

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

**CHAPTER 190**  
**SENATE BILL 1441**

AN ACT

AMENDING SECTIONS 20-3101 AND 20-3102, 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)

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

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

4 20-3101. Definitions

5 In this ~~chapter~~ ARTICLE, unless the context otherwise requires:

6 1. "Adjudicate" means an insurer's decision to deny or pay a claim,  
7 in whole or in part, including the decision as to how much to pay.

8 2. "Clean claim" means a written or electronic claim for health  
9 care services or benefits that may be processed without obtaining  
10 additional information, including coordination of benefits information,  
11 from the health care provider, the enrollee or a third party, except in  
12 cases of fraud.

13 3. "Enrollee" means an individual who is enrolled under a health  
14 care insurer's policy, contract or evidence of coverage.

15 4. "Grievance" means any written complaint that is subject to  
16 resolution through the insurer's system that is prescribed in section  
17 20-3102, subsection F and submitted by a health care provider and received  
18 by a health care insurer. Grievance does not include a complaint:

19 (a) By a noncontracted provider regarding an insurer's decision to  
20 deny the noncontracted provider admission to the insurer's network.

21 (b) About an insurer's decision to terminate a health care provider  
22 from the insurer's network.

23 (c) That is the subject of a health care appeal pursuant to chapter  
24 15, article 2 of this title.

25 5. "Health care insurer" means a disability insurer, group  
26 disability insurer, blanket disability insurer, health care services  
27 organization, prepaid dental plan organization, hospital service  
28 corporation, medical service corporation, dental service corporation,  
29 optometric service corporation, or hospital, medical, dental and  
30 optometric service corporation.

31 Sec. 2. Section 20-3102, Arizona Revised Statutes, is amended to  
32 read:

33 20-3102. Timely payment of health care providers' claims;  
34 grievances

35 A. A health care insurer shall adjudicate any clean claim from a  
36 contracted or noncontracted health care provider relating to health care  
37 insurance coverage within thirty days after the health care insurer  
38 receives the clean claim or within the time period specified by contract.  
39 Unless there is an express written contract between the health care  
40 insurer and the health care provider that specifies the period in which  
41 approved claims shall be paid, the health care insurer shall pay the  
42 approved portion of any clean claim within thirty days after the claim is  
43 adjudicated. If the claim is not paid within the ~~thirty day~~ THIRTY-DAY  
44 period or within the time period specified in the contract, the health  
45 care insurer shall pay interest on the claim at a rate that is equal to

1 the legal rate. Interest shall be calculated beginning on the date that  
2 the payment to the health care provider is due.

3 B. If the claim is not a clean claim and the health care insurer  
4 requires additional information to adjudicate the claim, the health care  
5 insurer shall send a written request for additional information to the  
6 contracted or noncontracted health care provider, enrollee or third party  
7 within thirty days after the health care insurer receives the claim. The  
8 health care insurer shall notify the contracted or noncontracted health  
9 care provider of all of the specific reasons for the delay in adjudicating  
10 the claim. The health care insurer shall record the date it receives the  
11 additional information and shall adjudicate the claim within thirty days  
12 after receiving all the additional information. The health care insurer  
13 shall also pay the approved portion of the adjudicated claim within the  
14 same ~~thirty day~~ THIRTY-DAY period allowed for adjudication or within the  
15 time period specified in the provider's contract. If the health care  
16 insurer fails to pay the claim as prescribed in this subsection, the  
17 health care insurer shall pay interest on the claim in the manner  
18 prescribed in subsection A.

19 C. A health care insurer shall not delay the payment of clean  
20 claims to a contracted or noncontracted provider or pay less than the  
21 amount agreed to by contract to a contracted health care provider without  
22 reasonable justification.

23 D. A health care insurer shall not request information from a  
24 contracted or noncontracted health care provider that does not apply to  
25 the medical condition at issue for the purposes of adjudicating a clean  
26 claim.

27 E. A health care insurer shall not request a contracted or  
28 noncontracted health care provider to resubmit claim information that the  
29 contracted or noncontracted health care provider can document it has  
30 already provided to the health care insurer unless the health care insurer  
31 provides a reasonable justification for the request and the purpose of the  
32 request is not to delay the payment of the claim.

