

House Engrossed

grievance process; payment methods; report

State of Arizona
House of Representatives
Fifty-sixth Legislature
Second Regular Session
2024

HOUSE BILL 2444

AN ACT

AMENDING SECTIONS 20-241, 20-3101, 20-3102 AND 20-3115, ARIZONA REVISED
STATUTES; RELATING TO HEALTH CARE PAYMENTS.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

2 Section 1. Section 20-241, Arizona Revised Statutes, is amended to
3 read:

4 20-241. Contracts to provide health care services; form of
5 payment; notice; explanation of benefits;
6 definitions

7 A. A contract between a health insurer and a health care provider
8 that is issued, amended or renewed on or after January 1, 2020 to provide
9 health care services to the health insurer's enrollees may not restrict
10 the method of payment from the health insurer to the health care provider
11 in which the only acceptable payment method is a credit card payment. **A**
12 **HEALTH INSURER SHALL ACCEPT TANGIBLE CHECKS AS A FORM OF ACCEPTABLE**
13 **PAYMENT.**

14 B. If a health insurer initiates or changes payments to a health
15 care provider using electronic funds transfer payments, including virtual
16 credit card payments, the health insurer shall do the following:

17 1. Notify the health care provider if any fee is associated with a
18 particular payment method.

19 2. Advise the health care provider of the available methods of
20 payment and provide clear instructions to the health care provider as to
21 how to select an alternative payment method.

22 3. Remit or associate with each payment the explanation of
23 benefits.

24 **C. IF A HEALTH CARE PROVIDER OPTS OUT OF A METHOD OF PAYMENT, THAT**
25 **DECISION REMAINS IN EFFECT UNTIL THE HEALTH CARE PROVIDER OPTS BACK IN TO**
26 **THE PRIOR METHOD OF PAYMENT OR A NEW CONTRACT IS EXECUTED.**

27 ~~C.~~ D. A health insurer that initiates or changes payment to a
28 health care provider using the health care electronic funds transfers and
29 ~~a~~ remittance advice transaction pursuant to 45 Code of Federal
30 Regulations sections 162.1601 and 162.1602 may not charge a fee solely to
31 transmit the payment to a health care provider unless the health care
32 provider has consented to the fee. A health care provider agent may
33 charge reasonable fees when transmitting an electronic funds transfer or
34 automatic clearing house related to transaction management, data
35 management, portal services and other value-added services above and
36 beyond the bank transmittal.

37 ~~D.~~ E. For the purposes of this section:

38 1. "Electronic funds transfer payment" means a payment by any
39 method of electronic funds transfer other than a standard health care
40 electronic funds transfers and remittance advice transaction pursuant to
41 45 Code of Federal Regulations sections 162.1601 and 162.1602.

42 2. "Health care provider" means a person who is licensed,
43 registered or certified as a health care professional under title 32 or a
44 laboratory or durable medical equipment provider that furnishes services
45 to an enrollee and that separately bills the enrollee for the services.

1 3. "Health care provider agent" means a person or entity that
2 contracts with a health care provider establishing an agency relationship
3 to process bills for services provided by the health care provider under
4 the terms and conditions of a contract between the agent and health care
5 provider, which may allow the agent to submit bills, request
6 reconsideration, and receive reimbursement.

7 4. "Health insurer" means a disability insurer, group disability
8 insurer, blanket disability insurer, health care services organization,
9 hospital service corporation, medical service corporation or hospital,
10 medical, dental and optometric service corporation and includes the health
11 insurer's designee.

12 Sec. 2. Section 20-3101, Arizona Revised Statutes, is amended to
13 read:

14 20-3101. Definitions

15 In this article, unless the context otherwise requires:

16 1. "Adjudicate" means an insurer's decision to deny or pay a claim,
17 in whole or in part, including the decision as to how much to pay.

18 2. "Clean claim" means a written or electronic claim for health
19 care services or benefits that may be processed without obtaining
20 additional information, including coordination of benefits information,
21 from the health care provider, the enrollee or a third party, except in
22 cases of fraud.

23 3. "Enrollee" means an individual who is enrolled under a health
24 care insurer's policy, contract or evidence of coverage.

