

REFERENCE TITLE: insurance; unfair practices; utilization review

State of Arizona  
Senate  
Fifty-first Legislature  
First Regular Session  
2013

## **SB 1362**

Introduced by  
Senator Murphy; Representative Allen; Senators Barto, Bradley;  
Representative Lovas

AN ACT

AMENDING SECTIONS 20-461, 20-2508 AND 20-2510, ARIZONA REVISED STATUTES;  
RELATING TO INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

2 Section 1. Section 20-461, Arizona Revised Statutes, is amended to  
3 read:

4 20-461. Unfair claim settlement practices

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

7 1. Misrepresenting pertinent facts or insurance policy provisions  
8 relating to coverages at issue.

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

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

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

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

17 6. Not attempting in good faith to effectuate prompt, fair and  
18 equitable settlements of claims in which liability has become reasonably  
19 clear.

20 7. As a property or casualty insurer, failing to recognize a valid  
21 assignment of a claim. The property or casualty insurer shall have the  
22 rights consistent with the provisions of its insurance policy to receive  
23 notice of loss or claim and to all defenses it may have to the loss or claim,  
24 but not otherwise to restrict an assignment of a loss or claim after a loss  
25 has occurred.

26 8. Compelling insureds to institute litigation to recover amounts due  
27 under an insurance policy by offering substantially less than the amounts  
28 ultimately recovered in actions brought by the insureds.

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

32 10. Attempting to settle claims on the basis of an application ~~which~~  
33 ~~THAT~~ was altered without notice to, or knowledge or consent of, the insured.

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

37 12. Making known to insureds or claimants a policy of appealing from  
38 arbitration awards in favor of insureds or claimants for the purpose of  
39 compelling them to accept settlements or compromises less than the amount  
40 awarded in arbitration.

41 13. Delaying the investigation or payment of claims by requiring an  
42 insured, a claimant or the physician of either to submit a preliminary claim  
43 report and then requiring the subsequent submission of formal proof of loss  
44 forms, both of which submissions contain substantially the same information.

1 14. Failing to promptly settle claims if liability has become  
2 reasonably clear under one portion of the insurance policy coverage in order  
3 to influence settlements under other portions of the insurance policy  
4 coverage.

5 15. Failing to promptly provide a reasonable explanation of the basis  
6 in the insurance policy relative to the facts or applicable law for denial of  
7 a claim or for the offer of a compromise settlement.

8 16. Attempting to settle claims for the replacement of any  
9 nonmechanical sheet metal or plastic part ~~which~~ THAT generally constitutes  
10 the exterior of a motor vehicle, including inner and outer panels, with an  
11 aftermarket crash part ~~which~~ THAT is not made by or for the manufacturer of  
12 an insured's motor vehicle unless the part meets the specifications of  
13 section 44-1292 and unless the consumer is advised in a written notice  
14 attached to or printed on a repair estimate ~~which~~ THAT:

15 (a) Clearly identifies each part.

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

17 This estimate has been prepared based on the use of replacement  
18 parts supplied by a source other than the manufacturer of your  
19 motor vehicle. Warranties applicable to these replacement parts  
20 are provided by the manufacturer or distributor of these parts  
21 rather than the manufacturer of your vehicle.

22 17. As an insurer subject to section 20-826, 20-1342, 20-1402 or  
23 20-1404, or as an insurer of the same type as those subject to section  
24 20-826, 20-1342, 20-1402 or 20-1404 that issues policies, contracts, plans,  
25 coverages or evidences of coverage for delivery in this state, failing to pay  
26 charges for reasonable and necessary services provided by any physician  
27 licensed pursuant to title 32, chapter 8, 13 or 17, if the services are  
28 within the lawful scope of practice of the physician and the insurance  
29 coverage includes diagnosis and treatment of the condition or complaint,  
30 regardless of the nomenclature used to describe the condition, complaint or  
31 service.

32 18. Failing to comply with chapter 15 of this title.

33 19. Denying liability for a claim under a motor vehicle liability  
34 policy in effect at the time of an accident without having substantial facts  
35 based on reasonable investigation to justify the denial for damages or  
36 injuries that are a result of the accident and that were caused by the  
37 insured if the denial is based solely on a medical condition that could  
38 affect the insured's driving ability.

