



Office of the Director

Arizona Department of Insurance and Financial Institutions

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Douglas A. Ducey, Governor

Evan G. Daniels, Director

REGULATORY BULLETIN 2021-03¹

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

From: Evan G. Daniels

A handwritten signature in blue ink that reads "Evan G. Daniels".

Director of Insurance and Financial Institutions

Date: September 27, 2021

Re: 2021 Arizona Insurance and Financial Institutions Laws

This Regulatory Bulletin summarizes the major, newly enacted legislation affecting the Department, its licensees and insurance consumers. This summary is not meant as an exhaustive list or a detailed analysis of all insurance-related bills. It generally describes the substantive content but does not capture all details or necessarily cover all bills that may be of interest to a particular reader. The Department may follow this bulletin with more detailed bulletins related to the implementation of specific legislation. All interested persons are encouraged to obtain copies of the enacted bills by contacting the Arizona Secretary of State's office at (602) 542-4086, or from the Arizona legislative website at <http://www.azleg.gov>. Please, direct any questions regarding this bulletin to Stephen Briggs, Legislative Liaison at (602) 364-3761 or stephen.briggs@difi.az.gov.

Arizona's Fifty-fifth Legislature, First Regular Session, adjourned *sine die* on June 30, 2021. Except as otherwise noted, all legislation has a general effective date of **September 29, 2021**.

¹ This Substantive Policy Statement is advisory only. A Substantive Policy Statement does not include internal procedural documents that only affect the internal procedures of the Agency, and does not impose additional requirements or penalties on regulated parties or include confidential information or rules made in accordance with the Arizona Administrative Procedure Act. If you believe that this Substantive Policy Statement does impose additional requirements or penalties on regulated parties you may petition the agency under Arizona Revised Statutes Section 41-1033 for a review of the Statement.

INSURANCE-RELATED BILLS ENACTED IN 2021

Laws 2021, Chapter 72 (H2047): Insurance; Optometrists; Contracts; Covered Services

Creates ARS §§ 20-849, 20-1057.18, 20-1342.07, 20-1402.05 and 20-1404.05

States that contracts entered into or renewed after January 1, 2022 between an optometrist and a health insurer cannot:

- a) Require the optometrist to provide services to an enrollee based on a fee set by the health insurer unless the service for which the fee applies is a covered service under the enrollee's policy;
- b) Prohibit an optometrist from offering a vision service that is not a covered service at a fee determined by the optometrist; and
- c) Require an optometrist to use one or more specific vendors to replenish the optometrist's inventory of lenses after the optometrist dispenses the inventory to eligible members of the vision plan.

Applies the contract requirements to an administrator providing third-party administration services or a provider network for a vision plan. The contract requirements do not restrict the ability of a health insurer to enter into a contract for an optometrist to participate in a discount program sponsored by the health insurer for services that are not covered if:

- a) Participation in the health insurers network is not contingent on participation in the sponsored discount program; and
- b) The health insurer offers equal treatment to an optometrist who does not participate in a sponsored discount program.

Allows a health insurer to identify whether an optometrist participates in a discount program for services not covered if all lists state that other discounts may be available with individual optometrists. All contracts between a health insurer and an optometrist must be in compliance by the first renewal period on or after January 1, 2022, but not later than December 31, 2022. Defines *covered service* as a service for which any reimbursement is available under a subscription contract, an evidence of coverage or Disability Insurers policy without regard to contractual limitations.

Laws 2021, Chapter 24 (HB2119): Health Care Insurance; Amendments

Repeal ARS §§ 20-110 AND 20-111, 20-827, 20-2318 AND 20-2320

Repeals laws relating to contracts and forms in effect prior to January 1, 1955.

Clarifies statute relating to prohibitive actions of a *person* applies to Service Corporations and HCSOs.

Applies statute relating to assignment of benefits to a service corporation.

Applies laws governing insurance company holding systems to service corporations.

Allows a corporation to pay any agent or employee any salary, compensation or emolument without preauthorization from the board of directors of the corporation.

Requires an HCSO to submit quarterly, rather than monthly, to the Department of Insurance and Financial Institutions, a list of all provider contracts that have been terminated during the previous three months, rather than the previous month.

Expands the definition of *COBRA continuation provision* to include statute relating to small group health plan continuation coverage. Excludes a policy or contract made available to persons eligible for AHCCCS from the definition of *creditable coverage*. Excludes a small employer who obtains a health benefits plan that is subject to and complies with federal law from statute governing accountable health care plan premium rate practices.

Repeals laws relating to basic health benefit plans and exchange of information by electronic means.

Exempts a person from specified laws relating to certification requirements provided certain criteria are met.

Provides that the state health care appeal process does not apply to a denial of a nonformulary exception if a provider or enrollee has already filed an appeal using the federal nonformulary exception appeal process. The processes available under this article does not apply to a denial of a nonformulary exception if a provider has already filed an appeal using the federal nonformulary exception appeal process.