25 4. "Grievance":

26 (a) Means any written complaint that is subject to resolution
27 through the insurer's system that is prescribed in section 20-3102,
28 subsection F and submitted by a health care provider and received by a
29 health care insurer.

30 (b) INCLUDES ANY DELAY IN THE TIMELINESS OF CLAIM ADJUDICATION THAT
31 RESULTS IN A DELAY OF PAYMENT OF A CLEAN CLAIM AS PRESCRIBED IN SECTION
32 20-3102.

33 (c) ~~Grievance~~ Does not include a complaint:

34 ~~(a)~~ (i) By a noncontracted provider regarding an insurer's
35 decision to deny the noncontracted provider admission to the insurer's
36 network.

37 ~~(b)~~ (ii) About an insurer's decision to terminate a health care
38 provider from the insurer's network.

39 ~~(c)~~ (iii) That is the subject of a health care appeal pursuant to
40 chapter 15, article 2 of this title.

41 5. "Health care insurer" means a disability insurer, group
42 disability insurer, blanket disability insurer, health care services
43 organization, prepaid dental plan organization, hospital service
44 corporation, medical service corporation, dental service corporation,

1 optometric service corporation, or hospital, medical, dental and
2 optometric service corporation.

3 Sec. 3. Section 20-3102, Arizona Revised Statutes, is amended to
4 read:

5 20-3102. Timely payment of health care providers' claims;
6 grievances

7 A. A health care insurer shall adjudicate any clean claim from a
8 contracted or noncontracted health care provider relating to health care
9 insurance coverage within thirty days after the health care insurer
10 receives the clean claim or within the time period specified by contract.
11 Unless there is an express written contract between the health care
12 insurer and the health care provider that specifies the period in which
13 approved claims shall be paid, the health care insurer shall pay the
14 approved portion of any clean claim within thirty days after the claim is
15 adjudicated. If the claim is not paid within the thirty-day period or
16 within the time period specified in the contract, the health care insurer
17 shall pay interest on the claim at a rate that is equal to the legal rate.
18 Interest shall be calculated beginning on the date that the payment to the
19 health care provider is due.

20 B. If the claim is not a clean claim and the health care insurer
21 requires additional information to adjudicate the claim, the health care
22 insurer shall send a written request for additional information to the
23 contracted or noncontracted health care provider, enrollee or third party
24 within thirty days after the health care insurer receives the claim. The
25 health care insurer shall notify the contracted or noncontracted health
26 care provider of all of the specific reasons for the delay in adjudicating
27 the claim. The health care insurer shall record the date it receives the
28 additional information and shall adjudicate the claim within thirty days
29 after receiving all the additional information. The health care insurer
30 shall also pay the approved portion of the adjudicated claim within the
31 same thirty-day period allowed for adjudication or within the time period
32 specified in the provider's contract. If the health care insurer fails to
33 pay the claim as prescribed in this subsection, the health care insurer
34 shall pay interest on the claim in the manner prescribed in subsection A
35 OF THIS SECTION.

36 C. A health care insurer shall not delay the payment of clean
37 claims to a contracted or noncontracted provider or pay less than the
38 amount agreed to by contract to a contracted health care provider without
39 reasonable justification.

40 D. A health care insurer shall not request information from a
41 contracted or noncontracted health care provider that does not apply to
42 the medical condition at issue for the purposes of adjudicating a clean
43 claim.

44 E. A health care insurer shall not request a contracted or
45 noncontracted health care provider to resubmit claim information that the

1 contracted or noncontracted health care provider can document it has
2 already provided to the health care insurer unless the health care insurer
3 provides a reasonable justification for the request and the purpose of the
4 request is not to delay the payment of the claim.

5 F. A health care insurer shall establish an internal system for
6 resolving payment disputes and other contractual grievances with health
7 care providers. The director may review the health care insurer's
8 internal system for resolving payment disputes and other contractual
9 grievances with health care providers. Each health care insurer shall
10 maintain records of health care provider grievances. Semiannually each
11 health care insurer shall provide the director with a summary of all
12 records of health care provider grievances received during the prior six
13 months. The records shall include at least the following information:

- 14 1. The name and any identification number of the health care
15 provider who filed a grievance.
- 16 2. The type of grievance.
- 17 3. The date the insurer received the grievance.
- 18 4. The date the grievance was resolved.

