Fifty-seventh Legislature
Second Regular Session

COMMITTEE ON HEALTH & HUMAN SERVICES
HOUSE OF REPRESENTATIVES AMENDMENTS TO S.B. 1628
(Reference to Senate engrossed bill)

Amendment instruction key:
[GREEN UNDERLINING IN BRACKETS] indicates text added to statute or previously enacted session law.
[Green underlining in brackets] indicates text added to new session law or text restoring existing law.
[~~GREEN STRIKEOUT IN BRACKETS~~] indicates new text removed from statute or previously enacted session law.
[~~Green strikeout in brackets~~] indicates text removed from existing statute, previously enacted session law or new session law.
<<Green carets>> indicate a section added to the bill.
<<~~Green strikeout in carets~~>> indicates a section removed from the bill.

The bill as proposed to be amended is reprinted as follows:

Section 1. Title 20, chapter 15, article 1, Arizona Revised Statutes, is amended by adding section 20-2512, to read:

20-2512. Health care services plans; claims denial practices; reporting requirements; definition

A. ON OR BEFORE JULY 1, 2027 AND EACH JULY 1 THEREAFTER, A HEALTH CARE SERVICES PLAN SHALL REPORT TO THE DEPARTMENT ON A FORM PRESCRIBED BY THE DEPARTMENT THE FOLLOWING AGGREGATED DATA THAT RELATES TO THE HEALTH CARE SERVICES PLAN'S CLAIMS DENIAL PRACTICES FOR THE PRIOR YEAR:

1. THE TOTAL NUMBER OF CLAIMS REQUESTS, INCLUDING THE TOTAL NUMBER OF CLAIMS REQUESTS THAT WERE NOT SUBMITTED ELECTRONICALLY.

2. THE TOTAL NUMBER OF CLAIMS REQUESTS THAT WERE PARTIALLY DENIED AND THE TOTAL NUMBER OF CLAIMS REQUESTS THAT WERE COMPLETELY DENIED.

3. THE TOTAL NUMBER OF APPEALS THAT WERE RECEIVED FOR ALL OF THE FOLLOWING LEVELS OF REVIEW:

(a) INITIAL APPEAL.

(b) VOLUNTARY INTERNAL APPEAL.

(c) EXTERNAL INDEPENDENT REVIEW.

(d) EXPEDITED MEDICAL REVIEW.

(e) EXPEDITED APPEAL.

(f) EXPEDITED EXTERNAL INDEPENDENT REVIEW.

4. THE TOTAL NUMBER OF ADVERSE DETERMINATIONS THAT WERE PARTIALLY REVERSED ON APPEAL AND THE TOTAL NUMBER OF ADVERSE DETERMINATIONS THAT WERE [COMPLETELY] REVERSED ON APPEAL.

[~~5. THE TOTAL NUMBER OF CLAIMS THAT WERE COMPLETELY DOWNCODED.~~]

[~~6.~~] [5.] THE TOP TEN INPATIENT AND TOP TEN OUTPATIENT SERVICES CLAIMS THAT WERE DENIED IN EACH OF THE FOLLOWING CATEGORIES:

(a) MEDICAL AND SURGICAL PROCEDURES.

(b) DIAGNOSTIC TESTS AND DIAGNOSTIC IMAGES.
(c) BEHAVIORAL HEALTH SERVICES.
(d) ORTHOPEDIC SERVICES.
[~~7.~~] [6.] THE TOP FIVE REASONS WHY CLAIMS REQUESTS WERE DENIED.
B. ON OR BEFORE OCTOBER 31, 2027 AND EACH OCTOBER 1 THEREAFTER, THE DEPARTMENT SHALL:
1. [~~AGGREGATE~~] [COMPILE] THE DATA THAT IS COLLECTED UNDER SUBSECTION A OF THIS SECTION INTO A STANDARD REPORT. THE REPORT MUST SEPARATE EACH HEALTH CARE SERVICES PLAN THAT SUBMITTED DATA BY NAME AND MUST BE WRITTEN IN EASILY UNDERSTANDABLE LANGUAGE.
2. POST THE REPORT ON THE DEPARTMENTS' PUBLICLY ACCESSIBLE WEBSITE.
3. MAINTAIN AT LEAST THREE YEARS OF REPORTS ON THE DEPARTMENT'S PUBLICLY ACCESSIBLE WEBSITE.
4. SEND A COPY OF THE REPORT TO THE SPEAKER OF THE HOUSE OF REPRESENTATIVES AND THE PRESIDENT OF THE SENATE.
C. THE DIRECTOR MAY ADOPT RULES TO IMPLEMENT THIS SECTION.
D. FOR THE PURPOSES OF THIS SECTION[,] [~~:~~
~~1. "DOWNCODE" MEANS THE UNILATERAL ALTERATION BY A HEALTH CARE INSURER OF THE LEVEL OF EVALUATION AND MANAGEMENT SERVICE CODE OR OTHER SERVICE CODE THAT WAS SUBMITTED ON A CLAIM AND THAT RESULTED IN A LOWER PAYMENT.~~
~~2.~~] "HEALTH CARE SERVICES PLAN" HAS THE SAME MEANING PRESCRIBED IN SECTION 20-3401.

Sec. 2. 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~~ OCTOBER 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.

