State of Arizona
House of Representatives
Fifty-second Legislature
First Regular Session
2015

HOUSE BILL 2417

AN ACT

AMENDING SECTIONS 32-3216 AND 36-437, ARIZONA REVISED STATUTES; REPEALING LAWS 2013, CHAPTER 202, SECTION 7; RELATING TO DIRECT PAYMENTS TO HEALTH CARE PROVIDERS AND FACILITIES.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Section 32-3216, Arizona Revised Statutes, is amended to read:

32-3216. Health care providers; charges; public availability; direct payment; notice; definitions

A. A health care provider must make available on request or online the direct pay price for at least the twenty-five most commonly provided services, if applicable, for the health care provider. The services may be identified by a common procedural terminology code or by a plain-English description. The direct pay prices must be updated at least annually and must be based on the services from a twelve-month period that occurred within the eighteen-month period preceding the annual update. The direct pay price must be for the standard treatment provided for the service and may include the cost of treatment for complications or exceptional treatment. Health care providers who are owners or employees of a legal entity with fewer than three licensed health care providers are exempt from the requirements of this subsection.

B. Subsection A of this section does not apply to emergency services.

C. The health care services provided by health care providers in veterans administration facilities, health facilities on military bases, Indian health services hospitals and other Indian health service facilities, tribal owned clinics, the Arizona state hospital and any health care facility determined to be exempt pursuant to section 36-437, subsection D, are exempt from the requirements ~~and provisions~~ of this section.

D. Subsection A of this section does not prevent a health care provider from offering either additional discounts or additional lawful health care services for an additional cost to a person or an employer paying directly.

E. A health care provider is not required to report the direct pay prices to a government agency or department or to a government-authorized or government-created entity for review or filing. A government agency or department or government-authorized or government-created entity may not approve, disapprove or limit a health care provider's direct pay price for services. A government agency or department or government-authorized or government-created entity may not approve, disapprove or limit a health care provider's ability to change the published or posted direct pay price for services.

F. A health care system may not punish a person or employer for paying directly for lawful health care services or a health care provider for accepting direct payment from a person or employer for lawful health care services.

G. Except as provided in subsection ~~J~~ N of this section, a health care provider who receives direct payment from a person or employer for a lawful health care service is deemed paid in full if the entire fee for the service is paid and shall not submit a claim for payment or reimbursement for

the service to any health care system. This subsection does not prevent a health care provider from pursuing a health care lien for customary charges pursuant to title 33. This subsection does not affect the ability of a health care provider to submit claims for the same service provided on other occasions to the same or a different person if no direct payment occurs. This subsection does not require a health care provider to refund or adjust any capitated payment, bundled payment or other form of prepayment or global payment made by a health care system to the health care provider for lawful health care services to be provided by the health care provider for the person who makes, or on whose behalf an employer makes, direct payment to the health care provider.

H. Before a health care provider who is contracted as a network provider for a health care system accepts direct payment from a person or an employer, and the person is an enrollee of the same health care system, the health care provider shall obtain the person's or employer's signature on a notice in a form that is substantially similar to the following:

Important notice about direct payment
for your health care services

The Arizona Constitution permits you to pay a health care provider directly for health care services. Before you make any agreement to do so, please read the following important information:

If you are an enrollee of a health care system (more commonly referred to as a health insurance plan) and your health care provider is contracted with the health insurance plan, the following apply:

1. You may not be required to pay the health care provider directly for the services covered by your plan, except for cost share amounts that you are obligated to pay under your plan, such as copayments, coinsurance and deductible amounts.

2. Your provider's agreement with the health insurance plan may prevent the health care provider from billing you for the difference between the provider's billed charges and the amount allowed by your health insurance plan for covered services.

3. If you pay directly for a health care service, your health care provider will not be responsible for submitting claim documentation to your health insurance plan for that claim. Before paying your claim, your health insurance plan may require you to provide information and submit documentation necessary to determine whether the services are covered under your plan.

4. If you do not pay directly for a health care service, your health care provider may be responsible for submitting

claim documentation to your health insurance plan for the health care service.

Your signature below acknowledges that you received this notice before paying directly for a health care service.

I. A health care provider who receives direct payment for a lawful health care service and who complies with subsection H of this section is not responsible for submitting documentation of any kind for purposes of reimbursement to any health care system for that claim if the failure to submit such documentation does not conflict with the terms of any federal or state contracts to which the health care system is a party and the health care provider has agreed to serve patients under or with applicable state or federal programs in which a health care provider and health care system participate.