33 F. A health care insurer shall establish an internal system for  
34 resolving payment disputes and other contractual grievances with health  
35 care providers. The director may review the health care insurer's  
36 internal system for resolving payment disputes and other contractual  
37 grievances with health care providers. Each health care insurer shall  
38 maintain records of health care provider grievances. Semiannually each  
39 health care insurer shall provide the director with a summary of all  
40 records of health care provider grievances received during the prior six  
41 months. The records shall include at least the following information:

- 42 1. The name and any identification number of the health care  
43 provider who filed a grievance.
- 44 2. The type of grievance.
- 45 3. The date the insurer received the grievance.

1 4. The date the grievance was resolved.

2 G. On review of the records, if the director finds a significant  
3 number of grievances that have not been resolved, the director may examine  
4 the health care insurer.

5 H. This section does not require or authorize the director to  
6 adjudicate the individual contracts or claims between health care insurers  
7 and health care providers.

8 I. Except in cases of fraud, a health care insurer or contracted or  
9 noncontracted health care provider shall not adjust or request adjustment  
10 of the payment or denial of a claim more than one year after the health  
11 care insurer has paid or denied that claim. If the health care insurer  
12 and health care provider agree through contract on a length of time to  
13 adjust or request adjustment of the payment of a claim, the health care  
14 insurer and health care provider must have the same length of time to  
15 adjust or request adjustment of the payment of the claim. If a claim is  
16 adjusted, neither the health care insurer nor the health care provider  
17 shall owe interest on the overpayment or underpayment resulting from the  
18 adjustment, as long as the adjusted payment is made or recoupment taken  
19 within thirty days of the date of the claim adjustment.

20 J. This ~~chapter~~ ARTICLE does not apply to licensed health care  
21 providers who are salaried employees of a health care insurer.

22 K. If a contracted or noncontracted health care provider files a  
23 claim or grievance with a health care insurer that has changed the  
24 location where providers were instructed to file claims or grievances, the  
25 health care insurer shall, for ninety days following the change:

26 1. Consider a claim or grievance delivered to the original location  
27 properly received.

28 2. Following receipt of a claim or grievance at the original  
29 location, promptly notify the health care provider of the change of  
30 address through mailed written notice or some other written communication.

31 L. ANY CLAIM THAT IS SUBJECT TO ARTICLE 2 OF THIS CHAPTER IS NOT  
32 SUBJECT TO THIS ARTICLE.

33 Sec. 3. Title 20, chapter 20, Arizona Revised Statutes, is amended  
34 by adding article 2, to read:

35 ARTICLE 2. OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION

36 20-3111. Definitions

37 IN THIS ARTICLE, UNLESS THE CONTEXT OTHERWISE REQUIRES:

38 1. "ARBITRATION" MEANS A DISPUTE RESOLUTION PROCESS IN WHICH AN  
39 IMPARTIAL ARBITRATOR DETERMINES THE DOLLAR AMOUNT A HEALTH CARE PROVIDER  
40 IS ENTITLED TO RECEIVE FOR PAYMENT OF A SURPRISE OUT-OF-NETWORK BILL.

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

43 3. "BILLING COMPANY" MEANS ANY AFFILIATED OR UNAFFILIATED COMPANY  
44 THAT IS HIRED BY A HEALTH CARE PROVIDER OR HEALTH CARE FACILITY TO  
45 COORDINATE THE PAYMENT OF BILLS WITH HEALTH INSURERS AND TO GENERATE OR

1 BILL AND COLLECT PAYMENT FROM ENROLLEES ON THE HEALTH CARE PROVIDER'S OR  
2 HEALTH CARE FACILITY'S BEHALF.

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

6 5. "COST SHARING REQUIREMENTS" MEANS AN ENROLLEE'S APPLICABLE  
7 OUT-OF-NETWORK COINSURANCE, COPAYMENT AND DEDUCTIBLE REQUIREMENTS UNDER A  
8 HEALTH PLAN BASED ON THE ADJUDICATED CLAIM.

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

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

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

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

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

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

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

32 20-3112. Applicability

33 THIS ARTICLE DOES NOT APPLY TO:

34 1. HEALTH CARE SERVICES THAT ARE NOT COVERED BY THE ENROLLEE'S  
35 HEALTH PLAN.

36 2. LIMITED BENEFIT COVERAGE AS DEFINED IN SECTION 20-1137.

37 3. CHARGES FOR HEALTH CARE SERVICES OR DURABLE MEDICAL EQUIPMENT  
38 THAT ARE SUBJECT TO A DIRECT PAYMENT AGREEMENT UNDER SECTION 32-3216 OR  
39 36-437.