Laws 2021, Chapter 320 (HB2454): Telehealth; Health Care Providers; Requirements

Amends ARS §§ 20-841.09, 20-1057.13, 20-1376.05, 20-1406.05, 23-1026, 32-1401, 32-1854, 32-1901.01, 32-2061, 32-3248.01, 32-3251, 36-2272, 36-3601, 36-3602, 36-3603, 36-3604, 38-672 and 38-673; creates 36-3605, 36-3606, 36-3607 and 36-3608; repeals 36-3608

Prohibits a health insurer from using contracted telehealth providers to meet network adequacy standards required by state and federal law. States a health insurer's contracted health care provider (provider) network is not considered adequate if enrollees are unable to access appropriate nonemergency in-person health care services from the network's contracted providers in a timely manner. Directs a health insurer to reimburse a provider for the cost of any waived copayment, coinsurance or other cost sharing measure that impacts a provider's reimbursement to ensure that the provider receives the full contracted rate. Requires a health insurer to provide notice in its provider network directories that all enrollees have the right to request and receive appropriate nonemergency in-person health care services from the network's providers in a timely manner.

Requires all contracts, evidences of coverage and policies issued in Arizona by a corporation, organization and disability insurer (health insurer) to provide coverage for health care services that are provided through telehealth if the health care service would be covered were it through an in-person encounter.

States that the following requirements apply to coverage of telehealth services:

- a) A health insurer may not limit or deny coverage of health care services provided through telehealth, including ancillary services, except for procedures or service for

- which the weight of evidence, based on peer-reviewed clinical publications or research recommends not be provided through telehealth;
- b) A health insurer must reimburse providers at the same level of payment for equivalent services, as identified by the diagnostic and procedure codes, whether provided through telehealth or in-person care, unless the telehealth encounter is provided through a platform sponsored by the health insurer;
 - c) A health insurer can establish reasonable requirements and parameters for telehealth services, including documentation, fraud prevention, identity verification and recordkeeping, but these requirements must not be discriminatory;
 - d) Telehealth services can be provided and must be covered regardless of where the subscriber is located or the type of site; and
 - e) Except in an emergency, the contract can limit the coverage to providers that are members of the health insurer's provider network.

States that a health insurer may not require a provider to use a telehealth platform that is sponsored or provided by the health insurer. Stipulates that, in order to qualify for the same level of payment, the provider must make telehealth services generally available to patients through the interactive use of audio, video or other electronic media. Asserts that the provider must access, at the time of the visit, any available clinical information and records and must inform the subscriber before the visit if there is a charge for the telehealth encounter.

A services provided through telehealth or resulting from a telehealth encounter are subject to the following:

- a) Arizona's laws governing prescribing, dispensing and administering prescription pharmaceuticals;
- b) Arizona licensure requirements; and
- c) Any practice guidelines established by the Committee, or if not addressed, the practice guidelines of a national association of medical professionals.

Modifies the definition of telehealth to:

- a) Include the use of an audio-only telephone encounter between a subscriber who has an existing relationship with a provider or provider group if the following apply:
 - i. An audio-visual telehealth encounter is not reasonably available due to the subscriber's preference, the functional status, lack of technology or telecommunications infrastructure limits; and
 - ii. The telehealth encounter is initiated at the request of the subscriber or authorized by the subscriber before the telehealth encounter;
- b) Include the use of an audio-only encounter, regardless of whether there is an existing relationship with the provider or provider group, if the encounter is for a behavioral health or substance use disorder service;
- c) Exclude the sole use of a fax machine, instant messages, voicemail or email.

Requires a request for a medical examination for an employee to fix a time and place with regard to whether the medical examination could be conducted through telehealth. Allows a medical examination to be conducted via telehealth with the consent of both the employee and the requesting party.

A licensed physician may conduct a physical or mental health status examination through telehealth with clinical evaluation that is appropriate for the patient and the condition for which the patient presents. It is unprofessional conduct for a licensed pharmacist to knowingly dispense a drug on a prescription order from a diagnosis by mail or the internet unless the order was written pursuant to a physical or mental status examination conducted through telehealth.

Changes the heading of Title 36, Chapter 36 from *telemedicine* to *telehealth*.

Modifies the definition of a *provider* by adding:

- a) Nursing care institution administrators and assisted living facilities managers, midwives and hearing aid dispensers, audiologists and speech language pathologists; and
- b) A licensed health care institution;
- c) A person who holds a training permit to be a physician or osteopathic physician.

Repeals the definition of *telemedicine*. Defines *health care provider regulatory board or agency*.

Defines *telehealth* as:

- a) The interactive use of audio, video or other electronic media for the practice of health care, assessment, diagnosis, consultation or treatment and the transfer of medical data;
- b) Including the use of an audio-only telephone encounter between the patient or client and provider if an audio-visual telehealth encounter is not reasonably available due to the patient's preference, functional status, lack of technology or telecommunication infrastructure limits; and
- c) Not including the use of a fax machine, instant messages, voicemail or email.