J. A HEALTH CARE PROVIDER WHO RECEIVES DIRECT PAYMENT PURSUANT TO THIS SECTION SHALL PROVIDE THE PERSON MAKING THE DIRECT PAYMENT WITH A RECEIPT THAT INCLUDES THE FOLLOWING INFORMATION:

1. THE AMOUNT OF THE DIRECT PAYMENT.

2. THE APPLICABLE PROCEDURE AND DIAGNOSIS CODES FOR THE SERVICES RENDERED.

3. A CLEAR NOTATION THAT THE SERVICES WERE SUBJECT TO DIRECT PAYMENT UNDER THIS SECTION.

K. IF AN ENROLLEE PAYS TO A HEALTH CARE PROVIDER WHO IS AN OUT-OF-NETWORK PROVIDER THE DIRECT PAY PRICE FOR A LAWFUL HEALTH CARE SERVICE THAT IS COVERED UNDER THE ENROLLEE'S HEALTH CARE PLAN, PURSUANT TO THE REQUIREMENTS OF THIS SECTION, THE AMOUNT PAID BY THE ENROLLEE SHALL BE APPLIED FIRST TO THE ENROLLEE'S IN-NETWORK DEDUCTIBLE WITH ANY REMAINING MONIES BEING APPLIED TO THE ENROLLEE'S OUT-OF-NETWORK DEDUCTIBLE, IF APPLICABLE. THE AMOUNT APPLIED TO THE IN-NETWORK DEDUCTIBLE SHALL BE THE AMOUNT PAID DIRECTLY OR THE INSURER'S PREVAILING CONTRACTED COMMERCIAL RATE FOR THE ENROLLEE'S HEALTH CARE PLAN IN THIS STATE FOR THE SERVICE OR SERVICES. IF THE SERVICE OR SERVICES DO NOT MATCH STANDARD CODES OR BUNDLED PAYMENT PROGRAMS IN USE IN THIS STATE BY THE INSURER, THE AMOUNT APPLIED TO THE IN-NETWORK DEDUCTIBLE SHALL BE THE AMOUNT PAID DIRECTLY. FOR THE PURPOSES OF THIS SUBSECTION, "PREVAILING CONTRACTED COMMERCIAL RATE" MEANS THE MOST USUAL AND CUSTOMARY RATE THAT AN INSURER OFFERS AS PAYMENT FOR A SPECIFIC SERVICE UNDER A SPECIFIC HEALTH CARE PLAN, NOT INCLUDING A PLAN OFFERED UNDER MEDICARE OR MEDICAID OR ON A HEALTH INSURANCE EXCHANGE.

L. IF AN ENROLLEE IS ENROLLED IN A HIGH DEDUCTIBLE PLAN THAT QUALIFIES THE ENROLLEE FOR A HEALTH SAVINGS ACCOUNT AS DEFINED IN 26 UNITED STATES CODE SECTION 223, THE HEALTH CARE SYSTEM IS NOT LIABLE IF THE ENROLLEE SUBMITS A CLAIM FOR DEDUCTIBLE APPLICATION OF A DIRECT PAY AMOUNT PURSUANT TO SUBSECTION K OF THIS SECTION THAT JEOPARDIZES THE ENROLLEE'S STATUS AS AN INDIVIDUAL ELIGIBLE FOR FAVORABLE TAX TREATMENT OF THE HEALTH SAVINGS ACCOUNT.

M. THIS SECTION DOES NOT CREATE ANY PRIVATE RIGHT OR CAUSE OF ACTION FOR OR ON BEHALF OF ANY PERSON AGAINST THE HEALTH INSURER. THIS SECTION PROVIDES SOLELY AN ADMINISTRATIVE REMEDY FOR ANY VIOLATION OF THIS SECTION OR ANY RELATED RULE.

~~J.~~ N. This section does not impair the provisions of a health care system's private health care network provider contract, except that a health care provider may accept direct payment from a person or employer or may decline to bill the health care system directly for services paid directly by a person or employer if the health care provider has complied with subsection H of this section and the health care provider's receipt of direct payment and the declination to bill the health care system do not conflict with the terms of any federal or state contract to which the health care system is a party and the health care provider has agreed to serve patients under or with applicable state or federal programs in which both a health care provider and health care system participate.