40 4. HEALTH PLANS THAT DO NOT INCLUDE COVERAGE FOR OUT-OF-NETWORK  
41 HEALTH CARE SERVICES, UNLESS OTHERWISE REQUIRED BY LAW.

42 5. STATE HEALTH AND ACCIDENT COVERAGE FOR FULL-TIME OFFICERS AND  
43 EMPLOYEES OF THIS STATE AND THEIR DEPENDENTS THAT IS PROVIDED PURSUANT TO  
44 TITLE 38, CHAPTER 4, ARTICLE 4.

1           20-3113. Surprise out-of-network bill; requirements; notice

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

6           1. THE BILL WAS FOR A HEALTH CARE SERVICE, A LABORATORY SERVICE OR  
7 DURABLE MEDICAL EQUIPMENT THAT WAS PROVIDED IN THE CASE OF AN EMERGENCY,  
8 INCLUDING UNDER CIRCUMSTANCES DESCRIBED BY SECTION 20-2803, SUBSECTION A  
9 AND SERVICES DIRECTLY RELATED TO THE EMERGENCY THAT ARE PROVIDED DURING AN  
10 INPATIENT ADMISSION TO ANY NETWORK FACILITY.

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

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

19           (b) THE ESTIMATED TOTAL COST TO BE BILLED BY THE HEALTH CARE  
20 PROVIDER OR THE PROVIDER'S REPRESENTATIVE.

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

24           3. THE BILL WAS FOR A HEALTH CARE SERVICE, A LABORATORY SERVICE OR  
25 DURABLE MEDICAL EQUIPMENT THAT WAS NOT PROVIDED IN THE CASE OF AN  
26 EMERGENCY AND THE ENROLLEE RECEIVED THE DISCLOSURE PRESCRIBED IN PARAGRAPH  
27 2 OF THIS SUBSECTION, BUT THE ENROLLEE OR THE ENROLLEE'S AUTHORIZED  
28 REPRESENTATIVE CHOSE NOT TO SIGN THE DISCLOSURE.

29           B. NOTWITHSTANDING ANY PROVISION OF THIS ARTICLE, A HEALTH INSURER  
30 AND ANY HEALTH PLAN OFFERED BY A HEALTH INSURER SHALL COMPLY WITH CHAPTER  
31 17, ARTICLE 1 OF THIS TITLE.

32           20-3114. Dispute resolution; settlement teleconference;  
33 arbitration; surprise out-of-network bills

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

37           1. THE ENROLLEE HAS RESOLVED ANY HEALTH CARE APPEAL PURSUANT TO  
38 CHAPTER 15, ARTICLE 2 OF THIS TITLE THAT THE ENROLLEE MAY HAVE HAD AGAINST  
39 THE HEALTH INSURER FOLLOWING THE HEALTH INSURER'S INITIAL ADJUDICATION OF  
40 THE CLAIM.

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

1           3. THE ENROLLEE RECEIVED A SURPRISE OUT-OF-NETWORK BILL.

2           B. IF AN ENROLLEE REQUESTS DISPUTE RESOLUTION OF A SURPRISE  
3 OUT-OF-NETWORK BILL, THE ENROLLEE SHALL PARTICIPATE IN AN INFORMAL  
4 SETTLEMENT TELECONFERENCE AND MAY PARTICIPATE IN THE ARBITRATION OF THE  
5 BILL. THE HEALTH CARE PROVIDER OR THE PROVIDER'S REPRESENTATIVE AND THE  
6 HEALTH INSURER SHALL PARTICIPATE IN THE INFORMAL SETTLEMENT TELECONFERENCE  
7 AND THE ARBITRATION.

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

13           20-3115. Conduct of arbitration proceedings

14           A. THE DEPARTMENT SHALL DEVELOP A SIMPLE, FAIR, EFFICIENT AND  
15 COST-EFFECTIVE ARBITRATION PROCEDURE FOR SURPRISE OUT-OF-NETWORK BILL  
16 DISPUTES AND SPECIFY TIME FRAMES, STANDARDS AND OTHER DETAILS OF THE  
17 ARBITRATION PROCEEDING, INCLUDING PROCEDURES FOR SCHEDULING AND NOTIFYING  
18 THE PARTIES OF THE SETTLEMENT TELECONFERENCE REQUIRED BY SUBSECTION D OF  
19 THIS SECTION. THE DEPARTMENT SHALL CONTRACT WITH ONE OR MORE ENTITIES TO  
20 PROVIDE ARBITRATORS WHO ARE QUALIFIED UNDER SECTION 20-3116 FOR THIS  
21 PROCESS. DEPARTMENT STAFF MAY NOT SERVE AS ARBITRATORS.