A health care provider regulatory board or agency may not enforce any statute, rule or policy that would require a licensed provider who is authorized to write prescriptions, to require an in-person examination of the patient before issuing a prescription. A physical or mental health status examination may be conducted during a telehealth encounter. Requires a provider to make a good faith effort in determining whether a health care service should be provided through telehealth instead of in person. Providers must use clinical judgement when considering whether the nature of the services necessitates physical interventions and close observation and the circumstances of the patient, as outlined. Providers must make a good faith effort in determining the communication medium of telehealth and, whenever reasonably practicable, the telehealth communication medium that allows the provider to most effectively assess, diagnose and treat the patient. A provider may consider lack of access to or inability to

use technology or limits in telecommunication infrastructure when determining the communication medium. Prohibits a provider from using their personal preference of convenience.

Allows a provider who is not licensed in Arizona to provide telehealth services to an Arizona resident if the provider complies with the all of the following:

- a) Registers in Arizona with the applicable provider regulatory board or agency that licenses comparable providers in Arizona on an application that contains specified information;
- b) Pays the registration fee as determined by the applicable provider board or agency;
- c) Holds a current, valid and unrestricted license to practice in another state that is similar to a license issued in Arizona to a comparable provider and is not subject to any past or pending disciplinary proceedings;
- d) Acts in full compliance with all applicable laws and rules, including scope of practice and telehealth requirements;
- e) Complies with all existing requirements in Arizona and any other state in which the provider is licensed regarding maintaining professional liability insurance;
- f) Consents to Arizona's jurisdiction for any disciplinary action or legal proceeding related to the provider's acts;
- g) Follows Arizona's standards of care for that particular licensed health profession; and
- h) Annually updates their registration and submits a report to the applicable board or agency with the number of patients they served and the total number of encounters in Arizona for the preceding year

Requires an interstate provider to notify the applicable regulatory board or agency within five days of any restriction placed on the provider's license or any disciplinary action imposed. Prohibits an interstate provider from opening an office in Arizona or providing in-person health care services to Arizona residents without first obtaining the applicable license. An interstate provider who fails to comply with the applicable laws and rules of Arizona is subject to investigation and disciplinary action by the applicable regulatory board or agency, which may include revoking the provider's practice privileges and referring the matter to the appropriate licensing authority. The venue for any action arising from a violation of the above-mentioned provisions is the patient's county of residence in Arizona. Further outlines circumstances in which an interstate provider who is licensed in another state and provides telehealth services to an Arizona resident is not required to register in Arizona.

Establishes the Committee consisting of specified health care professionals who are appointed by the Governor. Requires the Committee to:

- a) Review national and other standards for telehealth best practices and relevant peer-reviewed literature;

- b) Conduct public meetings at which testimony may be taken regarding the efficacy of various communication mediums and the types of services and populations for which telehealth is appropriate;
- c) By September 1, 2021, submit a report to the Governor and Legislature with recommendations, including best practice guidelines for telehealth use by providers; and
- d) Update the Committee's best practice guidelines when applicable.

Terminates the Committee on July 1, 2029.

Requires DHS, by September 1, 2021, to develop a three-year pilot program that allows the delivery of at-home acute care services provided by hospitals in Arizona working in coordination with licensed home health professionals. The pilot program must be designed in a manner and in coordination with the acute care at home program authorized by the Centers for Medicare and Medicaid Services.

Requires the Arizona Department of Insurance and Financial Institutions (DIFI), by January 1, 2023, to report to the Legislature the number of telehealth encounters in Arizona in the preceding year.

Removes the term *telemedicine* and replaces it with *telehealth* throughout various sections of statute. (2-5, 7-11, 13, 16-18, 20, 21) Makes technical and conforming changes.

Laws 2021, Chapter 263 (HB 2508): Money Transmitters; Exemptions; Authorized Delegates

Amends ARS §§ 6-1203, 6-1207 and 6-1208

Exempts, from money transmitter licensure and regulation, a person who, in their regular course of business, provides money transmitter services for a bank, financial institution holding company, credit union, savings and loan association or savings bank, if:

- a) The agency relationship is established through a written agreement; and
- b) The bank, financial institution holding company, credit union, savings and loan association or savings bank remains responsible for providing money transmitter services to its customers.

Removes the requirement that a contract between a licensed money transmitter and an authorized delegate contain a current copy of the statutes governing money transmitters.

Removes the requirement that a licensed money transmitter display their license in the principal place of business or any branch office. Removes the requirement that an authorized delegate display a notice indicating that they are an authorized delegate of a licensed money transmitter.

Laws 2021, Chapter 339 (HB 2544): Blockchain and Cryptocurrency Study Committee

Establishes the blockchain and Cryptocurrency study committee

Establishes the 19-member Committee and outlines the Committee membership.

Directs the Committee to:

- a) Meet as often as the chairperson deems necessary;
- b) Review data on the scope of blockchain and cryptocurrency throughout the country;
- c) Compile an overview of potential legislation; and
- d) Solicit ideas and opinions of industry experts on additional legislation.
- e) Submit a report regarding the Committee's findings and recommendations of legislative priorities that will foster a positive blockchain and cryptocurrency economic environment in this state to the Speaker of the House of Representatives and provide a copy to the Secretary of State.

Terminates the Committee October 1, 2023.

Laws 2021, Chapter 115 (HB2621): Prior Authorization; Uniform Request Forms

Amends ARS §§ 20-3401 and 20-3403 and creates 20-3406

Requires DIFI, by January 1, 2022, to approve a uniform prior authorization request form for prescription drug, devices or durable medical equipment and a uniform prior authorization request form for all other health care procedures, treatments and services.