~~K.~~ O. A health care provider who does not comply with the requirements of this section commits unprofessional conduct. Any disciplinary action taken by the health professional's licensing board may not include revocation of the health care provider's license.

~~L.~~ P. For the purposes of this section:

1. "Direct pay price" means the price that will be charged by a health care provider for a lawful health care service, regardless of the health insurance status of the person, if the entire fee for the service is paid in full directly to a health care provider by the person, including the person's health savings account, or by the person's employer and that does not prohibit a provider from establishing a payment plan with the person paying directly for services.

2. "Emergency services" means lawful health care services needed to evaluate and stabilize an emergency medical condition as defined in 42 United States Code section 1396u-2(b)(2)(C).

3. "Enrollee" means a person who is enrolled in a health care plan provided by a health insurer.

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

5. "Health care provider" means a person who is licensed pursuant to chapter 7, 8, 13, 16, 17, 19 or 34 of this title.

6. "Health care system" means a public or private entity whose function or purpose is the management, processing or enrollment of individuals or the payment, in full or in part, of health care services.

7. "Health insurer":

(a) Means a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, medical service corporation or hospital and medical service corporation as defined in title 20.

(b) DOES NOT INCLUDE A GOVERNMENTAL PLAN AS DEFINED IN THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (P.L. 93-406; 88 STAT. 829; 29 UNITED STATES CODE SECTION 1002).

8. "Lawful health care services" means any health-related service or treatment, to the extent that the service or treatment is permitted or not prohibited by law or regulation, that may be provided by persons or businesses otherwise permitted to offer the services or treatments.

9. "Punish" means to impose any penalty, surcharge or named fee with a similar effect that is used to discourage the exercise of rights under this section.

Sec. 2. Section 36-437, Arizona Revised Statutes, is amended to read:

36-437. Health care facilities; charges; public availability; direct payment; notice; definitions

A. A health care facility with more than fifty inpatient beds must make available on request or online the direct pay price for at least the fifty most used diagnosis-related group codes, if applicable, for the facility and at least the fifty most used outpatient service codes, if applicable, for the facility. The services may be identified by a common procedural terminology code or by a plain-English description. The health care facility must update the direct pay prices at least annually based on the services from a twelve-month period that occurred within the eighteen-month period preceding the annual update. The direct pay price must be for the standard treatment provided for the service and may include the cost of treatment for complications or exceptional treatment.

B. A health care facility with fifty or fewer inpatient beds must make available on request or online the direct pay price for at least the thirty-five most used diagnosis-related group codes, if applicable, for the facility and at least the thirty-five most used outpatient service codes if applicable, for the facility. The services may be identified by a common procedural terminology code or by a plain-English description. The health care facility must update the direct pay prices at least annually based on the services from a twelve-month period that occurred within the eighteen-month period preceding the annual update. The direct pay price must be for the standard treatment provided for the service and may include the cost of treatment for complications or exceptional treatment.

C. Subsections A and B of this section do not apply if a discussion of the direct pay price would be a violation of the federal emergency medical treatment and labor act.

D. Veterans administration facilities, health facilities on military bases, Indian health services hospitals and other Indian health services facilities, tribal owned clinics and the Arizona state hospital are exempt from the requirements ~~and provisions~~ of this section. If the director of the Arizona department of health services determines that a health care facility does not serve the general public, the health care facility shall be exempt

from the requirements ~~and provisions~~ of this section if the facility does not serve the general public.

E. Subsections A and B of this section do not prevent a health care facility from offering either additional discounts or additional lawful health care services for an additional cost to a person or an employer paying directly.

F. A health care facility is not required to report the direct pay prices to a government agency or department or to a government-authorized or government-created entity for review. A government agency or department or government-authorized or government-created entity may not approve, disapprove or limit a health care facility's direct pay price for services. A government agency or department or government-authorized or government-created entity may not approve, disapprove or limit a health care facility's ability to change the published or posted direct pay price for services.

G. A health care system may not punish a person or employer for paying directly for lawful health care services or a health care facility for accepting direct payment from a person or employer for lawful health care services.