22           B. AN ENROLLEE MAY REQUEST ARBITRATION OF A SURPRISE OUT-OF-NETWORK  
23 BILL BY SUBMITTING A REQUEST FOR ARBITRATION TO THE DEPARTMENT ON A FORM  
24 PRESCRIBED BY THE DEPARTMENT, WHICH SHALL INCLUDE CONTACT, BILLING AND  
25 PAYMENT INFORMATION REGARDING THE SURPRISE OUT-OF-NETWORK BILL AND ANY  
26 OTHER INFORMATION THE DEPARTMENT BELIEVES IS NECESSARY TO CONFIRM THAT THE  
27 BILL QUALIFIES FOR ARBITRATION. THE FORM SHALL BE MADE AVAILABLE ON THE  
28 DEPARTMENT'S WEBSITE.

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

31           D. IN AN EFFORT TO SETTLE THE SURPRISE OUT-OF-NETWORK BILL BEFORE  
32 ARBITRATION, THE DEPARTMENT SHALL ARRANGE AN INFORMAL SETTLEMENT  
33 TELECONFERENCE WITHIN THIRTY DAYS AFTER THE DEPARTMENT RECEIVES THE  
34 REQUEST FOR ARBITRATION. AS PART OF THE SETTLEMENT TELECONFERENCE THE  
35 HEALTH INSURER SHALL PROVIDE TO THE PARTIES THE ENROLLEE'S COST SHARING  
36 REQUIREMENTS UNDER THE ENROLLEE'S HEALTH PLAN BASED ON THE ADJUDICATED  
37 CLAIM. THE PARTIES SHALL NOTIFY THE DEPARTMENT OF THE RESULTS OF THE  
38 SETTLEMENT TELECONFERENCE.

39           E. IF AFTER PROPER NOTICE EITHER THE HEALTH INSURER OR HEALTH CARE  
40 PROVIDER OR THE PROVIDER'S REPRESENTATIVE FAILS TO PARTICIPATE IN THE  
41 TELECONFERENCE, THE OTHER PARTY MAY NOTIFY THE DEPARTMENT TO IMMEDIATELY  
42 INITIATE ARBITRATION AND THE NONPARTICIPATING PARTY SHALL BE REQUIRED TO  
43 PAY THE TOTAL COST OF THE ARBITRATION.

44           F. ON RECEIPT OF NOTICE THAT THE DISPUTE HAS NOT SETTLED OR THAT A  
45 PARTY HAS FAILED TO PARTICIPATE IN THE TELECONFERENCE, THE DEPARTMENT

1 SHALL APPOINT AN ARBITRATOR AND SHALL NOTIFY THE PARTIES OF THE  
2 ARBITRATION AND THE APPOINTED ARBITRATOR. THE HEALTH INSURER AND HEALTH  
3 CARE PROVIDER MUST AGREE ON THE ARBITRATOR. IF EITHER THE HEALTH INSURER  
4 OR HEALTH CARE PROVIDER OBJECTS TO THE ARBITRATOR, THE DEPARTMENT OR  
5 CONTRACTED ENTITY SHALL RANDOMLY ASSIGN FIVE ARBITRATORS. THE HEALTH  
6 INSURER AND THE HEALTH CARE PROVIDER SHALL EACH STRIKE TWO ARBITRATORS,  
7 AND THE LAST ARBITRATOR SHALL CONDUCT THE ARBITRATION.

8 G. BEFORE THE ARBITRATION:

9 1. THE ENROLLEE SHALL PAY OR MAKE ARRANGEMENTS IN WRITING TO PAY  
10 THE HEALTH CARE PROVIDER THE TOTAL AMOUNT OF THE ENROLLEE'S COST SHARING  
11 REQUIREMENTS THAT IS DUE FOR THE SERVICES THAT ARE THE SUBJECT OF THE  
12 SURPRISE OUT-OF-NETWORK BILL AS STATED BY THE HEALTH INSURER IN THE  
13 SETTLEMENT TELECONFERENCE.

