Enforcement, Innovation and Regulatory Policy Division
Arizona Department of Insurance and Financial Institutions
100 N 15th Avenue, Suite 261, Phoenix, Arizona 85007
(602) 364-3100 | difi.az.gov

Katie Hobbs
Governor

Barbara D. Richardson
Cabinet Executive Officer
Executive Deputy Director

Substantive Policy Statement 2024-01[1]

2024 Arizona Insurance and Financial Institutions Laws

Pursuant to Arizona Revised Statutes ("A.R.S.") § 41-1091 the Arizona Department of Insurance and Financial Institutions ("Department") occasionally issues Substantive Policy Statements to express the Department's position on current industry practices and to provide the Department's interpretation regarding Arizona law requirements. The Department's Substantive Policy Statements are intended to promote a level playing field and uniform application of statutory provisions to consumers and industry.

I. Purpose

The purpose of this Substantive Policy Statement is to summarize the major, newly enacted legislation affecting the Department, its licensees and consumers.

II. Scope

This Substantive Policy Statement is not meant as an exhaustive list or a detailed analysis of all Department-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.

III. Background

Arizona's Fifty-sixth Legislature, Second Regular Session, adjourned *sine die* on June 15, 2024. All legislation becomes effective on the general effective date of **September 14, 2024**, except as otherwise noted. The following 19 bills passed during the 2024 Legislative Session.

IV. Department Position

Note: Unless otherwise stated, "Director" means the Director of the Department.

[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 section 41-1033, Arizona Revised Statutes, for a review of the Statement.

Laws 2024, Chapter 4 (S. B. 1270) – reciprocal deposits; escrow agents; definitions

Amends A.R.S. § 6-834

Allows an escrow agent to use reciprocal deposits to provide access to additional Federal Deposit Insurance Corporation (FDIC) insurance for monies deposited with the escrow agent if the eligible depository institution: 1) arranges for deposit of the monies in the escrow agent's account in at least one FDIC-insured bank, savings bank or savings and loan association; and 2) receives an amount of FDIC-insured deposits from customers of other financial institutions equal to or greater than the amount of monies initially deposited by the escrow agent.

Laws 2024, Chapter 24 (H. B. 2093) – emergency services; prudent layperson; definition

Amends A.R.S. § 20-2801

Specifies that *emergency services* includes health care services that are provided to an enrollee in a licensed hospital emergency facility after the recent onset of a medical condition that manifests in symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to a bodily function or dysfunction of a bodily organ or part, jeopardy to the health, including mental health, of the enrollee or harm to the enrollee or others.

Laws 2024, Chapter 48 (S.B. 1070) – virtual credit cards; payment method

Amends A.R.S. § 20-241

Requires a health care insurer to accept tangible checks as a form of acceptable payment. If a health care provider opts out of a method of payment, that decision remains in effect until the health care provider opts back in to the prior method of payment or a new contract is executed.

Laws 2024, Chapter 51 (S. B. 1165) – pharmacy audit; procedures; prohibition

Amends A.R.S. § 20-3322

Adds, to the procedures that apply to an audit conducted by an auditing entity conducting a wholesale invoice audit, that the auditing entity must: 1) not audit the pharmacy claims of another auditing entity; 2) reverse a finding of discrepancy if the pharmacist or pharmacy dispensed the correct quantity of the drug according to the prescription as outlined; 3) as a presumption of validity of a purchase of a dispensed drug, accept supplier invoices and any other supporting documentation or reports required by a state board or agency to support the pharmacy's claims related to a dispensed drug as outlined; and 4) provide any supporting documentation that the pharmacy supplier provided to the auditing entity within 10 business days after receiving the pharmacy's request.

Prohibits an auditing entity from, directly or indirectly, retroactively reducing the amount of a claim payment to a pharmacist or a pharmacy after adjudication of the claim for a prescription drug unless the claim was: 1) found to be fraudulent; 2) a duplicate; or 3) reimbursed incorrectly due to an error that resulted in overpayment by an insurer or a pharmacy benefit manager (PBM). An auditing entity, insurer or PBM is not prohibited from increasing the amount of a claim payment after adjudication of the claim.

