REFERENCE TITLE: health care; costs; reimbursement

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

SB 1402

Introduced by
Senators Shamp: Carroll, Gowan, Kerr

AN ACT

AMENDING TITLE 20, CHAPTER 1, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-111; AMENDING SECTION 32-3216, ARIZONA REVISED STATUTES; RELATING TO HEALTH CARE SERVICES.

(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 1, article 1, Arizona Revised
3 Statutes, is amended by adding section 20-111, to read:
4 20-111. Health insurers; savings incentive programs;
5 disclosure; definitions
6 A. BEGINNING AT THE NEXT ENROLLMENT PERIOD AFTER THE EFFECTIVE DATE
7 OF THIS SECTION, EACH HEALTH INSURER SHALL ESTABLISH A PROGRAM IN EACH OF
8 THE HEALTH INSURER'S HEALTH CARE PLANS THAT WILL PROVIDE A SAVINGS
9 INCENTIVE FOR ENROLLEES FOR MEDICALLY NECESSARY COVERED HEALTH CARE
10 SERVICES AND ITEMS THAT HEALTH CARE PROVIDERS AND HEALTH CARE FACILITIES
11 PROVIDE AT A DIRECT PAY PRICE BELOW THE DEIDENTIFIED MINIMUM NEGOTIATED
12 CHARGE.
13 B. EACH HEALTH CARE PLAN SHALL DISCLOSE TO THE ENROLLEES OF THE
14 HEALTH CARE PLAN THE DEIDENTIFIED MINIMUM NEGOTIATED CHARGE FOR COVERED
15 HEALTH CARE SERVICES AND ITEMS UNDER THE ENROLLEE'S HEALTH CARE PLAN.
16 EACH HEALTH CARE PLAN SHALL PUBLISH THE DEIDENTIFIED MINIMUM NEGOTIATED
17 CHARGES AT LEAST ONCE EACH YEAR, SHALL MAKE DEIDENTIFIED MINIMUM
18 NEGOTIATED CHARGES AVAILABLE ELECTRONICALLY ON THE HEALTH CARE PLAN'S
19 WEBSITE AND SHALL PROVIDE AN ELECTRONIC COPY TO THE DEPARTMENT TO BE
20 POSTED ON DEPARTMENT'S PUBLIC WEBSITE.
21 C. AT THE BEGINNING OF EACH PLAN YEAR AND ONCE AN ENROLLEE MEETS
22 THE APPLICABLE DEDUCTIBLE OF THE ENROLLEE'S HEALTH CARE PLAN, THE HEALTH
23 CARE PLAN SHALL NOTIFY THE ENROLLEE OF THE SAVINGS INCENTIVE PROGRAM AND
24 PROVIDE INFORMATION REGARDING HOW THE PROGRAM WORKS.
25 D. AN ELIGIBLE ENROLLEE WHO RECEIVES COVERED HEALTH CARE SERVICES
26 OR ITEMS FROM A HEALTH CARE PROVIDER OR HEALTH CARE FACILITY AT A DIRECT
27 PAY PRICE BELOW THE DEIDENTIFIED MINIMUM NEGOTIATED CHARGE SHALL HAVE THE
28 AMOUNT THE ENROLLEE PAYS APPLIED TOWARD THE ENROLLEE'S DEDUCTIBLE AND
29 OUT-OF-POCKET MAXIMUM AND BE REIMBURSED FOR ONE-HALF OF THE AMOUNT OF THE
30 DIFFERENCE BETWEEN THE DIRECT PAY PRICE AND THE DEIDENTIFIED MINIMUM
31 NEGOTIATED CHARGE.
32 E. THE ELIGIBLE ENROLLEE MAY SPLIT A PORTION OF THE SAVINGS
33 INCENTIVE WITH ANY THIRD PARTY THAT ASSISTS THE ELIGIBLE ENROLLEE IN
34 LOCATING THE DIRECT PAY PRICE.
35 F. FOR THE PURPOSES OF THIS SECTION:
36 1. "DEIDENTIFIED MINIMUM NEGOTIATED CHARGE" MEANS THE LOWEST CHARGE
37 THAT A HEALTH CARE PROVIDER OR HEALTH CARE FACILITY HAS NEGOTIATED UNDER
38 THE ENROLLEE'S PARTICULAR HEALTH CARE PLAN.
39 2. "DIRECT PAY PRICE" HAS THE SAME MEANING PRESCRIBED IN SECTION
40 32-3216 AND APPLIES TO BOTH HEALTH CARE PROVIDERS AND HEALTH CARE
41 FACILITIES.
42 3. "HEALTH CARE FACILITY" MEANS A HOSPITAL, OUTPATIENT SURGICAL
43 CENTER, HEALTH CARE LABORATORY, DIAGNOSTIC IMAGING CENTER OR URGENT CARE
44 CENTER.