In approving the uniform prior authorization request forms, DIFI must consider:

- a) Any existing prior authorization request forms that the Centers for Medicare and Medicaid Services or the U.S. Department of Health and Human Services have developed;
- b) National standards relating to electronic prior authorization; and
- c) Forms adopted by the Director of DIFI or another state agency.

When approving the uniform prior authorization request forms, DIFI must seek input from interested stakeholders, including providers, health care service plans, utilization review agents, pharmacists and pharmacy benefit managers.

Requires all providers, by January 1, 2023, to use the DIFI-approved uniform prior authorization request forms and requires all health care service plans and utilization review agents to accept and process prior authorization requests submitted using the DIFI-approved prior authorization request forms.

Invalidates prior authorization requests that are submitted beginning January 1, 2023, that are not submitted on the DIFI-approved uniform prior authorization request forms.

Requires each uniform prior authorization request form to not exceed two printed pages, excluding provider's notes or documentation submitted in support of a prior authorization request and meet the prescribed statutory electronic submission and acceptance requirements.

Modifies the definition of *health care service* to be a health care procedure, treatment or service that is covered under a health care services plan, including providing a covered prescription drug, device or durable medical equipment, rather than procedures, treatments or services for the treatment or management of acute pain, chronic pain or opioid use disorder, including prescription drugs, devices or durable medical equipment.

Specifies that the uniform prior authorization request form procedures do not prohibit a payor or an entity acting for a payor to use a prior authorization methodology that uses an internet or web-based system if the methodology is consistent with the DIFI-approved uniform prior authorization request forms.

Laws 2021, Chapter 167 (HB2795): Insurance; Implementation Credits; Exceptions

Creates ARS § 20-450

Allows the payments of implementation credits a disability insurer or service corporation makes to offset expenses that a group policyholder incurs when the group policyholder initiates or changes new or existing group coverage to do either:

- a) Include implementation credits in the premium charged a policy holder and then reimburse the policy holder; or
- b) Pay for the implementation credits and provide appropriate disclosure in the group policy.

Specifies the payments of implementation credits made by a disability insurer or service corporation are not included within the definition of discrimination or rebates.

Laws 2021, Chapter 204 (SB 1042): Workers' compensation; Settings; Definition

Amends ARS §§ 23-908

Excludes mail order pharmacies delivering pharmaceutical services to workers' compensation claimants from settings that are not accessible to the general public, provided:

- a) The pharmacy does not limit or restrict access to claimants with an affiliation to a medical provider or other entity; and
- b) Any medical provider or other entity referring a claimant does not receive or accept any rebate, refund, commission, preference or other consideration as compensation for the referral.

Specifies the schedule of fee requirements do not prohibit:

- a) A healthcare provider or pharmacy from entering into a separate contract or network that governs fees, in which case reimbursement must be made according to the applicable contracted charge or negotiated rate; or
- b) An employer from directing medical, surgical or hospital care

Laws 2021, Chapter 357 (SB 1044): Credit for Reinsurance

Repeals ARS § 20-261.01, 20-261.02, 20-261.03, 20-261.04, 20-261.05, 20-261.06, 20-261.07 AND 20-261.08 and amends 20-821, 20-1068, 20-1085, 20-1094.01, 20-1098.03, 20-1098.11 AND 20-1557, BY ADDING CHAPTER 30

Requires credit to be allowed when the reinsurance is ceded to an assuming insurer who:

- a) Is domiciled or has its head office in, and is licensed in, a reciprocal jurisdiction;
- b) Has and maintains minimum capital and surplus calculated according to the methodology of its domiciliary jurisdiction;
- c) Has and maintains a minimum solvency or capital ratio, as applicable;
- d) Has agreed to and provides the following adequate assurance to the Director:
 - i. A prompt written notice and explanation if it falls below the minimum financial requirements or if any regulatory action is taken against it for serious noncompliance with applicable law;
 - ii. Written consent to the jurisdiction of Arizona's courts and to the appointment of the Director as agent for service or process;

- iii. Written consent to pay all final judgements obtained by a ceding insurer or its legal successor that have been declared enforceable;
- iv. A provision in the reinsurance agreement requiring the assuming insurer to provide security in an amount equal to 100 percent of liabilities attributable to reinsurance ceded pursuant to the agreement, if the assuming insurer resists enforcement of a final judgement enforceable under the law of the jurisdiction or a properly enforceable arbitration award; and
- v. Confirmation that it is not presently participating in any solvent scheme of arrangement that involves Arizona's ceding insurers with an agreement to notify the ceding insurer and the Director and provide security equal to 100 percent of their liabilities should a scheme be entered.
- e) Provides on behalf of itself and any legal predecessors, if requested by the Director, certain documentation to the Director as specified in rule;
- f) Maintains a practice of prompt payment of claims under reinsurance agreements, pursuant to rule;
- g) Confirms to the Director on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, that the assuming insurer complies with the prescribed requirements; and
- h) May provide the Director with additional information on a voluntary basis.