19 G. On review of the records, if the director finds a significant
20 number of grievances that have not been resolved, the director may examine
21 the health care insurer.

22 H. This section does not require or authorize the director to
23 adjudicate the individual contracts or claims between health care insurers
24 and health care providers.

25 I. ON OR BEFORE AUGUST 1 OF EACH YEAR, THE DIRECTOR SHALL POST A
26 REPORT ON THE DEPARTMENT'S PUBLICLY ACCESSIBLE WEBSITE THAT INCLUDES THE
27 INFORMATION PRESCRIBED IN SUBSECTION F OF THIS SECTION FOR THE PRIOR
28 FISCAL YEAR AND THAT INCLUDES:

- 29 1. THE TOTAL NUMBER OF GRIEVANCES RECEIVED.
- 30 2. THE AVERAGE TIME TO RESOLVE A GRIEVANCE.
- 31 3. THE PERCENTAGE OF GRIEVANCES WHERE A HEALTH CARE INSURER'S
32 DECISION WAS OVERTURNED.

33 ~~I.~~ J. Except in cases of fraud, a health care insurer or
34 contracted or noncontracted health care provider shall not adjust or
35 request adjustment of the payment or denial of a claim more than one year
36 after the health care insurer has paid or denied that claim. If the
37 health care insurer and health care provider agree through contract on a
38 length of time to adjust or request adjustment of the payment of a claim,
39 the health care insurer and health care provider must have the same length
40 of time to adjust or request adjustment of the payment of the claim. If a
41 claim is adjusted, neither the health care insurer nor the health care
42 provider shall owe interest on the overpayment or underpayment resulting
43 from the adjustment, as long as the adjusted payment is made or recoupment
44 taken within thirty days of the date of the claim adjustment.

1 ~~J~~ K. This article does not apply to licensed health care
2 providers who are salaried employees of a health care insurer.

3 ~~K~~ L. If a contracted or noncontracted health care provider files
4 a claim or grievance with a health care insurer that has changed the
5 location where providers were instructed to file claims or grievances, the
6 health care insurer shall, for ninety days following the change:

7 1. Consider a claim or grievance delivered to the original location
8 properly received.

9 2. Following receipt of a claim or grievance at the original
10 location, promptly notify the health care provider of the change of
11 address through mailed written notice or some other written communication.

12 M. THIS SECTION DOES NOT PRECLUDE A HEALTH CARE PROVIDER, WITH
13 WRITTEN INFORMED CONSENT OF THE PATIENT, FROM COLLECTING MONIES FOR A
14 MEDICAL SERVICE THAT IS EITHER:

15 1. NOT COVERED UNDER THE INSURANCE POLICY.

16 2. MEDICALLY NECESSARY AND A PAYMENT ON THE CLAIM WAS NOT MADE DUE
17 TO A DENIAL ON THE BASIS OF FREQUENCY OR A DISALLOWANCE ON THE BASIS OF
18 FREQUENCY. FOR THE PURPOSES OF THIS PARAGRAPH, A PROVIDER IS LIMITED TO
19 THE RATES PRESCRIBED BY THAT PROVIDER'S FEE SCHEDULE.

20 ~~L~~ N. Any claim that is subject to article 2 of this chapter is
21 not subject to this article.

22 Sec. 4. Section 20-3115, Arizona Revised Statutes, is amended to
23 read:

24 20-3115. Conduct of arbitration proceedings

25 A. The department shall develop a simple, fair, efficient and
26 cost-effective arbitration procedure for surprise out-of-network bill
27 disputes and specify time frames, standards and other details of the
28 arbitration proceeding, including procedures for scheduling and notifying
29 the parties of the settlement teleconference required by subsection E of
30 this section. The department shall contract with one or more entities to
31 provide arbitrators who are qualified under section 20-3116 for this
32 process. Department staff may not serve as arbitrators.