Laws 2024, Chapter 72 (H. B. 2444) – grievance process; payment methods; report

Amends A.R.S. §§ 20-241, 20-3101, 20-3102 and 20-3115

Contracts for Health Care Services – Requires a health care insurer to accept tangible checks as a form of acceptable payment. If a health care provider opts out of a method of payment, that decision remains in effect until the health care provider opts back in to the prior method of payment or a new contract is executed.

Provider Grievances – Specifies that a health care provider, with informed consent of the patient, is not precluded from collecting monies for a medical service that is: 1) not covered under the insurance policy; or 2) medically necessary and a payment on the claim was not made due to a denial or a disallowance on the basis of frequency, limited to the rates prescribed by the provider's fee schedule.

Includes, in the definition of *grievance*, any delay in the timeliness of claim adjudication that results in a delay of payment of a clean claim. By August 1 of each year the Department must post a report on the Department's website that includes the outlined information regarding provider grievances for the prior fiscal year.

Laws 2024, Chapter 74 (H. B. 2729) – insurance coverage requirements; transportation companies.

Amends A.R.S. §§ 28-4038 and 28-4039

Specifies that when a passenger to whom a transportation network company (TNC) is providing transportation network services (TNS) is occupying the TNC vehicle, the minimum amount of primary commercial motor vehicle liability insurance that covers a TNC driver's provision of TNS must be $1,000,000 per incident.

Requires, rather than $250,000 per incident, a TNC driver, the TNC or both and a taxi, livery vehicle or limousine driver or the taxi, livery vehicle or limousine company to maintain primary commercial uninsured motorist coverage in a minimum amount equal to the greater of: 1) $25,000 per person and $75,000 per incident; or 2) the minimum limits for bodily injury or death for a motor vehicle liability policy, which are $25,000 for one person or, subject to the limit for one person, $50,000 for two or more persons in any one accident.

Laws 2024, Chapter 82 (S. B. 1296) – credit unions; formation; loans; membership

Amends A.R.S. §§ 6-501, 6-506, 6-510, 6-516, 6-522, 6-523, 6-524, 6-531, 6-537, 6-542, 6-551, 6-556, 6-561, 6-563 and 6-564; Repeals A.R.S. § 6-512

Organization and Membership – Adds, to the definition of *credit union* (CU), that a purpose of a CU is to assist members to manage and control their financial resources to improve their social and economic conditions. Expands the authority of the Deputy Director of Financial Institutions (Deputy Director) to approve an insurer as an *insuring organization*.

Requires a CU's proposed field of membership to consist of one or more, rather than be limited to, groups having a common bond of interest, occupation, or association or within a well-defined neighborhood, community or rural district and expands the list of organizations that may be included in a CU's field of membership. A CU may deny membership based on policies established by the board of directors (board) and a person may appeal a denial within 30 days after the denial. A CU's management may expel a member pursuant to a written policy adopted by the board if the board delegates such authority and modifies procedures for the expulsion of a member, including notice and reconsideration requirements.

Powers of a CU – Allows a CU to purchase any of the assets and assume any of the liabilities of a CU chartered under the laws of any state, a federal CU, a bank or an out-of-state bank and adds that a CU may assume any of the liabilities of an Arizona-chartered CU.

Expands a CU's ability to join associations and organizations. Eliminates the authority for a CU to: 1) establish or maintain automated teller machines (ATMs) at locations other than its place of business; and 2) join through contractual agreement with one or more other CUs or other financial organizations in the operation of ATM networks. Repeals the stipulation that the fiscal year of a CU ends on December 31.

Board – Allows a CU's board to vote by electronic meeting and modifies meeting frequency requirements. The Deputy Director may direct a CU's board to meet more frequently to address specific matters. Removes the requirement that a CU's board must borrow or lend money to carry on the functions of the CU.

Modifies the procedures for removing a director, officer or member of a committee, including special meeting requirements to consider the suspension and requiring a majority, rather than two-thirds, vote of either the supervisory committee or the board for a suspension.

Accounts – Requires share accounts to be subscribed to and paid for in a manner as the board, rather than the bylaws, prescribes. Clarifies that a multiple party account entered into by a CU is subject to non-probate transfer laws relating to accounts and securities.

