

State of Arizona
Senate
Fifty-third Legislature
Second Regular Session
2018

SENATE BILL 1064

AN ACT

AMENDING SECTIONS 20-3111, 20-3112, 20-3113, 20-3114 AND 20-3115, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 20, ARTICLE 2, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-3119; RELATING TO TIMELY PAYMENT OF CLAIMS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

2 Section 1. Section 20-3111, Arizona Revised Statutes, is amended to
3 read:

4 20-3111. Definitions

5 In this article, unless the context otherwise requires:

6 1. "Arbitration" means a dispute resolution process in which an
7 impartial arbitrator determines the dollar amount a health care provider
8 is entitled to receive for payment of a surprise out-of-network bill.

9 2. "Arbitrator" means an impartial person who is appointed to
10 conduct an arbitration.

11 3. "Billing company" means any affiliated or unaffiliated company
12 that is hired by a health care provider or health care facility to
13 coordinate the payment of bills with health insurers and to generate or
14 bill and collect payment from enrollees on the health care provider's or
15 health care facility's behalf.

16 4. "Contracted provider" means a health care provider that has
17 entered into a contract with a health insurer to provide health care
18 services to the health insurer's enrollees at agreed on rates.

19 5. "Cost sharing requirements" means an enrollee's applicable
20 out-of-network coinsurance, copayment and deductible requirements under a
21 health plan based on the adjudicated claim.

22 6. "EMERGENCY SERVICES" HAS THE SAME MEANING PRESCRIBED IN SECTION
23 20-2801.

24 ~~6.~~ 7. "Enrollee" means an individual who is eligible to receive
25 benefits through a health plan.

26 ~~7.~~ 8. "Health care facility" has the same meaning prescribed in
27 section 36-437.

28 ~~8.~~ 9. "Health care provider" means a person who is licensed,
29 registered or certified as a health care professional under title 32 or a
30 laboratory or durable medical equipment provider that furnishes services
31 to a patient in a network facility and that separately bills the patient
32 for the services.

33 10. "HEALTH CARE SERVICES" MEANS TREATMENT, SERVICES, MEDICATIONS,
34 TESTS, EQUIPMENT, DEVICES, DURABLE MEDICAL EQUIPMENT, LABORATORY SERVICES
35 OR SUPPLIES RENDERED OR PROVIDED TO AN ENROLLEE FOR THE PURPOSE OF
36 DIAGNOSING, PREVENTING, ALLEVIATING, CURING OR HEALING HUMAN DISEASE,
37 ILLNESS OR INJURY.

38 ~~9.~~ 11. "Health insurer" means a disability insurer, group
39 disability insurer, blanket disability insurer, hospital service
40 corporation or medical service corporation that provides health insurance
41 in this state.

42 ~~10.~~ 12. "Health plan" means a group or individual health plan that
43 finances or furnishes health care services and that is issued by a health
44 insurer.

1 ~~11.~~ 13. "Network facility" means a health care facility that has
2 entered into a contract with a health insurer to provide health care
3 services to the health insurer's enrollees at agreed on rates.

4 ~~12.~~ 14. "Surprise out-of-network bill" means a bill for a health
5 care service, ~~a laboratory service or durable medical equipment~~ that was
6 provided in a network facility by a health care provider that is not a
7 contracted provider and that meets one of the requirements listed in
8 section 20-3113.

9 Sec. 2. Section 20-3112, Arizona Revised Statutes, is amended to
10 read:

11 20-3112. Applicability

12 This article does not apply to:

13 1. Health care services that are not covered by the enrollee's
14 health plan.

15 2. Limited benefit coverage as defined in section 20-1137.

16 3. Charges for health care services ~~or durable medical equipment~~
17 that are subject to a direct payment agreement under section 32-3216 or
18 36-437.

19 4. Health plans that do not include coverage for out-of-network
20 health care services, unless otherwise required by law.

21 5. State health and accident coverage for full-time officers and
22 employees of this state and their dependents that is provided pursuant to
23 title 38, chapter 4, article 4.