33 B. An enrollee may request arbitration of a surprise out-of-network
34 bill by submitting a request for arbitration to the department on a form
35 prescribed by the department, which shall include contact, billing and
36 payment information regarding the surprise out-of-network bill and any
37 other information the department believes is necessary to confirm that the
38 bill qualifies for arbitration. The form shall be made available on the
39 department's website.

40 C. Within fifteen days after receipt of a request for arbitration,
41 the department shall do one of the following:

42 1. Determine that the surprise out-of-network bill qualifies for
43 arbitration under this article and notify the enrollee, health insurer and
44 health care provider that the request qualifies.

1 2. Determine that the surprise out-of-network bill does not qualify
2 for arbitration under this article and notify the enrollee that the
3 surprise out-of-network bill does not qualify and state the reason for the
4 determination.

5 3. If the department cannot determine whether the surprise
6 out-of-network bill qualifies for arbitration, request in writing any
7 additional information from the enrollee, health insurer or health care
8 provider or its billing company that is needed to determine whether the
9 surprise out-of-network bill qualifies for arbitration and all of the
10 following apply:

11 (a) The enrollee, health insurer or health care provider or its
12 billing company shall respond to the department's request for additional
13 information within fifteen days after the date of the department's
14 request.

15 (b) Within seven days after receipt of the additional requested
16 information, the department shall determine whether the surprise
17 out-of-network bill qualifies for arbitration and send the notices
18 required under this subsection.

19 (c) If the health insurer or health care provider or its billing
20 company fails to respond within the time frame specified in
21 subdivision (a) of this paragraph to a department request for information,
22 the department shall deem the request for arbitration as eligible for
23 arbitration. If the enrollee fails to respond within the time frame
24 specified in subdivision (a) of this paragraph, the request for
25 arbitration is denied.

26 D. The determination by the department of whether a surprise
27 out-of-network bill qualifies for arbitration is a final and binding
28 decision with no right of appeal to the department. The department's
29 determination is solely an administrative remedy and does not bar any
30 private right or cause of action for or on behalf of any enrollee, **HEALTH**
31 **CARE** provider or other person. The court shall decide the matter,
32 including any interpretation of statute or rule, without deference to any
33 previous determination that may have been made on the question by the
34 department.

35 E. In an effort to settle the surprise out-of-network bill before
36 arbitration, the department shall arrange an informal settlement
37 teleconference within thirty days after the department sends the notices
38 required by this section. The department is not a party to and may not
39 participate in the informal settlement teleconference. As part of the
40 settlement teleconference the health insurer shall provide to the parties
41 the enrollee's cost sharing requirements under the enrollee's health plan
42 based on the adjudicated claim. The **HEALTH** insurer shall notify the
43 department whether the informal settlement teleconference resulted in
44 settlement of the disputed surprise out-of-network bill and, if settlement

1 was reached, notify the department of the terms of the settlement within
2 seven days.

3 F. If after proper notice from the department or contracted entity
4 either the health insurer or health care provider or the provider's
5 representative fails to participate in the teleconference, the other party
6 may notify the department to immediately initiate arbitration and the
7 nonparticipating party shall be required to pay the total cost of the
8 arbitration.

9 G. On receipt of notice that the dispute has not settled or that a
10 party has failed to participate in the teleconference, the department
11 shall appoint an arbitrator and shall notify the parties of the
12 arbitration and the appointed arbitrator. The department's notice shall
13 specify whether one party is responsible for the total cost of the
14 arbitration pursuant to subsection F of this section. The health insurer
15 and health care provider must agree on the arbitrator and may mutually
16 agree to use an arbitrator who is not on the department's list. If either
17 the health insurer or health care provider objects to the arbitrator, and
18 the parties are unable to agree on a mutually acceptable alternative
19 arbitrator, the department or contracted entity shall randomly assign
20 three arbitrators. The health insurer and the health care provider shall
21 each strike one arbitrator, and the last arbitrator shall conduct the
22 arbitration unless there are two arbitrators remaining, in which case the
23 department or contracted entity shall randomly assign the arbitrator.

24 H. Before the arbitration:

25 1. The enrollee shall pay or make arrangements in writing to pay
26 the health care provider the total amount of the enrollee's cost sharing
27 requirements that is due for the health care services that are the subject
28 of the surprise out-of-network bill as stated by the health insurer in the
29 settlement teleconference.

