

REFERENCE TITLE: claims denial; prior authorization; reporting

State of Arizona  
Senate  
Fifty-seventh Legislature  
Second Regular Session  
2026

## **SB 1628**

Introduced by  
Senators Angius: Werner

### AN ACT

AMENDING TITLE 20, CHAPTER 15, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-2512; AMENDING SECTION 20-3102, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 26, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-3408; RELATING TO INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

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

4 20-2512. Health care insurers; claims denial practices;  
5 reporting requirements

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

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

12 2. THE TOTAL NUMBER OF CLAIMS REQUESTS THAT WERE DENIED.

13 3. THE TOTAL NUMBER OF APPEALS THAT WERE RECEIVED.

14 4. THE TOTAL NUMBER OF ADVERSE DETERMINATIONS THAT WERE REVERSED ON  
15 APPEAL.

16 5. THE TOP TEN SERVICES THAT WERE DENIED IN EACH OF THE FOLLOWING  
17 CATEGORIES:

18 (a) MEDICAL AND SURGICAL PROCEDURES.

19 (b) DIAGNOSTIC TESTS AND DIAGNOSTIC IMAGES.

20 (c) BEHAVIORAL HEALTH SERVICES.

21 (d) ORTHOPEDIC SERVICES.

22 (e) OUTPATIENT SERVICES.

23 6. THE TOP FIVE REASONS WHY CLAIMS REQUESTS WERE DENIED.

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

26 1. AGGREGATE THE DATA THAT IS COLLECTED UNDER SUBSECTION A OF THIS  
27 SECTION INTO A STANDARD REPORT. THE REPORT MUST SEPARATE EACH HEALTH CARE  
28 INSURER THAT SUBMITTED DATA BY NAME AND MUST BE WRITTEN IN EASILY  
29 UNDERSTANDABLE LANGUAGE.

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

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

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

35 Sec. 2. Section 20-3102, Arizona Revised Statutes, is amended to  
36 read:

37 20-3102. Timely payment of health care providers' claims;  
38 grievances

39 A. A health care insurer shall adjudicate any clean claim from a  
40 contracted or noncontracted health care provider relating to health care  
41 insurance coverage within thirty days after the health care insurer  
42 receives the clean claim or within the time period specified by contract.  
43 Unless there is an express written contract between the health care  
44 insurer and the health care provider that specifies the period in which  
45 approved claims shall be paid, the health care insurer shall pay the

1 approved portion of any clean claim within thirty days after the claim is  
2 adjudicated. If the claim is not paid within the thirty-day period or  
3 within the time period specified in the contract, the health care insurer  
4 shall pay interest on the claim at a rate that is equal to the legal rate.  
5 Interest shall be calculated beginning on the date that the payment to the  
6 health care provider is due.

7 B. If the claim is not a clean claim and the health care insurer  
8 requires additional information to adjudicate the claim, the health care  
9 insurer shall send a written request for additional information to the  
10 contracted or noncontracted health care provider, enrollee or third party  
11 within thirty days after the health care insurer receives the claim. The  
12 health care insurer shall notify the contracted or noncontracted health  
13 care provider of all of the specific reasons for the delay in adjudicating  
14 the claim. The health care insurer shall record the date it receives the  
15 additional information and shall adjudicate the claim within thirty days  
16 after receiving all the additional information. The health care insurer  
17 shall also pay the approved portion of the adjudicated claim within the  
18 same thirty-day period allowed for adjudication or within the time period  
19 specified in the provider's contract. If the health care insurer fails to  
20 pay the claim as prescribed in this subsection, the health care insurer  
21 shall pay interest on the claim in the manner prescribed in subsection A  
22 of this section.

23 C. A health care insurer shall not delay the payment of clean  
24 claims to a contracted or noncontracted provider or pay less than the  
25 amount agreed to by contract to a contracted health care provider without  
26 reasonable justification.

27 D. A health care insurer shall not request information from a  
28 contracted or noncontracted health care provider that does not apply to  
29 the medical condition at issue for the purposes of adjudicating a clean  
30 claim.

31 E. A health care insurer shall not request a contracted or  
32 noncontracted health care provider to resubmit claim information that the  
33 contracted or noncontracted health care provider can document it has  
34 already provided to the health care insurer unless the health care insurer  
35 provides a reasonable justification for the request and the purpose of the  
36 request is not to delay the payment of the claim.

