and without regard to any health  
37 status-related factor of the individuals and without regard to whether the  
38 individuals are eligible individuals.

39 G. If a health care insurer denies health insurance coverage in this  
40 state pursuant to subsection F of this section, the health care insurer shall  
41 not offer that coverage in the individual market in this state for one  
42 hundred eighty days after the date the coverage is denied or until the health  
43 care insurer demonstrates to the director that the health care insurer has  
44 sufficient financial reserves to underwrite additional coverage, whichever  
45 is later.

1 H. An accountable health plan as defined in section 20-2301 that  
2 offers conversion policies on an individual or group basis in connection with  
3 a health benefits plan pursuant to this title is not a health care insurer  
4 that offers individual health insurance coverage solely because of the offer  
5 of a conversion policy.

6 I. Nothing in this section:

7 1. Creates additional restrictions on the amount of the premium rates  
8 that a health care insurer may charge an individual for health insurance  
9 coverage provided in the individual market.

10 2. Prevents a health care insurer that offers health insurance  
11 coverage in the individual market from establishing premium rates or  
12 modifying otherwise applicable copayments or deductibles in return for  
13 adherence to programs of health promotion and disease prevention.

14 3. Requires a health care insurer that offers only short-term limited  
15 duration insurance limited benefit coverage or to individuals and no other  
16 coverage to individuals in the individual market to offer individual health  
17 insurance coverage in the individual market.

18 4. Requires a health care insurer offering health care coverage only  
19 on a group basis or through one or more bona fide associations, or both, to  
20 offer health insurance coverage in the individual market.

21 J. A health care insurer shall provide, without charge, a written  
22 certificate of creditable coverage as described in this section for  
23 creditable coverage occurring after June 30, 1996 if the individual:

24 1. Ceases to be covered under a policy offered by a health care  
25 insurer. An individual who is covered by a policy that is issued on a group  
26 basis by a health care insurer, that is terminated or not renewed at the  
27 choice of the sponsor of the group and where the replacement of the coverage  
28 is without a break in coverage is not entitled to receive the certification  
29 prescribed in this paragraph but is instead entitled to receive the  
30 certification prescribed in paragraph 2 of this subsection.

31 2. Requests certification from the health care insurer within  
32 twenty-four months after the coverage under a health insurance coverage  
33 policy offered by a health care insurer ceases.

34 K. The certificate of creditable coverage provided by a health care  
35 insurer is a written certification of the period of creditable coverage of  
36 the individual under the health insurance coverage offered by the health care  
37 insurer. The department may enforce and monitor the issuance and delivery  
38 of the notices and certificates by health care insurers as required by this  
39 section, section 20-1380, the health insurance portability and accountability  
40 act of 1996 (P.L. 104-191; 110 Stat. 1936) and any federal regulations  
41 adopted to implement the health insurance portability and accountability act  
42 of 1996.

43 L. Any health care insurer, accountable health plan or other entity  
44 that issues health care coverage in this state, as applicable, shall issue

1 and accept a certificate of creditable coverage of the individual that  
2 contains at least the following information:

- 3 1. The date that the certificate is issued.
- 4 2. The name of the individual or dependent for whom the certificate  
5 applies and any other information that is necessary to allow the issuer  
6 providing the coverage specified in the certificate to identify the  
7 individual, including the individual's identification number under the policy  
8 and the name of the policyholder if the certificate is for or includes a  
9 dependent.
- 10 3. The name, address and telephone number of the issuer providing the  
11 certificate.
- 12 4. The telephone number to call for further information regarding the  
13 certificate.
- 14 5. One of the following:
  - 15 (a) A statement that the individual has at least eighteen months of  
16 creditable coverage. For purposes of this subdivision, eighteen months means  
17 five hundred forty-six days.
  - 18 (b) Both the date that the individual first sought coverage, as  
19 evidenced by a substantially complete application, and the date that  
20 creditable coverage began.
- 21 6. The date creditable coverage ended, unless the certificate  
22 indicates that creditable coverage is continuing from the date of the  
23 certificate.
- 24 7. The consumer assistance telephone number for the department.
- 25 8. The following statement in at least fourteen point type:

26 **Important notice!**

27 Keep this certificate with your important personal records to  
28 protect your rights under the health insurance portability and  
29 accountability act of 1996 ("HIPAA"). This certificate is proof  
30 of your prior health insurance coverage. You may need to show  
31 this certificate to have a guaranteed right to buy new health  
32 insurance ("Guaranteed issue"). This certificate may also help  
33 you avoid waiting periods or exclusions for preexisting  
34 conditions. Under HIPAA, these rights are guaranteed only for  
35 a very short time period. After your group coverage ends, you  
36 must apply for new coverage within 63 days to be protected by  
37 HIPAA. If you have questions, call the Arizona department of  
38 insurance.

39 M. A health care insurer has satisfied the certification requirement  
40 under this section if the insurer offering the health benefits plan provides  
41 the certificate of creditable coverage in accordance with this section within  
42 thirty days after the event that triggered the issuance of the certificate.

43 N. Periods of creditable coverage for an individual are established  
44 by the presentation of the certificate described in this section and section  
45 20-2310. In addition to the written certificate of creditable coverage as

1 described in this section, individuals may establish creditable coverage  
2 through the presentation of documents or other means. In order to make a  
3 determination that is based on the relevant facts and circumstances of the  
4 amount of creditable coverage that an individual has, a health care insurer  
5 shall take into account all information that the insurer obtains or that is  
6 presented to the insurer on behalf of the individual.

7       0. A health care insurer shall calculate creditable coverage according  
8 to the following rules:

9       1. The health care insurer shall allow an individual credit for each  
10 day the individual was covered by creditable coverage.

11       2. The health care insurer shall not count a period of creditable  
12 coverage for an individual enrolled under any form of health insurance  
13 coverage if after the period of coverage and before the enrollment date there  
14 were sixty-three consecutive days during which the individual was not covered  
15 by any creditable coverage.

16       3. The health care insurer shall not include any period that an  
17 individual is in a waiting period or an affiliation period for any health  
18 coverage or is awaiting action by a health care insurer on an application for  
19 the issuance of health insurance coverage when the health care insurer  
20 determines the continuous period pursuant to paragraph 1 of this subsection.

21       4. The health care insurer shall not include any period that an  
22 individual is waiting for approval of an application for health care  
23 coverage, provided the individual submitted an application to the health care  
24 insurer for health care coverage within sixty-three consecutive days after  
25 the individual's most recent creditable coverage.

26       5. The health care insurer shall not count a period of creditable  
27 coverage with respect to enrollment of an individual, if, after the most  
28 recent period of creditable coverage and before the enrollment date,  
29 sixty-three consecutive days lapse during all of which the individual was not  
30 covered under any creditable coverage. The health care insurer shall not  
31 include in the determination of the period of continuous coverage described  
32 in this section any period that an individual is in a waiting period for  
33 health insurance coverage offered by a health care insurer, is in a waiting  
34 period for benefits under a health benefits plan offered by an accountable  
35 health plan or is in an affiliation period.

36       6. In determining the extent to which an individual has satisfied any  
37 portion of any applicable preexisting condition period the health care  
38 insurer shall count a period of creditable coverage without regard to the  
39 specific benefits covered during that period.

40       P. An individual is an eligible individual if, on the date the  
41 individual seeks coverage pursuant to this section, the individual has an  
42 aggregate period of creditable coverage as defined and calculated pursuant  
43 to this section of at least eighteen months and all of the following apply:

44       1. The most recent creditable coverage for the individual was under  
45 a plan offered by:

1 (a) An employee welfare benefit plan that provides medical care to  
2 employees or the employees' dependents directly or through insurance,  
3 reimbursement or otherwise pursuant to the employee retirement income  
4 security act of 1974 (P.L. 93-406; 88 Stat. 829; 29 United States Code  
5 sections 1001 through 1461).

6 (b) A church plan as defined in the employee retirement income  
7 security act of 1974.

8 (c) A governmental plan as defined in the employee retirement income  
9 security act of 1974, including a plan established or maintained for its  
10 employees by the government of the United States or by any agency or  
11 instrumentality of the United States.