Loans – Allows a CU to make loans to members for the purposes and on the conditions prescribed by the board, rather than the bylaws. Prepayment penalties may be charged on loans that are not made for personal, family or household purposes, rather than on member business loans. Reduces, from 10 percent to 5 percent, the outstanding principal balance that a CU must maintain of a joint loan to a member with another CU, CU organization or other organization.

Requires any loan that would result in an official becoming obligated as a direct obligor, endorser, cosigner or guarantor in an aggregate amount of more than one percent of the CU's net worth, rather than $20,000 or a greater amount determined by the Deputy Director, to be approved by the board. Modifies reporting requirements for an official's obligations to the CU.

Laws 2024, Chapter 83 (S. B. 1367) – occupational license; criminal record

Amends A.R.S. § 41-1093.04

Reduces, from seven years prior to three years prior, the period of time preceding the date of a petition for review of a criminal record (petition) within which a person's conviction of any of the outlined offenses may be determined by a state agency to disqualify the person from obtaining a license, permit, certificate or other state recognition (license). A state agency, in determining whether the person's criminal record disqualifies the person from obtaining a license, may not consider: 1) any conviction that has been sealed; or 2) negatively whether the person would qualify for a fingerprint clearance card without a good cause exception. A state agency that determines that a person's criminal record disqualifies the person from obtaining a license must, rather than may, advise the person of the actions that the person may take to remedy the disqualification. By July 1 of each year, each state agency must post the agency's annual petitions report on its website.

Laws 2024, Chapter 102 (S. B. 1034) – (NOW: money transmission; notice)

Adds A.R.S. § 6-1235

Requires, before transmitting any money, a licensed money transmitter (licensee) that engages in the business of receiving money for transmission on behalf of consumers for personal, family or household purposes to provide consumer fraud warnings to the consumer, either in-person or through electronic transmission as outlined, that include the prescribed information.

Exempts, from the fraud warning requirements: 1) an electronic funds transfer where the monies are not transferred directly to another person and are not available for immediate use; 2) an electronic funds transfer that is made with a gift certificate; and 3) a licensee that can demonstrate that they, or require their authorized delegate to, provide annual fraud prevention training to employees that covers the indicia of fraud associated with electronic money transfers.

Laws 2024, Chapter 103 (S. B. 1042) – (NOW: title companies; recorded documents; DIFI)

Amends A.R.S. § 20-1591

Stipulates that an agreement by a person to indemnify or hold harmless a title insurer from risks that arise from an instrument that is or becomes properly recorded and indexed in the office of the county recorder and is only enforceable if the agreement is in writing and any of the outlined criteria apply. Such an agreement: 1) does not affect the enforceability of title warranties provided by a person in a deed or a mortgage; and 2) must be separate from and not included in the title insurance policy.

Laws 2024, Chapter 138 (H. B. 2199) – (NOW: life care contract; disclosure)

Amends A.R.S. § 20-1812

Requires, for new and existing life care contracts (contracts), if a contract offers a refund, the contract provider to deliver to the contract holder a separate disclosure document that indicates: 1) whether and when the contract holder must pay an entrance fee; 2) whether any part of the entrance fee, or any other amount, paid by the contract holder will be refunded; 3) the amount of the refund and time for payment of the refund; and 4) any conditions or limits on the payment of a refund.

Prescribes requirements for the formatting and execution of the disclosure document. The Director may recommend or require that the disclosures be in a specified form.

Laws 2024, Chapter 139 (H. B. 2204) – (NOW: workers' compensation; premiums)

Amends A.R.S. §§ 23-902, 23-961 and 23-1065

Allows a workers' compensation insurer to reduce the amount of premiums paid by an employer by up to five percent if: 1) the insured employer is part of a membership organization whose membership is comprised of persons that are in a similar or related line of commerce, organized to promote and improve business conditions in that line of commerce, not engage in regular business of a kind that is ordinarily carried on for profit and whose net earnings do not inure to the benefit of any member; and 2) the insurer has a program agreement with the membership organization of which the employer is a member.

Laws 2024, Chapter 149 (H. B. 2609) – auto theft authority; fee overpayment

Amends A.R.S. § 41-3453

Entitles an insurer that has overpaid the Arizona Automobile Theft Authority (AATA) fee to a refund of the overpaid amount. The insurer must submit a written request for a refund to the AATA within one year after the date that the overpaid fee was due and payable and include documentation or any other information satisfactory to the Director to substantiate the actual overpaid amount. The Director must approve or deny a refund of the amount specified in the insurer's request and, if approved, refund the amount to the insurer from the AATA Fund.

