REFERENCE TITLE: health insurance; interstate purchase

State of Arizona
House of Representatives
Fifty-third Legislature
First Regular Session
2017

HB 2522

Introduced by
Representative Cobb

AN ACT

AMENDING SECTIONS 20-221 AND 20-224, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 2, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-241; AMENDING SECTIONS 20-441, 20-2102, 20-2531, 20-3101 AND 20-3151, ARIZONA REVISED STATUTES; RELATING TO HEALTH INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Section 20-221, Arizona Revised Statutes, is amended to read:

20-221. Director as agent for service of process

A. Each authorized foreign or alien insurer, INCLUDING FOREIGN INSURERS THAT ISSUE POLICIES IN THIS STATE PURSUANT TO SECTION 20-241, shall appoint the director as its attorney to receive service of legal process issued against it in this state. The appointment shall be irrevocable, shall bind any successor in interest or to the assets or liabilities of the insurer and shall remain in effect as long as there is in force in this state any contract made by the insurer or obligations arising therefrom.

B. Service of process against a foreign or alien insurer shall be made only by service of process ~~upon~~ ON the director. Service of process against a domestic insurer shall be made ~~upon~~ ON the insurer corporation in the manner provided by laws applying to corporations generally, or ~~upon~~ ON the insurer's attorney-in-fact if a reciprocal insurer.

C. Each foreign or alien insurer at the time of application for a certificate of authority, OR BEFORE A FOREIGN INSURER ISSUES A POLICY IN THIS STATE PURSUANT TO SECTION 20-241, shall file with the director the name and address of a designated person to whom process against it served ~~upon~~ ON the director is to be forwarded. The insurer may change such designation by a new filing.

D. Any authorized domestic insurer who does not have or maintain a statutory agent shall appoint the director as its attorney to receive service of legal process issued against it in this state.

Sec. 2. Section 20-224, Arizona Revised Statutes, is amended to read:

20-224. Premium tax; reports

A. On or before March 1 of each year each authorized domestic insurer, EACH FOREIGN INSURER THAT ISSUES POLICIES IN THIS STATE PURSUANT TO SECTION 20-241, each other insurer and each formerly authorized insurer referred to in section 20-206, subsection B shall file with the director a report in a form prescribed by the director showing total direct premium income including policy membership and other fees and all other considerations for insurance from all classes of business whether designated as a premium or otherwise received by it during the preceding calendar year on account of policies and contracts covering property, subjects or risks located, resident or to be performed in this state, after deducting from such total direct premium income applicable cancellations, returned premiums, the amount of reduction in or refund of premiums allowed to industrial life policyholders for payment of premiums direct to an office of the insurer and all policy dividends, refunds, savings coupons and other similar returns paid or credited to policyholders within this state and not reapplied as premiums for new,

additional or extended insurance. No deduction shall be made of the cash surrender values of policies or contracts. Considerations received on annuity contracts, as well as the unabsorbed portion of any premium deposit, shall not be included in total direct premium income, and neither shall be subject to tax. The report shall separately indicate the total direct fire insurance premium income received from property located in the incorporated cities and towns certified by the state fire marshal pursuant to section 9-951, subsection B, as procuring the services of a private fire company.

B. Coincident with the filing of such tax report each insurer shall pay to the director for deposit, pursuant to sections 35-146 and 35-147, a tax on such net premiums at the following rates:

1. For fire insurance:

(a) On property located in a city or town certified by the state fire marshal pursuant to section 9-951, subsection B, as procuring the services of a private fire company, .66 percent.

(b) On all other property, 2.2 percent.

2. For disability insurance, 2.0 percent.

3. For health care service plans, the rates prescribed under sections 20-837, 20-1010 and 20-1060.

4. For other insurance:

(a) For premiums received in calendar year 2016, 1.95 percent.

(b) For premiums received in calendar year 2017, 1.90 percent.

(c) For premiums received in calendar year 2018, 1.85 percent.

(d) For premiums received in calendar year 2019, 1.80 percent.

(e) For premiums received in calendar year 2020, 1.75 percent.

(f) For premiums received in calendar year 2021 and for each subsequent calendar year, 1.70 percent.

