Senate Engrossed

AHCCCS; claims

State of Arizona
Senate
Fifty-sixth Legislature
Second Regular Session
2024

SENATE BILL 1250

AN ACT

AMENDING SECTION 36-2923, ARIZONA REVISED STATUTES; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM ADMINISTRATION.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Section 36-2923, Arizona Revised Statutes, is amended to read:

36-2923. Insurer claims data reporting requirements; administration as payor of last resort; report; definition

A. A health care insurer shall:

1. Provide all enrollment information necessary to determine the time period in which a person who is defined as an eligible person pursuant to section 36-2901, paragraph 6, subdivision (a) or that person's spouse or dependents may be or may have been covered by the health care insurer and the nature of that coverage. The information shall be provided to the administration in the manner prescribed by the secretary of the United States department of health and human services or in a manner agreed to between the health care insurer and the administration.

2. Accept ~~the~~ THIS state's right of recovery from a third party payor pursuant to section 36-2903 and the assignment to this state of any right of an individual or other entity to payment from the third party payor for an item or service for which payment has been made pursuant to this chapter. This paragraph does not expand the scope of coverage, benefits or rights under the policy issued by the health care insurer.

3. Respond WITHIN SIXTY DAYS to any inquiry made by the director regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of the provision of the health care item or service. This paragraph applies to a claim in which the administration determines there is a reasonable belief that the individual was insured by the health care insurer on the date of service referenced by the claim.

4. NOT DENY A CLAIM FOR PAYMENT SUBMITTED BY THIS STATE PURSUANT TO THIS CHAPTER SOLELY ON THE BASIS OF LACK OF PRIOR AUTHORIZATION IF THE ADMINISTRATION AUTHORIZED THE ITEM OR SERVICE. THIS PARAGRAPH DOES NOT EXPAND THE SCOPE OF COVERAGE, BENEFITS OR RIGHTS UNDER THE POLICY ISSUED BY THE HEALTH CARE INSURER.

~~4.~~ 5. Not deny a claim submitted by this state solely on the basis of the date of the submission of the claim, the type or format of the claim form or the failure to present proper documentation at the point of sale that is the basis of the claim if the following conditions have been met:

(a) The claim is submitted by this state in the three-year period beginning on the date on which the item or service was furnished.

(b) An action by this state to enforce its rights with respect to the claim is commenced within six years after ~~the~~ THIS state submitted the claim. The health care insurer may deny the claim submitted by ~~the~~ THIS state if the health care insurer has already paid the claim in accordance

with the benefit plan under which the member was covered by the health care insurer on the date of service.

B. On or before January 1 of each year, the director shall publish a report on health care insurer compliance with the claims data reporting requirements of this section. The report shall include the following:

1. A list of each health care insurer that has not materially complied with the requirements of this section.

2. Corrective actions, if any, that health care insurers have taken to comply with the requirements of this section.

C. The director shall submit a copy of each report to the governor, the president of the senate and the speaker of the house of representatives and shall provide a copy of each report to the secretary of state ~~and the director of the Arizona state library, archives and public records~~.

D. Any information obtained by the director or the administration under this section shall be maintained as confidential as required by the health insurance portability and accountability act of 1996 (P.L. 104-191; 110 Stat. 1936) and other applicable law and shall be used solely for the purpose of determining whether a health care insurer was also providing coverage to an individual during the period that the individual was an eligible member, for the purposes of avoiding payments by the system for services covered through other insurance and for enforcing the administration's right to assignment under subsection A of this section.

E. For the purposes of this section, "health care insurer" means a self-insured health benefit plan, a group health plan as defined in section 607(1) of the employment retirement income security act of 1974, a pharmacy benefit manager or any other party that by statute, contract or agreement is responsible for paying for items or services provided to an eligible person under this chapter, including:

1. An entity transacting disability insurance as defined in section 20-253.

2. Hospital service corporations, medical service corporations, dental service corporations, optometric service corporations and hospital, medical, dental and optometric service corporations as defined in section 20-822.

3. A prepaid dental plan organization as defined in section 20-1001.

4. A health care services organization as defined in section 20-1051.

5. An entity transacting group disability insurance pursuant to section 20-1401.

6. An entity transacting blanket disability insurance pursuant to section 20-1404.