4. "HEALTH CARE PLAN" HAS THE SAME MEANING PRESCRIBED IN SECTION 32-3216.

5. "HEALTH CARE PROVIDER" HAS THE SAME MEANING PRESCRIBED IN SECTION 32-3216.

6. "HEALTH INSURER" HAS THE SAME MEANING PRESCRIBED IN SECTION 32-3216.

Sec. 2. Section 32-3216, Arizona Revised Statutes, is amended to read:

32-3216. Health care providers; charges; public availability; direct payment; notice; definitions

A. A health care provider must make available on request ~~or~~ AND online IN A MACHINE-READABLE FORMAT the direct pay price for ~~at least the twenty-five most commonly provided~~ ALL services~~, if applicable, for~~ PROVIDED BY the health care provider. The services may be identified by a common procedural terminology code or by a plain-English description. The direct pay prices must be updated at least annually and must be based on the services from a twelve-month period that occurred within the eighteen-month period preceding the annual update. The direct pay price must be for the standard treatment provided for the service and may include the cost of treatment for complications or exceptional treatment. Health care providers who are owners or employees of a legal entity with fewer than three licensed health care providers are exempt from the requirements of this subsection.

B. Subsection A of this section does not apply to emergency services.

C. The health care services provided by health care providers in veterans administration facilities, health facilities on military bases, Indian health services hospitals and other Indian health service facilities, tribal owned clinics, the Arizona state hospital and any health care facility determined to be exempt pursuant to section 36-437, subsection D~~,~~ are exempt from the requirements of this section.

D. Subsection A of this section does not prevent a health care provider from offering either additional discounts or additional lawful health care services for an additional cost to a person or an employer paying directly.

E. A health care provider is not required to report the direct pay prices to a government agency or department or to a government-authorized or government-created entity for review or filing. A government agency or department or government-authorized or government-created entity may not approve, disapprove or limit a health care provider's direct pay price for services. A government agency or department or government-authorized or government-created entity may not approve, disapprove or limit a health care provider's ability to change the published or posted direct pay price for services.

F. A health care system may not punish a person or employer for paying directly for lawful health care services or a health care provider for accepting direct payment from a person or employer for lawful health care services.

G. Except as provided in subsection ~~N~~ P of this section, a health care provider who receives direct payment from a person or employer for a lawful health care service is deemed paid in full if the entire fee for the service is paid and shall not submit a claim for payment or reimbursement for the service to any health care system. THIS SUBSECTION DOES NOT PREVENT A HEALTH CARE PROVIDER FROM SUBMITTING CLAIMS TO A HEALTH INSURER ON BEHALF OF A PATIENT WHO IS SEEKING CREDIT TOWARD THE PATIENT'S DEDUCTIBLES OR TOWARD THE HEALTH CARE PLAN'S SAVINGS INCENTIVE ESTABLISHED PURSUANT TO SECTION 20-111. This subsection does not prevent a health care provider from pursuing a health care lien for customary charges pursuant to title 33. This subsection does not affect the ability of a health care provider to submit claims for the same service provided on other occasions to the same or a different person if no direct payment occurs. This subsection does not require a health care provider to refund or adjust any capitated payment, bundled payment or other form of prepayment or global payment made by a health care system to the health care provider for lawful health care services to be provided by the health care provider for the person who makes, or on whose behalf an employer makes, direct payment to the health care provider.