C. Any payments of tax pursuant to subsection F of this section shall be deducted from the tax payable pursuant to subsection B of this section. Each insurer shall reflect the cost savings attributable to the lower tax in fire insurance premiums charged on property located in an incorporated city or town certified by the state fire marshal pursuant to section 9-951, subsection B, as procuring the services of a private fire company. No insurer shall be liable to the state or to any other person, or shall be subject to regulatory action, relating to the calculation or submittal of fire insurance premium taxes based in good faith on the state fire marshal's certification.

D. Eighty-five percent of the tax paid under this section by an insurer on account of premiums received for fire insurance shall be separately specified in the report and shall be apportioned in the manner provided by sections 9-951, 9-952 and 9-972, except that all of the tax so allocated to a fund of a municipality or fire district that has no volunteer firefighters or pension obligations to volunteer firefighters shall be appropriated to the account of the municipality or fire district

in the public safety personnel retirement system and all of the tax so allocated to a fund of a municipality or fire district that has both full-time paid firefighters and volunteer firefighters or pension obligations to full-time paid firefighters or volunteer firefighters shall be appropriated to the account of the municipality or fire district in the public safety personnel retirement system where it shall be reallocated by actuarial procedures proportionately to the municipality or fire district for the account of the full-time paid firefighters and to the municipality or fire district for the account of the volunteer firefighters. A municipality or fire district shall provide to the public safety personnel retirement system all information that the system deems necessary to perform the reallocation prescribed by this section. A full accounting of such reallocation shall be forwarded to the municipality or fire district and their local boards.

E. This section shall not apply to title insurance, and such insurers shall be taxed as provided in section 20-1566.

F. Any insurer that paid or is required to pay a tax of two thousand dollars or more on net premiums received during the preceding calendar year, pursuant to subsection B of this section and sections 20-224.01, 20-837, 20-1010, 20-1060 and 20-1097.07, shall file on or before the fifteenth day of each month from March through August a report for that month, on a form prescribed by the director, accompanied by a payment in an amount equal to fifteen percent of the amount paid or required to be paid during the preceding calendar year pursuant to subsection B of this section and sections 20-224.01, 20-837, 20-1010, 20-1060 and 20-1097.07. The payments are due and payable on or before the fifteenth day of each month and shall be made to the director for deposit, pursuant to sections 35-146 and 35-147.

G. Except for the tax paid on fire insurance premiums pursuant to subsections B and D of this section, an insurer may claim a premium tax credit if the insurer qualifies for a credit pursuant to section 20-224.03, 20-224.04, 20-224.06 or 20-224.07.

H. On receipt of a properly documented claim, a refund shall be provided to an insurer from available funds for the excess amount of any fire insurance premium improperly paid by the insurer. The insurer shall reflect the refund in the fire insurance premiums charged on the property that was charged the excessive amount.

I. On or before September 30 of each year, the director of insurance shall report to the directors of the joint legislative budget committee and the governor's office of strategic planning and budgeting on the amount of insurance premium tax credits established by sections 20-224.03, 20-224.04, 20-224.05, 20-224.06 and 20-224.07 that were used during the previous fiscal year.

J. For the purposes of:

1. Subsection B of this section, fire insurance is one hundred percent of fire lines, forty percent of commercial multiple peril nonliability lines, thirty-five percent of homeowners' multiple peril lines, twenty-five percent of farm owners' multiple peril lines and twenty percent of allied lines.

2. Section 20-416, fire insurance is eighty-five percent of fire and allied lines.

Sec. 3. Title 20, chapter 2, article 1, Arizona Revised Statutes, is amended by adding section 20-241, to read:

20-241. Foreign insurers; requirements; registration; fee; revocation; notice; rulemaking; definition