Allows the Director to adopt rules that specify additional requirements that relate to or set forth:

- a) The valuation of assets or reserve credits;
- b) The amount and forms of security supporting reinsurance arrangements; and
- c) Circumstances contingent of the credit reduction or elimination.

Requires the Director to create and publish a list of qualified reciprocal jurisdictions following certain guidelines. Allows the Director to remove a jurisdiction from the list on a determination of failure to meet requirements. Requires the Director, in a timely manner, to create and publish a list of assuming insurers to which cessions will be granted credit. Allows the Director to add an insurer to the list if certain requirements are met.

The Director may revoke or suspend the eligibility of an assuming insurer if the Director determines that the assuming insurer no longer meets specified requirements. Prohibits the granting of credit in cases of revocation or suspension.

The ceding insurer, in a legal process of rehabilitation, liquidation or conservation, to seek and obtain an order requiring the assuming insurer post security for all outstanding ceded liabilities.

Outlines certain limitations of credits of reinsurance.

Allows the rules adopted by the Director to include regulation of reinsurance arrangements relating to:

- a) Life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits;
- b) Universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period;
- c) Variable annuities with guaranteed death or living benefits;
- d) Long-term care insurance policies; and

- e) Any other life and health insurance and annuity products that the NAIC adopts model regulatory requirements with respect to credit for reinsurance.

Outlines the applicability and requirements of rules adopted by the Director relating to the regulation of reinsurance arrangements of life and health insurance. Specifies that the authority to adopt rules relating to the regulation of reinsurance arrangements of life and health insurance does not limit the Department's general authority to adopt administrative rules.

Specifies the applicability of Credit for Insurance requirements to certain cessions.

Contains a purpose, intent and declaration clause.

Laws 2021, Chapter 308 (SB 1048): Health Care Ministries; Exemption; Definition

Amends ARS § 20-122

Removes the requirement for an HCSM, or its predecessor, to have been in existence and sharing member medical expenses continuously and without interruption since December 31, 1999.

Laws 2021, Chapter 5 (SB 1049): Insurance; Omnibus

Amends ARS §§ 20-117, 20-151, 20-239, 20-283, 20-321, 20-321.01, 20-367.01, 20-611, 20-614, 20-630, 20-631, 20-636, 20-637, 20-676, 20-694, 20-1095, 20-1095.02, 20-1095.06 and 20-1676

Allows DIFI to send orders and notices by mail, personal delivery, fax or by electronic means, rather than only allowing personal delivery, notification or mail.

The Workers' Compensation Appeals Board shall mail, rather than send, a written notice of its decision in a requested review of the application of a rating system.

Requires an insurer, if the insurer uploads a document or notice to a portal or secure website, to send a separate notice to the receiving party that:

- a) Specifies that the document or notice has been uploaded; and
- b) Includes a description of the document or notice.

Deems, as sufficient proof of consent to receive notices and documents electronically, a named insured that effectuates insurance transactions by electronic means, unless the named insured opts out of electronic delivery and chooses delivery by hard copy. Removes the requirement that an insurer confirm consent electronically with a party in advance in order to deliver a notice or document by electronic means. Removes the requirement that an insurer obtain distinct advanced electronic consent from a named insured for delivery of a notice of cancellation, nonrenewal or reduction of limits of motor vehicle insurance.

Applies electronic communications and records requirements to the following policies and annuities: disability; marine and transportation; surety; prepaid legal; prepaid dental; title; identity theft; workers' compensation; and policies and contracts issued by health care services organizations and hospital, medical, dental and optometric service corporations.

Exempts a person from insurance producer licensing requirements whose activities in Arizona are limited to providing a website or other electronic platform for insurers or insurance producers to sell insurance and who processes payments or charges for insurance premiums, if the person does not sell, solicit or negotiate insurance.

Prohibits, in insurance receivership and insolvency proceedings, an FHL Bank from being stayed, enjoined or prohibited from exercising or enforcing any right or cause of action against collateral pledged by an insurer member under any FHL Bank security agreement or pledge, security, collateral or guarantee agreement, or other similar arrangement or credit enhancement relating to a security agreement to which an FHL Bank is a party.

Prohibits a receiver, rehabilitator, liquidator or conservator from voiding any transfer of money or other property in connection with any FHL Bank security agreement or similar arrangement with an insurer member, unless the transfer is made with actual intent to hinder, delay or defraud existing or future creditors.

Modifies the definition of *consumer product* as any property, rather than only tangible personal property, which is normally used for personal, family or household purposes and becomes part of the intended usefulness of real property or is typically transferred with real property as an integral functioning utility appliance or system.

Removes the requirement that a corporation's annual financial statement be independently audited and certified by a certified public accountant to qualify for exemption from DIFI service company requirements.

Specifies that the definition of *service contract* is a written contract or agreement that covers, in whole or in part, services performed for the operational or structural failure of a consumer product, with or without additional indemnity payments. Removes the limitation on circumstances that a service contract may provide for indemnity payments and adds a roof leak to the list of circumstances that may result in an indemnity payment.