39 20. AS AN INSURER SUBJECT TO SECTION 20-826, 20-1342, 20-1402 OR  
40 20-1404, OR AS AN INSURER OF THE SAME TYPE AS THOSE SUBJECT TO SECTION  
41 20-826, 20-1342, 20-1402 OR 20-1404 THAT ISSUES POLICIES, CONTRACTS, PLANS,  
42 COVERAGES OR EVIDENCES OF COVERAGE FOR DELIVERY IN THIS STATE, APPLYING A  
43 HIGHER COPAYMENT FOR A PHYSICIAN LICENSED PURSUANT TO TITLE 32, CHAPTER 8, 13  
44 OR 17 THAN THE INSURER REQUIRES FOR A PRIMARY CARE PHYSICIAN IF THAT INSURER

1 DOES NOT REQUIRE A REFERRAL TO THAT PHYSICIAN FROM A PRIMARY CARE PHYSICIAN  
2 UNDER A PLAN OR POLICY THE INSURER OFFERS IN THIS STATE.

3 B. Nothing in subsection A, paragraph 17 of this section shall be  
4 construed to prohibit the application of deductibles, coinsurance, preferred  
5 provider organization requirements, cost containment measures or quality  
6 assurance measures if they are equally applied to all ~~types-of~~ physicians  
7 referred to in this section, and if any limitation or condition placed upon  
8 payment to or upon services, diagnosis or treatment by any physician covered  
9 by this section is equally applied to all physicians referred to in  
10 subsection A, paragraph ~~16~~ 17 of this section AS IT PERTAINS TO A PARTICULAR  
11 DIAGNOSIS OR CONDITION, without discrimination to the usual and customary  
12 procedures of any ~~type-of~~ physician. A determination under this section of  
13 discrimination to the usual and customary procedures of any ~~type-of~~ physician  
14 shall not be based on whether an insurer applies medical necessity review ~~to~~  
15 ~~a particular type of service or treatment~~ IF IT IS APPLIED EQUALLY TO ALL  
16 PHYSICIANS AS IT PERTAINS TO A PARTICULAR DIAGNOSIS OR CONDITION.

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

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

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

28 Sec. 2. Section 20-2508, Arizona Revised Statutes, is amended to read:  
29 20-2508. Denial, suspension or revocation of certificates;  
30 hearing; civil penalties

31 A. The director shall deny a certificate if the director finds that  
32 the utilization review agent does not:

33 1. Have an allopathic or osteopathic physician OR A CHIROPRACTOR  
34 available to supervise utilization review activities of any medical, surgical  
35 or health care services except that:

36 (a) A dental service corporation that is licensed pursuant to chapter  
37 4, article 3 of this title and a prepaid dental plan organization that is  
38 licensed pursuant to chapter 4, article 7 of this title may have a licensed  
39 dentist supervise or conduct utilization review activities for health care  
40 services that involve dental care.

41 (b) An optometric service corporation that is licensed pursuant to  
42 chapter 4, article 3 of this title may have a licensed optometrist supervise  
43 or conduct utilization review activities for health care services that  
44 involve optometric care.

1           2. Meet all applicable department rules relating to the qualifications  
2 of utilization review agents or the performance of utilization review.

3           3. Provide assurances satisfactory to the director that the procedure  
4 and policies of the utilization review agent will protect the confidentiality  
5 of medical records and the utilization review agent will be reasonably  
6 accessible to patients and providers in this state and the department by a  
7 toll free telephone line or by acceptance of long-distance collect calls for  
8 forty hours each week during normal business hours.

9           B. The director shall deny a certificate to a utilization review agent  
10 who has been convicted of a misdemeanor involving moral turpitude or a felony  
11 or who employs a person who has been convicted of a felony.

12           C. The director may suspend, revoke or refuse to renew a certificate  
13 issued under this chapter if after giving notice to the utilization review  
14 agent, and holding a hearing if demanded by the agent, the director finds  
15 that the agent has violated this chapter or a rule adopted under this  
16 chapter.

17           D. If after a hearing the director finds that the agent has violated  
18 this chapter or an applicable rule or order adopted under this chapter, the  
19 director shall issue an order that specifies the violation and may impose a  
20 civil penalty of not more than two hundred fifty dollars for each violation  
21 or an aggregate civil penalty of not more than two thousand five hundred  
22 dollars. The director may also impose a civil penalty of not more than two  
23 thousand five hundred dollars for each knowing violation or an aggregate  
24 civil penalty of not more than fifteen thousand dollars. The director shall  
25 deposit, pursuant to sections 35-146 and 35-147, all monies in the state  
26 general fund. A civil penalty is in addition to any other applicable penalty  
27 or restraint provided in this chapter and may be recovered in a civil action  
28 brought by the director.