24 6. A SELF-FUNDED OR SELF-INSURED EMPLOYEE BENEFIT PLAN IF THE
25 REGULATION OF THAT PLAN IS PREEMPTED BY THE EMPLOYEE RETIREMENT INCOME
26 SECURITY ACT OF 1974 (P.L. 93-406; 88 STAT. 829; 29 UNITED STATES CODE
27 SECTION 1144(b)).

28 Sec. 3. Section 20-3113, Arizona Revised Statutes, is amended to
29 read:

30 20-3113. Surprise out-of-network bill; requirements; notice

31 A. A bill for a health care service, ~~a laboratory service or~~
32 ~~durable medical equipment~~ that was provided in a network facility by a
33 health care provider that is not a contracted provider must meet one of
34 the following requirements to qualify as a surprise out-of-network bill:

35 1. The bill was for ~~a health care service, a laboratory service or~~
36 ~~durable medical equipment that was provided in the case of an~~ emergency
37 SERVICES, including under circumstances described by section 20-2803,
38 subsection A and HEALTH CARE services directly related to the emergency
39 SERVICES that are provided during an inpatient admission to any network
40 facility.

41 2. The bill was for a health care service, ~~a laboratory service or~~
42 ~~durable medical equipment~~ that was not provided in the case of an
43 emergency and the health care provider or the provider's representative
44 did not provide to the enrollee, or did not provide to the enrollee within

1 a reasonable amount of time before the enrollee received the services, a
2 written DATED disclosure that contained the following information:

3 (a) Notice that CONTAINS THE NAME OF THE BILLING HEALTH CARE
4 PROVIDER AND THAT STATES the health care provider is not a contracted
5 provider.

6 (b) The estimated total cost to be billed by the health care
7 provider or the provider's representative.

8 (c) Notice that ~~if~~ the enrollee or the enrollee's authorized
9 representative IS NOT REQUIRED TO SIGN THE DISCLOSURE TO OBTAIN MEDICAL
10 CARE BUT IF THE ENROLLEE OR THE ENROLLEE'S REPRESENTATIVE signs the
11 disclosure, the enrollee may have waived any rights to dispute resolution
12 under this article.

13 3. The bill was for a health care service, ~~a laboratory service or~~
14 ~~durable medical equipment~~ that was not provided in the case of an
15 emergency and the enrollee received the disclosure prescribed in paragraph
16 2 of this subsection, but the enrollee or the enrollee's authorized
17 representative chose not to sign the disclosure.

18 B. Notwithstanding any provision of this article, a health insurer
19 and any health plan offered by a health insurer shall comply with chapter
20 17, article 1 of this title.

21 Sec. 4. Section 20-3114, Arizona Revised Statutes, is amended to
22 read:

23 20-3114. Dispute resolution; settlement teleconference;
24 arbitration; surprise out-of-network bills

25 A. An enrollee who has received a surprise out-of-network bill and
26 who disputes the amount of the bill may seek dispute resolution of the
27 bill BY FILING A REQUEST FOR ARBITRATION WITH THE DEPARTMENT NOT LATER
28 THAN ONE YEAR AFTER THE DATE OF SERVICE NOTED IN THE SURPRISE
29 OUT-OF-NETWORK BILL, EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, if all
30 of the following apply:

31 1. The enrollee has resolved any health care appeal pursuant to
32 chapter 15, article 2 of this title that the enrollee may have had against
33 the health insurer following the health insurer's initial adjudication of
34 the claim. THE ONE YEAR TIME PERIOD FOR REQUESTING ARBITRATION IS TOLLED
35 FROM THE DATE THAT THE ENROLLEE FILES A HEALTH CARE APPEAL UNTIL THE DATE
36 OF FINAL RESOLUTION OF THE APPEAL.

