Senate Engrossed

State of Arizona
Senate
Fifty-fourth Legislature
Second Regular Session
2020

SENATE BILL 1024

AN ACT

AMENDING SECTIONS 20-2540, 20-3111, 20-3112 AND 20-3114, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 20, ARTICLE 2, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-3114.01; AMENDING SECTION 20-3115, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 20, ARTICLE 2, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-3120; RELATING TO INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Section 20-2540, Arizona Revised Statutes, is amended to read:

20-2540. Health care appeals fund

A. The health care appeals fund is established consisting of monies collected pursuant to subsection B of this section. The fund is a special state fund pursuant to section 35-142, subsection A, paragraph 8. Monies in the fund do not revert to the state general fund. The department shall administer the fund. Monies in the fund are continuously appropriated and are exempt from the provisions of section 35-190 relating to lapsing of appropriations.

B. The director shall charge an appealing member's health care insurer for all amounts owed to the independent review organization, pursuant to subsection C of this section, to decide the member's appeal. The director may assess each health care insurer for administrative costs for implementing and maintaining the external independent review process as prescribed in this section and section 20-2538. The director shall deposit all collected monies in the fund.

C. The director shall use monies in the fund to:

1. Compensate procured independent review organizations for performing independent medical reviews on a per case rate unless the director determines that another method is necessary to carry out the purposes of this article.

2. Perform the responsibilities relating to the procurement of independent review organizations and to implement and maintain the external independent review process.

3. PERFORM THE ADMINISTRATIVE FUNCTION OF THE OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION PROCESS PRESCRIBED IN CHAPTER 20, ARTICLE 2 OF THIS TITLE.

D. An independent review organization shall submit to the director for approval a detailed invoice consistent with the method of payment prescribed in subsection C of this section.

Sec. 2. Heading change

The article heading of title 20, chapter 20, article 2, Arizona Revised Statutes, is changed from "OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION" to "OUT-OF-NETWORK SURPRISE BILLS AND BALANCE BILLS DISPUTE RESOLUTION".

Sec. 3. 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. "BALANCE BILL" MEANS THE DIFFERENCE BETWEEN THE HEALTH CARE PROVIDER'S BILLED CHARGE AND THE HEALTH CARE SERVICES ORGANIZATION'S ALLOWED AMOUNT FOR A COVERED HEALTH CARE SERVICE UNDER AN ENROLLEE'S HEALTH CARE PLAN AS DEFINED IN SECTION 20-1051.

~~3.~~ 4. "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.~~ 5. "Contracted provider" means a health care provider that has entered into a contract with a health insurer OR HEALTH CARE SERVICES ORGANIZATION to provide health care services to the health insurer's enrollees at agreed on rates.

~~5.~~ 6. "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.~~ 7. "Emergency services" has the same meaning prescribed in section 20-2801.

~~7.~~ 8. "Enrollee" means an individual who is eligible to receive benefits through a health plan.

~~8.~~ 9. "Health care facility" has the same meaning prescribed in section 36-437.

~~9.~~ 10. "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.~~ 11. "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.

12. "HEALTH CARE SERVICES ORGANIZATION" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-1051.

~~11.~~ 13. "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.

~~12.~~ 14. "Health plan" means a group or individual health plan that finances or furnishes health care services and that is issued by a health insurer OR HEALTH CARE SERVICES ORGANIZATION.

~~13.~~ 15. "Network facility" means a health care facility that has entered into a contract with a health insurer OR HEALTH CARE SERVICES ORGANIZATION to provide health care services to the health insurer's enrollees at agreed on rates.

