Senate Engrossed

State of Arizona
Senate
Fifty-third Legislature
First Regular Session
2017

SENATE BILL 1441

AN ACT

AMENDING SECTION 20-3101, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 20, ARIZONA REVISED STATUTES, BY ADDING ARTICLE 2; RELATING TO INSURANCE DISPUTE RESOLUTIONS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Section 20-3101, Arizona Revised Statutes, is amended to read:

20-3101. Definitions

In this ~~chapter~~ ARTICLE, 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.

Sec. 2. Title 20, chapter 20, Arizona Revised Statutes, is amended by adding article 2, to read:

ARTICLE 2. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

20-3111. Definitions

IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

1. "ARBITRATION" MEANS A PROCESS IN WHICH AN IMPARTIAL ARBITRATOR FACILITATES AND PROMOTES AGREEMENT BETWEEN A HEALTH INSURER, AN ENROLLEE AND A HEALTH CARE PROVIDER OR ITS BILLING COMPANY OR AUTHORIZED REPRESENTATIVE THAT HAS ISSUED A SURPRISE OUT-OF-NETWORK BILL TO THE ENROLLEE FOR HEALTH CARE SERVICES OR DURABLE MEDICAL EQUIPMENT TO SETTLE THE BILL.

2. "ARBITRATOR" MEANS AN IMPARTIAL PERSON WHO IS APPOINTED TO CONDUCT AN ARBITRATION.

3. "BILLING COMPANY" MEANS ANY AFFILIATED OR UNAFFILIATED COMPANY THAT IS HIRED BY A HEALTH CARE PROVIDER OR HEALTH CARE FACILITY TO

COORDINATE THE PAYMENT OF BILLS WITH HEALTH INSURERS AND TO GENERATE OR BILL AND COLLECT PAYMENT FROM ENROLLEES ON THE HEALTH CARE PROVIDER'S OR HEALTH CARE FACILITY'S BEHALF.

4. "CONTRACTED PROVIDER" MEANS A HEALTH CARE PROVIDER THAT HAS ENTERED INTO A CONTRACT WITH A HEALTH INSURER TO PROVIDE HEALTH CARE SERVICES TO THE HEALTH INSURER'S ENROLLEES AT AGREED ON RATES.

5. "COST SHARING REQUIREMENTS" MEANS AN ENROLLEE'S APPLICABLE COINSURANCE, COPAYMENT AND DEDUCTIBLE REQUIREMENTS UNDER A HEALTH PLAN.

6. "ENROLLEE" MEANS AN INDIVIDUAL WHO IS ELIGIBLE TO RECEIVE BENEFITS THROUGH A HEALTH PLAN.

7. "HEALTH CARE FACILITY" HAS THE SAME MEANING PRESCRIBED IN SECTION 36-437.

8. "HEALTH CARE PROVIDER" MEANS A PERSON WHO IS LICENSED, REGISTERED OR CERTIFIED AS A HEALTH CARE PROFESSIONAL UNDER TITLE 32 OR A LABORATORY OR DURABLE MEDICAL EQUIPMENT PROVIDER THAT FURNISHES SERVICES TO A PATIENT IN A NETWORK FACILITY AND THAT SEPARATELY BILLS THE PATIENT FOR THE SERVICES.

9. "HEALTH INSURER" MEANS A DISABILITY INSURER, GROUP DISABILITY INSURER, BLANKET DISABILITY INSURER, HOSPITAL SERVICE CORPORATION OR MEDICAL SERVICE CORPORATION THAT PROVIDES HEALTH INSURANCE IN THIS STATE.

10. "HEALTH PLAN" MEANS A GROUP OR INDIVIDUAL HEALTH PLAN THAT FINANCES OR FURNISHES HEALTH CARE SERVICES AND THAT IS ISSUED BY A HEALTH INSURER.

11. "NETWORK FACILITY" MEANS A HEALTH CARE FACILITY THAT HAS ENTERED INTO A CONTRACT WITH A HEALTH INSURER TO PROVIDE HEALTH CARE SERVICES TO THE HEALTH INSURER'S ENROLLEES AT AGREED ON RATES.