12 (d) An accountable health plan as defined in section 20-2301.

13 (e) A plan made available to a person defined as eligible pursuant to  
14 section 36-2901, paragraph 4, subdivision (f) or a dependent pursuant to  
15 section 36-2901, paragraph 4, subdivision (g) of a person eligible under  
16 section 36-2901, paragraph 4, subdivision (f), provided the person was most  
17 recently employed by a business in this state with at least two but not more  
18 than fifty full-time employees.

19 2. The individual is not eligible for coverage under:

20 (a) An employee welfare benefit plan that provides medical care to  
21 employees or the employees' dependents directly or through insurance,  
22 reimbursement or otherwise pursuant to the employee retirement income  
23 security act of 1974.

24 (b) A health benefits plan issued by an accountable health plan as  
25 defined in section 20-2301.

26 (c) Part A or part B of title XVIII of the social security act.

27 (d) Title 36, chapter 29, except coverage to persons defined as  
28 eligible under section 36-2901, paragraph 4, subdivisions (d), (e), (f) and  
29 (g), or any other plan established under title XIX of the social security  
30 act, and the individual does not have other health insurance coverage.

31 3. The most recent coverage within the coverage period was not  
32 terminated based on any factor described in section 20-2309, subsection B,  
33 paragraph 1 or 2 relating to nonpayment of premiums or fraud.

34 4. The individual was offered and elected the option of continuation  
35 coverage under a COBRA continuation provision pursuant to the consolidated  
36 omnibus budget reconciliation act of 1985 (P.L. 99-272; 100 Stat. 82) or a  
37 similar state program.

38 5. The individual exhausted the continuation coverage pursuant to the  
39 consolidated omnibus budget reconciliation act of 1985.

40 Q. Notwithstanding subsection P of this section, a newborn child,  
41 adopted child or child placed for adoption is an eligible individual if the  
42 child was timely enrolled and otherwise would have met the definition of an  
43 eligible individual as prescribed in this section other than the required  
44 period of creditable coverage and the child is not subject to any preexisting  
45 condition exclusion or limitation if the child has been continuously covered

1 under health insurance coverage or a health benefits plan offered by an  
2 accountable health plan since birth, adoption or placement for adoption.

3 R. If a health care insurer imposes a waiting period for coverage of  
4 preexisting conditions, within a reasonable period of time after receiving  
5 an individual's proof of creditable coverage and not later than the date by  
6 which the individual must select an insurance plan, the health care insurer  
7 shall give the individual written disclosure of the insurer's determination  
8 regarding any preexisting condition exclusion period that applies to that  
9 individual. The disclosure shall include all of the following information:

10 1. The period of creditable coverage allowed toward the waiting period  
11 for coverage of preexisting conditions.

12 2. The basis for the insurer's determination and the source and  
13 substance of any information on which the insurer has relied.

14 3. A statement of any right the individual may have to present  
15 additional evidence of creditable coverage and to appeal the insurer's  
16 determination, including an explanation of any procedures for submission and  
17 appeal.

18 S. This section and section 20-1380 apply to all health insurance  
19 coverage that is offered, sold, issued, renewed, in effect or operated in the  
20 individual market after June 30, 1997, regardless of when a period of  
21 creditable coverage occurs.

22 T. For the purposes of this section and section 20-1380 as applicable:

23 1. "Affiliation period" has the same meaning prescribed in section  
24 20-2301.

25 2. "Bona fide association" means, for health care coverage issued by  
26 a health care insurer, an association that meets the requirements of section  
27 20-2324.

28 3. "Creditable coverage" means coverage solely for an individual,  
29 other than limited benefits coverage, under any of the following:

30 (a) An employee welfare benefit plan that provides medical care to  
31 employees or the employees' dependents directly or through insurance,  
32 reimbursement or otherwise pursuant to the employee retirement income  
33 security act of 1974.

34 (b) A church plan as defined in the employee retirement income  
35 security act of 1974.

36 (c) A health benefits plan issued by an accountable health plan as  
37 defined in section 20-2301.