A. NOTWITHSTANDING ANY OTHER LAW, INSURERS OF THE SAME TYPE AS THOSE SUBJECT TO SECTION 20-826, 20-1057, 20-1342, 20-1402 OR 20-1404 THAT ISSUE POLICIES, CONTRACTS, PLANS, COVERAGES OR EVIDENCES OF COVERAGE AND THAT HOLD A CERTIFICATE OF AUTHORITY IN ANOTHER STATE MAY ISSUE HEALTH OR SICKNESS INSURANCE IN THIS STATE, AND A PERSON MAY PURCHASE A POLICY, CONTRACT, PLAN, COVERAGE OR EVIDENCE OF COVERAGE, IF THE INSURER PROVIDES EVIDENCE TO THE DIRECTOR THAT WHILE PROVIDING HEALTH OR SICKNESS INSURANCE THE INSURER IS SUBJECT TO THE JURISDICTION OF ANOTHER STATE'S INSURANCE DEPARTMENT AND THAT THE INSURER'S CERTIFICATE OF AUTHORITY REQUIRES THE INSURER TO MAINTAIN FINANCIAL RESERVES OF NOT LESS THAN THE AMOUNT REQUIRED IN THIS STATE. ANY POLICY, CONTRACT, PLAN, COVERAGE OR EVIDENCE OF COVERAGE THAT IS ISSUED FOR HEALTH OR SICKNESS COVERAGE PURSUANT TO THIS SUBSECTION MUST MEET THE BENEFIT REQUIREMENTS OF OTHER POLICIES, CONTRACTS, PLANS, COVERAGES OR EVIDENCES OF COVERAGE ISSUED IN THE STATE WHERE THE FOREIGN INSURER HOLDS A CERTIFICATE OF AUTHORITY. ANY POLICY, CONTRACT, PLAN, COVERAGE OR EVIDENCE OF COVERAGE THAT IS ISSUED PURSUANT TO THIS SUBSECTION IS SUBJECT ONLY TO THE BENEFIT REQUIREMENTS OF THAT STATE.

B. BEFORE A FOREIGN INSURER ISSUES A POLICY, CONTRACT, PLAN, COVERAGE OR EVIDENCE OF COVERAGE, THE FOREIGN INSURER SHALL REGISTER WITH THE DEPARTMENT. AN APPLICATION SHALL BE IN A FORM PRESCRIBED BY THE DIRECTOR AND SHALL BE ACCOMPANIED BY A FEE TO BE ESTABLISHED BY THE DIRECTOR. IF THE DIRECTOR REVOKES A FOREIGN INSURER'S REGISTRATION PURSUANT TO SUBSECTION E OF THIS SECTION, THE DIRECTOR MAY NOT REGISTER THE FOREIGN INSURER UNDER THIS SUBSECTION FOR TWO YEARS AFTER THE DATE OF REVOCATION.

C. IF A FOREIGN INSURER ISSUES A POLICY, CONTRACT, PLAN, COVERAGE OR EVIDENCE OF COVERAGE IN THIS STATE THAT DOES NOT INCLUDE A MANDATED HEALTH COVERAGE UNDER THIS TITLE, AN INSURER THAT HOLDS A CERTIFICATE OF AUTHORITY FROM THIS STATE AND THAT IS SUBJECT TO SECTION 20-826, 20-1057, 20-1342, 20-1402 OR 20-1404 MAY ISSUE A POLICY, CONTRACT, PLAN, COVERAGE OR EVIDENCE OF COVERAGE IN THIS STATE THAT DOES NOT INCLUDE THAT MANDATED HEALTH COVERAGE.

D. A FOREIGN INSURER MUST NOTIFY THE DEPARTMENT IF THE INSURER HAS BEEN SUBJECT TO ANY REGULATORY ACTION LEVEL EVENT SIMILAR TO A REGULATORY ACTION LEVEL EVENT AS DEFINED IN SECTION 20-488 IN THE STATE WHERE THE INSURER HOLDS A CERTIFICATE OF AUTHORITY.

E. THE DIRECTOR MAY REVOKE AN INSURER'S REGISTRATION PURSUANT TO SUBSECTION B OF THIS SECTION IF ANY OF THE FOLLOWING OCCURS:

1. THE STATE THAT ISSUED THE INSURER'S CERTIFICATE OF AUTHORITY CHANGES THAT STATE'S FINANCIAL RESERVE REQUIREMENTS TO LESS THAN THE AMOUNT REQUIRED BY THIS STATE.

2. THE DIRECTOR ESTABLISHES THAT THE STATE THAT ISSUED THE INSURER'S CERTIFICATE OF AUTHORITY HAS IDENTIFIED AND REPEATEDLY ENFORCED PENALTIES ON THE INSURER FOR VIOLATIONS RELATED TO CLAIM DENIALS, PROMPT PAYMENT, POOR CUSTOMER SERVICE, DECEPTIVE MARKETING PRACTICES OR FRAUDULENT ACTIVITIES.