H. A PERSON OR EMPLOYER SHALL BE INFORMED OF THE ABILITY TO ACCESS A DIRECT PAY PRICE DURING AN INTAKE PROCESS TO SCHEDULE AN APPOINTMENT OR WHEN CHECKING IN FOR THE SERVICE.

~~H.~~ I. Before a health care provider who is contracted as a network provider for a health care system accepts direct payment from a person or an employer, and the person is an enrollee of the same health care system, the health care provider shall obtain the person's or employer's signature on a notice in a form that is substantially similar to the following:

Important notice about direct payment
for your health care services

The Arizona Constitution ~~permits~~ ALLOWS you to pay a health care provider directly for health care services. Before you make any agreement to do so, please read the following important information:

If you are an enrollee of a health care system (more commonly referred to as a "health insurance plan") and your health care provider is contracted with the health insurance plan, the following apply:

1. You may not be required to pay the health care provider directly for the services covered by your HEALTH INSURANCE plan, except for cost share amounts that you are

obligated to pay under your HEALTH INSURANCE plan, such as copayments, coinsurance and deductible amounts.

2. Your HEALTH CARE provider's agreement with the health insurance plan may prevent the health care provider from billing you for the difference between the HEALTH CARE provider's billed charges and the amount allowed by your health insurance plan for covered services.

3. If you pay directly for a health care service, your health care provider will not be responsible for submitting claim documentation to your health insurance plan for that claim. Before paying your claim, your health insurance plan may require you to provide information and submit documentation necessary to determine whether the services are covered under your HEALTH INSURANCE plan.

4. If you do not pay directly for a health care service, your health care provider may be responsible for submitting claim documentation to your health insurance plan for the health care service.

Your signature below acknowledges that you received this notice before paying directly for a health care service.

~~I.~~ J. A health care provider who receives direct payment for a lawful health care service and who complies with subsection ~~H~~ I of this section is not responsible for submitting documentation of any kind for purposes of reimbursement to any health care system for that claim if the failure to submit such documentation does not conflict with the terms of any federal or state contracts to which the health care system is a party and the health care provider has agreed to serve patients under or with applicable state or federal programs in which a health care provider and health care system participate.

~~J.~~ K. A health care provider who receives direct payment pursuant to this section shall provide the person making the direct payment with a receipt that includes the following information:

1. The amount of the direct payment.

2. The applicable procedure and diagnosis codes for the services rendered.

3. A clear notation that the services were subject to direct payment under this section.

4. THE HEALTH CARE PROVIDER'S NAME AND ADDRESS.

5. THE PATIENT'S NAME.

6. THE DATE OF THE SERVICES.

~~K.~~ L. If an enrollee pays to a health care provider who is an out-of-network provider the direct pay price for a lawful health care service that is covered under the enrollee's health care plan, pursuant to the requirements of this section, the amount paid by the enrollee shall be applied first to the enrollee's in-network deductible with any remaining

monies being applied to the enrollee's out-of-network deductible, if applicable. The amount applied to the in-network deductible shall be the amount paid directly or the HEALTH insurer's prevailing contracted commercial rate for the enrollee's health care plan in this state for the service or services. If the service or services do not match standard codes or bundled payment programs in use in this state by the HEALTH insurer, the amount applied to the in-network deductible shall be the amount paid directly. For the purposes of this subsection, "prevailing contracted commercial rate" means the most usual and customary rate that ~~an~~ A HEALTH insurer offers as payment for a specific service under a specific health care plan, not including a plan offered under medicare or medicaid or on a health insurance exchange.

~~L.~~ M. If an enrollee is enrolled in a high deductible plan that qualifies the enrollee for a health savings account as defined in 26 United States Code section 223, the health care system is not liable if the enrollee submits a claim for deductible application of a direct pay amount pursuant to subsection ~~K~~ L of this section that jeopardizes the enrollee's status as an individual eligible for favorable tax treatment of the health savings account.