38 (d) Part A or part B of title XVIII of the social security act.

39 (e) Title XIX of the social security act, other than coverage  
40 consisting solely of benefits under section 1928.

41 (f) Title 10, chapter 55 of the United States Code.

42 (g) A medical care program of the Indian health service or of a tribal  
43 organization.

44 (h) A health benefits risk pool operated by any state of the United  
45 States.

1 (i) A health plan offered pursuant to title 5, chapter 89 of the  
2 United States Code.

3 (j) A public health plan as defined by federal law.

4 (k) A health benefit plan pursuant to section 5(e) of the peace corps  
5 act (P.L. 87-293; 75 Stat. 612; 22 United States Code sections 2501 through  
6 2523).

7 (l) A policy or contract, including short-term limited duration  
8 insurance, issued on an individual basis by an insurer, a health care  
9 services organization, a hospital service corporation, a medical service  
10 corporation or a hospital, medical, dental and optometric service corporation  
11 or made available to persons defined as eligible under section 36-2901,  
12 paragraph 4, subdivision (d), (e), (f) or (g).

13 (m) A policy or contract issued by a health care insurer or an  
14 accountable health plan to a member of a bona fide association.

15 4. "Different policy forms" means variations between policy forms  
16 offered by a health care insurer, including policy forms which have different  
17 cost sharing arrangements or different riders.

18 5. "Genetic information" means information about genes, gene products  
19 and inherited characteristics that may derive from the individual or a family  
20 member, including information regarding carrier status and information  
21 derived from laboratory tests that identify mutations in specific genes or  
22 chromosomes, physical medical examinations, family histories and direct  
23 analysis of genes or chromosomes.

24 6. "Health care insurer" means a disability insurer, group disability  
25 insurer, blanket disability insurer, ~~benefit insurer~~, health care services  
26 organization, hospital service corporation, medical service corporation or  
27 a hospital, medical, dental and optometric service corporation.

28 7. "Health status-related factor" means any factor in relation to the  
29 health of the individual or a dependent of the individual enrolled or to be  
30 enrolled in a health care services organization including:

31 (a) Health status.

32 (b) Medical condition, including physical and mental illness.

33 (c) Claims experience.

34 (d) Receipt of health care.

35 (e) Medical history.

36 (f) Genetic information.

37 (g) Evidence of insurability, including conditions arising out of acts  
38 of domestic violence as defined in section 20-448.

39 (h) The existence of a physical or mental disability.

40 8. "Higher level of coverage" means a policy form for which the  
41 actuarial value of the benefits under the health insurance coverage offered  
42 by a health care insurer is at least fifteen per cent more than the actuarial  
43 value of the health insurance coverage offered by the health care insurer as  
44 a lower level of coverage in this state but not more than one hundred twenty  
45 per cent of a policy form weighted average.

1           9. "Individual health insurance coverage" means health insurance  
2 coverage offered by a health care insurer to individuals in the individual  
3 market but does not include limited benefit coverage or short-term limited  
4 duration insurance. A health care insurer that offers limited benefit  
5 coverage or short-term limited duration insurance to individuals and no other  
6 coverage to individuals in the individual market is not a health care insurer  
7 that offers health insurance coverage in the individual market.

8           10. "Limited benefit coverage" has the same meaning prescribed in  
9 section 20-1137.

10           11. "Lower level of coverage" means a policy form offered by a health  
11 care insurer for which the actuarial value of the benefits under the health  
12 insurance coverage is at least eighty-five per cent but not more than one  
13 hundred per cent of the policy form weighted average.

14           12. "Network plan" means a health care plan provided by a health care  
15 insurer under which the financing and delivery of health care services are  
16 provided, in whole or in part, through a defined set of providers under  
17 contract with the health care insurer in accordance with the determination  
18 made by the director pursuant to section 20-1053 regarding the geographic or  
19 service area in which a health care insurer may operate.