37 2. THE ENROLLEE HAS NOT INSTITUTED A CIVIL LAWSUIT OR OTHER LEGAL
38 ACTION AGAINST THE INSURER OR HEALTH CARE PROVIDER RELATED TO THE SAME
39 SURPRISE OUT-OF-NETWORK BILL OR THE HEALTH CARE SERVICES PROVIDED.

40 ~~2.~~ 3. The amount of the surprise out-of-network bill for which the
41 enrollee is responsible for all related health care services provided by
42 the health care provider whether contained in one or multiple bills, after
43 deduction of the enrollee's cost sharing requirements and the insurer's
44 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 OR THE ENROLLEE'S AUTHORIZED REPRESENTATIVE shall participate in an informal settlement teleconference and may participate in the arbitration of the bill. IF THE ENROLLEE OR ENROLLEE'S AUTHORIZED REPRESENTATIVE FAILS TO ATTEND THE INFORMAL SETTLEMENT TELECONFERENCE, THE CONFERENCE SHALL BE TERMINATED AND THE ENROLLEE, WITHIN FOURTEEN DAYS AFTER THE FIRST SCHEDULED INFORMAL SETTLEMENT TELECONFERENCE, MAY REQUEST THAT THE DEPARTMENT RESCHEDULE THE INFORMAL SETTLEMENT TELECONFERENCE. IF THE ENROLLEE DOES NOT REQUEST THAT THE DEPARTMENT RESCHEDULE THE INFORMAL SETTLEMENT TELECONFERENCE, THE ENROLLEE FORFEITS THE RIGHT TO ARBITRATE THE SURPRISE OUT-OF-NETWORK 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, SUBSECTION A, paragraph 2 and the amount actually billed to the enrollee is less than or equal to the estimated total cost provided in the disclosure.

Sec. 5. Section 20-3115, Arizona Revised Statutes, is amended to read:

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~~ E 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.~~

C. WITHIN FIFTEEN DAYS AFTER RECEIPT OF A REQUEST FOR ARBITRATION, THE DEPARTMENT SHALL DO ONE OF THE FOLLOWING:

1 1. DETERMINE THAT THE SURPRISE OUT-OF-NETWORK BILL QUALIFIES FOR
2 ARBITRATION UNDER THIS ARTICLE AND NOTIFY THE ENROLLEE, HEALTH INSURER AND
3 HEALTH CARE PROVIDER THAT THE REQUEST QUALIFIES.

4 2. DETERMINE THAT THE SURPRISE OUT-OF-NETWORK BILL DOES NOT QUALIFY
5 FOR ARBITRATION UNDER THIS ARTICLE AND NOTIFY THE ENROLLEE THAT THE
6 SURPRISE OUT-OF-NETWORK BILL DOES NOT QUALIFY AND STATE THE REASON FOR THE
7 DETERMINATION.

8 3. IF THE DEPARTMENT CANNOT DETERMINE WHETHER THE SURPRISE
9 OUT-OF-NETWORK BILL QUALIFIES FOR ARBITRATION, REQUEST IN WRITING ANY
10 ADDITIONAL INFORMATION FROM THE ENROLLEE, HEALTH INSURER OR HEALTH CARE
11 PROVIDER OR ITS BILLING COMPANY THAT IS NEEDED TO DETERMINE WHETHER THE
12 SURPRISE OUT-OF-NETWORK BILL QUALIFIES FOR ARBITRATION AND ALL OF THE
13 FOLLOWING APPLY:

14 (a) THE ENROLLEE, HEALTH INSURER OR HEALTH CARE PROVIDER OR ITS
15 BILLING COMPANY SHALL RESPOND TO THE DEPARTMENT'S REQUEST FOR ADDITIONAL
16 INFORMATION WITHIN FIFTEEN DAYS AFTER THE DATE OF THE DEPARTMENT'S
17 REQUEST.

18 (b) WITHIN SEVEN DAYS AFTER RECEIPT OF THE ADDITIONAL REQUESTED
19 INFORMATION, THE DEPARTMENT SHALL DETERMINE WHETHER THE SURPRISE
20 OUT-OF-NETWORK BILL QUALIFIES FOR ARBITRATION AND SEND THE NOTICES
21 REQUIRED UNDER THIS SUBSECTION.

