REFERENCE TITLE: behavioral health services; insurance coverage

State of Arizona
House of Representatives
Fifty-seventh Legislature
First Regular Session
2025

HB 2348

Introduced by
Representatives Contreras P: Abeytia, Austin, Connolly, Contreras L, Crews, De Los Santos, Gutierrez, Luna-Nájera, Mathis, Peshlakai, Sandoval, Stahl Hamilton

AN ACT

AMENDING TITLE 20, CHAPTER 4, ARTICLE 3, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-841.14; AMENDING TITLE 20, CHAPTER 4, ARTICLE 9, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1057.20; AMENDING TITLE 20, CHAPTER 6, ARTICLE 4, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1376.11; AMENDING TITLE 20, CHAPTER 6, ARTICLE 5, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-1406.11; RELATING TO HEALTH INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Title 20, chapter 4, article 3, Arizona Revised Statutes, is amended by adding section 20-841.14, to read:

20-841.14. Behavioral health services; coverage; definitions

A. A HOSPITAL SERVICE CORPORATION OR MEDICAL SERVICE CORPORATION THAT ISSUES, AMENDS, DELIVERS OR RENEWS A SUBSCRIPTION CONTRACT ON OR AFTER JANUARY 1, 2026 SHALL PROVIDE COVERAGE FOR BEHAVIORAL HEALTH SERVICES.

B. A HOSPITAL SERVICE CORPORATION OR MEDICAL SERVICE CORPORATION SHALL ESTABLISH A DOCUMENTED PROCEDURE TO ASSIST A SUBSCRIBER WITH ACCESSING AN OUT-OF-NETWORK BEHAVIORAL HEALTH CARE PROVIDER WHEN AN IN-NETWORK BEHAVIORAL HEALTH CARE PROVIDER IS NOT AVAILABLE WITHIN A TIMELY MANNER.

C. IF A SUBSCRIBER IS UNABLE TO OBTAIN COVERED BEHAVIORAL HEALTH SERVICES FROM AN IN-NETWORK PROVIDER IN A TIMELY MANNER, INCLUDING THROUGH MEDICALLY APPROPRIATE TELEHEALTH SERVICES, THE SUBSCRIPTION CONTRACT MUST ENSURE COVERAGE FOR BEHAVIORAL HEALTH SERVICES FROM AN OUT-OF-NETWORK PROVIDER AND ARRANGE A NETWORK EXCEPTION WITH A NEGOTIATED RATE FROM AN OUT-OF-NETWORK PROVIDER. THE ARRANGEMENT BETWEEN THE SUBSCRIPTION CONTRACT AND THE OUT-OF-NETWORK PROVIDER SHALL HOLD THE SUBSCRIBER HARMLESS FOR ANY AMOUNT GREATER THAN THE IN-NETWORK COST SHARING AMOUNT, INCLUDING A COPAYMENT, COINSURANCE AND DEDUCTIBLE, THAT THE SUBSCRIBER WOULD HAVE PAID FOR THE SAME BEHAVIORAL HEALTH SERVICE PROVIDED BY AN IN-NETWORK PROVIDER. THE SUBSCRIPTION CONTRACT SHALL ACCEPT AS PAYMENT IN FULL THE NEGOTIATED RATE FOR THE NETWORK EXCEPTION AND THE SUBSCRIBER'S IN-NETWORK COST SHARING AMOUNT. A SUBSCRIBER MAY NOT PAY MORE THAN THE IN-NETWORK COST SHARING AMOUNT FOR BEHAVIORAL HEALTH SERVICES.

D. A HOSPITAL SERVICE CORPORATION OR MEDICAL SERVICE CORPORATION IS NOT RESPONSIBLE IF BEHAVIORAL HEALTH SERVICES ARE AVAILABLE WITHIN A TIMELY MANNER AND THE SUBSCRIBER CHOOSES TO SCHEDULE BEHAVIORAL HEALTH SERVICES OUTSIDE OF THE TIMELY MANNER REQUIREMENTS.

