REFERENCE TITLE: health insurance claims; consumer assistance

State of Arizona
Senate
Fifty-seventh Legislature
First Regular Session
2025

SB 1397

Introduced by
Senators Burch: Alston, Epstein, Fernandez, Gabaldón

AN ACT

AMENDING TITLE 20, CHAPTER 1, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-127; RELATING TO THE DEPARTMENT OF INSURANCE AND FINANCIAL INSTITUTIONS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Title 20, chapter 1, article 1, Arizona Revised Statutes, is amended by adding section 20-127, to read:

20-127. Health care claims consumer assistance program; educational outreach; appeal process; civil penalty; data collection; reporting requirements; public posting; rules; definitions

A. A HEALTH CARE CLAIMS CONSUMER ASSISTANCE PROGRAM IS ESTABLISHED IN THE DEPARTMENT TO PROVIDE SUPPORT TO CONSUMERS WHO ARE ENROLLED IN A HEALTH PLAN OR WHO ARE SEEKING TO ENROLL IN A HEALTH PLAN.

B. THE HEALTH CARE CLAIMS CONSUMER ASSISTANCE PROGRAM SHALL:

1. ASSIST CONSUMERS WITH FILING COMPLAINTS AND APPEALS WITH A HEALTH INSURER OR WITH THE UTILIZATION REVIEW PROCESS AS PROVIDED IN CHAPTER 15 OF THIS TITLE.

2. ASSIST CONSUMERS WITH SETTLING CONFLICTS, DISPUTED CLAIMS OR CLAIMS DENIALS WITH A HEALTH INSURER.

3. EDUCATE CONSUMERS ON THEIR RIGHTS AND RESPONSIBILITIES WITH RESPECT TO HEALTH INSURANCE COVERAGE.

4. ASSIST CONSUMERS WITH OBTAINING HEALTH INSURANCE COVERAGE BY PROVIDING INFORMATION, REFERRALS OR OTHER ASSISTANCE.

5. ASSIST CONSUMERS WITH OBTAINING FEDERAL HEALTH INSURANCE PREMIUM TAX CREDITS UNDER SECTION 36B OF THE UNITED STATES INTERNAL REVENUE CODE OF 1986, AS AMENDED.

6. COLLECT, TRACK AND QUANTIFY INQUIRIES REGARDING HEALTH INSURANCE AND PROBLEMS ENCOUNTERED BY CONSUMERS.

7. PROVIDE INFORMATION TO THE PUBLIC ABOUT THE SERVICES OF THE HEALTH CARE CLAIMS CONSUMER ASSISTANCE PROGRAM THROUGH A COMPREHENSIVE OUTREACH PROGRAM AND A TOLL-FREE TELEPHONE NUMBER.

C. A HEALTH INSURER IN THIS STATE SHALL PLACE A PROMINENT, PLAIN LANGUAGE NOTICE ABOUT THE HEALTH CARE CLAIMS CONSUMER ASSISTANCE PROGRAM ON THE FRONT PAGE OF ALL HEALTH INSURANCE EXPLANATIONS OF BENEFITS, DENIALS OR OTHER RELATED HEALTH PLAN COMMUNICATIONS.

D. THE DEPARTMENT MAY CONTRACT WITH A NONPROFIT, INDEPENDENT HEALTH INSURANCE CONSUMER ASSISTANCE ENTITY TO SERVE AS THE HEALTH CARE CLAIMS CONSUMER ASSISTANCE PROGRAM. THE NONPROFIT, INDEPENDENT HEALTH INSURANCE CONSUMER ASSISTANCE ENTITY MAY NOT BE A HEALTH PLAN OR HEALTH INSURER OR AN AFFILIATE OF A HEALTH PLAN OR HEALTH INSURER.

E. THE HEALTH CARE CLAIMS CONSUMER ASSISTANCE PROGRAM SHALL CONSULT WITH THE DEPARTMENT TO FULFILL THE DATA COLLECTION AND REPORTING REQUIREMENTS PRESCRIBED IN THIS SECTION.

F. IT IS UNLAWFUL FOR A HEALTH INSURER IN THIS STATE TO WRONGFULLY DENY OR INSUFFICIENTLY COVER A VALID CONSUMER INSURANCE CLAIM. IF THE DEPARTMENT DETERMINES A HEALTH INSURER COMMITTED AN ACT OR OMISSION THAT CONSTITUTES GROUNDS FOR DISCIPLINARY ACTION, THE DEPARTMENT MAY SUSPEND OR REVOKE THE HEALTH INSURER'S LICENSE AND MAY IMPOSE CIVIL PENALTIES. THE

DEPARTMENT MAY REFER THE MATTER TO THE ATTORNEY GENERAL'S OFFICE FOR CIVIL ENFORCEMENT PURSUANT TO TITLE 44, CHAPTER 10, ARTICLE 7.