22 (c) IF THE HEALTH INSURER OR HEALTH CARE PROVIDER OR ITS BILLING
23 COMPANY FAILS TO RESPOND WITHIN THE TIME FRAME SPECIFIED IN SUBDIVISION
24 (a) OF THIS PARAGRAPH TO A DEPARTMENT REQUEST FOR INFORMATION, THE
25 DEPARTMENT SHALL DEEM THE REQUEST FOR ARBITRATION AS ELIGIBLE FOR
26 ARBITRATION. IF THE ENROLLEE FAILS TO RESPOND WITHIN THE TIME FRAME
27 SPECIFIED IN SUBDIVISION (a) OF THIS PARAGRAPH, THE REQUEST FOR
28 ARBITRATION IS DENIED.

29 D. THE DETERMINATION BY THE DEPARTMENT OF WHETHER A SURPRISE
30 OUT-OF-NETWORK BILL QUALIFIES FOR ARBITRATION IS A FINAL AND BINDING
31 DECISION WITH NO RIGHT OF APPEAL TO THE DEPARTMENT. THE DEPARTMENT'S
32 DETERMINATION IS SOLELY AN ADMINISTRATIVE REMEDY AND DOES NOT BAR ANY
33 PRIVATE RIGHT OR CAUSE OF ACTION FOR OR ON BEHALF OF ANY ENROLLEE,
34 PROVIDER OR OTHER PERSON. THE COURT SHALL DECIDE THE MATTER, INCLUDING
35 ANY INTERPRETATION OF STATUTE OR RULE, WITHOUT DEFERENCE TO ANY PREVIOUS
36 DETERMINATION THAT MAY HAVE BEEN MADE ON THE QUESTION BY THE DEPARTMENT.

37 ~~D.~~ E. In an effort to settle the surprise out-of-network bill
38 before arbitration, the department shall arrange an informal settlement
39 teleconference within thirty days after the department ~~receives the~~
40 ~~request for arbitration~~ SENDS THE NOTICES REQUIRED BY THIS SECTION. THE
41 DEPARTMENT IS NOT A PARTY TO AND MAY NOT PARTICIPATE IN THE INFORMAL
42 SETTLEMENT TELECONFERENCE. As part of the settlement teleconference the
43 health insurer shall provide to the parties the enrollee's cost sharing
44 requirements under the enrollee's health plan based on the adjudicated

1 claim. ~~The parties shall notify the department of the results of the~~
2 ~~settlement teleconference.~~ THE INSURER SHALL NOTIFY THE DEPARTMENT WHETHER
3 THE INFORMAL SETTLEMENT TELECONFERENCE RESULTED IN SETTLEMENT OF THE
4 DISPUTED SURPRISE OUT-OF-NETWORK BILL AND, IF SETTLEMENT WAS REACHED,
5 NOTIFY THE DEPARTMENT OF THE TERMS OF THE SETTLEMENT WITHIN SEVEN DAYS.

6 ~~F.~~ F. If after proper notice FROM THE DEPARTMENT OR CONTRACTED
7 ENTITY either the health insurer or health care provider or the provider's
8 representative fails to participate in the teleconference, the other party
9 may notify the department to immediately initiate arbitration and the
10 nonparticipating party shall be required to pay the total cost of the
11 arbitration.

