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

CHAPTER 272

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)

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

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

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

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

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

~~8.~~ 9. "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.

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

~~9.~~ 11. "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.~~ 12. "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.~~ 13. "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.~~ 14. "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.

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

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.

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

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

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 SERVICES, including under circumstances described by section 20-2803, subsection A and HEALTH CARE services directly related to the emergency SERVICES 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 DATED disclosure that contained the following information:

(a) Notice that CONTAINS THE NAME OF THE BILLING HEALTH CARE PROVIDER AND THAT STATES 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 IS NOT REQUIRED TO SIGN THE DISCLOSURE TO OBTAIN MEDICAL CARE BUT IF THE ENROLLEE OR THE ENROLLEE'S 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.

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

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 BY FILING A REQUEST FOR ARBITRATION WITH THE DEPARTMENT NOT LATER THAN ONE YEAR AFTER THE DATE OF SERVICE NOTED IN THE SURPRISE OUT-OF-NETWORK BILL, EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, 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. THE ONE YEAR TIME PERIOD FOR REQUESTING ARBITRATION IS TOLLED FROM THE DATE THAT THE ENROLLEE FILES A HEALTH CARE APPEAL UNTIL THE DATE OF FINAL RESOLUTION OF THE APPEAL.

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

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

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

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

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

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

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

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

~~D.~~ E. 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~~ SENDS THE NOTICES REQUIRED BY THIS SECTION. THE DEPARTMENT IS NOT A PARTY TO AND MAY NOT PARTICIPATE IN THE INFORMAL SETTLEMENT TELECONFERENCE. 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.~~ THE INSURER SHALL NOTIFY THE DEPARTMENT WHETHER THE INFORMAL SETTLEMENT TELECONFERENCE RESULTED IN SETTLEMENT OF THE DISPUTED SURPRISE OUT-OF-NETWORK BILL AND, IF SETTLEMENT WAS REACHED, NOTIFY THE DEPARTMENT OF THE TERMS OF THE SETTLEMENT WITHIN SEVEN DAYS.

~~E.~~ F. If after proper notice FROM THE DEPARTMENT OR CONTRACTED ENTITY 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.~~ G. 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 DEPARTMENT'S NOTICE SHALL SPECIFY WHETHER ONE PARTY IS RESPONSIBLE FOR THE TOTAL COST OF THE ARBITRATION PURSUANT TO SUBSECTION F OF THIS SECTION. The health insurer and health care provider must agree on the arbitrator AND MAY MUTUALLY AGREE TO USE AN ARBITRATOR WHO IS NOT ON THE DEPARTMENT'S LIST. If either the health insurer or health care provider objects to the arbitrator, AND THE PARTIES ARE UNABLE TO AGREE ON A MUTUALLY ACCEPTABLE ALTERNATIVE ARBITRATOR, the department or contracted entity shall randomly assign ~~five~~ THREE arbitrators. The health insurer and the health care provider shall each strike ~~two arbitrators~~ ONE ARBITRATOR, and the last arbitrator shall conduct the arbitration UNLESS THERE ARE TWO ARBITRATORS REMAINING, IN WHICH CASE THE DEPARTMENT OR CONTRACTED ENTITY SHALL RANDOMLY ASSIGN THE ARBITRATOR.

~~G.~~ H. 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 HEALTH CARE 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 HEALTH CARE services that were provided by the health care provider.

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

~~H.~~ I. 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 UNLESS OTHERWISE AGREED BY ~~on the agreement of~~ all of the REQUIRED participants.

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

~~J.~~ K. 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 HEALTH CARE 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~~ GEOGRAPHIC 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.~~ L. 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.~~ M. Except on the agreement of the parties participating in the arbitration, the arbitration may not last more than four hours.

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

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

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

~~O.~~ Q. 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~~ AFTER resolution of the claim.

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

~~P.~~ S. 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 HEALTH CARE 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.~~ T. Unless all the parties otherwise agree or unless required by subsection ~~E~~ F 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. THE HEALTH INSURER AND HEALTH CARE PROVIDER SHALL MAKE PAYMENT ARRANGEMENTS WITH THE ARBITRATOR FOR THEIR RESPECTIVE SHARE OF THE COSTS OF THE ARBITRATION.

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

20-3119. Right of civil action

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

Sec. 7. Department of insurance; rulemaking; exemption

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

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

Sec. 8. Effective date

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

APPROVED BY THE GOVERNOR MAY 1, 2018.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MAY 1, 2018.