12. "SURPRISE OUT-OF-NETWORK BILL" MEANS A BILL FOR A HEALTH CARE SERVICE, A LABORATORY SERVICE OR DURABLE MEDICAL EQUIPMENT THAT WAS PROVIDED IN A NETWORK FACILITY BY A HEALTH CARE PROVIDER THAT IS NOT A CONTRACTED PROVIDER AND THAT MEETS ONE OF THE REQUIREMENTS LISTED IN SECTION 20-3113.

20-3112. Applicability

THIS ARTICLE DOES NOT APPLY TO NONCOVERED HEALTH CARE SERVICES, TO LIMITED BENEFIT COVERAGE AS DEFINED IN SECTION 20-1137 OR TO CHARGES FOR HEALTH CARE SERVICES OR DURABLE MEDICAL EQUIPMENT SUBJECT TO A DIRECT PAYMENT AGREEMENT UNDER SECTION 32-3216 OR 36-437.

20-3113. Surprise out-of-network bill; requirements; notice

A BILL FOR A HEALTH CARE SERVICE, A LABORATORY SERVICE OR DURABLE MEDICAL EQUIPMENT THAT WAS PROVIDED IN A NETWORK FACILITY BY A HEALTH CARE PROVIDER THAT IS NOT A CONTRACTED PROVIDER MUST MEET ONE OF THE FOLLOWING REQUIREMENTS TO QUALIFY AS A SURPRISE OUT-OF-NETWORK BILL:

1. THE BILL WAS FOR A HEALTH CARE SERVICE, A LABORATORY SERVICE OR DURABLE MEDICAL EQUIPMENT THAT WAS PROVIDED IN THE CASE OF AN EMERGENCY, INCLUDING UNDER CIRCUMSTANCES DESCRIBED BY SECTION 20-2803, SUBSECTION A.

2. THE BILL WAS NOT FOR A HEALTH CARE SERVICE, A LABORATORY SERVICE OR DURABLE MEDICAL EQUIPMENT THAT WAS PROVIDED IN THE CASE OF AN EMERGENCY AND THE HEALTH CARE PROVIDER DID NOT PROVIDE TO THE ENROLLEE WITHIN A REASONABLE AMOUNT OF TIME BEFORE THE ENROLLEE RECEIVED THE SERVICES A WRITTEN DISCLOSURE THAT CONTAINED THE FOLLOWING INFORMATION:

(a) NOTICE THAT THE HEALTH CARE PROVIDER IS NOT A CONTRACTED PROVIDER.

(b) THE ESTIMATED TOTAL COST TO BE BILLED BY THE HEALTH CARE PROVIDER.

(c) NOTICE THAT IF THE ENROLLEE OR THE ENROLLEE'S AUTHORIZED REPRESENTATIVE SIGNS THE DISCLOSURE, THE ENROLLEE MAY HAVE WAIVED ANY RIGHTS TO DISPUTE RESOLUTION UNDER THIS ARTICLE.

3. THE BILL WAS NOT FOR A HEALTH CARE SERVICE, A LABORATORY SERVICE OR DURABLE MEDICAL EQUIPMENT THAT WAS PROVIDED IN THE CASE OF AN EMERGENCY AND THE ENROLLEE RECEIVED THE DISCLOSURE PRESCRIBED IN PARAGRAPH 2 OF THIS SECTION, BUT THE ENROLLEE OR THE ENROLLEE'S AUTHORIZED REPRESENTATIVE CHOSE NOT TO SIGN THE DISCLOSURE.

20-3114. Settlement teleconference; arbitration; surprise out-of-network bills

A. AN ENROLLEE WHO HAS RECEIVED A SURPRISE OUT-OF-NETWORK BILL AND WHO DISPUTES THE AMOUNT OF THE BILL MAY SEEK ARBITRATION OF THE BILL IF ALL OF THE FOLLOWING APPLY:

1. THE AMOUNT OF THE SURPRISE OUT-OF-NETWORK BILL FOR WHICH THE ENROLLEE IS RESPONSIBLE FOR ALL RELATED HEALTH CARE SERVICES PROVIDED BY THE HEALTH CARE PROVIDER WHETHER CONTAINED IN ONE OR MULTIPLE BILLS, AFTER DEDUCTION OF THE ENROLLEE'S COST SHARING REQUIREMENTS AND THE INSURER'S ALLOWABLE REIMBURSEMENT, IS AT LEAST ONE THOUSAND DOLLARS.