12 ~~F.~~ G. On receipt of notice that the dispute has not settled or
13 that a party has failed to participate in the teleconference, the
14 department shall appoint an arbitrator and shall notify the parties of the
15 arbitration and the appointed arbitrator. THE DEPARTMENT'S NOTICE SHALL
16 SPECIFY WHETHER ONE PARTY IS RESPONSIBLE FOR THE TOTAL COST OF THE
17 ARBITRATION PURSUANT TO SUBSECTION F OF THIS SECTION. The health insurer
18 and health care provider must agree on the arbitrator AND MAY MUTUALLY
19 AGREE TO USE AN ARBITRATOR WHO IS NOT ON THE DEPARTMENT'S LIST. If either
20 the health insurer or health care provider objects to the arbitrator, AND
21 THE PARTIES ARE UNABLE TO AGREE ON A MUTUALLY ACCEPTABLE ALTERNATIVE
22 ARBITRATOR, the department or contracted entity shall randomly assign ~~five~~
23 THREE arbitrators. The health insurer and the health care provider shall
24 each strike ~~two arbitrators~~ ONE ARBITRATOR, and the last arbitrator shall
25 conduct the arbitration UNLESS THERE ARE TWO ARBITRATORS REMAINING, IN
26 WHICH CASE THE DEPARTMENT OR CONTRACTED ENTITY SHALL RANDOMLY ASSIGN THE
27 ARBITRATOR.

28 ~~G.~~ H. Before the arbitration:

29 1. The enrollee shall pay or make arrangements in writing to pay
30 the health care provider the total amount of the enrollee's cost sharing
31 requirements that is due for the HEALTH CARE services that are the subject
32 of the surprise out-of-network bill as stated by the health insurer in the
33 settlement teleconference.

34 2. The enrollee shall pay any amount that has been received by the
35 enrollee from the enrollee's health insurer as payment for the
36 out-of-network HEALTH CARE services that were provided by the health care
37 provider.

38 3. If a health insurer pays for out-of-network HEALTH CARE services
39 directly to a health care provider, the health insurer that has not
40 remitted its payment for the out-of-network HEALTH CARE services shall
41 remit the amount due to the health care provider.

1 ~~H.~~ I. Arbitration of any surprise out-of-network bill shall be
2 conducted ~~in the county in which the health care services giving rise to~~
3 ~~the bill were rendered and may be conducted~~ telephonically UNLESS
4 OTHERWISE AGREED BY ~~on the agreement of~~ all of the REQUIRED participants.

5 ~~I.~~ J. Arbitration of the surprise out-of-network bill shall take
6 place with or without the enrollee's participation.

7 ~~J.~~ K. The arbitrator shall determine the amount the health care
8 provider is entitled to receive as payment for the health care
9 services, ~~laboratory services or durable medical equipment~~. The
10 arbitrator shall allow each party to provide information the arbitrator
11 reasonably determines to be relevant in evaluating the surprise
12 out-of-network bill, including the following information:

13 1. The average contracted amount that the health insurer pays for
14 the health care services at issue in the county where the HEALTH CARE
15 services were performed.

16 2. The average amount that the health care provider has contracted
17 to accept for the health care services at issue in the county where the
18 services were performed.

19 3. The amount that medicare and medicaid pay for the health care
20 services at issue.

21 4. The health care provider's direct pay rate for the health care
22 services at issue, if any, under section 32-3216.

23 5. Any information that would be evaluated in determining whether a
24 fee is reasonable under title 32 and not excessive for the health care
25 services at issue, including the usual and customary charges for the
26 health care services at issue performed by a health care provider in the
27 same or similar specialty and provided in the same ~~geographical~~ GEOGRAPHIC
28 area.

29 6. Any other reliable databases or sources of information on the
30 amount paid for the health care services at issue in the county where the
31 services were performed.

32 ~~K.~~ L. Except on the agreement of the parties participating in the
33 arbitration, the arbitration shall be conducted within one hundred twenty
34 days after the department's notice of arbitration.

35 ~~L.~~ M. Except on the agreement of the parties participating in the
36 arbitration, the arbitration may not last more than four hours.

37 ~~M.~~ N. The arbitrator shall issue a final written decision within
38 ten business days following the arbitration hearing. The arbitrator shall
39 provide a copy of the decision to the enrollee, the health insurer and the
40 health care provider or its billing company or authorized representative.