30 2. The enrollee shall pay any amount that has been received by the
31 enrollee from the enrollee's health insurer as payment for the
32 out-of-network health care services that were provided by the health care
33 provider.

34 3. If a health insurer pays for out-of-network health care services
35 directly to a health care provider, the health insurer that has not
36 remitted its payment for the out-of-network health care services shall
37 remit the amount due to the health care provider.

38 I. Arbitration of any surprise out-of-network bill shall be
39 conducted telephonically unless otherwise agreed by all of the required
40 participants.

41 J. Arbitration of the surprise out-of-network bill shall take place
42 with or without the enrollee's participation.

43 K. The arbitrator shall determine the amount the health care
44 provider is entitled to receive as payment for the health care services.
45 The arbitrator shall allow each party to provide information the

1 arbitrator reasonably determines to be relevant in evaluating the surprise
2 out-of-network bill, including the following information:

3 1. The average contracted amount that the health insurer pays for
4 the health care services at issue in the county where the health care
5 services were performed.

6 2. The average amount that the health care provider has contracted
7 to accept for the health care services at issue in the county where the
8 services were performed.

9 3. The amount that medicare and medicaid pay for the health care
10 services at issue.

11 4. The health care provider's direct pay rate for the health care
12 services at issue, if any, under section 32-3216.

13 5. Any information that would be evaluated in determining whether a
14 fee is reasonable under title 32 and not excessive for the health care
15 services at issue, including the usual and customary charges for the
16 health care services at issue performed by a health care provider in the
17 same or similar specialty and provided in the same geographic area.

18 6. Any other reliable databases or sources of information on the
19 amount paid for the health care services at issue in the county where the
20 services were performed.

21 L. Except on the agreement of the parties participating in the
22 arbitration, the arbitration shall be conducted within one hundred twenty
23 days after the department's notice of arbitration.

24 M. Except on the agreement of the parties participating in the
25 arbitration, the arbitration may not last more than four hours.

26 N. The arbitrator shall issue a final written decision within ten
27 business days following the arbitration hearing. The arbitrator shall
28 provide a copy of the decision to the enrollee, the health insurer and the
29 health care provider or its billing company or authorized representative.

30 O. All pricing information provided by health insurers and health
31 care providers in connection with the arbitration of a surprise
32 out-of-network bill is confidential and may not be disclosed by the
33 arbitrator or any other party participating in the arbitration or used by
34 anyone, other than the providing party, for any purpose other than to
35 resolve the surprise out-of-network bill.

36 P. All information received by the department or contracted entity
37 in connection with an arbitration is confidential and may not be disclosed
38 by the department or contracted entity to any person other than the
39 arbitrator.

40 Q. A claim that is the subject of an arbitration request is not
41 subject to article 1 of this chapter during the pendency of the
42 arbitration. A health insurer shall remit its portion of the payment
43 resulting from the informal settlement teleconference or the amount
44 awarded by the arbitrator within thirty days after resolution of the
45 claim.

1 R. A claim that is reprocessed by ~~an~~ A HEALTH insurer as a result
2 of a settlement, arbitration decision or other action under this article
3 is not in violation of section 20-3102, subsection ~~F~~ N.

4 S. Notwithstanding any informal settlement or the arbitrator's
5 decision under this article, the enrollee is responsible for only the
6 amount of the enrollee's cost sharing requirements and any amount received
7 by the enrollee from the enrollee's health insurer as payment for the
8 out-of-network health care services that were provided by the health care
9 provider, and the health care provider may not issue, either directly or
10 through its billing company, any additional balance bill to the enrollee
11 related to the health care service that was the subject of the informal
12 settlement teleconference or arbitration.

13 T. Unless all the parties otherwise agree or unless required by
14 subsection F of this section, the health insurer and the health care
15 provider shall share the costs of the arbitration equally, and the
16 enrollee is not responsible for any portion of the cost of the
17 arbitration. The health insurer and health care provider shall make
18 payment arrangements with the arbitrator for their respective share of the
19 costs of the arbitration.