2. THE ENROLLEE RECEIVED A SURPRISE OUT-OF-NETWORK BILL.

B. IF AN ENROLLEE REQUESTS ARBITRATION OF A SURPRISE OUT-OF-NETWORK BILL, THE ENROLLEE SHALL PARTICIPATE IN AN INFORMAL SETTLEMENT TELECONFERENCE AND MAY PARTICIPATE IN THE ARBITRATION. THE HEALTH CARE PROVIDER AND THE HEALTH INSURER SHALL PARTICIPATE IN THE INFORMAL SETTLEMENT TELECONFERENCE AND THE ARBITRATION.

C. AN ENROLLEE MAY NOT SEEK ARBITRATION OF A BILL IF THE ENROLLEE OR THE ENROLLEE'S AUTHORIZED REPRESENTATIVE SIGNED THE DISCLOSURE PRESCRIBED IN SECTION 20-3113, PARAGRAPH 2 AND THE AMOUNT ACTUALLY BILLED TO THE ENROLLEE IS LESS THAN OR EQUAL TO THE ESTIMATED TOTAL COST PROVIDED IN THE DISCLOSURE.

20-3115. Conduct of arbitration proceedings

A. THE DEPARTMENT SHALL DEVELOP A SIMPLE, FAIR, EFFICIENT AND COST-EFFECTIVE ARBITRATION PROCEDURE FOR SURPRISE OUT-OF-NETWORK BILL DISPUTES AND SPECIFY TIME FRAMES, STANDARDS AND OTHER DETAILS OF THE ARBITRATION PROCEEDING. THE DEPARTMENT SHALL CONTRACT WITH ONE OR MORE ENTITIES TO PROVIDE ARBITRATORS WHO ARE QUALIFIED UNDER SECTION 20-3116 FOR THIS PROCESS. DEPARTMENT STAFF MAY NOT SERVE AS ARBITRATORS.

B. AN ENROLLEE MAY REQUEST ARBITRATION OF A SURPRISE OUT-OF-NETWORK BILL BY SUBMITTING A REQUEST FOR ARBITRATION TO THE DEPARTMENT ON A FORM PRESCRIBED BY THE DEPARTMENT.

C. ON RECEIPT OF A REQUEST FOR ARBITRATION, THE DEPARTMENT SHALL NOTIFY THE HEALTH INSURER AND HEALTH CARE PROVIDER OF THE REQUEST.

D. IN AN EFFORT TO SETTLE THE SURPRISE OUT-OF-NETWORK BILL BEFORE ARBITRATION, THE DEPARTMENT SHALL ARRANGE AN INFORMAL SETTLEMENT TELECONFERENCE WITHIN THIRTY DAYS AFTER THE DEPARTMENT RECEIVES THE REQUEST FOR ARBITRATION. IF THE DISPUTE IS NOT SETTLED IN THE TELECONFERENCE, THE PARTIES SHALL NOTIFY THE DEPARTMENT.

E. IF EITHER THE HEALTH INSURER OR HEALTH CARE PROVIDER FAILS TO PARTICIPATE IN THE TELECONFERENCE, THE OTHER PARTY MAY NOTIFY THE DEPARTMENT TO IMMEDIATELY INITIATE ARBITRATION AND THE NONPARTICIPATING PARTY SHALL BE REQUIRED TO PAY THE TOTAL COST OF THE ARBITRATION.