20           13. "Policy form weighted average" means the average actuarial value  
21 of the benefits provided by a health care insurer that issues health coverage  
22 in this state that is provided by either the health care insurer or, if the  
23 data are available, by all health care insurers that issue health coverage  
24 in this state in the individual health coverage market during the previous  
25 calendar year, except coverage pursuant to this section, weighted by the  
26 enrollment for all coverage forms.

27           14. "Preexisting condition" means a condition, regardless of the cause  
28 of the condition, for which medical advice, diagnosis, care, or treatment was  
29 recommended or received within not more than six months before the date of  
30 the enrollment of the individual under the health insurance policy or other  
31 contract that provides health coverage benefits. A genetic condition is not  
32 a preexisting condition in the absence of a diagnosis of the condition  
33 related to the genetic information and shall not result in a preexisting  
34 condition limitation or preexisting condition exclusion.

35           15. "Preexisting condition limitation" or "preexisting condition  
36 exclusion" means a limitation or exclusion of benefits for a preexisting  
37 condition under a health insurance policy or other contract that provides  
38 health coverage benefits.

39           16. "Short-term limited duration insurance" means health insurance  
40 coverage that is offered by a health care insurer, that remains in effect for  
41 no more than one hundred eighty-five days, that cannot be renewed or  
42 otherwise continued for more than one hundred eighty days and that is not  
43 intended or marketed as health insurance coverage subject to guaranteed  
44 issuance or guaranteed renewal provisions of the laws of this state but that

1 is creditable coverage within the meaning of this section and section  
2 20-2301.

3 Sec. 16. Section 20-2501, Arizona Revised Statutes, is amended to  
4 read:

5 20-2501. Definitions; scope

6 A. In this chapter, unless the context otherwise requires:

7 1. "Adverse decision" means a utilization review determination by the  
8 utilization review agent that a requested service or claim for service is not  
9 a covered service or is not medically necessary under the plan if that  
10 determination results in a documented denial or nonpayment of the service or  
11 claim.

12 2. "Benefits based on the health status of the insured" means a  
13 contract of insurance to pay a fixed benefit amount, without regard to the  
14 specific services received, to a policyholder who meets certain eligibility  
15 criteria based on health status including:

16 (a) A disability income insurance policy that pays a fixed daily,  
17 weekly or monthly benefit amount to an insured who is deemed disabled as  
18 defined by the policy terms.

19 (b) A hospital indemnity policy that pays a fixed daily benefit during  
20 hospital confinement.

21 (c) A disability insurance policy that pays a fixed daily, weekly or  
22 monthly benefit amount to an insured who is certified by a licensed health  
23 care professional as chronically ill as defined by the policy terms.

24 (d) A disability insurance policy that pays a fixed daily, weekly or  
25 monthly benefit amount to an insured who suffers from a prolonged physical  
26 illness, disability or cognitive disorder as defined by the policy terms.

27 3. "Claim" means a request for payment for a service already provided.  
28 Claim does not include:

29 (a) Claim adjustments for usual and customary charges for a service  
30 or coordination of benefits between health care insurers.

31 (b) A request for payment under a policy or contract that pays  
32 benefits based on the health status of the insured and that does not  
33 reimburse the cost of or provide covered services.

34 4. "Covered service" means a service that is included in a policy,  
35 evidence of coverage or similar document that specifies which services,  
36 insurance or other benefits are included or covered.

37 5. "Denial" means a direct or indirect determination regarding all or  
38 part of a request for any service or a direct determination regarding a claim  
39 that may trigger a request for review or reconsideration. Denial does not  
40 include:

41 (a) Enforcement of a health care insurer's deductibles, copayments or  
42 coinsurance requirements or adjustments for usual and customary charges,  
43 deductibles, copayments or coinsurance requirements for a service or  
44 coordination of benefits between health care insurers.

1 (b) The rejection of a request for payment under a policy or contract  
2 that pays benefits based on the health status of the insured and that does  
3 not reimburse the cost of or provide covered services.

4 6. "Department" means the department of insurance.

5 7. "Director" means the director of the department of insurance.

6 8. "Health care insurer" means a disability insurer, group disability  
7 insurer, blanket disability insurer, ~~benefit insurer~~, health care services  
8 organization, hospital service corporation, prepaid dental plan organization,  
9 medical service corporation, dental service corporation or optometric service  
10 corporation or a hospital, medical, dental and optometric service  
11 corporation.