E. A SUBSCRIPTION CONTRACT THAT MAKES A PAYMENT TO AN OUT-OF-NETWORK PROVIDER SHALL DOCUMENT THE DETAILS OF THE PAYMENT AND MAKE THAT INFORMATION AVAILABLE TO THE DEPARTMENT NOT LATER THAN TWENTY DAYS FROM THE DATE OF REQUEST.

F. FOR THE PURPOSES OF THIS SECTION:

1. "BEHAVIORAL HEALTH SERVICES" INCLUDES:

(a) MENTAL HEALTH SERVICES.

(b) SUBSTANCE USE DISORDER SERVICES.

2. "TIMELY MANNER" MEANS:

(a) WITHIN THIRTY DAYS FROM THE DATE A SUBSCRIBER REQUESTS AN APPOINTMENT, SERVICE OR RELATED BEHAVIORAL HEALTH SERVICE, IF THE REQUEST IS:

(i) FOR A ROUTINE APPOINTMENT.

(ii) BASED ON A HEALTH CARE PROVIDER'S REFERRAL.

(iii) FOR A NEW TREATMENT OR MEDICATION.

(iv) FOR OTHER RELATED SERVICES AS DETERMINED BY THE DEPARTMENT.

(b) WITHIN SEVEN DAYS FROM THE DATE A SUBSCRIBER FIRST ATTEMPTS TO RECEIVE BEHAVIORAL HEALTH RESIDENTIAL CARE OR HOSPITALIZATION.

(c) WITHIN TWENTY-FOUR HOURS FROM THE DATE AND TIME THE SUBSCRIBER FIRST ATTEMPTS TO RECEIVE URGENT, EMERGENT OR CRISIS BEHAVIORAL HEALTH SERVICES.

Sec. 2. Title 20, chapter 4, article 9, Arizona Revised Statutes, is amended by adding section 20-1057.20, to read:

20-1057.20. Behavioral health services; coverage; definitions

A. A HEALTH CARE SERVICES ORGANIZATION THAT ISSUES, AMENDS, DELIVERS OR RENEWS AN EVIDENCE OF COVERAGE ON OR AFTER JANUARY 1, 2026 SHALL PROVIDE COVERAGE FOR BEHAVIORAL HEALTH SERVICES.

B. A HEALTH CARE SERVICES ORGANIZATION SHALL ESTABLISH A DOCUMENTED PROCEDURE TO ASSIST AN ENROLLEE WITH ACCESSING AN OUT-OF-NETWORK BEHAVIORAL HEALTH CARE PROVIDER WHEN AN IN-NETWORK BEHAVIORAL HEALTH CARE PROVIDER IS NOT AVAILABLE WITHIN A TIMELY MANNER.

C. IF AN ENROLLEE IS UNABLE TO OBTAIN COVERED BEHAVIORAL HEALTH SERVICES FROM AN IN-NETWORK PROVIDER IN A TIMELY MANNER, INCLUDING THROUGH MEDICALLY APPROPRIATE TELEHEALTH SERVICES, THE EVIDENCE OF COVERAGE MUST ENSURE COVERAGE FOR BEHAVIORAL HEALTH SERVICES FROM AN OUT-OF-NETWORK PROVIDER AND ARRANGE A NETWORK EXCEPTION WITH A NEGOTIATED RATE FROM AN OUT-OF-NETWORK PROVIDER. THE ARRANGEMENT BETWEEN THE EVIDENCE OF COVERAGE AND THE OUT-OF-NETWORK PROVIDER SHALL HOLD THE ENROLLEE HARMLESS FOR ANY AMOUNT GREATER THAN THE IN-NETWORK COST SHARING AMOUNT, INCLUDING A COPAYMENT, COINSURANCE AND DEDUCTIBLE, THAT THE ENROLLEE WOULD HAVE PAID FOR THE SAME BEHAVIORAL HEALTH SERVICE PROVIDED BY AN IN-NETWORK PROVIDER. THE EVIDENCE OF COVERAGE SHALL ACCEPT AS PAYMENT IN FULL THE NEGOTIATED RATE FOR THE NETWORK EXCEPTION AND THE ENROLLEE'S IN-NETWORK COST SHARING AMOUNT. AN ENROLLEE MAY NOT PAY MORE THAN THE IN-NETWORK COST SHARING AMOUNT FOR BEHAVIORAL HEALTH SERVICES.