G. THE DEPARTMENT MAY IMPOSE ADDITIONAL PENALTIES IF THE DEPARTMENT FINDS THAT THE HEALTH INSURER CONTINUOUSLY VIOLATES A HEALTH PLAN. IF THE DEPARTMENT PROVIDES PROPER NOTICE AND AN OPPORTUNITY TO THE HEALTH INSURER TO REMEDY REPEATED VIOLATIONS AND THE HEALTH INSURER CONTINUES TO VIOLATE A HEALTH PLAN, THE DEPARTMENT MAY IMPOSE A CIVIL PENALTY OF NOT MORE THAN $25,000 FOR EACH VIOLATION FOR WHICH THE HEALTH INSURER WRONGFULLY DENIED OR INSUFFICIENTLY PAID A VALID CONSUMER INSURANCE CLAIM.

H. THE DEPARTMENT SHALL REVIEW THE FOLLOWING FACTORS WHEN DETERMINING WHETHER A CIVIL PENALTY IS APPROPRIATE:

1. THE NATURE, SCOPE AND GRAVITY OF THE VIOLATION.

2. THE GOOD FAITH OR BAD FAITH OF THE HEALTH INSURER.

3. THE HEALTH INSURER'S HISTORY OF VIOLATIONS.

4. THE WILFULNESS OF THE VIOLATION.

5. WHETHER THE VIOLATION IS AN ISOLATED INCIDENT.

6. THE NATURE AND EXTENT TO WHICH THE HEALTH INSURER COOPERATED WITH THE DEPARTMENT.

7. THE NATURE AND EXTENT TO WHICH THE HEALTH INSURER AGGRAVATED OR MITIGATED ANY INJURY OR DAMAGE CAUSED BY THE VIOLATION.

8. THE NATURE AND EXTENT TO WHICH THE HEALTH INSURER HAS TAKEN CORRECTIVE ACTION TO ENSURE THE VIOLATION WILL NOT RECUR.

9. THE FINANCIAL STATUS OF THE HEALTH INSURER ON AN EVALUATION OF:

(a) THE AMOUNT OF RESERVE CAPITAL.

(b) THE SOLVENCY OF THE HEALTH INSURER.

(c) THE AMOUNT OF EXCESS REVENUES MINUS EXPENDITURES.

(d) ANY OTHER RELATED FACTOR, INCLUDING:

(i) THE COST OF THE HEALTH CARE SERVICE THAT WAS DENIED, DELAYED OR MODIFIED, INCLUDING WHETHER THE PENALTY IS COMMENSURATE WITH OR EXCEEDS THE AVOIDED COST BASED ON THE NUMBER OF INSUREDS THAT ARE ESTIMATED TO BE AFFECTED.

(ii) THE FREQUENCY OF THE VIOLATIONS BASED ON THE NUMBER OF DAYS FOR A CONTINUOUS VIOLATION OR THE ESTIMATED NUMBER OF INCIDENTS WITH POTENTIAL HARM TO INSUREDS.

(iii) THE SEVERITY OF THE POTENTIAL HARM IN TERMS OF LOSS OF LIFE, LOSS OF HEALTH, EMOTIONAL DISTRESS OR FINANCIAL HARM TO INSUREDS.

(iv) THE AMOUNT OF THE PENALTY THAT IS NECESSARY TO DETER SIMILAR VIOLATIONS IN THE FUTURE.

I. IF THE COURT FINDS THAT A HEALTH INSURER HAS WRONGFULLY DENIED OR INSUFFICIENTLY COVERED A VALID CONSUMER INSURANCE CLAIM, THE COURT MAY AWARD DAMAGES TO AN INJURED CONSUMER.

J. IF THE DEPARTMENT OR A COURT FINDS THAT A HEALTH INSURER HAS WRONGFULLY DENIED OR INSUFFICIENTLY COVERED A VALID CONSUMER INSURANCE CLAIM, THE HEALTH INSURER IS AUTOMATICALLY LIABLE TO PAY DOUBLE THE AMOUNT THAT WAS WRONGFULLY DENIED OR INSUFFICIENTLY COVERED, INCLUDING ATTORNEY FEES.

K. THE DEPARTMENT OR THE COURT MAY ASSESS ADDITIONAL DAMAGES TO BE PAID TO AN INSURED ON REVIEW OF THE FOLLOWING FACTORS, AS APPROPRIATE, IF THE HARM WAS SEVERE:

1. THE NATURE, SCOPE AND GRAVITY OF THE VIOLATION.

2. THE SEVERITY OF THE POTENTIAL HARM TO THE POLICYHOLDER, INCLUDING:

(a) LOSS OF LIFE.

(b) LOSS OF HEALTH.

(c) EMOTIONAL DISTRESS.

(d) FINANCIAL HARM.

3. THE NATURE AND EXTENT TO WHICH THE HEALTH INSURER COOPERATED WITH THE DEPARTMENT.

4. THE NATURE AND EXTENT TO WHICH THE HEALTH INSURER AGGRAVATED OR MITIGATED ANY INJURY OR DAMAGED CAUSED BY THE VIOLATION.

