ARIZONA STATE SENATE

Fifty-Sixth Legislature, Second Regular Session

FACT SHEET FOR H.B. 2035

insurance; claims; appeals; provider credentialing

Purpose

Establishes procedures and requirements in the health care claim denial, dispute resolution and provider credentialing processes.

Background

Statute requires health care insurers to establish internal systems for resolving payment disputes and other contractual grievances with health care providers, subject to review by the Director of the Department of Insurance and Financial Institutions (DIFI). Insurers must maintain records of provider grievances and provide DIFI with a semiannual summary of grievances received in the prior six months. Records must include: 1) the name and identification number of any provider who filed a grievance; 2) the type of grievance; 3) the date of receipt of the grievance; and 4) the date of resolution (A.R.S. § 20-3102).

Health care provider *credentialing* is the process whereby health care insurers collect, verify and assess whether a provider meets relevant licensing, education and training requirements to become or remain a participating provider. Insurers must conclude the process of credentialing and loading an applicant's information into the insurer's billing system within 100 days of receipt of an application. Insurers may not deny a claim for a covered service provided to a subscriber by a participating provider who has a fully executed contract with a network plan if the services are provided after the date of approval of the credentialing application (A.R.S. Title 20, Chapter 27).

A *health care insurer* is 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 (A.R.S. § 20-3101).

The Joint Legislative Budget Committee fiscal note on H.B. 2035 estimates the bill would have an annual state General Fund impact of between $981,000 and $2,900,000 beginning in FY 2025 for costs of the Office of Administrative Hearings (OAH) (JLBC fiscal note).

Provisions

Health Care Claim Denials and Disputes

1. Requires a health care insurer that denies a health care services claim, in whole or in part, to provide the health care provider at the time of denial with contact information for an individual who is able to respond to questions about the denial, including a telephone number and email address.

2. Requires a health care insurer, at the request of a health care provider, to provide the following information within 15 days:
   a) if a denial was based on lack of medical necessity, a detailed reason why the service was not medically necessary and the provider's right to appeal;
   b) a provider's right to dispute the insurer's decision, including how to file a dispute using the insurer's internal grievance process and how to request a hearing if the grievance is unresolved; and
   c) if the health care plan is not subject to DIFI regulation, a notification to the provider of the appropriate regulatory authority.

3. Requires a health care insurer, within 30 days of receiving a written grievance, to respond in writing with a decision, unless the health care provider and insurer mutually agree to a longer time period.

4. Requires a health care insurer's decision regarding a grievance to include the:
   a) date of the decision;
   b) factual and legal basis for the decision;
   c) health care provider's right to request a hearing; and
   d) manner in which a health care provider may request a hearing.

5. Allows a health care provider with an unresolved grievance, in whole or in part, to submit a written request for a hearing to DIFI within 30 days of receiving the health care insurer's decision or the date on which the provider should have received the insurer's decision

6. Requires health care insurers to receive a copy of any hearing requests submitted to DIFI.

7. Requires DIFI to request a hearing within OAH if a health care provider timely submits a request.

8. Stipulates that, if a health care provider decides to withdraw a hearing request, the provider must send a written request for withdrawal to DIFI.

9. Requires DIFI to accept a written request for withdrawal if the request is received prior to DIFI's hearing request.

10. Requires a health care provider seeking to withdraw a hearing request to send a request to OAH if DIFI has already submitted a hearing request.

11. Stipulates that, if a party to a decision seeks further administrative review, DIFI may not be a party to the action unless it files a motion to intervene in the action.

Credentialing

12. Removes the ability of a health care insurer's designee to credential providers.

13. Reduces, from 100 to 45, the number of days a health care insurer has to conclude the process of credentialing and loading an applicant's information into the insurer's billing system after receiving a complete credentialing application.

14. Requires health care insurers to pay claims for covered services provided to a subscriber by a participating provider who has a fully executed contract with a network plan and whose credentialing application has been approved by the insurer retroactively to the date of the provider's complete credentialing application.

Miscellaneous

15. Defines *complete credentialing application*, *health care facility*, *health care plan*, *health care provider* and *hearing*.

16. Makes technical and conforming changes.

17. Becomes effective on the general effective date.

House Action

HHS	2/12/24	DP	9-0-0-1
3rd Read	2/22/24		57-1-1-0-1

Prepared by Senate Research
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MM/slp