~~14.~~ 16. "Surprise out-of-network bill" means a bill for a health care service 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. 4. Section 20-3112, Arizona Revised Statutes, is amended to read:

20-3112. Applicability

A. THIS ARTICLE APPLIES TO A SELF-FUNDED OR SELF-INSURED EMPLOYEE BENEFIT PLAN THAT IS OTHERWISE PREEMPTED FROM STATE REGULATION BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (P.L. 93-406; 88 STAT. 829; 29 UNITED STATES CODE SECTION 1144(b)) IF THE ENTITY THAT ADMINISTERS THE PLAN ENTERS INTO A WRITTEN AGREEMENT WITH THE DEPARTMENT PURSUANT TO SECTION 20-3120 TO VOLUNTARILY COMPLY WITH THE REQUIREMENTS OF THIS ARTICLE.

B. 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 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.~~ 4. EXCEPT AS PROVIDED IN SUBSECTION A OF THIS SECTION, 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)).

C. THIS SECTION DOES NOT NEGATE OR LIMIT A HEALTH CARE SERVICES ORGANIZATION'S OBLIGATION TO ITS MEMBERS TO ENSURE THAT COVERED HEALTH CARE SERVICES ARE DELIVERED IN ACCORDANCE WITH EACH MEMBER'S HEALTH CARE PLAN AS DEFINED IN SECTION 20-1051.

D. A HEALTH CARE SERVICES ORGANIZATION ENROLLEE IS NOT A PARTY TO ANY PAYMENT DISPUTE BETWEEN THE HEALTH CARE SERVICES ORGANIZATION AND A HEALTH CARE PROVIDER. BOTH THE HEALTH CARE SERVICES ORGANIZATION AND HEALTH CARE PROVIDER SHALL HOLD THE ENROLLEE HARMLESS FOR DISPUTED AMOUNTS THAT EXCEED THE ENROLLEE'S IN-NETWORK COST SHARING AMOUNT.

Sec. 5. Section 20-3114, Arizona Revised Statutes, is amended to read:

20-3114. Health care insurers; 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 HEALTH insurer or health care provider related to the same surprise out-of-network bill or the health care services provided.

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 HEALTH insurer's allowable reimbursement, is at least ~~one thousand dollars~~ $1,000.

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~~ TELECONFERENCE 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 HEALTH CARE 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. 6. Title 20, chapter 20, article 2, Arizona Revised Statutes, is amended by adding section 20-3114.01, to read:

20-3114.01. Health care services organizations; dispute resolution; settlement teleconference; arbitration; balance bills

A. A HEALTH CARE SERVICES ORGANIZATION THAT RECEIVES OR A HEALTH CARE PROVIDER THAT SEEKS TO COLLECT A DISPUTED BALANCE BILL MAY SEEK

DISPUTE RESOLUTION OF THE BALANCE BILL BY FILING A REQUEST FOR ARBITRATION WITH THE DEPARTMENT NOT LATER THAN ONE YEAR AFTER THE DATE OF SERVICE NOTED IN THE CLAIM TO WHICH THE BALANCE BILL APPLIES, EXCEPT AS OTHERWISE PROVIDED IN THIS SECTION, IF ALL OF THE FOLLOWING APPLY:

1. THE ENROLLEE FOR THE CLAIM AT ISSUE HAS RESOLVED ANY HEALTH CARE APPEAL PURSUANT TO CHAPTER 15, ARTICLE 2 OF THIS TITLE THAT THE ENROLLEE MAY HAVE HAD AGAINST THE HEALTH CARE SERVICES ORGANIZATION FOLLOWING THE HEALTH CARE SERVICES ORGANIZATION'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 HEALTH CARE SERVICES ORGANIZATION OR HEALTH CARE PROVIDER RELATED TO THE SAME CLAIM OR THE HEALTH CARE SERVICES PROVIDED.

