

Senate Engrossed

AHCCCS; claims

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

CHAPTER 54
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)

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

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

4 36-2923. Insurer claims data reporting requirements;
5 administration as payor of last resort; report;
6 definition

7 A. A health care insurer shall:

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

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

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

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

34 ~~4.~~ 5. Not deny a claim submitted by this state solely on the basis
35 of the date of the submission of the claim, the type or format of the
36 claim form or the failure to present proper documentation at the point of
37 sale that is the basis of the claim if the following conditions have been
38 met:

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

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

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

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

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

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

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

15 D. Any information obtained by the director or the administration
16 under this section shall be maintained as confidential as required by the
17 health insurance portability and accountability act of 1996 (P.L. 104-191;
18 110 Stat. 1936) and other applicable law and shall be used solely for the
19 purpose of determining whether a health care insurer was also providing
20 coverage to an individual during the period that the individual was an
21 eligible member, for the purposes of avoiding payments by the system for
22 services covered through other insurance and for enforcing the
23 administration's right to assignment under subsection A of this section.

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

30 1. An entity transacting disability insurance as defined in section
31 20-253.

32 2. Hospital service corporations, medical service corporations,
33 dental service corporations, optometric service corporations and hospital,
34 medical, dental and optometric service corporations as defined in section
35 20-822.

36 3. A prepaid dental plan organization as defined in section
37 20-1001.

38 4. A health care services organization as defined in section
39 20-1051.

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

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

S.B. 1250

APPROVED BY THE GOVERNOR MARCH 29, 2024.

FILED IN THE OFFICE OF THE SECRETARY OF STATE MARCH 29, 2024.