3. THE INSURER FAILED TO COMPLY WITH CHAPTER 2, ARTICLE 6 OF THIS TITLE.

4. THE INSURER FAILS TO COMPLY WITH CHAPTER 11 OF THIS TITLE.

5. THE INSURER FAILS TO COMPLY WITH CHAPTER 20 OF THIS TITLE.

6. THE INSURER HAS BEEN SUBJECT TO ANY REGULATORY ACTION LEVEL EVENT IN THE STATE WHERE THE INSURER HOLDS A CERTIFICATE OF AUTHORITY.

F. EACH WRITTEN APPLICATION FOR A POLICY, CONTRACT, PLAN, COVERAGE OR EVIDENCE OF COVERAGE FOR HEALTH OR SICKNESS INSURANCE ISSUED UNDER THIS SECTION SHALL CONTAIN THE FOLLOWING NOTICE AT THE BEGINNING OF THE DOCUMENT PRINTED IN AT LEAST TWELVE-POINT BOLD-FACED TYPE:

> NOTICE: THIS POLICY IS ISSUED BY (NAME OF INSURER) AND IS GOVERNED BY THE LAWS AND RULES OF THE STATE OF (STATE THAT ISSUED THE INSURER'S CERTIFICATE OF AUTHORITY). THIS POLICY IS NOT SUBJECT TO ALL OF THE INSURANCE LAWS AND RULES OF THE STATE OF ARIZONA, INCLUDING COVERAGE OF SERVICES OR BENEFITS MANDATED BY LAW IN ARIZONA. AS WITH ALL INSURANCE PRODUCTS, BEFORE PURCHASING THIS POLICY, YOU SHOULD CAREFULLY REVIEW THE POLICY AND DETERMINE WHAT HEALTH CARE SERVICES THE POLICY COVERS AND WHAT BENEFITS IT PROVIDES, INCLUDING ANY EXCLUSIONS, LIMITATIONS OR CONDITIONS FOR SUCH SERVICES OR BENEFITS.

G. RESIDENTS OF THIS STATE WHO OBTAIN A POLICY FROM A FOREIGN INSURER MAY PARTICIPATE IN THE HEALTH CARE APPEALS PROCESS PRESCRIBED IN CHAPTER 15, ARTICLE 2 OF THIS TITLE.

H. EACH INSURER THAT ISSUES ANY POLICY, CONTRACT, PLAN, COVERAGE OR EVIDENCE OF COVERAGE FOR HEALTH OR SICKNESS INSURANCE PURSUANT TO SUBSECTION A OF THIS SECTION SHALL ON OR BEFORE MARCH 1 OF EACH YEAR FILE WITH THE DIRECTOR A REPORT OF ITS FINANCIAL CONDITION, TRANSACTIONS AND AFFAIRS AS OF THE PRECEDING DECEMBER 31 FOR TRANSACTIONS IN THIS STATE.

I. THE DIRECTOR MAY ADOPT RULES TO IMPLEMENT THIS SECTION.

J. A COURT OF THIS STATE MAY EXERCISE JURISDICTION OVER A FOREIGN INSURER THAT ISSUES A POLICY, CONTRACT, PLAN, COVERAGE OR EVIDENCE OF COVERAGE PURSUANT TO THIS SECTION IN THIS STATE WITH RESPECT TO THE POLICY, CONTRACT, PLAN, COVERAGE OR EVIDENCE OF COVERAGE THAT IS ISSUED BY THE FOREIGN INSURER.

K. FOR THE PURPOSES OF THIS SECTION, "FOREIGN INSURER" MEANS AN INSURER THAT IS FORMED UNDER THE LAWS OF ANOTHER STATE OF THE UNITED STATES.

Sec. 4. Section 20-441, Arizona Revised Statutes, is amended to read:

20-441. Purpose of article; definition

A. Among the purposes of this article is the regulation of trade practices in the business of insurance in accordance with the intent of Congress as expressed in the act of Congress of March 9, 1945, 59 Stat. 33, by defining, or providing for the determination of, all such practices in this state that constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

B. For the purposes of this article, "insurance company" or "insurer" means any:

1. Stock, mutual, reciprocal or title insurer.
2. Fraternal benefit society.
3. Health care services organization.
4. Hospital, medical, dental and optometric service corporation.
5. Prepaid dental plan organization.
6. Mechanical reimbursement reinsurer.
7. Prepaid legal plan.
8. Lloyd's association.
9. Service company as defined in this title.
10. FOREIGN INSURER THAT ISSUES POLICIES IN THIS STATE PURSUANT TO SECTION 20-241.
~~10.~~ 11. ~~Any~~ Other entity licensed under this title.