H. Except as provided in subsection ~~K~~ O of this section, a health care facility that receives direct payment from a person or employer for a lawful health care service is deemed paid in full if the entire fee for the service is paid and shall not submit a claim for payment or reimbursement for the service to any health care system. This subsection does not prevent a health care facility from pursuing a health care lien for customary charges pursuant to title 33. This subsection does not affect the ability of a health care facility to submit claims for the same service provided on other occasions to the same or a different person if no direct payment occurs. This subsection does not require a health care facility to refund or adjust any capitated payment, bundled payment or ~~any~~ other form of prepayment or global payment made by a health care system to the health care facility for lawful health care services to be provided by the health care facility for the person who makes, or on whose behalf an employer makes, direct payment to the health care facility.

I. Before a health care facility that is contracted as a network provider for a health care system accepts direct payment from a person or an employer, and the person is an enrollee of the same health care system, the health care facility shall obtain the person's or employer's signature on a notice in a form that is substantially similar to the following:

Important notice about direct payment
for your health care services

The Arizona Constitution permits you to pay a health care facility directly for health care services. Before you make any agreement to do so, please read the following important information:

If you are an enrollee of a health care system (more commonly referred to as a health insurance plan) and your health care facility is contracted with the health insurance plan, the following apply:

1. You may not be required to pay the health care facility directly for the services covered by your plan, except for cost share amounts that you are obligated to pay under your plan, such as copayments, coinsurance and deductible amounts.

2. Your provider's agreement with the health insurance plan may prevent the health care facility from billing you for the difference between the facility's billed charges and the amount allowed by your health insurance plan for covered services.

3. If you pay directly for a health care service, your health care facility will not be responsible for submitting claim documentation to your health insurance plan for that claim. Before paying your claim, your health insurance plan may require you to provide information and submit documentation necessary to determine whether the services are covered under your plan.

4. If you do not pay directly for a health care service, your health care facility may be responsible for submitting claim documentation to your health insurance plan for the health care service.

Your signature below acknowledges that you received this notice before paying directly for a health care service.

J. A health care facility that receives direct payment for a lawful health care service and that complies with subsection I of this section is not responsible for submitting documentation of any kind for purposes of reimbursement to any health care system for that claim if the failure to submit such documentation does not conflict with the terms of any federal or state contracts to which the health care system is a party and the health care facility has agreed to serve patients under or with applicable state or federal programs in which a health care facility and health care system participate.

K. A HEALTH CARE FACILITY THAT RECEIVES DIRECT PAYMENT PURSUANT TO THIS SECTION SHALL PROVIDE THE PERSON MAKING THE DIRECT PAYMENT WITH A RECEIPT THAT INCLUDES THE FOLLOWING INFORMATION:

1. THE AMOUNT OF THE DIRECT PAYMENT.

2. THE APPLICABLE PROCEDURE AND DIAGNOSIS CODES FOR THE SERVICES RENDERED.

3. A CLEAR NOTATION THAT THE SERVICES WERE SUBJECT TO DIRECT PAYMENT UNDER THIS SECTION.

L. IF AN ENROLLEE PAYS TO A HEALTH CARE FACILITY THAT IS AN OUT-OF-NETWORK PROVIDER THE DIRECT PAY PRICE FOR A LAWFUL HEALTH CARE SERVICE

THAT IS COVERED UNDER THE ENROLLEE'S HEALTH CARE PLAN, PURSUANT TO THE REQUIREMENTS OF THIS SECTION, THE AMOUNT PAID BY THE ENROLLEE SHALL BE APPLIED FIRST TO THE ENROLLEE'S IN-NETWORK DEDUCTIBLE WITH ANY REMAINING MONIES BEING APPLIED TO THE ENROLLEE'S OUT-OF-NETWORK DEDUCTIBLE, IF APPLICABLE. THE AMOUNT APPLIED TO THE IN-NETWORK DEDUCTIBLE SHALL BE THE AMOUNT PAID DIRECTLY OR THE INSURER'S PREVAILING CONTRACTED COMMERCIAL RATE FOR THE ENROLLEE'S HEALTH CARE PLAN IN THIS STATE FOR THE SERVICE OR SERVICES. IF THE SERVICE OR SERVICES DO NOT MATCH STANDARD CODES OR BUNDLED PAYMENT PROGRAMS IN USE IN THIS STATE BY THE INSURER, THE AMOUNT APPLIED TO THE IN-NETWORK DEDUCTIBLE SHALL BE THE AMOUNT PAID DIRECTLY. FOR THE PURPOSES OF THIS SUBSECTION, "PREVAILING CONTRACTED COMMERCIAL RATE" MEANS THE MOST USUAL AND CUSTOMARY RATE THAT AN INSURER OFFERS AS PAYMENT FOR A SPECIFIC SERVICE UNDER A SPECIFIC HEALTH CARE PLAN, NOT INCLUDING A PLAN OFFERED UNDER MEDICARE OR MEDICAID OR ON A HEALTH INSURANCE EXCHANGE.