Decreases, from \$100,000,000 to \$25,000,000, the minimum net worth that certain corporations must maintain to qualify for exemption from DIFI service company permit requirements.

Requires a service contract to disclose whether the service contract covers or excludes preexisting conditions. Prohibits administrative expenses associated with a service contract cancellation from exceeding the lesser of \$75 or 10 percent of the service contract purchase price, rather than 10 percent of the gross amount paid by a service contract holder for the service contract.

Allows a service contract's disclosure of material acts or omissions of a contract holder that cancel or void coverage to include fraudulent or unlawful acts by the contract holder arising out of or relating to the service contract and the contract holder's use of a covered consumer product in an unintended manner that is likely to increase the likelihood that the consumer product will be damaged or require repairs.

Allows a service contract to exclude preexisting conditions only if the conditions were known or would have been known by visually inspecting, operating or testing the covered property.

[Laws 2021, Chapter 16 \(SB 1149\): Occupational and Professional Licensure; Notice](#)

Amends ARS § 32-4302

Requires a professional or occupational regulating entity to which reciprocity requirements apply to prominently print on all license and certificate applications and regulating entity websites the following notice:

"Pursuant to section 32-4302, Arizona Revised Statutes, a person shall be granted an occupational or professional license or certificate if the person has been licensed or certified in another state for at least twelve months, the license or certificate is in the same discipline and at the same practice level as the license or certificate for which the person is applying in this state and the person meets other conditions prescribed by section 32-4302, Arizona Revised Statutes."

Laws 2021, Chapter 353 (SB 1234): Insurance; Continuing Education; Proctor Prohibited*Amends ARS § 20-1234*

Prohibits DIFI from requiring a proctor to administer any required post-course examination for a self-study continuing education course that an individual insurance producer completes online.

Laws 2021, Chapter 431 (SB 1270): Insurance; Prescription Drugs; Step Therapy*Creates ARS §§ 20-3601, 20-3602, 20-3603, 20-3604*

Applies the step therapy requirements to any state-regulated health care insurance plan issued or renewed on or after December 31, 2022, that provides prescription drug benefits and that includes coverage for a step therapy protocol; any policy, contract or evidence of coverage issued or renewed after December 31, 2022; and any contractor, agent or other entity that implements step therapy protocol coverage on behalf of a health care plan, PBM or URA.

Requires an insurer, PBM or utilization review agent (URA), when establishing a step therapy protocol, to use clinical review criteria based on clinical practice guidelines that:

- a) Recommend prescription drugs to be taken in a specific sequence required by the step therapy protocol;
- b) Are developed and endorsed by a multidisciplinary panel of experts that manages conflicts of interest among members of the writing and review groups by:
 - i. Requiring the members to disclose any potential conflict of interest with an entity and recuse themselves from voting if they have a conflict of interest; and
 - ii. Using a methodologist to work with writing and review groups to provide objectivity in data analysis and ranking of evidence through preparing evidence tables and facilitating consensus;
- c) Are based on high-quality studies, research and medical practice;
- d) Are created by an explicit and transparent process that:
 - i. Minimizes biases and conflicts of interest;
 - ii. Explains the relationship between treatment options and outcomes;
 - iii. Rates the quality of the evidence supporting recommendations; and
 - iv. Considers relevant patient subgroups and preferences; and
- e) Are regularly updated, at least annually, through a review of new evidence and research and newly developed treatments.

Allows, if no clinical guidelines are developed and endorsed by a multidisciplinary panel of experts, an insurer, PBM or URA to use peer review publications to fulfill that requirement. Requires URAs, when considering clinical review criteria to establish a step therapy protocol, to also consider the needs of atypical patient populations and diagnoses. Directs each insurer, PBM and URA to annually certify to DIFI that the clinical review criteria used in their step therapy protocol meet the prescribed requirements. Requires an insurer, PBM or URA to submit their clinical review criteria for DIFI approval upon request. Specifies that an insurer is not required to establish a new entity to develop clinical review criteria used for a step therapy protocol. Authorizes DIFI to require an insurer to submit an annual certification or clinical review criteria for a PBM or URA that acts on the insurer's behalf and holds both parties jointly responsible for any omissions, errors or other deficiencies included in an annual submission or certification. Obligates an insurer to provide 15 days' advance notice to a PBM or URA of the certification or submission and permits a PBM or URA to submit a certification or submission independently of an insurer.

Mandates a patient and prescribing provider to have access to a clear and convenient process to request a step therapy exception if coverage of a prescription drug is restricted for use by an insurer, PBM or utilization review agent through the use of a step therapy protocol.

Allows an insurer, PBM or utilization review agent to use its existing medical exceptions process to satisfy this requirement, if that process is consistent with statutory requirements.

Requires the medical exception process to:

- a) Be easily accessible on the insurer's, health benefit plan's, PBM's or utilization review agent's website;
- b) Include a list of the information and documentation required; and
- c) Include where and to whom the patient and prescribing provider must send the step therapy exception request.

