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

Section 1. Section 20-241, Arizona Revised Statutes, is amended to read:

20-241. Contracts to provide health care services; form of payment; notice; explanation of benefits; definitions

A. A contract between a health insurer and a health care provider that is issued, amended or renewed on or after January 1, 2020 to provide health care services to the health insurer's enrollees may not restrict the method of payment from the health insurer to the health care provider in which the only acceptable payment method is a credit card payment. A HEALTH INSURER SHALL ACCEPT TANGIBLE CHECKS AS A FORM OF ACCEPTABLE PAYMENT.

B. If a health insurer initiates or changes payments to a health care provider using electronic funds transfer payments, including virtual credit card payments, the health insurer shall do the following:

1. Notify the health care provider if any fee is associated with a particular payment method.

2. Advise the health care provider of the available methods of payment and provide clear instructions to the health care provider as to how to select an alternative payment method.

3. Remit or associate with each payment the explanation of benefits.

C. IF A HEALTH CARE PROVIDER OPTS OUT OF A METHOD OF PAYMENT, THAT DECISION REMAINS IN EFFECT UNTIL THE HEALTH CARE PROVIDER OPTS BACK IN TO THE PRIOR METHOD OF PAYMENT OR A NEW CONTRACT IS EXECUTED.

D. A health insurer that initiates or changes payment to a health care provider using the health care electronic funds transfers and remittance advice transaction pursuant to 45 Code of Federal Regulations sections 162.1601 and 162.1602 may not charge a fee solely to transmit the payment to a health care provider unless the health care provider has consented to the fee. A health care provider agent may charge reasonable fees when transmitting an electronic funds transfer or automatic clearing house related to transaction management, data management, portal services and other value-added services above and beyond the bank transmittal.

E. For the purposes of this section:

1. "Electronic funds transfer payment" means a payment by any method of electronic funds transfer other than a standard health care electronic funds transfers and remittance advice transaction pursuant to 45 Code of Federal Regulations sections 162.1601 and 162.1602.

2. "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 an enrollee and that separately bills the enrollee for the services.
3. "Health care provider agent" means a person or entity that contracts with a health care provider establishing an agency relationship to process bills for services provided by the health care provider under the terms and conditions of a contract between the agent and health care provider, which may allow the agent to submit bills, request reconsideration, and receive reimbursement.

4. "Health insurer" means a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, medical service corporation or hospital, medical, dental and optometric service corporation and includes the health insurer's designee.

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

20-3101. Definitions
In this 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":
   (a) 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.
   (b) INCLUDES ANY DELAY IN THE TIMELINESS OF PAYMENT OR DENIAL OF PAYMENT.
   (c) Grievance Does not include a complaint:
   (i) By a noncontracted provider regarding an insurer's decision to deny the noncontracted provider admission to the insurer's network.
   (ii) About an insurer's decision to terminate a health care provider from the insurer's network.
   (iii) 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. 3. 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 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 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 OF THIS SECTION.

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. ON OR BEFORE AUGUST 1 OF EACH YEAR, THE DIRECTOR SHALL POST A
REPORT ON THE DEPARTMENT'S PUBLICLY ACCESSIBLE WEBSITE THAT INCLUDES THE
INFORMATION PRESCRIBED IN SUBSECTION F OF THIS SECTION FOR THE PRIOR
FISCAL YEAR AND THAT INCLUDES:
1. THE TOTAL NUMBER OF GRIEVANCES RECEIVED.
2. THE AVERAGE TIME TO RESOLVE A GRIEVANCE.
3. THE PERCENTAGE OF GRIEVANCES WHERE A HEALTH CARE INSURER'S
DECISION WAS OVERTURNED.

J. 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.

K. This article does not apply to licensed health care
providers who are salaried employees of a health care insurer.
K. L. 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.

M. THIS SECTION DOES NOT PRECLUDE A HEALTH CARE PROVIDER FROM COLLECTING MONIES FOR A MEDICAL SERVICE THAT IS NOT COVERED UNDER THE INSURANCE POLICY OR FOR THE FREQUENCY OF A MEDICAL SERVICE THAT IS NOT COVERED UNDER THE INSURANCE POLICY.

N. Any claim that is subject to article 2 of this chapter is not subject to this article.

Sec. 4. 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 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. 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, 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 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 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 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.
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.
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 three arbitrators. The health insurer 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:

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

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.

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.

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 after resolution of the claim.

R. A claim that is reprocessed by a HEALTH insurer as a result of a settlement, arbitration decision or other action under this article is not in violation of section 20-3102, subsection N.

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 that was the subject of the informal settlement teleconference or arbitration.

T. Unless all the parties otherwise agree or unless required by subsection 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.