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

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)

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. Section 20-3102, Arizona Revised Statutes, is amended to read:

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

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

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

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

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

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

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

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

1. The name and any identification number of the health care provider who filed a grievance.

2. The type of grievance.

3. The date the insurer received the grievance.

4. The date the grievance was resolved.

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

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

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

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

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

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

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

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

Sec. 3. 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 DISPUTE RESOLUTION PROCESS IN WHICH AN IMPARTIAL ARBITRATOR DETERMINES THE DOLLAR AMOUNT A HEALTH CARE PROVIDER IS ENTITLED TO RECEIVE FOR PAYMENT OF A SURPRISE OUT-OF-NETWORK 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 OUT-OF-NETWORK COINSURANCE, COPAYMENT AND DEDUCTIBLE REQUIREMENTS UNDER A HEALTH PLAN BASED ON THE ADJUDICATED CLAIM.

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:

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

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

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

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

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

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

A. 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 AND SERVICES DIRECTLY RELATED TO THE EMERGENCY THAT ARE PROVIDED DURING AN INPATIENT ADMISSION TO ANY NETWORK FACILITY.

2. THE BILL WAS FOR A HEALTH CARE SERVICE, A LABORATORY SERVICE OR DURABLE MEDICAL EQUIPMENT THAT WAS NOT PROVIDED IN THE CASE OF AN EMERGENCY AND THE HEALTH CARE PROVIDER OR THE PROVIDER'S REPRESENTATIVE DID NOT PROVIDE TO THE ENROLLEE, OR 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 OR THE PROVIDER'S REPRESENTATIVE.

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

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

20-3114. Dispute resolution; 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 DISPUTE RESOLUTION OF THE BILL IF ALL OF THE FOLLOWING APPLY:

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

2. 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.

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

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

C. AN ENROLLEE MAY NOT SEEK DISPUTE RESOLUTION 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, INCLUDING PROCEDURES FOR SCHEDULING AND NOTIFYING THE PARTIES OF THE SETTLEMENT TELECONFERENCE REQUIRED BY SUBSECTION D OF THIS SECTION. 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, WHICH SHALL INCLUDE CONTACT, BILLING AND PAYMENT INFORMATION REGARDING THE SURPRISE OUT-OF-NETWORK BILL AND ANY OTHER INFORMATION THE DEPARTMENT BELIEVES IS NECESSARY TO CONFIRM THAT THE BILL QUALIFIES FOR ARBITRATION. THE FORM SHALL BE MADE AVAILABLE ON THE DEPARTMENT'S WEBSITE.

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. AS PART OF THE SETTLEMENT TELECONFERENCE THE HEALTH INSURER SHALL PROVIDE TO THE PARTIES THE ENROLLEE'S COST SHARING REQUIREMENTS UNDER THE ENROLLEE'S HEALTH PLAN BASED ON THE ADJUDICATED CLAIM. THE PARTIES SHALL NOTIFY THE DEPARTMENT OF THE RESULTS OF THE SETTLEMENT TELECONFERENCE.

E. IF AFTER PROPER NOTICE EITHER THE HEALTH INSURER OR HEALTH CARE PROVIDER OR THE PROVIDER'S REPRESENTATIVE 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:

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

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

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

4. THE HEALTH CARE PROVIDER'S DIRECT PAY RATE FOR THE HEALTH CARE SERVICES AT ISSUE, 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 FOR THE HEALTH CARE SERVICES AT ISSUE, INCLUDING THE USUAL AND CUSTOMARY CHARGES FOR THE

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

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 FINAL 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. 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.

O. 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.

P. 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 ANY AMOUNT RECEIVED BY THE ENROLLEE FROM THE ENROLLEE'S HEALTH INSURER AS PAYMENT FOR THE OUT-OF-NETWORK SERVICES THAT WERE PROVIDED BY THE HEALTH CARE PROVIDER, 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.

Q. 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 AND SHALL COMPLY WITH ANY OTHER QUALIFICATIONS ESTABLISHED BY THE DEPARTMENT.

20-3117. Dispute resolution; notice of rights

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11. THE AVERAGE PERCENTAGE BY WHICH DISPUTED SURPRISE OUT-OF-NETWORK BILLS WERE REDUCED FROM THE INITIALLY BILLED AMOUNT.

12. ANY ADDITIONAL INFORMATION THAT THE DEPARTMENT DETERMINES IS RELEVANT IN EVALUATING THE EFFECTIVENESS OF THE DISPUTE RESOLUTION PROCESS.

B. THE DEPARTMENT SHALL SUBMIT THE REPORT TO THE GOVERNOR, THE PRESIDENT OF THE SENATE AND THE SPEAKER OF THE HOUSE OF REPRESENTATIVES AND SHALL PROVIDE A COPY OF THE REPORT TO THE SECRETARY OF STATE.

Sec. 4. Effective date

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