Requires a step therapy exception request to be granted if sufficient justification and any necessary supporting clinical documentation are submitted to establish that:

- a) The required prescription drug is contraindicated or will likely cause a serious adverse reaction by or physical or mental harm to the patient;
- b) The required prescription drug is expected to be ineffective based on known clinical characteristics of the patient and the prescription drug regimen;
- c) The patient has tried the required prescription drug while under a current or previous health care plan, or another prescription drug in the same pharmacologic class with a similar efficacy and side effect profile;
- d) The required prescription drug is not in the best interest of the patient based on medical necessity because the patient's use of the prescription drug is expected to cause specified conditions; and
- e) The patient has experienced a positive therapeutic outcome on a prescribed drug selected by the patient's health care provider.

Prohibits a provider from using a pharmaceutical sample for the purpose of qualifying for an exception to step therapy. Requires an insurer, PBM and utilization review agent to authorize coverage for the prescribed prescription drug if it is covered by the patient's health care plan. Requires an insurer, PBM and utilization review agent to grant or deny an exception request within 72 hours, or within 24 hours if an exigent circumstance exists, after receiving the request. Instructs an insurer, PBM and utilization review agent to notify a prescribing provider within 72 hours of receiving an incomplete exception request, or within 24 hours if an exigent circumstance exists, that additional or clinically relevant information is required in order to approve or deny the exception request. States that an exception request is granted if the prescribing provider does not receive a determination or request for additional information from an insurer, PBM or utilization review agent within the prescribed time period.

Allows an insured, enrollee or subscriber to appeal an adverse step therapy exception determination. Stipulates that the step therapy exception request requirements do not prevent:

- a) An insurer, PBM or utilization review agent from requiring a patient to try an ab-rated generic equivalent before providing coverage for the equivalent branded prescription drug; and
- b) A provider from prescribing a prescription drug that is determined to be medically necessary.

Applies to any policy, contract or evidence of coverage delivered, issued for delivery or renewed on or after December 31, 2022.

Laws 2021, Chapter 217 (SB 1356): Pharmacy Benefit Managers; Prohibited Fees

Creates ARS § 20-3332

Precludes a PBM, on behalf of itself, an insurance plan sponsor or insurer, from charging or holding a pharmacist or pharmacy responsible for a fee associated with any step, component or mechanism related to the claims adjudication process, including:

- a) Adjudicating a pharmacy benefit claim;
- b) Processing or transmitting a pharmacy benefit claim; and
- c) Developing, managing or participating in a claims processing or adjudication network.

Permits a pharmacy to submit a complaint regarding PBM claims adjudication fees to the Director of the Department of Insurance and Financial Institutions (Director). Specifies that a complaint must include supporting documentation at the time the complaint is filed. Requires the Director to investigate a complaint and permits the Director to examine and audit PBM records to determine if a violation has occurred.

Allows the Director to do the following upon a determination that a violation has occurred:

- a) Seek an injunction in court and apply for permanent and temporary orders as deemed necessary by the Director to restrain a PBM from continuing to commit a violation; and
- b) Issue a cease and desist order on the PBM.

Subjects a PBM who commits a violation of the claims adjudication fee prohibition to penalties prescribed for other defined prohibited practices. Permits any person who is damaged by the acts of a PBM who violates the fee prohibition to bring a civil action for damages against the PBM in court.

Laws 2021, Chapter 229 (SB 1451): Workers' Compensation; Rates; Firefighters; Cancer

Amends ARS §§ 20-343, 202-359, 20-371, 23-901, 23-901.01. Creates 23-901.09, 23-971

Allows insurers covering firefighters and fire investigators to file one uniform percentage deviation that increases the statewide rates under the rating organization's rate filing for the class codes associated with firefighters and fire investigators to address the anticipated increase in losses and expenses for claims that are compensable pursuant to section 23-901.09,. Requires the deviation filing to be accompanied by actuarial analysis that substantively illustrates the basis for the rate increase. Outlines the information required for the analysis and the requirements for the supporting documents. The deviations specific to firefighter and fire investigator class codes must be on file with the DIFI director for at least 60 days before it becomes effective.

Allows insurers to also file and apply a schedule rating plan to adjust premiums specifically associated with firefighter and fire investigator class codes, based on loss control programs or activities undertaken by the insurer to reduce losses associated with section 23-901.09. The schedule rating plan must be filed and approved by the Director.

Allows the DIFI Director to use independent contractor examiners to analyze a deviation or schedule rating filing.

Removes firefighters from statutes relating to firefighter and peace officer presumptive occupational diseases and creates a separate section of statute relating to firefighter presumptive occupational diseases. Removes the following qualifications that grants presumptions to firefighters or peace officers:

- a) Having been exposed to a known carcinogen reasonably related to cancer; and
- b) Informing the Director of the Department of Insurance and Financial Institutions (DIFI) about the exposure of a carcinogen.

Increases the rebuttal standard of cancer presumptions, from preponderance of evidence to clear and convincing evidence, that there is a specific cause of the cancer other than an occupational exposure to a carcinogen. Specifies that the outlined presumptive occupational diseases arising out of employment apply to firefighters, fire investigators and peace officers currently in service.

Adds disease, infirmity or impairment of a firefighter or fire investigator's health caused by ovarian or breast cancer to conditions presumed to be an occupational disease arising out of employment.