M. IF AN ENROLLEE IS ENROLLED IN A HIGH DEDUCTIBLE PLAN THAT QUALIFIES THE ENROLLEE FOR A HEALTH SAVINGS ACCOUNT AS DEFINED IN 26 UNITED STATES CODE SECTION 223, THE HEALTH CARE SYSTEM IS NOT LIABLE IF THE ENROLLEE SUBMITS A CLAIM FOR DEDUCTIBLE APPLICATION OF A DIRECT PAY AMOUNT PURSUANT TO SUBSECTION L OF THIS SECTION THAT JEOPARDIZES THE ENROLLEE'S STATUS AS AN INDIVIDUAL ELIGIBLE FOR FAVORABLE TAX TREATMENT OF THE HEALTH SAVINGS ACCOUNT.

N. THIS SECTION DOES NOT CREATE ANY PRIVATE RIGHT OR CAUSE OF ACTION FOR OR ON BEHALF OF ANY PERSON AGAINST THE HEALTH INSURER. THIS SECTION PROVIDES SOLELY AN ADMINISTRATIVE REMEDY FOR ANY VIOLATION OF THIS SECTION OR ANY RELATED RULE.

~~K.~~ O. This section does not impair the provisions of a health care system's private health care network provider contract, except that a health care facility may accept direct payment from a person or employer or may decline to bill the health care system directly for services paid directly by a person or employer if the health care facility has complied with subsection I of this section and the health care facility's receipt of direct payment and the declination to bill the health care system do not conflict with the terms of any federal or state contract to which the health care system is a party and the health care facility has agreed to serve patients under or with applicable state or federal programs in which a health care facility and health care system participate.

~~L.~~ P. This section may not prevent the ~~Arizona~~ department of health services from performing an investigation of a health care facility under the department's powers and duties as ~~defined~~ PRESCRIBED in THIS title ~~36~~. If a health care facility fails to comply with this section, the penalty shall not include the revocation of the license to deliver health care services.

~~M.~~ Q. For the purposes of this section:

1. "Direct pay price" means the entire price that will be charged by a health care facility for a lawful health care service, regardless of the health insurance status of the person, if the entire fee for the service is

paid in full directly to a health care facility by the person, including the person's health savings account, or by the person's employer and that does not prohibit a facility from establishing a payment plan with the person paying directly for services.

2. "Enrollee" means a person who is enrolled in a health care plan provided by a health insurer.

3. "Health care facility" means a hospital, outpatient surgical center, health care laboratory, diagnostic imaging center or urgent care center.

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

5. "Health care provider" means a person who is licensed pursuant to TITLE 32, chapter 7, 8, 13, 16, 17, 19 or 34 ~~of title 32~~.

6. "Health care system" means a public or private entity whose function or purpose is the management, processing or enrollment of individuals or the payment, in full or in part, of health care services.

7. "Health insurer":

(a) Means a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, medical service corporation or hospital and medical service corporation as defined in title 20.

(b) DOES NOT INCLUDE A GOVERNMENTAL PLAN AS DEFINED IN THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (P.L. 93-406; 88 STAT. 829; 29 UNITED STATES CODE SECTION 1002).

8. "Lawful health care services" means any health-related service or treatment, to the extent that the service or treatment is permitted or not prohibited by law or regulation, that may be provided by persons or businesses otherwise permitted to offer the services or treatments.

9. "Punish" means to impose any penalty, surcharge or named fee with a similar effect that is used to discourage the exercise of rights under this section.

Sec. 3. Repeal

Laws 2013, chapter 202, section 7 is repealed.

Sec. 4. Effective date

Sections 32-3216 and 36-437, Arizona Revised Statutes, as amended by this act, are effective from and after December 31, 2016 and apply to policies, contracts and plans that are issued or renewed from and after December 31, 2016.