3. THE AMOUNT OF THE BALANCE BILL FOR WHICH THE HEALTH CARE SERVICES ORGANIZATION IS RESPONSIBLE IS AT LEAST $1,000.

B. IF A HEALTH CARE SERVICES ORGANIZATION REQUESTS DISPUTE RESOLUTION OF A BALANCE BILL, THE HEALTH CARE PROVIDER OR THE HEALTH CARE PROVIDER'S AUTHORIZED REPRESENTATIVE SHALL PARTICIPATE IN AN INFORMAL SETTLEMENT TELECONFERENCE WITH AN AUTHORIZED HEALTH CARE SERVICES ORGANIZATION REPRESENTATIVE. IF THE HEALTH CARE PROVIDER OR THE HEALTH CARE PROVIDER'S REPRESENTATIVE FAILS TO ATTEND THE INFORMAL SETTLEMENT TELECONFERENCE, THE TELECONFERENCE SHALL BE TERMINATED AND THE HEALTH CARE SERVICES ORGANIZATION, WITHIN FOURTEEN DAYS AFTER THE SCHEDULED INFORMAL SETTLEMENT TELECONFERENCE, MAY REQUEST THAT THE DEPARTMENT SET THE CASE FOR ARBITRATION.

Sec. 7. 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 AND BALANCE 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 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 AND A HEALTH CARE SERVICES ORGANIZATION OR HEALTH CARE PROVIDER MAY REQUEST ARBITRATION OF A BALANCE 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 OR BALANCE 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. 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 OR BALANCE BILL qualifies for arbitration under this article, ~~and~~ notify the ~~enrollee,~~ health insurer OR HEALTH CARE SERVICES ORGANIZATION and health care provider that the request qualifies, AND FOR A SURPRISE OUT-OF-NETWORK BILL, ALSO NOTIFY THE ENROLLEE.

2. Determine that the surprise out-of-network bill OR BALANCE BILL does not qualify for arbitration under this article and notify the ~~enrollee~~ AFFECTED PARTIES 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 OR BALANCE BILL qualifies for arbitration, request in writing any additional information from the enrollee, health insurer, HEALTH CARE SERVICES ORGANIZATION 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, HEALTH CARE SERVICES ORGANIZATION 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, HEALTH CARE SERVICES ORGANIZATION 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 OF A SURPRISE OUT-OF-NETWORK BILL is denied.

D. The determination by the department of whether a surprise out-of-network bill OR BALANCE 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, HEALTH CARE 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.

E. In an effort to settle the surprise out-of-network bill OR BALANCE BILL before arbitration, the department shall arrange an informal

settlement teleconference within thirty days after the department 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 FOR A SURPRISE OUT-OF-NETWORK BILL 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 HEALTH insurer OR HEALTH CARE SERVICES ORGANIZATION shall notify the department whether the informal settlement teleconference resulted in settlement of the disputed surprise out-of-network bill OR BALANCE BILL and, if settlement was reached, notify the department of the terms of the settlement within seven days.

F. If after proper notice from the department or contracted entity either the health insurer OR HEALTH CARE SERVICES ORGANIZATION 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.

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 OR HEALTH CARE SERVICES ORGANIZATION 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 SERVICES ORGANIZATION 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 three arbitrators. The health insurer OR HEALTH CARE SERVICES ORGANIZATION and the health care provider shall each strike 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.

H. Before the arbitration OF A SURPRISE OUT-OF-NETWORK BILL:

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.

I. Arbitration of any surprise out-of-network bill OR BALANCE BILL shall be conducted telephonically unless otherwise agreed by all of the required participants.

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

K. AN ENROLLEE IS NOT A PARTY TO ANY BALANCE BILL DISPUTE BETWEEN A HEALTH CARE SERVICES ORGANIZATION AND A HEALTH CARE PROVIDER. BOTH THE HEALTH CARE SERVICES ORGANIZATION AND THE HEALTH CARE PROVIDER SHALL HOLD THE ENROLLEE HARMLESS FOR THE BALANCE BILL AMOUNT.

~~K.~~ L. The arbitrator shall determine the amount the health care provider is entitled to receive as payment for the health care services. The arbitrator shall allow each party to provide information the arbitrator reasonably determines to be relevant in evaluating the surprise out-of-network bill OR BALANCE BILL, including the following information:

1. The average contracted amount that the health insurer OR HEALTH CARE SERVICES ORGANIZATION 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 foe 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 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.