Sec. 5. Section 20-2102, Arizona Revised Statutes, is amended to read:

20-2102. Definitions

In this chapter, unless the context otherwise requires:

1. "Adverse underwriting decision" means any of the following actions involving insurance coverage which is individually underwritten:

(a) A declination of insurance coverage.

(b) A termination of insurance coverage.

(c) Failure of an insurance producer to apply for insurance coverage with a specific insurance institution which the insurance producer represents and which is requested by an applicant.

(d) In the case of property or casualty insurance coverage, placement by an insurance institution or insurance producer of a risk with

a residual market mechanism, an unauthorized insurer or an insurance institution which specializes in substandard risks, or the charging of a higher rate on the basis of information which differs from that which the applicant or policyholder furnished.

(e) In the case of life, health or disability insurance coverage, an offer to insure at higher than standard rates.

(f) In the case of property or casualty insurance, assigning an applicant or policyholder to a higher rating tier or failing to apply a premium discount or credit based on any credit related information derived from the applicant's or policyholder's consumer report, insurance score or lack of credit history.

Notwithstanding subdivisions (a) through (f) of this paragraph, the termination of an individual policy form on a class or statewide basis, a declination of insurance coverage solely because the coverage is not available on a class or statewide basis or the rescission of a policy is not considered an adverse underwriting decision, but the insurance institution or insurance producer responsible for its occurrence shall provide the applicant or policyholder with the specific reasons for its occurrence.

2. "Affiliate" or "affiliated" means a person that directly or indirectly through one or more intermediaries controls, is controlled by or is under common control with another person.

3. "Applicant" means any person who seeks to contract for insurance coverage other than a person seeking group insurance that is not individually underwritten.

4. "Consumer report" means any written, oral or other communication of information that bears on a natural person's creditworthiness, credit standing, credit capacity, character, general reputation, personal characteristics or mode of living and that is used or expected to be used in connection with an insurance transaction.

5. "Consumer reporting agency" means any person who does any of the following:

(a) Regularly engages, in whole or in part, in the practice of assembling or preparing consumer reports for a monetary fee.

(b) Obtains information primarily from sources other than insurance institutions.

(c) Furnishes consumer reports to other persons.

6. "Control", including the terms "controlled by" or "under common control with", means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person.

7. "Declination of insurance coverage" means a denial, in whole or in part, by an insurance institution or insurance producer of requested insurance coverage.

8. "Individual" means any natural person who:

(a) In the case of property or casualty insurance, is a past, present or proposed named insured or certificate holder.

(b) In the case of life, health or disability insurance, is a past, present or proposed principal insured or certificate holder.

(c) Is a past, present or proposed policyowner.

(d) Is a past or present applicant.

(e) Is a past or present claimant.

(f) Derived, derives or is proposed to derive insurance coverage under an insurance policy or certificate subject to this chapter.

9. "Institutional source" means any person or governmental entity that provides information about an individual to an insurance producer, insurance institution or insurance support organization, other than an insurance producer, the individual who is the subject of the information or a natural person acting in a personal capacity rather than in a business or professional capacity.

10. "Insurance institution" means any corporation, association, partnership, reciprocal insurer, inter-insurer, Lloyd's association, fraternal benefit society or other person engaged in the business of insurance, including health care service organizations, ~~and~~ hospital, medical, dental and optometric service corporations as defined in this title AND FOREIGN INSURERS THAT ISSUE POLICIES IN THIS STATE PURSUANT TO SECTION 20-241. Insurance institution does not include insurance producers or insurance support organizations.

11. "Insurance producer" means an insurance producer as defined in section 20-281.

12. "Insurance score" means, for the purpose of insurance underwriting or rating, a designation that is derived by using a variety of data sources, including an individual's consumer report in an algorithm, computer program, model or other process that reduces the data to a number, alpha character or rating that is used for insurance underwriting and rating decisions.