F. ON RECEIPT OF NOTICE THAT THE DISPUTE HAS NOT SETTLED OR THAT A PARTY HAS FAILED TO PARTICIPATE IN THE TELECONFERENCE, THE DEPARTMENT SHALL APPOINT AN ARBITRATOR AND SHALL NOTIFY THE PARTIES OF THE ARBITRATION AND THE APPOINTED ARBITRATOR. THE HEALTH INSURER AND HEALTH CARE PROVIDER MUST AGREE ON THE ARBITRATOR. IF EITHER THE HEALTH INSURER OR HEALTH CARE PROVIDER OBJECTS TO THE ARBITRATOR, THE DEPARTMENT OR CONTRACTED ENTITY SHALL RANDOMLY ASSIGN FIVE ARBITRATORS. THE HEALTH INSURER AND THE HEALTH CARE PROVIDER SHALL EACH STRIKE TWO ARBITRATORS, AND THE LAST ARBITRATOR SHALL CONDUCT THE ARBITRATION.

G. BEFORE THE ARBITRATION, THE ENROLLEE SHALL AGREE IN WRITING TO PAY THE HEALTH CARE PROVIDER THE TOTAL AMOUNT OF THE ENROLLEE'S COST SHARING THAT IS DUE FOR THE SERVICES THAT ARE THE SUBJECT OF THE SURPRISE OUT-OF-NETWORK BILL AND ANY AMOUNT RECEIVED FROM THE ENROLLEE'S HEALTH INSURER AS PAYMENT FOR THE OUT-OF-NETWORK SERVICES THAT WERE PROVIDED BY THE HEALTH CARE PROVIDER.

H. ARBITRATION OF ANY SURPRISE OUT-OF-NETWORK BILL SHALL BE CONDUCTED IN THE COUNTY IN WHICH THE HEALTH CARE SERVICES GIVING RISE TO THE BILL WERE RENDERED AND MAY BE CONDUCTED TELEPHONICALLY ON THE AGREEMENT OF ALL OF THE PARTICIPANTS.

I. ARBITRATION OF THE SURPRISE OUT-OF-NETWORK BILL SHALL TAKE PLACE WITH OR WITHOUT THE ENROLLEE'S PARTICIPATION.

J. THE ARBITRATOR SHALL DETERMINE THE AMOUNT THE HEALTH CARE PROVIDER IS ENTITLED TO RECEIVE AS PAYMENT FOR THE HEALTH CARE SERVICES, LABORATORY SERVICES OR DURABLE MEDICAL EQUIPMENT. THE ARBITRATOR SHALL ALLOW EACH PARTY TO PROVIDE INFORMATION THE ARBITRATOR REASONABLY DETERMINES TO BE RELEVANT IN EVALUATING THE SURPRISE OUT-OF-NETWORK BILL, INCLUDING THE FOLLOWING INFORMATION:

1. THE AVERAGE CONTRACTED AMOUNT THAT THE HEALTH INSURER PAYS FOR THE HEALTH CARE SERVICES AT ISSUE IN THE COUNTY WHERE THE SERVICES WERE PERFORMED.

2. THE AVERAGE AMOUNT THAT THE HEALTH CARE PROVIDER HAS CONTRACTED TO ACCEPT FOR THE HEALTH CARE SERVICES AT ISSUE IN THE COUNTY WHERE THE SERVICES WERE PERFORMED.

3. THE AMOUNT THAT MEDICARE AND MEDICAID PAY FOR THE HEALTH CARE SERVICES.

4. THE HEALTH CARE PROVIDER'S DIRECT PAY RATE, IF ANY, UNDER SECTION 32-3216.

5. ANY INFORMATION THAT WOULD BE EVALUATED IN DETERMINING WHETHER A FEE IS REASONABLE UNDER TITLE 32 AND NOT EXCESSIVE, INCLUDING THE FEE CUSTOMARILY CHARGED IN THE LOCALITY FOR SIMILAR HEALTH CARE SERVICES AND THE TIME REQUIRED, THE COMPLEXITY OF AND THE SKILL REQUIRED TO PERFORM THE HEALTH CARE SERVICES.

6. ANY OTHER RELIABLE DATABASES OR SOURCES OF INFORMATION ON THE AMOUNT PAID FOR THE HEALTH CARE SERVICES AT ISSUE IN THE COUNTY WHERE THE SERVICES WERE PERFORMED.