D. A HEALTH CARE SERVICES ORGANIZATION IS NOT RESPONSIBLE IF BEHAVIORAL HEALTH SERVICES ARE AVAILABLE WITHIN A TIMELY MANNER AND THE ENROLLEE CHOOSES TO SCHEDULE BEHAVIORAL HEALTH SERVICES OUTSIDE OF THE TIMELY MANNER REQUIREMENTS.

E. AN EVIDENCE OF COVERAGE THAT MAKES A PAYMENT TO AN OUT-OF-NETWORK PROVIDER SHALL DOCUMENT THE DETAILS OF THE PAYMENT AND MAKE THAT INFORMATION AVAILABLE TO THE DEPARTMENT NOT LATER THAN TWENTY DAYS FROM THE DATE OF REQUEST.

F. FOR THE PURPOSES OF THIS SECTION:

1. "BEHAVIORAL HEALTH SERVICES" INCLUDES:

(a) MENTAL HEALTH SERVICES.

(b) SUBSTANCE USE DISORDER SERVICES.

2. "TIMELY MANNER" MEANS:

(a) WITHIN THIRTY DAYS FROM THE DATE AN ENROLLEE REQUESTS AN APPOINTMENT, SERVICE OR RELATED BEHAVIORAL HEALTH SERVICE, IF THE REQUEST IS:

(i) FOR A ROUTINE APPOINTMENT.

(ii) BASED ON A HEALTH CARE PROVIDER'S REFERRAL.

(iii) FOR A NEW TREATMENT OR MEDICATION.

(iv) FOR OTHER RELATED SERVICES AS DETERMINED BY THE DEPARTMENT.

(b) WITHIN SEVEN DAYS FROM THE DATE AN ENROLLEE FIRST ATTEMPTS TO RECEIVE BEHAVIORAL HEALTH RESIDENTIAL CARE OR HOSPITALIZATION.

(c) WITHIN TWENTY-FOUR HOURS FROM THE DATE AND TIME THE ENROLLEE FIRST ATTEMPTS TO RECEIVE URGENT, EMERGENT OR CRISIS BEHAVIORAL HEALTH SERVICES.

Sec. 3. Title 20, chapter 6, article 4, Arizona Revised Statutes, is amended by adding section 20-1376.11, to read:

20-1376.11. Behavioral health services; coverage; definitions

A. A DISABILITY INSURER THAT ISSUES, AMENDS, DELIVERS OR RENEWS A POLICY ON OR AFTER JANUARY 1, 2026 SHALL PROVIDE COVERAGE FOR BEHAVIORAL HEALTH SERVICES.

B. A DISABILITY INSURER SHALL ESTABLISH A DOCUMENTED PROCEDURE TO ASSIST AN INSURED WITH ACCESSING AN OUT-OF-NETWORK BEHAVIORAL HEALTH CARE PROVIDER WHEN AN IN-NETWORK BEHAVIORAL HEALTH CARE PROVIDER IS NOT AVAILABLE WITHIN A TIMELY MANNER.