13. "Insurance support organization" means:

(a) Any person who regularly engages, in whole or in part, in the practice of assembling or collecting information about natural persons for the primary purpose of providing the information to an insurance institution or insurance producer for insurance transactions, including the furnishing of consumer reports or investigative consumer reports to an insurance institution or insurance producer for use in connection with an insurance transaction or the collection of personal information from insurance institutions, insurance producers or other insurance support organizations for the purpose of detecting or preventing fraud, material

misrepresentation or material nondisclosure in connection with insurance underwriting or insurance claim activity.

(b) Notwithstanding subdivision (a) of this paragraph the following persons are not considered insurance support organizations for purposes of this chapter:

(i) Insurance producers.

(ii) Government institutions.

(iii) Insurance institutions.

(iv) Medical care institutions.

(v) Medical professionals.

14. "Insurance transaction" means any transaction that involves insurance primarily for personal, family or household needs rather than business or professional needs and that entails the determination of an individual's eligibility for an insurance coverage, benefit or payment or the servicing of an insurance application, policy, contract or certificate, including transfers of business.

15. "Investigative consumer report" means a consumer report or portion of a consumer report in which information about a natural person's character, general reputation, personal characteristics or mode of living is obtained through personal interviews with the person's neighbors, friends, associates, acquaintances or others who may have knowledge concerning those items of information.

16. "Medical care institution" means any facility or institution that is licensed to provide health care services to natural persons including:

(a) Health care service organizations.

(b) Home health agencies.

(c) Hospitals.

(d) Medical clinics.

(e) Public health agencies.

(f) Rehabilitation agencies.

(g) Skilled nursing facilities.

17. "Medical professional" means any person licensed or certified to provide health care services to natural persons, including a chiropractor, clinical dietitian, clinical psychologist, dentist, nurse, occupational therapist, optometrist, pharmacist, physical therapist, physician, podiatrist, psychiatric social worker or speech therapist.

18. "Medical record information" means personal information that relates to an individual's physical or mental condition, medical history or medical treatment and that is obtained from a medical professional or medical care institution, the individual or the individual's spouse, parent or legal guardian.

19. "Personal information" means any individually identifiable information gathered in connection with an insurance transaction and from which judgments can be made about an individual's character, habits,

avocations, finances, occupation, general reputation, credit, health or any other personal characteristics. Personal information includes an individual's name and address and medical record information but does not include privileged information.

20. "Policyholder" means any person who:

(a) In the case of individual property or casualty insurance, is a present named insured.

(b) In the case of individual life, health or disability insurance, is a present policyowner.

(c) In the case of group insurance which is individually underwritten, is a present group certificate holder.

21. "Pretext interview" means an interview in which a person, in an attempt to obtain information about a natural person, performs one or more of the following acts:

(a) Pretends to be someone he or she is not.

(b) Pretends to represent a person he or she is not in fact representing.

(c) Misrepresents the true purpose of the interview.

(d) Refuses to identify himself or herself on request.

22. "Privileged information" means any individually identifiable information that relates to a claim for insurance benefits or a civil or criminal proceeding involving an individual and that is collected in connection with or in reasonable anticipation of a claim for insurance benefits or a civil or criminal proceeding involving an individual, except that information otherwise meeting the requirements of this paragraph is considered personal information under this chapter if it is disclosed in violation of section 20-2113.

23. "Residual market mechanism" means an agreement for the equitable apportionment among insurers of insurance afforded applicants who are in good faith entitled to but who are unable to procure insurance through ordinary methods.

24. "Termination of insurance coverage" or "termination of an insurance policy" means either a cancellation or nonrenewal of an insurance policy, in whole or in part, for any reason other than the failure to pay a premium as required by the policy.

25. "Transfer of business":

(a) Means the transfer by an insurance institution or insurance producer that owns the policy expiration of a policyholder's existing policy of insurance or the transfer of a group of policyholders' existing policies of insurance to another insurance institution.

(b) Does not include the transfer of business by an insurance producer that is under an exclusive contract or a contract requiring the insurance producer to submit all eligible business to an insurer or group of insurers under a common management.

26. "Unauthorized insurer" means an insurance institution that has not been granted a certificate of authority by the director to transact insurance in this state.

Sec. 6. Section 20-2531, Arizona Revised Statutes, is amended to read:

20-2531. Applicability; requirements

A. Notwithstanding article 1 of this chapter and subject to subsection B of this section, this article applies to all utilization review decisions made by utilization review agents and health care insurers operating in this state.

