ARIZONA STATE SENATE

Fifty-Sixth Legislature, Second Regular Session

FACT SHEET FOR S.B. 1402

health care; costs; reimbursement

Purpose

Directs health insurers (insurers) to establish health care plan saving incentive programs (programs). Outlines program disclosure and requirements. Expands public availability of direct pay prices for health care provider (provider) services.

Background

Statute requires a provider to make available, on request or online, the direct pay price for at least the 25 most commonly provided services, if applicable, for the 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 12-month period that occurred within the 18-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. Statute outlines certain exemptions from this requirement, including emergency services and providers who are owners or employees of a legal entity with fewer than three licensed providers. Similar direct pay requirements are in place for health care facilities with similar exceptions, depending on how many inpatient beds the facility holds (A.R.S. § 36-437).

Direct pay price is the price that will be charged by a 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 the provider by the person or by the person's employer and that does not prohibit a provider from establishing a payment plan with the person paying directly for services.

A provider who receives direct payment from a person must provide the person making the direct payment with a receipt that includes: 1) the amount of the direct payment; 2) the applicable procedure and diagnosis codes for the services rendered; and 3) a clear notation that the services were subject to direct payment (A.R.S. § 32-3216).

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

Provisions

1. Requires each insurer, beginning the next enrollment period after the general effective date, to establish a program in each of the insurer's health care plans that will provide enrollees a savings incentive for medically necessary covered health care services and items that providers and health care facilities provide at a direct pay price below the deidentified minimum negotiated charge.

2. Defines *deidentified minimum negotiated charge* as the lowest charge that a provider or health care facility has negotiated under an enrollee's particular health care plan.

3. Requires each health care plan to:
   a) disclose, to health care plan enrollees, the deidentified minimum negotiated charge for covered health care services and items under the enrollee's health care plan;
   b) publish the deidentified minimum negotiated charges at least once each year; and
   c) make deidentified minimum negotiated charges available electronically on the health care plan's website and provide an electronic copy to the Department of Insurance and Financial Institutions (DIFI) to be posted on the DIFI website.

4. Requires a health care plan, at the beginning of each plan year and once an enrollee meets the applicable deductible, to notify the enrollee of the program and provide information regarding how the program works.

5. Requires an eligible enrollee who receives covered health care services or items from provider or health care facility at a direct pay price below the deidentified minimum negotiated charge to:
   a) have the amount the enrollee pays applied toward the enrollee's deductible and out-of-pocket maximum; and
   b) be reimbursed for one-half of the amount of the difference between the direct pay price and the deidentified minimum negotiated charge.

6. Allows an eligible enrollee to split a portion of the savings incentive with any third party that assists the enrollee in locating the direct pay price.

7. Requires a provider to make available the direct pay price for all services, rather than at least 25 of the most common services, on request and online in a machine-readable format.

8. Authorizes a provider who receives direct payment to submit a claim to a health insurer on behalf of a patient who is seeking credit toward the patient's deductibles or health care plan's savings incentive.

9. Requires a person or employer to be informed of the ability to access a direct pay price during an intake process to schedule an appointment or when checking in for service.

10. Requires a provider who receives a direct payment from a person to provide the person making the payment a receipt that includes the provider's name and address, the patient's name and the date of the services.

11. Allows an enrollee to appeal a decision to deny payment under a health care plan following the statutory health care appeals process.

12. Requires a health insurer, after determination that lawful health care service provided to an enrollee should have been covered, to:
   a) apply the direct pay price to the enrollee's deductible and out-of-pocket maximum;
   b) reimburse the enrollee for the health insurer's share of the direct pay price of the lawful health care service; and
   c) pay the enrollee for all costs and reasonable attorney fees.

13. Prohibits a health care system from discriminating in the form of payment for any network provider solely on the basis that an enrollee's referral was made by a provider who is not a member of the health care system's network.

14. Defines terms.

15. Makes technical and conforming changes.

16. Becomes effective on the general effective date.

Prepared by Senate Research
February 8, 2024
MG/AB/sdr