Requires insurance carriers, self-insuring employers and workers' compensation pools securing workers' compensation for firefighters and fire investigators (insurers) to compile and report to the ICA claim and claim reserve information for cancer-related claims filed by or on behalf of firefighters or firefighter investigators.

Requires the ICA to compile and make available to insurers, rating organizations, employers and public safety workers the claim-related information to:

- a) Assist with setting workers' compensation insurance rates; and
- b) Ensure the adequate reserving for cancer claims for class codes associated with firefighters and fire investigators.

Requires cancer-related claim and claim reserve information to include:

- a) Type of cancer;
- b) Total claim costs;
- c) Claim reserved by the insurance carrier, self-insuring employer or workers' compensation pool; and
- d) Any other information requested by the ICA.

Prohibits the ICA from requiring or obtaining any personally identifiable information for a claimant.

Laws 2021, Chapter 356 (SB 1463): DIFI; Omnibus

Amends ARS §§ 6-101 through 6-1419; repeals Title 6 Chapter 12.1 and 6-1304; amends ARS §§ 10-2251 through 10-2605, 13-2317, 14-3603, 14-5411, 20-466, 20-3251, 25-519, 32-1001, 32-1004, 32-1021, 32-1022, 32-1023, 32-1024, 32-1025, 32-1026, 32-1027, 32-1053, 32-3601, 32-3605, 32-3607 AND 32-3609; Creates 32-3610; Amends 32-3611 through 32-3680, 35-323, 38-871, 41-3451, 44-281, 48-101

Transfers the responsibilities and duties of the superintendent of DIFI to the deputy director.

Modifies the applications fees for financial enterprises as below:

- a) Removes the \$1000 application fee for a deferred presentment company license;
- b) Removes the \$500 branch application fees for a collection agency or a deferred presentment company and for approval of the articles of incorporation of a business development corporation;
- c) Repeals the fees related to moving an established office of an enterprise, issuing a duplicate or replacing a lost enterprise's license, changing a responsible person on a mortgage broker, commercial mortgage broker, mortgage banker and commercial mortgage banker license and changing an active or branch manager on a collection agency license;
- d) Exempts a loan originator or appraiser license from the licensee name changing fee;
- e) Removes the statutorily outlined minimum and maximum for a full or partial year license, renewal or branch office permit of a premium finance company and enacts a \$300 fee plus \$300 for each branch office for a premium finance company; and
- f) Moves the \$50 fee for an advance fee loan broker from ARS §§6-1304 to 6-126.

Requires an applicant for a license or permit for an enterprise or consumer lender to pay the first year's annual assessment prorated according to the number of quarters remaining until the date of the next annual assessment or renewal at the time of application rather than after the approval of the application.

Requires DIFI to refund the prorated annual assessment that an applicant for an enterprise or consumer lender license or permit paid, if the application ends in denial.

Stipulates that annual renewal fees are nonrefundable for an application of a license or permit for an enterprise or consumer lender.

Sets the annual renewal fee paid for an advance fee loan broker at \$25 and removes the \$25 fee for supplemental statements.

Sets the annual renewal fee for a collection agency at \$600, rather than \$600 plus an annual assessment of \$200 for each branch office.

Specifies that the account of receipts and disbursements from the DIFI Revolving Fund is to be distributed on or before the 15th day of February, May, August and November *of each year*.

Stipulates that a consumer loan made pursuant to a consumer lender license is not a secondary motor vehicle finance transaction.

Directs a trust company applicant to, *after approval or* after addressing the deficiencies, file the *approved or* revised articles of incorporation with the corporation commission.

Allows the Deputy Director to contract for the testing of mortgage broker license applicants. Requires DIFI's contractor to reasonably prescribe the time, place and conduct of testing and collect a fee for administration of the test. Requires the \$50 testing fee to be paid by the applicant directly to the contractor if the Deputy Director contracts for the testing of applicants. Allows the Deputy Director to allow a contractor to charge a reasonable testing fee that is more than the \$50 testing fee.

Repeals statute relating to deferred presentment companies that terminated on July 1, 2010.

Specifies that monies collected from each insurer must be deposited in the state general fund for appropriation to the DIFI fraud unit.

Stipulates that the Uniform Standards of Professional Appraisal Practice published by the Appraisal Standards Board are the standards for appraisal practice in Arizona, unless the Deputy Director objects. Allows an individual who is not a state-licensed or state-certified appraiser to provide clerical or administrative assistance in the preparation of an appraisal document.

Allows an individual who is a registered trainee appraiser to be involved in developing and reporting the appraisal if certain conditions are met. Specifies that the exemption from statutes governing appraisal management companies applies to a state or federally regulated department or unit within a financial institution that receives requests for the performance of real estate appraisals from the financial institution. Exempts a federally regulated appraisal management company from statutes governing appraisal management companies.

Defines *federally regulated appraisal management company*.

Requires the ATA to make grants awarded from the ATA Fund. Requires DIFI to provide administrative support for the ATA. Requires all monies appropriated to DIFI for the ATA be used exclusively for the operation of the ATA.

Makes numerous technical and conforming changes. (*Sec. 1-292, 294-309, 311-351, 353-355*)