12 9. "Indirect denial" means a failure to communicate authorization or  
13 nonauthorization to the member by the utilization review agent within ten  
14 business days after the utilization review agent receives the request for a  
15 covered service.

16 10. "Provider" means the physician or other licensed practitioner  
17 identified to the utilization review agent as having primary responsibility  
18 for providing care, treatment and services rendered to a patient.

19 11. "Service" means a diagnostic or therapeutic medical or health care  
20 service, benefit or treatment.

21 12. "Utilization review" means a system for reviewing the appropriate  
22 and efficient allocation of inpatient hospital resources, inpatient medical  
23 services and outpatient surgery services that are being given or are proposed  
24 to be given to a patient, and of any medical, surgical and health care  
25 services or claims for services that may be covered by a health care insurer  
26 depending on determinable contingencies, including without limitation  
27 outpatient services, in-office consultations with medical specialists,  
28 specialized diagnostic testing, mental health services, emergency care and  
29 inpatient and outpatient hospital services. Utilization review does not  
30 include elective requests for the clarification of coverage.

31 13. "Utilization review agent" means a person or entity that performs  
32 utilization review. For purposes of article 2 of this chapter, utilization  
33 review agent has the same meaning prescribed in section 20-2530. For purposes  
34 of this chapter, utilization review agent does not include:

35 (a) A governmental agency.

36 (b) An agent that acts on behalf of the governmental agency.

37 (c) An employee of a utilization review agent.

38 14. "Utilization review plan" means a summary description of the  
39 utilization review guidelines, protocols, procedures and written standards  
40 and criteria of a utilization review agent.

41 B. For the purposes of this chapter, utilization review by an  
42 optometric service corporation applies only to nonsurgical medical and health  
43 care services.

44 Sec. 17. Section 20-3101, Arizona Revised Statutes, is amended to  
45 read:





1 meet the circumstances specified in contract under which the administration  
2 could operate the entity directly or that the public health, safety or  
3 welfare require emergency action relative to the entity, the director shall  
4 notify the director of the department of insurance and may request that the  
5 department of insurance take appropriate actions.

6 Sec. 20. Laws 2000, chapter 37, section 36 is amended to read:

7 Sec. 36. Contracted chiropractic physicians; report to the  
8 department of insurance

9 Any ~~benefit insurer pursuant to section 20-936.03, Arizona Revised~~  
10 ~~Statutes, as added by this act or health care services organization pursuant~~  
11 ~~to section 20-1057.03, Arizona Revised Statutes, as added by this act, shall~~  
12 submit an annual report to the director of the department of insurance on or  
13 before January 1 that includes the number of chiropractic physicians under  
14 contract with the ~~benefit insurer or health care services organization and~~  
15 the name and address for each contracted chiropractic physician.

APPROVED BY THE GOVERNOR APRIL 6, 2001.

FILED IN THE OFFICE OF THE SECRETARY OF STATE APRIL 6, 2001.

Passed the House April 03, 20 01,

by the following vote: 60 Ayes,

0 Nays, 0 Not Voting

[Signature]  
Speaker of the House

[Signature]  
Chief Clerk of the House

Passed the Senate January 22, 20 01,

by the following vote: 28 Ayes,

0 Nays, 2 Not Voting

[Signature]  
President of the Senate

[Signature]  
Secretary of the Senate

EXECUTIVE DEPARTMENT OF ARIZONA  
OFFICE OF GOVERNOR

This Bill was received by the Governor this

4 day of April, 2001,

at 11:58 o'clock A M.

[Signature]  
Secretary to the Governor

Approved this 6 day of

April, 2001,

at 11:12 o'clock A M.

[Signature]  
Governor of Arizona

S.B. 1022

EXECUTIVE DEPARTMENT OF ARIZONA  
OFFICE OF SECRETARY OF STATE

This Bill was received by the Secretary of State

this 6 day of April, 2001,

at 4:00 o'clock P M.

[Signature]  
Secretary of State