N. AN ENROLLEE MAY APPEAL A DECISION TO DENY PAYMENT UNDER THE HEALTH CARE PLAN PURSUANT TO TITLE 20, CHAPTER 15, ARTICLE 2. IF IT IS DETERMINED THAT THE LAWFUL HEALTH CARE SERVICE SHOULD HAVE BEEN COVERED, THE HEALTH INSURER SHALL APPLY THE DIRECT PAY PRICE TO THE ENROLLEE'S DEDUCTIBLE AND OUT-OF-POCKET MAXIMUM, REIMBURSE THE ENROLLEE THE HEALTH INSURER'S SHARE OF THE DIRECT PAY PRICE OF THE LAWFUL HEALTH CARE SERVICE AND PAY THE ENROLLEE FOR ALL COSTS AND REASONABLE ATTORNEY FEES.

~~M.~~ O. This section does not create any private right or cause of action for or on behalf of any person against the health insurer. This section provides solely an administrative remedy for any violation of this section or any related rule.

~~N.~~ P. This section does not impair the provisions of a health care system's private health care network provider contract, except that a health care provider may accept direct payment from a person or employer or may decline to bill the health care system directly for services paid directly by a person or employer if the health care provider has complied with subsection ~~H~~ I of this section and the health care provider's receipt of direct payment and the declination to bill the health care system do not conflict with the terms of any federal or state contract to which the health care system is a party and the health care provider has agreed to serve patients under or with applicable state or federal programs in which both a health care provider and health care system participate.

~~O.~~ Q. A health care provider who does not comply with the requirements of this section commits unprofessional conduct. Any

disciplinary action taken by the health professional's licensing board may not include revocation of the health care provider's license.

R. A HEALTH CARE SYSTEM MAY NOT DISCRIMINATE IN THE FORM OF PAYMENT FOR ANY NETWORK HEALTH CARE PROVIDER SOLELY ON THE BASIS THAT THE ENROLLEE'S REFERRAL WAS MADE BY A HEALTH CARE PROVIDER WHO IS NOT A MEMBER OF THE HEALTH CARE SYSTEM'S NETWORK.

~~P.~~ S. For the purposes of this section:

1. "Direct pay price" means the price that will be charged by a health care provider for a lawful health care service, regardless of the health insurance status of the person, if the entire fee for the service is paid in full directly to a health care provider by the person, including the person's health savings account, or by the person's employer and that does not prohibit a HEALTH CARE provider from establishing a payment plan with the person paying directly for services.

2. "Emergency services" means lawful health care services needed to evaluate and stabilize an emergency medical condition as defined in 42 United States Code section 1396u-2(b)(2)(C).

3. "Enrollee" means a person who is enrolled in a health care plan provided by a health insurer.

4. "Health care plan":

(a) Means a policy, contract or evidence of coverage issued to an enrollee. ~~Health care plan~~

(b) Does not include limited benefit coverage as defined in section 20-1137.

5. "Health care provider" means a person who is licensed pursuant to chapter 7, 8, 13, 16, 17, 19 or 34 of this title.

6. "Health care system" means a public or private entity whose function or purpose is the management, processing or enrollment of individuals or the payment, in full or in part, of health care services.

7. "Health insurer":

(a) Means a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, medical service corporation or hospital and medical service corporation as defined in title 20.

(b) Does not include a governmental plan as defined in the employee retirement income security act of 1974 (P.L. 93-406; 88 Stat. 829; 29 United States Code section 1002).

8. "Lawful health care services" means any health-related service or treatment, to the extent that the service or treatment is ~~permitted~~ ALLOWED or not prohibited by law or regulation, that may be provided by persons or businesses THAT ARE otherwise ~~permitted~~ ALLOWED to offer the services or treatments.

9. "Punish" means to impose any penalty, surcharge or named fee with a similar effect that is used to discourage the exercise of rights under this section.