Requires the Director to approve a written request submitted to the AATA by December 31, 2024, for a refund of the actual overpaid amount of the AATA fee that was the subject of a claim initiated by an insurer in 2023 if the insurer includes documentation or any other information satisfactory to the Director to substantiate the actual overpaid amount.

Allows the Director to audit, at the insurer's expense, an insurer that issues motor vehicle liability policies in Arizona for the purposes of determining compliance with AATA statutes.

Laws 2024, Chapter 178 (H. B. 2599) – health care appeals

Amends A.R.S. §§ 20-2501, 20-2532, 20-2533, 20-2534, 20-2535, 20-2536 and 20-2537; Adds A.R.S. § 20-2542

Levels of Review – Effective January 1, 2025, replaces the informal reconsideration with an initial appeal and the formal appeal with a voluntary internal appeal. A health care insurer (insurer), for group plans and grandfathered individual plans, may elect to offer a voluntary internal appeal as an additional level of review after an initial appeal. A minimum dollar amount may not be imposed on a claim that is the subject of an adverse determination for a member to pursue the health care appeals process. Eliminates the authorization for an insurer to offer additional levels of review.

Requires, at each internal level of review, an insurer to provide a written determination that includes the basis, criteria used, clinical reasons and rationale for the determination within the prescribed timeframes. Adds, for all internal levels of review, advanced practice registered nurses to the list of health care providers (providers) that a utilization review agent (URA) may either consult with or select to render a determination for cases involving medical necessity or appropriateness or experimental or investigational services. Before an insurer makes a final internal adverse determination that relies on new or additional evidence generated directly or indirectly by the insurer, the insurer must provide the new or additional information to the member free of charge sufficiently in advance of the determination to allow the member a reasonable opportunity to respond within the applicable timeframe for the determination. A member must be considered to have exhausted an insurer's internal levels of review, except as prescribed, if the insurer fails to comply with health care appeals laws, except to the extent that the member requested or agreed to the delay and that the member may simultaneously initiate an expedited external independent review. An insurer may waive the internal levels of review.

Specifies that an insurer's approved appeal process information packet must be prominently displayed on the insurer's website. An insurer and an independent review organization (IRO) must maintain all records related to internal and external appeals and exception requests for at least three years after the completion of the respective process.

Initial and Voluntary Internal Appeals – Requires the URA's written determination of an initial appeal to include a notice of the option to proceed to the voluntary internal appeal, if applicable. Eliminates the requirement for the URA to send a written acknowledgement to the member and the member's treating provider within five business days after the URA receives an initial or voluntary internal appeal request.

External Independent Review – Requires the URA's written acknowledgment to include notice to the member that the member has five business days after receiving the notice to submit additional written evidence to the Department, of which the Director must provide a copy to the insurer and the IRO within one business day after the Director receives the information, for consideration by the assigned IRO. An IRO must consider timely submitted evidence in making its determination and may, at its discretion, consider untimely submitted evidence.

Requires the IRO's determination to be consistent with the utilization review plan and the IRO reviewer to consider the prescribed information when rendering a determination and include the outlined information in the reviewer's written determination.

Expedited Medical Review – Requires a URA to make a determination within 72 hours, rather than one business day, after an expedited medical review request. Includes optometrists and psychologists in the list of providers that the URA may consult with in making a determination for an issue of medical necessity or appropriateness or is investigational or experimental.

Expedited External Independent Review – Increases, from five business days to four months, the timeframe within which the member may request an expedited external independent review after the member receives an adverse determination at the expedited internal levels of review. A member may make an oral request for expedited external independent review for an adverse determination involving an experimental or investigational service if the member's treating provider certifies in writing that the recommended service or treatment would be significantly less effective if not promptly initiated.

Adds that a member may initiate an expedited external independent review if: 1) the URA denies a health care service for which the member received emergency services but has not been discharged or denies, reduces or terminates coverage for a member's admission, the availability of care, a continued stay for a course of treatment before the end of the period of time or number of treatments recommended by the treating provider; or 2) the member exhausted or the insurer waived the insurer's internal levels of review.