5. THE NATURE AND EXTENT TO WHICH THE HEALTH INSURER HAS TAKEN CORRECTIVE ACTION TO ENSURE THE VIOLATION WILL NOT RECUR.

L. ON OR BEFORE DECEMBER 31, 2026 AND EVERY YEAR THEREAFTER, THE DEPARTMENT SHALL ADJUST THE PENALTY AMOUNT PRESCRIBED IN SUBSECTION G OF THIS SECTION BASED ON WHICHEVER IS THE HIGHER OF:

1. THE AVERAGE RATE OF CHANGE IN PREMIUM RATES FOR INSUREDS IN A GROUP MARKET THAT IS WEIGHTED BY ENROLLMENT SINCE THE PREVIOUS ADJUSTMENT.

2. ANY ADJUSTMENT BASED ON INFLATION.

M. THE DEPARTMENT SHALL KEEP RECORDS OF WRONGFUL CLAIMS DENIALS THAT ARE BROUGHT TO THE HEALTH CARE CLAIMS CONSUMER ASSISTANCE PROGRAM.

N. A HEALTH INSURER SHALL DISCLOSE DATA ON WRONGFUL CLAIMS DENIALS TO THE DEPARTMENT ON REQUEST AND IN A READABLE FORMAT THAT INCLUDES:

1. THE NUMBER, PERCENTAGE AND TYPES OF DENIED CLAIMS.

2. THE NUMBER, PERCENTAGE AND TYPES OF WRONGFULLY DENIED CLAIMS.

O. THE DEPARTMENT MAY INVESTIGATE HEALTH INSURERS FOR VIOLATIONS OF THIS SECTION.

P. IF A HEALTH INSURER IS FOUND TO HAVE VIOLATED THIS SECTION MORE THAN THE MEDIAN PERCENTAGE OF WRONGFUL DENIALS SINCE THE PREVIOUS YEAR, THE DEPARTMENT SHALL REVIEW EACH VIOLATION IN THE CURRENT YEAR TO DETERMINE WHETHER PENALTIES SHOULD BE IMPOSED.

Q. ONE YEAR AFTER THE EFFECTIVE DATE OF THIS SECTION AND EVERY YEAR THEREAFTER, THE DEPARTMENT SHALL:

1. COMPILE A REPORT THAT CONTAINS ALL OF THE FOLLOWING:

(a) THE NUMBER AND TYPE OF DENIED CLAIMS, INCLUDING RAW NUMBERS AND NUMBERS AS A PERCENTAGE OF THE TOTAL CLAIMS.

(b) THE NUMBER AND TYPE OF WRONGFULLY DENIED CLAIMS, INCLUDING RAW NUMBERS AND NUMBERS AS A PERCENTAGE OF THE TOTAL CLAIMS.

(c) THE NUMBER AND TYPE OF DENIED CLAIMS THAT WERE APPEALED AND REPORTED TO THE HEALTH CARE CLAIMS CONSUMER ASSISTANCE PROGRAM.

(d) THE NUMBER OF DENIED CLAIMS THAT WERE APPEALED AND BROUGHT TO THE HEALTH CARE CLAIMS CONSUMER ASSISTANCE PROGRAM.

(e) THE NUMBER, TYPE AND PERCENTAGE OF WRONGFULLY DENIED CLAIMS BY EACH INSURER FOR EACH HEALTH PLAN.

(f) THE OUTCOME OF ANY INVESTIGATION FOR EACH HEALTH INSURER THAT WAS CONDUCTED BY THE DEPARTMENT FOR A VIOLATION OF THIS SECTION.

2. POST THE REPORT ON THE DEPARTMENT'S PUBLICLY ACCESSIBLE WEBSITE AND PROVIDE A COPY TO:

(a) THE GOVERNOR'S OFFICE.

(b) THE PRESIDENT OF THE SENATE.

(c) THE SPEAKER OF THE HOUSE OF REPRESENTATIVES.

(d) THE MINORITY LEADER IN THE SENATE.

(e) THE MINORITY LEADER IN THE HOUSE OF REPRESENTATIVES.

(f) THE SECRETARY OF STATE.

R. THE DEPARTMENT SHALL ADOPT RULES TO IMPLEMENT THIS SECTION.

S. FOR THE PURPOSES OF THIS SECTION:

1. "CONSUMER" MEANS CUSTOMERS OR POTENTIAL CUSTOMERS OF A HEALTH PLAN.

2. "ENROLLED" MEANS AN INDIVIDUAL OR PERSON WHO IS UNDER A HEALTH CARE PLAN.

3. "HEALTH CARE PLAN" MEANS ANY CONTRACT FOR COVERAGE BETWEEN AN INSURED AND A HEALTH PLAN THAT INCLUDES:

(a) A SUBSCRIPTION CONTRACT.

(b) AN EVIDENCE OF COVERAGE.

(c) A POLICY.

4. "INSURED" MEANS ANY INDIVIDUAL OR PERSON WHO HAS AN ACTIVE HEALTH CARE PLAN.

5. "INSURER" MEANS ANY OF THE FOLLOWING:

(a) A HOSPITAL SERVICE CORPORATION OR MEDICAL SERVICE CORPORATION.

(b) A HEALTH CARE SERVICES ORGANIZATION.

(c) A DISABILITY INSURER.

(d) A GROUP OR BLANKET DISABILITY INSURER.