14 2. THE ENROLLEE SHALL PAY ANY AMOUNT THAT HAS BEEN RECEIVED BY THE  
15 ENROLLEE FROM THE ENROLLEE'S HEALTH INSURER AS PAYMENT FOR THE  
16 OUT-OF-NETWORK SERVICES THAT WERE PROVIDED BY THE HEALTH CARE PROVIDER.

17 3. IF A HEALTH INSURER PAYS FOR OUT-OF-NETWORK SERVICES DIRECTLY TO  
18 A HEALTH CARE PROVIDER, THE HEALTH INSURER THAT HAS NOT REMITTED ITS  
19 PAYMENT FOR THE OUT-OF-NETWORK SERVICES SHALL REMIT THE AMOUNT DUE TO THE  
20 HEALTH CARE PROVIDER.

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

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

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

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

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

39 3. THE AMOUNT THAT MEDICARE AND MEDICAID PAY FOR THE HEALTH CARE  
40 SERVICES AT ISSUE.

41 4. THE HEALTH CARE PROVIDER'S DIRECT PAY RATE FOR THE HEALTH CARE  
42 SERVICES AT ISSUE, IF ANY, UNDER SECTION 32-3216.

43 5. ANY INFORMATION THAT WOULD BE EVALUATED IN DETERMINING WHETHER A  
44 FEE IS REASONABLE UNDER TITLE 32 AND NOT EXCESSIVE FOR THE HEALTH CARE  
45 SERVICES AT ISSUE, INCLUDING THE USUAL AND CUSTOMARY CHARGES FOR THE



1 HEALTH CARE SERVICES AT ISSUE PERFORMED BY A HEALTH CARE PROVIDER IN THE  
2 SAME OR SIMILAR SPECIALTY AND PROVIDED IN THE SAME GEOGRAPHICAL AREA.

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

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

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

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

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

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

24 P. NOTWITHSTANDING ANY INFORMAL SETTLEMENT OR THE ARBITRATOR'S  
25 DECISION UNDER THIS ARTICLE, THE ENROLLEE IS RESPONSIBLE FOR ONLY THE  
26 AMOUNT OF THE ENROLLEE'S COST SHARING REQUIREMENTS AND ANY AMOUNT RECEIVED  
27 BY THE ENROLLEE FROM THE ENROLLEE'S HEALTH INSURER AS PAYMENT FOR THE  
28 OUT-OF-NETWORK SERVICES THAT WERE PROVIDED BY THE HEALTH CARE PROVIDER,  
29 AND THE HEALTH CARE PROVIDER MAY NOT ISSUE, EITHER DIRECTLY OR THROUGH ITS  
30 BILLING COMPANY, ANY ADDITIONAL BALANCE BILL TO THE ENROLLEE RELATED TO  
31 THE HEALTH CARE SERVICE, LABORATORY SERVICE OR DURABLE MEDICAL EQUIPMENT  
32 THAT WAS THE SUBJECT OF THE INFORMAL SETTLEMENT TELECONFERENCE OR  
33 ARBITRATION.

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

39 20-3116. Arbitrator qualifications

40 TO QUALIFY AS AN ARBITRATOR, A PERSON SHALL HAVE AT LEAST THREE  
41 YEARS' EXPERIENCE IN HEALTH CARE SERVICES CLAIMS AND SHALL COMPLY WITH ANY  
42 OTHER QUALIFICATIONS ESTABLISHED BY THE DEPARTMENT.

1           20-3117. Dispute resolution; notice of rights

2           A. THE DEPARTMENT IN CONJUNCTION WITH THE APPROPRIATE HEALTH CARE  
3 BOARDS SHALL PRESCRIBE THE NOTICE OUTLINING AN ENROLLEE'S RIGHTS TO  
4 DISPUTE SURPRISE OUT-OF-NETWORK BILLS UNDER THIS ARTICLE.

5           B. HEALTH INSURERS SHALL INCLUDE THE NOTICE PRESCRIBED PURSUANT TO  
6 SUBSECTION A OF THIS SECTION IN EACH EXPLANATION OF BENEFITS OR OTHER  
7 SIMILAR CLAIM ADJUDICATION NOTICE THAT IS ISSUED TO ENROLLEES AND THAT  
8 INVOLVES COVERED SERVICES PROVIDED BY A NONCONTRACTED HEALTH CARE  
9 PROVIDER.

