ARIZONA STATE SENATE

Fifty-Fifth Legislature, First Regular Session

AMENDED

FACT SHEET FOR S.B. 1075

health care insurance; amendments.

Purpose

Makes various changes relating to hospital service corporations, accountable health care plans and utilization review.

Background

Service Corporations

Hospital service corporations, medical service corporations, dental service corporations, optometric service corporations and hospital, medical, dental and optometric service corporations (service corporations) are exempt from Arizona insurance laws, unless expressly provided otherwise in law or in rule (A.R.S. § 20-821). A service corporation must obtain approval from their board of directors to pay over $5,000 to any officer, agent or employee in a single year (A.R.S. § 20-832).

Statute prohibits a *person* who engages in the business of insurance from restricting or prohibiting, by means of a policy or contract, a licensed health care professional's good faith communication with a patient concerning the patient's health care or medical needs, treatment options, health care risks or benefits. Additionally, a *person* may not terminate a contract with, or refuse to renew a contract with, a health care professional solely because the health care professional in good faith: 1) advocates in private or in public on behalf of a patient; 2) assists a patient in seeking reconsideration of a decision made by the *person* to deny coverage for a health care service; or 3) reports a violation of law to an appropriate authority (A.R.S. § 20-118). For this purpose, a *person* includes an: 1) individual; 2) company; 3) insurer; 4) association; 5) organization; 6) society; 7) reciprocal or inter-insurance exchange; 8) partnership; 9) syndicate; 10) business trust; 11) corporation; and 12) entity (A.R.S. § 20-105).

Assignment of Benefits

If an insured is assigned to a covered health care provider performing services covered by the contract payment for benefits under a disability insurance contract, a group disability insurance contract or a blanket disability contract, the contract does not prohibit assignment of benefits and the assignment is delivered to the insurer. A payment may be made only to the health care provider to whom the payment has been assigned (A.R.S. § 20-464).

Utilization Review

Statute exempts a *person* from utilization review certification requirements, standards and violations, if the person: 1) is accredited by the Utilization Review Accreditation Commission, the National Committee for Quality Assurance or any other nationally recognized accreditation process

recognized by the Director of the Department of Insurance and Financial Institutions (DIFI); 2) conducts internal utilization review for certain entities, if the review does not result in the approval or denial of payment for hospital or medical services; 3) conducts utilization review activities exclusively for work related injuries and illnesses covered under workers' compensation laws; and 4) conducts utilization review activities exclusively for a self-funded or self-insured employee benefit plan, if the regulation of that plan is preempted by federal law (A.R.S. § 20-2502).

There is no anticipated fiscal impact to the state General Fund associated with this legislation.

Provisions

Service Corporations

1. Applies the statutory permissions relating to the assignment of benefits under a disability insurance contract, a group disability insurance contract or a blanket disability insurance contract to a hospital and medical service corporation.

2. Narrows the statutory prohibition on interfering with communications between a health care professional and a patient to apply to only a service corporation and a health care service organization (HCSO), rather than to any person subject to Title 20.

3. Applies insurance holding company system requirements, standards and disclosures to service corporations.

4. Removes the prohibition on a service corporation from:
   a) paying any agent or employee of the service corporation any salary, compensation or emolument in an annual amount of $5,000 or more without authorization from the service corporation's board of directors; and
   b) making any agreement with an agent or employee, for any services rendered or to be rendered, regarding a salary, compensation or emolument for more than a three-year period.

5. Requires an HCSO to submit quarterly, rather than monthly, to the Director of DIFI a list of all provider contracts that have been terminated during the prior three months.

6. Removes the statutory authorization relating to who may be a party to a service corporation contract.

Accountable Health Care Plans

7. Excludes a small employer who obtains a health benefits plan that is subject to and in compliance with federal law from accountable health care plan premium rate practices.

8. Removes, from the definition of *creditable coverage*, a policy or contract made available to persons defined as eligible under the Arizona Health Care Cost Containment System.

9. Repeals threshold requirements for electronic claims submissions and payments and electronic eligibility verifications for an accountable health care plan.

Utilization Review

10. Narrows, for a person who meets outlined conditions, the exemption from utilization review statutes to only utilization review certification requirements, rather than utilization review certification requirements, standards and violations.

11. Allows a provider or enrollee to appeal a denial of non-formulary exception for a federally covered plan through the external exception request review process.

12. Specifies that the statutorily outlined health care appeals process does not apply to a denial of a non-formulary exception request appealed using the external exception request review process prescribed by federal rule.

Miscellaneous

13. Includes, in the definition of *COBRA continuation provision*, small group health plan continuation coverage.

14. Removes the definition of *basic health benefit plan.*

15. Removes statutory declarations applicable to insurance contracts that were lawfully in force prior to January 1, 1955.

16. Makes technical and conforming changes.

17. Becomes effective on the general effective date.

Amendments Adopted by the Finance Committee

- Allows outlined individuals to appeal a denial of non-formulary exception, rather than a formulary exception, for a federally covered plan.

Senate Action

FIN	1/27/21	DPA	9-0-1

Prepared by Senate Research
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MG/ML/gs