41 ~~N.~~ O. All pricing information provided by health insurers and
42 health care providers in connection with the arbitration of a surprise
43 out-of-network bill is confidential and may not be disclosed by the
44 arbitrator or any other party participating in the arbitration OR USED BY

1 ANYONE, OTHER THAN THE PROVIDING PARTY, FOR ANY PURPOSE OTHER THAN TO
2 RESOLVE THE SURPRISE OUT-OF-NETWORK BILL.

3 P. ALL INFORMATION RECEIVED BY THE DEPARTMENT OR CONTRACTED ENTITY
4 IN CONNECTION WITH AN ARBITRATION IS CONFIDENTIAL AND MAY NOT BE DISCLOSED
5 BY THE DEPARTMENT OR CONTRACTED ENTITY TO ANY PERSON OTHER THAN THE
6 ARBITRATOR.

7 ~~Q.~~ Q. A claim that is the subject of an arbitration request is not
8 subject to article 1 of this chapter during the pendency of the
9 arbitration. A health insurer shall remit its portion of the payment
10 resulting from the informal settlement teleconference or the amount
11 awarded by the arbitrator within thirty days ~~of~~ AFTER resolution of the
12 claim.

13 R. A CLAIM THAT IS REPROCESSED BY AN INSURER AS A RESULT OF A
14 SETTLEMENT, ARBITRATION DECISION OR OTHER ACTION UNDER THIS ARTICLE IS NOT
15 IN VIOLATION OF SECTION 20-3102, SUBSECTION L.

16 ~~P.~~ S. Notwithstanding any informal settlement or the arbitrator's
17 decision under this article, the enrollee is responsible for only the
18 amount of the enrollee's cost sharing requirements and any amount received
19 by the enrollee from the enrollee's health insurer as payment for the
20 out-of-network HEALTH CARE services that were provided by the health care
21 provider, and the health care provider may not issue, either directly or
22 through its billing company, any additional balance bill to the enrollee
23 related to the health care service, ~~laboratory service or durable medical~~
24 ~~equipment~~ that was the subject of the informal settlement teleconference
25 or arbitration.

26 ~~Q.~~ T. Unless all the parties otherwise agree or unless required by
27 subsection ~~F~~ F of this section, the health insurer and the health care
28 provider shall share the costs of the arbitration equally, and the
29 enrollee is not responsible for any portion of the cost of the
30 arbitration. THE HEALTH INSURER AND HEALTH CARE PROVIDER SHALL MAKE
31 PAYMENT ARRANGEMENTS WITH THE ARBITRATOR FOR THEIR RESPECTIVE SHARE OF THE
32 COSTS OF THE ARBITRATION.

33 Sec. 6. Title 20, chapter 20, article 2, Arizona Revised Statutes,
34 is amended by adding section 20-3119, to read:

35 20-3119. Right of civil action

36 AN ENROLLEE WHO IS AGGRIEVED BY AN ARBITRATION DECISION REGARDING A
37 DISPUTED SURPRISE OUT-OF-NETWORK BILL MAY FILE A CIVIL ACTION IN SUPERIOR
38 COURT NOT LATER THAN ONE YEAR AFTER THE DATE OF THE DISPUTED DECISION TO
39 OBTAIN APPROPRIATE RELIEF WITH RESPECT TO THE SAME SURPRISE OUT-OF-NETWORK
40 BILL.

41 Sec. 7. Department of insurance; rulemaking; exemption

42 For the purposes of title 20, chapter 20, article 2, Arizona Revised
43 Statutes, the department of insurance is exempt from the rulemaking
44 requirements of title 41, chapter 6, Arizona Revised Statutes, for one

1 year after the effective date of this act, except that the department
2 shall hold at least one public hearing to provide the public the
3 opportunity to comment on the proposed rules.

4 Sec. 8. Effective date

5 Sections 20-3111, 20-3112, 20-3113, 20-3114 and 20-3115, Arizona
6 Revised Statutes, as amended by this act, and section 20-3119, Arizona
7 Revised Statutes, as added by this act, are effective from and after
8 December 31, 2018.