29           E. A certificate does not expire or terminate until a pending  
30 department investigation is resolved but is suspended on the date it would  
31 otherwise expire or terminate. The utilization review agent shall not  
32 transact business in this state until the investigation is completed.

33           F. When the director suspends or revokes a certificate the director  
34 shall immediately notify the utilization review agent either by personal  
35 service or by mail addressed to the agent at the agent's address of record.  
36 Notice by mail is effective at the time it is mailed.

37           G. The utilization review agent shall deliver a revoked or suspended  
38 certificate to the director on the director's request.

39           H. The director shall not issue a new certificate earlier than one  
40 year after the date of a previous revocation. Agents shall reapply to the  
41 director and shall meet all the requirements of this chapter to obtain a new  
42 certificate.

43           I. If the certificate of a firm or corporation is suspended or  
44 revoked, no member of that firm or officer or director of the corporation may  
45 hold a certificate during the period of the suspension or revocation unless

1 the director determines, based on substantial evidence, that the member,  
2 officer or corporation director was not personally at fault.

3 Sec. 3. Section 20-2510, Arizona Revised Statutes, is amended to read:  
4 20-2510. Health care insurers requirements; medical directors

5 A. A health care insurer that proposes to provide coverage of  
6 inpatient hospital and medical benefits, outpatient surgical benefits or any  
7 medical, surgical or health care service for residents of this state with  
8 utilization review of those benefits shall meet at least one of the following  
9 requirements:

10 1. Have a certificate issued pursuant to this chapter.

11 2. Be accredited by the utilization review accreditation commission,  
12 the national committee for quality assurance or any other nationally  
13 recognized accreditation process recognized by the director.

14 3. Contract with a utilization review agent that has a certificate  
15 issued pursuant to this chapter.

16 4. Contract with a utilization review agent that is accredited by the  
17 utilization review accreditation commission, the national committee for  
18 quality assurance or any other nationally recognized accreditation process  
19 recognized by the director.

20 5. Provide to the director a signed and notarized statement that the  
21 health care insurer has submitted an application for accreditation to the  
22 utilization review accreditation commission or the national committee for  
23 quality assurance and is awaiting completion of the accreditation review  
24 process. On completion of the accreditation review process, the insurer  
25 shall provide to the director adequate proof that the insurer has been  
26 accredited. If the insurer is denied accreditation, within sixty days after  
27 the denial the insurer shall meet at least one of the requirements set forth  
28 in paragraph 1, 2, 3 or 4 of this subsection.

29 B. Except as provided in subsections C, D and E of this section, any  
30 direct denial of prior authorization of a service requested by a health care  
31 provider on the basis of medical necessity by a health care insurer shall be  
32 made in writing by a medical director who holds an active unrestricted  
33 license to practice medicine in this state pursuant to title 32, chapter 13  
34 or 17. The written denial shall include an explanation of why the treatment  
35 was denied, and the medical director who made the denial shall sign the  
36 written denial. The health care insurer shall send a copy of the written  
37 denial to the health care provider who requested the treatment. Health care  
38 insurers shall maintain copies of all written denials and shall make the  
39 copies available to the department for inspection during regular business  
40 hours. The medical director is responsible for all direct denials that are  
41 made on the basis of medical necessity. Nothing in this section prohibits a  
42 health care insurer from consulting with a licensed physician whose scope of  
43 practice may provide the health care insurer with a more thorough review of  
44 the medical necessity.

1           C. For determinations made pursuant to subsection B of this section, a  
2 dental service corporation as defined in section 20-822 or a prepaid dental  
3 plan organization as defined in section 20-1001 may use as a medical director  
4 either:  
5           1. An individual who holds an active unrestricted license to practice  
6 dentistry in this state pursuant to title 32, chapter 11.  
7           2. A physician who holds an active unrestricted license to practice  
8 medicine in this state pursuant to title 32, chapter 13 or 17.  
9           D. For determinations made pursuant to subsection B of this section,  
10 an optometric service corporation may use as a medical director either:  
11           1. An individual who holds an active unrestricted license to practice  
12 optometry in this state pursuant to title 32, chapter 16.  
13           2. A physician who holds an active unrestricted license to practice  
14 medicine in this state pursuant to title 32, chapter 13 or 17.  
15           E. For determinations made pursuant to subsection B of this section, a  
16 health care insurer ~~may~~ SHALL use a chiropractor licensed in this state  
17 pursuant to title 32, chapter 8 ~~or by any regulatory board in another state~~  
18 to review any direct denial of prior authorization of a chiropractic service  
19 requested by a chiropractor on the basis of medical necessity.