Definition of Adverse Determination – Replaces an *adverse decision* with an *adverse determination*. Adds, in the definition of *adverse determination*, a rescission and a determination by a URA that, in whole or in part: 1) a requested service or claim for service is not appropriate, including the health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational; and 2) a denial, reduction or termination of a service, is not a covered service, or is not medically necessary or appropriate, including the health care setting, level of care or effectiveness of a covered benefit, or is experimental or investigational.

Laws 2024, Chapter 184 (S. B. 1402) – health care; costs; reimbursement

Adds A.R.S. § 20-111

Allows a health care insurer to establish a program that provides a savings incentive for enrollees for medically necessary covered health care services that health care providers and health care facilities provide at a price that is below the health care insurer's usual reimbursement. The program may enable an eligible enrollee to: 1) have the amount the enrollee pays applied toward the enrollee's deductible and out-of-pocket maximum; and 2) be reimbursed for a portion of the amount of the difference between the price the enrollee paid and the health care insurer's usual reimbursement.

Laws 2024, Chapter 194 (H. B. 2490) – proper venue; challenges; policy statements

Adds A.R.S. § 41-1010.01

Allows a party that appeals a final administrative decision to the superior court to bring the action in any proper venue which, unless the proper venue is otherwise prescribed by statute, may include: 1) the county where the appellant resides; 2) the county where the appellant's principal place of business is located; 3) the county where the agency is headquartered; and 4) Maricopa County. If the proper venue for an action to review a final administrative decision is expressly prescribed by statute, such venue must control.

Prohibits an agency from, unless otherwise provided by statute: 1) restricting the proper venue for any appeal of a final administrative decision; or 2) requiring a party to travel to the agency's county, venue or headquarters to submit or receive documentation that supports the analysis used to propose or finalize a final administrative decision.

Laws 2024, Chapter 203 (S. B. 1677) – firefighters; peace officers; PTSD; therapy

Adds A.R.S. § 23-972

Conditional on the U.S. Food and Drug Administration's approval of the use of midomafetamine for the treatment of post-traumatic stress disorder (PTSD) by December 31, 2025, requires employers to provide workers' compensation coverage to firefighters and certified peace officers who have been diagnosed with PTSD by a licensed mental health professional and who have an accepted workers' compensation claim for PTSD under Arizona labor laws. Workers' compensation coverage may include one complete course of a treatment protocol of midomafetamine as prescribed by a psychiatrist if an independent medical examination reveals a treatment protocol of midomafetamine is deemed a reasonable and necessary treatment and follows the treatment guidelines established by the Industrial Commission of Arizona. Midomafetamine prescribed for such purposes must meet the statutory requirements for a controlled substance.

FY 2024-2025 Budget

Laws 2024, Chapter 209 (H. B. 2897) – general appropriations act; 2024-2025

Session Law

Requires monies in the Arizona Vehicle Theft Task Force (VTTF) line item to be used by the Department to pay 75 percent of the personal services and employee-related expenses for city, town and county sworn officers who participate in the VTTF. The Arizona Automobile Theft Authority's Local Grants must be awarded with consideration given to areas with greater automobile theft problems and must be used to combat economic auto theft operations.

Laws 2024, Chapter 212 (H. B. 2900) – commerce; 2024-2025

Amends A.R.S. §§ 6-135, 18-441 and 20-466; Adds A.R.S. § 20-466.05

Increases, from $200,000 to $700,000, the threshold over which excess unencumbered monies at the end of the fiscal year in the Department's Revolving Fund must be deposited into the Department's Receivership Revolving Fund.

Effective July 1, 2025, establishes the Fraud Unit Assessment Fund (Fund) and requires monies collected from Fraud Unit assessments to be deposited in the Fund rather than the state General Fund. The Department must use monies in the Fund to administer and operate the Fraud Unit. Monies in the Fund are continuously appropriated.

All interested persons are encouraged to obtain copies of the enacted legislation from the Arizona State Legislature's website at azleg.gov or by contacting the Arizona Secretary of State's Office at (602) 542-4086. Please direct any questions regarding this bulletin to Fausto Burruel, Legislative Liaison at (602) 531-3069 or fausto.burruel@difi.az.gov.