~~L.~~ M. 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.

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

~~N.~~ O. 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,

AND IF THE DISPUTE IS RELATED TO A SURPRISE OUT-OF-NETWORK BILL, PROVIDE A COPY TO THE ENROLLEE.

~~O.~~ P. All pricing information provided by health insurers, HEALTH CARE SERVICES ORGANIZATIONS and health care providers in connection with the arbitration of a surprise out-of-network bill OR BALANCE 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.~~ Q. 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.

~~Q.~~ R. 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. IF NOT ALREADY PAID, a health insurer OR HEALTH CARE SERVICES ORGANIZATION shall remit its portion of the payment resulting from the informal settlement teleconference or the amount awarded by the arbitrator within thirty days after resolution of the claim. IF THE HEALTH CARE SERVICES ORGANIZATION HAS ALREADY PAID THE HEALTH CARE PROVIDER MORE THAN THE AMOUNT AWARDED, THE HEALTH CARE PROVIDER SHALL REFUND ANY OVERPAYMENT WITHIN THIRTY DAYS AFTER RESOLUTION OF THE CLAIM.

~~R.~~ S. A claim that is reprocessed by ~~an~~ A HEALTH insurer OR HEALTH CARE SERVICES ORGANIZATION as a result of a settlement, arbitration decision or other action under this article is not in violation of section 20-3102, subsection L.

~~S.~~ T. 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 that was the subject of the informal settlement teleconference or arbitration.

~~T.~~ U. Unless all the parties otherwise agree or unless required by subsection F of this section, the health insurer OR HEALTH CARE SERVICES ORGANIZATION 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 OR HEALTH CARE SERVICES ORGANIZATION and health care provider shall make payment arrangements with the arbitrator for their respective share of the costs of the arbitration.

Sec. 8. Title 20, chapter 20, article 2, Arizona Revised Statutes, is amended by adding section 20-3120, to read:

20-3120. Self-funded and self-insured employee benefit plans; voluntary compliance; fee

AN ENTITY THAT ADMINISTERS A SELF-FUNDED OR SELF-INSURED EMPLOYEE BENEFIT PLAN THAT IS OTHERWISE PREEMPTED FROM STATE REGULATION BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (P.L. 93-406; 88 STAT. 829; 29 UNITED STATES CODE SECTION 1144(b)) MAY ENTER INTO A WRITTEN AGREEMENT WITH THE DEPARTMENT IN WHICH THE ENTITY AGREES TO COMPLY WITH THE REQUIREMENTS PRESCRIBED IN THIS ARTICLE AND THE DEPARTMENT AGREES TO ALLOW THE PLAN'S ENROLLEES TO PARTICIPATE IN THE DISPUTE RESOLUTION AND ARBITRATION PROCEEDINGS PRESCRIBED IN THIS ARTICLE. THE DEPARTMENT MAY CHARGE THE ENTITY A FEE FOR ENTERING INTO A WRITTEN AGREEMENT PURSUANT TO THIS SECTION IN AN AMOUNT TO BE DETERMINED BY THE DIRECTOR.

Sec. 9. Intent

The legislature intends that the fee the department of insurance and financial institutions charges pursuant to section 20-3120, Arizona Revised Statutes, as added by this act, cover the costs of administering the dispute resolution and arbitration proceedings prescribed in title 20, chapter 20, article 2, Arizona Revised Statutes, as amended by this act, for entities that administer self-funded or self-insured employee benefit plans that are otherwise preempted from state regulation by the employee retirement income security act of 1974 (P.L. 93-406; 88 Stat. 829; 29 United States Code section 1144(b)) and that choose to participate in the dispute resolution and arbitration proceedings prescribed in title 20, chapter 20, article 2, Arizona Revised Statutes, as amended by this act.