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, with written informed consent of the patient, from collecting monies for a medical service that is either:

1. Not covered under the insurance policy.
2. Medically necessary and a payment on the claim was not made due to a denial on the basis of frequency or a disallowance on the basis of frequency. For the purposes of this paragraph, a provider is limited to the rates prescribed by that provider's fee schedule.

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

Sec. 3. Title 20, chapter 26, article 1, Arizona Revised Statutes, is amended by adding section 20-3408, to read:

20-3408. Health care services plans; prior authorization practices; reporting requirements; rules

A. ON OR BEFORE JULY 1, 2027 AND EACH JULY 1 THEREAFTER, A HEALTH CARE SERVICES PLAN SHALL REPORT TO THE DEPARTMENT ON A FORM PRESCRIBED BY THE DEPARTMENT THE FOLLOWING AGGREGATED DATA THAT RELATES TO THE HEALTH CARE SERVICES PLAN'S PRIOR AUTHORIZATION PRACTICES FOR THE PRIOR YEAR:

1. THE TOTAL NUMBER OF PRIOR AUTHORIZATION REQUESTS, INCLUDING THE TOTAL NUMBER OF PRIOR AUTHORIZATION REQUESTS THAT WERE NOT SUBMITTED ELECTRONICALLY.

2. THE TOTAL NUMBER OF PRIOR AUTHORIZATION REQUESTS THAT WERE PARTIALLY DENIED AND THE TOTAL NUMBER OF PRIOR AUTHORIZATION REQUESTS THAT WERE COMPLETELY DENIED.

3. THE TOTAL NUMBER OF APPEALS THAT WERE RECEIVED FOR ALL OF THE FOLLOWING LEVELS OF REVIEW:

(a) INITIAL APPEAL.

(b) VOLUNTARY INTERNAL APPEAL.

(c) EXTERNAL INDEPENDENT REVIEW.

(d) EXPEDITED MEDICAL REVIEW.

(e) EXPEDITED APPEAL.

(f) EXPEDITED EXTERNAL INDEPENDENT REVIEW.

4. THE TOTAL NUMBER OF ADVERSE DETERMINATIONS THAT WERE PARTIALLY REVERSED ON APPEAL AND THE TOTAL NUMBER OF ADVERSE DETERMINATIONS THAT WERE COMPLETELY REVERSED ON APPEAL.

5. THE TOP TEN INPATIENT AND TOP TEN OUTPATIENT SERVICES PRIOR AUTHORIZATION REQUESTS THAT WERE DENIED IN EACH OF THE FOLLOWING CATEGORIES:

(a) MEDICAL AND SURGICAL PROCEDURES.

(b) DIAGNOSTIC TESTS AND DIAGNOSTIC IMAGES.

(c) BEHAVIORAL HEALTH.

(d) ORTHOPEDIC SERVICES.

6. THE TOP FIVE REASONS WHY PRIOR AUTHORIZATION REQUESTS WERE DENIED.

7. THE AVERAGE AND MEDIAN TIME THAT ELAPSED BETWEEN THE SUBMISSION OF A REQUEST AND A DETERMINATION BY THE ISSUER FOR STANDARD PRIOR AUTHORIZATIONS.

8. THE AVERAGE AND MEDIAN TIME THAT ELAPSED BETWEEN THE SUBMISSION OF A REQUEST AND A DETERMINATION BY THE ISSUER FOR EXPEDITED PRIOR AUTHORIZATIONS.

B. ON OR BEFORE OCTOBER 31, 2027 AND EACH OCTOBER 1 THEREAFTER, THE DEPARTMENT SHALL:

1. [~~AGGREGATE~~] [COMPILE] THE DATA THAT IS COLLECTED UNDER SUBSECTION A OF THIS SECTION INTO A STANDARD REPORT. THE REPORT MUST SEPARATE EACH HEALTH CARE SERVICES PLAN THAT SUBMITTED DATA BY NAME AND MUST BE WRITTEN IN EASILY UNDERSTANDABLE LANGUAGE.

2. POST THE REPORT ON THE DEPARTMENTS' PUBLICLY ACCESSIBLE WEBSITE.

3. MAINTAIN AT LEAST THREE YEARS OF REPORTS ON THE DEPARTMENT'S PUBLICLY ACCESSIBLE WEBSITE.

4. SEND A COPY OF THE REPORT TO THE SPEAKER OF THE HOUSE OF REPRESENTATIVES AND THE PRESIDENT OF THE SENATE.

C. THE DIRECTOR MAY ADOPT RULES TO IMPLEMENT THIS SECTION.

Sec. 4. Stakeholders meeting; report

A. On or before July 1, 2032, the department of insurance and financial institutions shall convene a stakeholders meeting that includes health care insurers, health care services plans, health care institutions that are regulated by the department of health services, health care providers who are licensed under title 32, Arizona Revised Statutes, businesses and consumers to determine the quality, relevance and usefulness of the data that was reported pursuant to sections 20-2512 and 20-3408, Arizona Revised Statutes, as added by this act.

B. On or before October 31, 2032, the department of insurance and financial institutions shall submit a report to the governor, the president of the senate and the speaker of the house of representatives with recommendations to amend or repeal[,] or to make no changes to, sections 20-2512 and 20-3408, Arizona Revised Statutes, as added by this act.

Sec. 5. Retroactivity

Section 20-3102, Arizona Revised Statutes, as amended by this act, applies retroactively to from and after June 30, 2026.

Enroll and engross to conform
Amend title to conform
And, as so amended, it do pass

SELINA BLISS
CHAIRMAN

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