37 F. A health care insurer shall establish an internal system for  
38 resolving payment disputes and other contractual grievances with health  
39 care providers. The director may review the health care insurer's  
40 internal system for resolving payment disputes and other contractual  
41 grievances with health care providers. Each health care insurer shall  
42 maintain records of health care provider grievances. Semiannually each  
43 health care insurer shall provide the director with a summary of all  
44 records of health care provider grievances received during the prior six  
45 months. The records shall include at least the following information:

- 1           1. The name and any identification number of the health care
- 2 provider who filed a grievance.
- 3           2. The type of grievance.
- 4           3. The date the insurer received the grievance.
- 5           4. The date the grievance was resolved.
- 6           G. On review of the records, if the director finds a significant
- 7 number of grievances that have not been resolved, the director may examine
- 8 the health care insurer.
- 9           H. This section does not require or authorize the director to
- 10 adjudicate the individual contracts or claims between health care insurers
- 11 and health care providers.
- 12           I. On or before ~~August~~ **OCTOBER** 1 of each year, the director shall
- 13 post a report on the department's publicly accessible website that
- 14 includes the information prescribed in subsection F of this section for
- 15 the prior fiscal year and that includes:
- 16           1. The total number of grievances received.
- 17           2. The average time to resolve a grievance.
- 18           3. The percentage of grievances where a health care insurer's
- 19 decision was overturned.
- 20           J. Except in cases of fraud, a health care insurer or contracted or
- 21 noncontracted health care provider shall not adjust or request adjustment
- 22 of the payment or denial of a claim more than one year after the health
- 23 care insurer has paid or denied that claim. If the health care insurer
- 24 and health care provider agree through contract on a length of time to
- 25 adjust or request adjustment of the payment of a claim, the health care
- 26 insurer and health care provider must have the same length of time to
- 27 adjust or request adjustment of the payment of the claim. If a claim is
- 28 adjusted, neither the health care insurer nor the health care provider
- 29 shall owe interest on the overpayment or underpayment resulting from the
- 30 adjustment, as long as the adjusted payment is made or recoupment taken
- 31 within thirty days of the date of the claim adjustment.
- 32           K. This article does not apply to licensed health care providers
- 33 who are salaried employees of a health care insurer.
- 34           L. If a contracted or noncontracted health care provider files a
- 35 claim or grievance with a health care insurer that has changed the
- 36 location where providers were instructed to file claims or grievances, the
- 37 health care insurer shall, for ninety days following the change:
- 38           1. Consider a claim or grievance delivered to the original location
- 39 properly received.
- 40           2. Following receipt of a claim or grievance at the original
- 41 location, promptly notify the health care provider of the change of
- 42 address through mailed written notice or some other written communication.
- 43           M. This section does not preclude a health care provider, with
- 44 written informed consent of the patient, from collecting monies for a
- 45 medical service that is either:

1 1. Not covered under the insurance policy.

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

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

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

10 20-3408. Health care services plans: prior authorization  
11 practices; reporting requirements

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

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

20 2. THE TOTAL NUMBER OF PRIOR AUTHORIZATION REQUESTS THAT WERE  
21 DENIED.

22 3. THE TOTAL NUMBER OF APPEALS THAT WERE RECEIVED.

23 4. THE TOTAL NUMBER OF ADVERSE DETERMINATIONS THAT WERE REVERSED ON  
24 APPEAL.

25 5. THE TOP TEN SERVICES THAT WERE DENIED IN EACH OF THE FOLLOWING  
26 CATEGORIES:

27 (a) MEDICAL AND SURGICAL PROCEDURES.

28 (b) DIAGNOSTIC TESTS AND DIAGNOSTIC IMAGES.

29 (c) BEHAVIORAL HEALTH.

30 (d) ORTHOPEDIC SERVICES.

31 (e) OUTPATIENT SERVICES.

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

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

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

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

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

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

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

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

6           Sec. 4. Stakeholders meeting; report

7           A. On or before July 1, 2032, the department of insurance and  
8 financial institutions shall convene a stakeholders meeting that includes  
9 health care insurers, health care services plans, health care institutions  
10 that are regulated by the department of health services, health care  
11 providers who are licensed under title 32, Arizona Revised Statutes,  
12 businesses and consumers to determine the quality, relevance and  
13 usefulness of the data that was reported pursuant to sections 20-2512 and  
14 20-3408, Arizona Revised Statutes, as added by this act.

15           B. On or before October 31, 2032, the department of insurance and  
16 financial institutions shall submit a report to the governor, the  
17 president of the senate and the speaker of the house of representatives  
18 with recommendations to amend or repeal or to make no changes to, sections  
19 20-2512 and 20-3408, Arizona Revised Statutes, as added by this act.

20           Sec. 5. Retroactivity

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