K. EXCEPT ON THE AGREEMENT OF THE PARTIES PARTICIPATING IN THE ARBITRATION, THE ARBITRATION SHALL BE CONDUCTED WITHIN ONE HUNDRED TWENTY DAYS AFTER THE DEPARTMENT'S NOTICE OF ARBITRATION.

L. EXCEPT ON THE AGREEMENT OF THE PARTIES PARTICIPATING IN THE ARBITRATION, THE ARBITRATION MAY NOT LAST MORE THAN FOUR HOURS.

M. THE ARBITRATOR SHALL ISSUE A WRITTEN DECISION WITHIN TEN BUSINESS DAYS FOLLOWING THE ARBITRATION HEARING. THE ARBITRATOR SHALL PROVIDE A COPY OF THE DECISION TO THE ENROLLEE, THE HEALTH INSURER AND THE HEALTH CARE PROVIDER OR ITS BILLING COMPANY OR AUTHORIZED REPRESENTATIVE.

N. ANY PARTY TO THE ARBITRATION MAY APPEAL THE ARBITRATOR'S DECISION TO THE SUPERIOR COURT IN THE COUNTY IN WHICH THE ARBITRATION TAKES PLACE BY FILING, WITHIN THE TIME LIMITED BY RULE OF COURT, A DEMAND FOR TRIAL DE NOVO ON LAW AND FACT.

O. ALL PRICING INFORMATION PROVIDED BY HEALTH INSURERS AND HEALTH CARE PROVIDERS IN CONNECTION WITH THE ARBITRATION OF A SURPRISE OUT-OF-NETWORK BILL IS CONFIDENTIAL AND MAY NOT BE DISCLOSED BY THE ARBITRATOR OR ANY OTHER PARTY PARTICIPATING IN THE ARBITRATION.

P. A CLAIM THAT IS THE SUBJECT OF AN ARBITRATION REQUEST IS NOT SUBJECT TO ARTICLE 1 OF THIS CHAPTER DURING THE PENDENCY OF THE ARBITRATION. A HEALTH INSURER SHALL REMIT ITS PORTION OF THE PAYMENT RESULTING FROM THE INFORMAL SETTLEMENT TELECONFERENCE OR THE AMOUNT AWARDED BY THE ARBITRATOR WITHIN THIRTY DAYS OF RESOLUTION OF THE CLAIM.

Q. NOTWITHSTANDING ANY INFORMAL SETTLEMENT OR THE ARBITRATOR'S DECISION UNDER THIS ARTICLE, THE ENROLLEE IS RESPONSIBLE FOR ONLY THE AMOUNT OF THE ENROLLEE'S COST SHARING REQUIREMENTS, AND THE HEALTH CARE PROVIDER MAY NOT ISSUE, EITHER DIRECTLY OR THROUGH ITS BILLING COMPANY, ANY ADDITIONAL BALANCE BILL TO THE ENROLLEE RELATED TO THE HEALTH CARE SERVICE, LABORATORY SERVICE OR DURABLE MEDICAL EQUIPMENT THAT WAS THE SUBJECT OF THE INFORMAL SETTLEMENT TELECONFERENCE OR ARBITRATION.

R. UNLESS ALL THE PARTIES OTHERWISE AGREE OR UNLESS REQUIRED BY SUBSECTION E OF THIS SECTION, THE HEALTH INSURER AND THE HEALTH CARE PROVIDER SHALL SHARE THE COSTS OF THE ARBITRATION EQUALLY, AND THE ENROLLEE IS NOT RESPONSIBLE FOR ANY PORTION OF THE COST OF THE ARBITRATION.

20-3116. Arbitrator qualifications

TO QUALIFY AS AN ARBITRATOR, A PERSON SHALL HAVE AT LEAST THREE YEARS' EXPERIENCE IN HEALTH CARE SERVICES CLAIMS ADJUDICATION.

Sec. 3. Effective date

This act is effective from and after December 31, 2018.