10          C. IF AN ENROLLEE CONTACTS A HEALTH CARE PROVIDER, A PROVIDER'S  
11 REPRESENTATIVE OR A BILLING COMPANY REGARDING A DISPUTE INVOLVING A  
12 SURPRISE OUT-OF-NETWORK BILL, THE HEALTH CARE PROVIDER, THE PROVIDER'S  
13 REPRESENTATIVE OR THE BILLING COMPANY SHALL PROVIDE WRITTEN NOTICE AS  
14 PRESCRIBED IN SUBSECTION A OF THIS SECTION TO THE ENROLLEE OF THE DISPUTE  
15 RESOLUTION PROCESS.

16          D. THE DEPARTMENT SHALL POST ON ITS WEBSITE INFORMATION FOR HEALTH  
17 CARE CONSUMERS REGARDING WHAT CONSTITUTES A SURPRISE OUT-OF-NETWORK BILL,  
18 HOW TO TRY TO AVOID A SURPRISE OUT-OF-NETWORK BILL AND HOW THE DISPUTE  
19 RESOLUTION PROCESS MAY BE USED TO RESOLVE A SURPRISE OUT-OF-NETWORK BILL.

20           20-3118. Surprise out-of-network bills; annual report

21           A. ON OR BEFORE DECEMBER 31, 2019 AND EACH DECEMBER 31 THEREAFTER,  
22 THE DEPARTMENT SHALL REPORT ON THE RESOLUTION OF DISPUTED SURPRISE  
23 OUT-OF-NETWORK BILLS. THE REPORT SHALL INCLUDE:

24           1. THE TOTAL NUMBER OF INQUIRIES REGARDING DISPUTE RESOLUTION OF  
25 SURPRISE OUT-OF-NETWORK BILLS.

26           2. THE TOTAL NUMBER OF REQUESTS THAT DID NOT QUALIFY FOR DISPUTE  
27 RESOLUTION AND THE REASONS WHY THE DISPUTED BILLS DID NOT QUALIFY.

28           3. THE NUMBER OF REQUESTS THAT QUALIFIED FOR DISPUTE RESOLUTION.

29           4. THE MOST COMMON REQUESTS FOR DISPUTE RESOLUTION BY HEALTH CARE  
30 PROVIDER SPECIALTY AREA.

31           5. THE MOST COMMON REQUESTS FOR DISPUTE RESOLUTION BY HEALTH CARE  
32 SERVICE.

33           6. THE NUMBER OF REQUESTS FOR DISPUTE RESOLUTION BY GEOGRAPHIC AREA  
34 IN THIS STATE.

35           7. THE MOST COMMON REQUESTS FOR DISPUTE RESOLUTION BASED ON THE  
36 TYPE OF HEALTH CARE FACILITY IN WHICH THE HEALTH CARE SERVICES WERE  
37 PROVIDED.

38           8. THE NUMBER OF REQUESTS FOR DISPUTE RESOLUTION THAT WERE SETTLED  
39 DURING A SETTLEMENT TELECONFERENCE.

40           9. THE NUMBER OF REQUESTS FOR DISPUTE RESOLUTION THAT WERE SETTLED  
41 DURING ARBITRATION.

42           10. THE NUMBER OF TIMES A HEALTH INSURER, A HEALTH CARE PROVIDER OR  
43 THE PROVIDER'S REPRESENTATIVE OR AN ENROLLEE FAILED TO ATTEND THE  
44 SETTLEMENT TELECONFERENCE.

1           11. THE AVERAGE PERCENTAGE BY WHICH DISPUTED SURPRISE  
2 OUT-OF-NETWORK BILLS WERE REDUCED FROM THE INITIALLY BILLED AMOUNT.  
3           12. ANY ADDITIONAL INFORMATION THAT THE DEPARTMENT DETERMINES IS  
4 RELEVANT IN EVALUATING THE EFFECTIVENESS OF THE DISPUTE RESOLUTION  
5 PROCESS.  
6           B. THE DEPARTMENT SHALL SUBMIT THE REPORT TO THE GOVERNOR, THE  
7 PRESIDENT OF THE SENATE AND THE SPEAKER OF THE HOUSE OF REPRESENTATIVES  
8 AND SHALL PROVIDE A COPY OF THE REPORT TO THE SECRETARY OF STATE.  
9           Sec. 4. Effective date  
10           This act is effective from and after December 31, 2018.

APPROVED BY THE GOVERNOR APRIL 24, 2017.

FILED IN THE OFFICE OF THE SECRETARY OF STATE APRIL 24, 2017.