B. Each utilization review agent and each health care insurer operating in this state whose utilization review system includes the power to affect the direct or indirect denial of requested medical or health care services or claims for medical or health care services shall adopt written utilization review standards and criteria and processes for the review, reconsideration and appeal of denials that do all of the following:

1. Meet the requirements of this article.

2. Are consistent with chapter 1 of this title.

3. Comply with section 20-2505, paragraphs 2 through 6.

C. THIS ARTICLE APPLIES TO FOREIGN INSURERS THAT ISSUE POLICIES IN THIS STATE PURSUANT TO SECTION 20-241.

~~C.~~ D. This article does not apply to utilization review:

1. Performed under contract with the federal government for utilization review of patients eligible for all services under title XVIII of the social security act.

2. Performed by a self-insured or self-funded employee benefit plan or a multiemployer employee benefit plan created in accordance with and pursuant to 29 United States Code section 186(c) if the regulation of that plan is preempted by section 514(b) of the employee retirement income security act of 1974 (29 United States Code section 1144(b)), but this article does apply to a health care insurer that provides coverage for services as part of an employee benefit plan.

3. Of work related injuries and illnesses covered under the workers' compensation laws in title 23.

4. Performed under the terms of a policy that pays benefits based on the health status of the insured and does not reimburse the cost of or provide covered services.

5. Performed under the terms of a long-term care insurance policy as defined in section 20-1691.

6. Performed under the terms of a medicare supplement policy as defined by the department.

~~D.~~ E. This article does not create any new private right or cause of action for or on behalf of any member. This article provides only an

administrative process for a member to pursue an external independent review of a denial for a covered service or claim for a covered service.

~~E.~~ F. Utilization review activities involving retrospective claims review shall be limited to the provisions of this article only as clearly and specifically provided in the provisions of this article.

Sec. 7. Section 20-3101, Arizona Revised Statutes, is amended to read:

20-3101. Definitions

In this chapter, unless the context otherwise requires:

1. "Adjudicate" means an insurer's decision to deny or pay a claim, in whole or in part, including the decision as to how much to pay.

2. "Clean claim" means a written or electronic claim for health care services or benefits that may be processed without obtaining additional information, including coordination of benefits information, from the health care provider, the enrollee or a third party, except in cases of fraud.

3. "Enrollee" means an individual who is enrolled under a health care insurer's policy, contract or evidence of coverage.

4. "Grievance" means any written complaint that is subject to resolution through the insurer's system that is prescribed in section 20-3102, subsection F and submitted by a health care provider and received by a health care insurer. Grievance does not include a complaint:

(a) By a noncontracted provider regarding an insurer's decision to deny the noncontracted provider admission to the insurer's network.

(b) About an insurer's decision to terminate a health care provider from the insurer's network.

(c) That is the subject of a health care appeal pursuant to chapter 15, article 2 of this title.

5. "Health care insurer" means a disability insurer, group disability insurer, blanket disability insurer, health care services organization, prepaid dental plan organization, hospital service corporation, medical service corporation, dental service corporation, optometric service corporation, ~~or~~ hospital, medical, dental and optometric service corporation OR A FOREIGN INSURER THAT ISSUES POLICIES IN THIS STATE PURSUANT TO SECTION 20-241.

Sec. 8. Section 20-3151, Arizona Revised Statutes, is amended to read:

20-3151. Definitions

For the purposes of this ~~section~~ CHAPTER:

1. "Enrollee" means an individual who is enrolled in a health care plan provided by a health care insurer.

2. "Health care insurer" means a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, medical service corporation,

~~or~~ hospital and medical service corporation OR A FOREIGN INSURER THAT ISSUES POLICIES IN THIS STATE PURSUANT TO SECTION 20-241.

3. "Health care plan" means a policy, contract or evidence of coverage issued to an enrollee. Health care plan does not include limited benefit coverage as defined in section 20-1137.

4. "Health care professional" means a professional who is regulated pursuant to title 32, chapter 7, 8, 11, 13, 14, 15, 15.1, 16, 17, 18, 19, 19.1, 25, 28, 29, 33, 34, 35, 39 or 41, title 36, chapter 6, article 7 or title 36, chapter 17.

Sec. 9. Severability

If a provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act that can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.