C. IF AN INSURED IS UNABLE TO OBTAIN COVERED BEHAVIORAL HEALTH SERVICES FROM AN IN-NETWORK PROVIDER IN A TIMELY MANNER, INCLUDING THROUGH MEDICALLY APPROPRIATE TELEHEALTH SERVICES, THE POLICY MUST ENSURE COVERAGE FOR BEHAVIORAL HEALTH SERVICES FROM AN OUT-OF-NETWORK PROVIDER AND ARRANGE A NETWORK EXCEPTION WITH A NEGOTIATED RATE FROM AN OUT-OF-NETWORK PROVIDER. THE ARRANGEMENT BETWEEN THE POLICY AND THE OUT-OF-NETWORK PROVIDER SHALL HOLD THE INSURED HARMLESS FOR ANY AMOUNT GREATER THAN THE IN-NETWORK COST SHARING AMOUNT, INCLUDING A COPAYMENT, COINSURANCE AND DEDUCTIBLE, THAT THE INSURED WOULD HAVE PAID FOR THE SAME BEHAVIORAL HEALTH SERVICE PROVIDED BY AN IN-NETWORK PROVIDER. THE POLICY SHALL ACCEPT AS PAYMENT IN FULL THE NEGOTIATED RATE FOR THE NETWORK EXCEPTION AND THE INSURED'S IN-NETWORK COST SHARING AMOUNT. AN INSURED MAY NOT PAY MORE THAN THE IN-NETWORK COST SHARING AMOUNT FOR BEHAVIORAL HEALTH SERVICES.

D. A DISABILITY INSURER IS NOT RESPONSIBLE IF BEHAVIORAL HEALTH SERVICES ARE AVAILABLE WITHIN A TIMELY MANNER AND THE INSURED CHOOSES TO SCHEDULE BEHAVIORAL HEALTH SERVICES OUTSIDE OF THE TIMELY MANNER REQUIREMENTS.

E. A POLICY THAT MAKES A PAYMENT TO AN OUT-OF-NETWORK PROVIDER SHALL DOCUMENT THE DETAILS OF THE PAYMENT AND MAKE THAT INFORMATION AVAILABLE TO THE DEPARTMENT NOT LATER THAN TWENTY DAYS FROM THE DATE OF REQUEST.

F. FOR THE PURPOSES OF THIS SECTION:

1. "BEHAVIORAL HEALTH SERVICES" INCLUDES:

(a) MENTAL HEALTH SERVICES.

(b) SUBSTANCE USE DISORDER SERVICES.

2. "TIMELY MANNER" MEANS:

(a) WITHIN THIRTY DAYS FROM THE DATE AN INSURED REQUESTS AN APPOINTMENT, SERVICE OR RELATED BEHAVIORAL HEALTH SERVICE, IF THE REQUEST IS:

(i) FOR A ROUTINE APPOINTMENT.

(ii) BASED ON A HEALTH CARE PROVIDER'S REFERRAL.

(iii) FOR A NEW TREATMENT OR MEDICATION.

(iv) FOR OTHER RELATED SERVICES AS DETERMINED BY THE DEPARTMENT.

(b) WITHIN SEVEN DAYS FROM THE DATE AN INSURED FIRST ATTEMPTS TO RECEIVE BEHAVIORAL HEALTH RESIDENTIAL CARE OR HOSPITALIZATION.

(c) WITHIN TWENTY-FOUR HOURS FROM THE DATE AND TIME THE INSURED FIRST ATTEMPTS TO RECEIVE URGENT, EMERGENT OR CRISIS BEHAVIORAL HEALTH SERVICES.

Sec. 4. Title 20, chapter 6, article 5, Arizona Revised Statutes, is amended by adding section 20-1406.11, to read:

20-1406.11. Behavioral health services; coverage; definitions

A. A GROUP OR BLANKET DISABILITY INSURER THAT ISSUES, AMENDS, DELIVERS OR RENEWS A POLICY ON OR AFTER JANUARY 1, 2026 SHALL PROVIDE COVERAGE FOR BEHAVIORAL HEALTH SERVICES.

