Senate Engrossed

FILED

JANICE K. BREWER
SECRETARY OF STATE

State of Arizona
Senate
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Second Regular Session
2004

CHAPTER 5

SENATE BILL 1094

AN ACT

AMENDING SECTION 20-461, ARIZONA REVISED STATUTES; RELATING TO UNFAIR CLAIM SETTLEMENT PRACTICES.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

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

20-461. Unfair claim settlement practices

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) Clearly identifies each part.

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

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

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

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

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

B. Nothing in subsection A, paragraph 16 of this section shall be construed to prohibit the application of deductibles, coinsurance, preferred provider organization requirements, cost containment measures or quality assurance measures if they are equally applied to all types of physicians referred to in this section, and if any limitation or condition placed upon payment to or upon services, diagnosis or treatment by any physician covered by this section is equally applied to all physicians referred to in subsection A, paragraph 16 of this section, without discrimination to the usual and customary procedures of any type of physician. A DETERMINATION UNDER THIS SECTION OF DISCRIMINATION TO THE USUAL AND CUSTOMARY PROCEDURES OF ANY TYPE OF PHYSICIAN SHALL NOT BE BASED ON WHETHER AN INSURER APPLIES MEDICAL NECESSITY REVIEW TO A PARTICULAR TYPE OF SERVICE OR TREATMENT.

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

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

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

Sec. 2. Health plans; medical necessity review; report

Health plans that do not predominately engage in the process of medical necessity review but apply medical necessity review to a particular type of service or treatment pursuant to section 20-461, subsection B, Arizona Revised Statutes, as amended by this act, shall submit a report annually on or before December 15 to the director of the department of insurance. The report shall include the particular type of service or treatment for which medical necessity reviews were conducted and the number of claims denied by the health plan that were overturned at the external independent review level of an appeal. The information shall be reviewed by the department of insurance to make sure that the health plan, as a general business practice, does not use medical necessity review in a discriminatory fashion pursuant to section 20-461, Arizona Revised Statutes, as amended by this act.

Sec. 3. Delayed repeal

Section 2 of this act, relating to medical necessity review reports of health plans, is repealed from and after December 31, 2006.

Sec. 4. Effective date

Section 20-461, Arizona Revised Statutes, as amended by this act, and section 2 of this act, relating to medical necessity review reports of health plans, are effective from and after December 31, 2004.

APPROVED BY THE GOVERNOR MARCH 22, 2004.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MARCH 22, 2004.