B. A GROUP OR BLANKET DISABILITY INSURER SHALL ESTABLISH A DOCUMENTED PROCEDURE TO ASSIST AN INSURED WITH ACCESSING AN OUT-OF-NETWORK BEHAVIORAL HEALTH CARE PROVIDER WHEN AN IN-NETWORK BEHAVIORAL HEALTH CARE PROVIDER IS NOT AVAILABLE WITHIN A TIMELY MANNER.

C. IF AN INSURED IS UNABLE TO OBTAIN COVERED BEHAVIORAL HEALTH SERVICES FROM AN IN-NETWORK PROVIDER IN A TIMELY MANNER, INCLUDING THROUGH MEDICALLY APPROPRIATE TELEHEALTH SERVICES, THE POLICY MUST ENSURE COVERAGE FOR BEHAVIORAL HEALTH SERVICES FROM AN OUT-OF-NETWORK PROVIDER AND ARRANGE A NETWORK EXCEPTION WITH A NEGOTIATED RATE FROM AN OUT-OF-NETWORK PROVIDER. THE ARRANGEMENT BETWEEN THE POLICY AND THE OUT-OF-NETWORK PROVIDER SHALL HOLD THE INSURED HARMLESS FOR ANY AMOUNT GREATER THAN THE IN-NETWORK COST SHARING AMOUNT, INCLUDING A COPAYMENT, COINSURANCE AND DEDUCTIBLE, THAT THE INSURED WOULD HAVE PAID FOR THE SAME BEHAVIORAL HEALTH SERVICE PROVIDED BY AN IN-NETWORK PROVIDER. THE POLICY SHALL ACCEPT AS PAYMENT IN FULL THE NEGOTIATED RATE FOR THE NETWORK EXCEPTION AND THE INSURED'S IN-NETWORK COST SHARING AMOUNT. AN INSURED MAY NOT PAY MORE THAN THE IN-NETWORK COST SHARING AMOUNT FOR BEHAVIORAL HEALTH SERVICES.

D. A GROUP OR BLANKET DISABILITY INSURER IS NOT RESPONSIBLE IF BEHAVIORAL HEALTH SERVICES ARE AVAILABLE WITHIN A TIMELY MANNER AND THE INSURED CHOOSES TO SCHEDULE BEHAVIORAL HEALTH SERVICES OUTSIDE OF THE TIMELY MANNER REQUIREMENTS.

E. A POLICY THAT MAKES A PAYMENT TO AN OUT-OF-NETWORK PROVIDER SHALL DOCUMENT THE DETAILS OF THE PAYMENT AND MAKE THAT INFORMATION AVAILABLE TO THE DEPARTMENT NOT LATER THAN TWENTY DAYS FROM THE DATE OF REQUEST.

F. FOR THE PURPOSES OF THIS SECTION:

1. "BEHAVIORAL HEALTH SERVICES" INCLUDES:

(a) MENTAL HEALTH SERVICES.

(b) SUBSTANCE USE DISORDER SERVICES.

2. "TIMELY MANNER" MEANS:

(a) WITHIN THIRTY DAYS FROM THE DATE AN INSURED REQUESTS AN APPOINTMENT, SERVICE OR RELATED BEHAVIORAL HEALTH SERVICE, IF THE REQUEST IS:

(i) FOR A ROUTINE APPOINTMENT.

(ii) BASED ON A HEALTH CARE PROVIDER'S REFERRAL.

(iii) FOR A NEW TREATMENT OR MEDICATION.

(iv) FOR OTHER RELATED SERVICES AS DETERMINED BY THE DEPARTMENT.

(b) WITHIN SEVEN DAYS FROM THE DATE AN INSURED FIRST ATTEMPTS TO RECEIVE BEHAVIORAL HEALTH RESIDENTIAL CARE OR HOSPITALIZATION.

(c) WITHIN TWENTY-FOUR HOURS FROM THE DATE AND TIME THE INSURED FIRST ATTEMPTS TO RECEIVE URGENT, EMERGENT OR CRISIS BEHAVIORAL HEALTH SERVICES.