BLISS FLOOR AMENDMENT
HOUSE OF REPRESENTATIVES AMENDMENTS TO S.B. 1291
(Reference to Senate engrossed bill)

Amendment instruction key:
[GREEN UNDERLINING IN BRACKETS] indicates text added to statute or previously enacted session law.
[Green underlining in brackets] indicates text added to new session law or text restoring existing law.
[~~GREEN STRIKEOUT IN BRACKETS~~] indicates new text removed from statute or previously enacted session law.
[~~Green strikeout in brackets~~] indicates text removed from existing statute, previously enacted session law or new session law.
<<Green carets>> indicate a section added to the bill.
<<~~Green strikeout in carets~~>> indicates a section removed from the bill.

The bill as proposed to be amended is reprinted as follows:

Section 1. Section 20-3451, Arizona Revised Statutes, is amended to read:

20-3451. Definitions

In this chapter, unless the context otherwise requires:

1. "Applicant" means a provider that submits a credentialing application to a health insurer to become a participating provider in the health insurer's network.

2. "Application" means an applicant's initial application to be credentialed as a participating provider.

3. "COMPLETE credentialing APPLICATION":

(a) Means ~~to collect, verify and assess whether a provider meets relevant licensing, education and training requirements to become or remain a participating provider~~ AN APPLICATION THAT INCLUDES ALL THE INFORMATION, ANY REQUIRED SUPPORTING DOCUMENTATION AND A CURRENT AUTHORIZATION TO ACCESS ELECTRONIC DOCUMENTATION THAT A HEALTH INSURER NEEDS IN ORDER TO PROCESS THE CREDENTIALING REQUEST THROUGH A CREDENTIALING SYSTEM THAT IS DEVELOPED BY A NATIONALLY RECOGNIZED, NONPROFIT ALLIANCE OF HEALTH PLANS AND TRADE ASSOCIATIONS[, INCLUDING A NONPROFIT ORGANIZATION THAT IS INCORPORATED AS A MUTUAL HEALTH CORPORATION AND THAT IS WORKING TO STREAMLINE THE BUSINESS OF HEALTH CARE].

(b) INCLUDES A [~~NONPROFIT ORGANIZATION THAT IS INCORPORATED AS A MUTUAL HEALTH CORPORATION AND THAT IS WORKING TO STREAMLINE THE BUSINESS OF HEALTH CARE~~] [CREDENTIALING SYSTEM THAT IS OPERATED BY A DENTAL SERVICES CORPORATION].

4. "Designee" means a third party to whom the health insurer has delegated credentialing activities or responsibilities.

5. "Health insurer" means a disability insurer, group disability insurer, blanket disability insurer, health care services organization, hospital service corporation, medical service corporation or ~~a~~ hospital, medical, dental and optometric service corporation and includes the health insurer's designee. Health insurer does not include a pharmacy benefits manager as defined in section 20-3321.

6. "Loading" means to input a participating provider's information into a health insurer's billing system for the purpose of processing claims and submitting reimbursement for covered services.

7. "Participating provider" means a provider that has been credentialed AND CONTRACTED by a health insurer ~~or its designee~~ to provide health care items or services to subscribers in at least one of the health insurer's provider networks.

8. "Provider" means a physician, hospital or other person that is licensed in this state or that is otherwise authorized to furnish health care services in this state.

9. "~~Recredentialing~~ RECREDENTIAL" means to confirm that a participating provider is in good standing by a health insurer ~~or its designee~~ and does not require submitting an application or going through a contracting and loading process.

10. "Subscriber" means a person who is eligible to receive health care benefits pursuant to a health insurance policy or coverage issued or provided by a health insurer.

Sec. 2. Section 20-3453, Arizona Revised Statutes, is amended to read:

20-3453. Credentialing; loading; timelines; exception

A. Except as provided in subsection C of this section, the health insurer shall conclude the process of credentialing WITHIN SIXTY CALENDAR DAYS and loading the applicant's information into the health insurer's billing system within ~~one hundred~~ THIRTY calendar days after the date the health insurer receives a complete CREDENTIALING application.

B. A health insurer shall provide written or electronic notice of the approval or denial of a credentialing application to an applicant within seven calendar days after the conclusion of the credentialing process.

C. If a licensed health care facility has a delegated credentialing agreement with a health insurer, the health insurer is not responsible for compliance with the timeline prescribed in subsection A of this section for an applicant who works for that facility, but shall conclude the loading process for that applicant within ten calendar days after the health insurer receives a roster of demographic changes related to newly credentialed, terminated or suspended participating providers.

Sec. 3. Section 20-3454, Arizona Revised Statutes, is amended to read:

20-3454. Acknowledgement of receipt of an application; notification of incomplete applications

A. WHEN SUBMITTING A CREDENTIALING APPLICATION, a health insurer shall provide written or electronic acknowledgement to an applicant within seven calendar days after the health insurer's receipt of the ~~applicant's~~ application. The applicant shall include in the application a contact name, telephone number and ~~e-mail~~ EMAIL address ~~to~~ OF AN INDIVIDUAL WHO CAN address discrepancies in the application.

B. On receipt of an application, a health insurer shall promptly review the application to determine if the application is complete.

C. ~~If the~~ NOT LATER THAN SEVEN CALENDAR DAYS AFTER RECEIPT OF A CREDENTIALING APPLICATION, A health insurer ~~determines that the application is incomplete, the health insurer~~ shall ~~notify~~ CONTACT the applicant in writing or by electronic means ~~that~~ TO ACKNOWLEDGE RECEIPT OF THE APPLICATION AND INFORM THE APPLICANT WHETHER the application is ~~incomplete within seven calendar days after the date the health insurer received the application~~ A COMPLETE CREDENTIALING APPLICATION. IF THE APPLICATION IS NOT A COMPLETE CREDENTIALING APPLICATION, the notice shall include a detailed list of all of the items required to complete the application. A health insurer may request supplemental information to complete the credentialing process.

D. If the health insurer does not send the notice to the applicant within the required time frame specified in this section, the application is deemed complete for the purposes of section 20-3453.

E. If the health insurer notifies the applicant ~~of an incomplete~~ PURSUANT TO SUBSECTION C OF THIS SECTION THAT THE application ~~in compliance with subsection C of this section~~ IS NOT A COMPLETE CREDENTIALING APPLICATION, the time periods specified under section 20-3453 are tolled, and the application is suspended from the date the notification was sent to the applicant until the date on which the health insurer receives the information from the applicant to complete the application. NOT LATER THAN SEVEN CALENDAR DAYS AFTER THE APPLICANT SUBMITS INFORMATION TO COMPLETE THE APPLICATION, THE HEALTH INSURER SHALL CONTACT THE APPLICANT TO ACKNOWLEDGE RECEIPT OF THE ADDITIONAL INFORMATION AND INFORM THE APPLICANT WHETHER THE APPLICATION IS A COMPLETE CREDENTIALING APPLICATION. If the health insurer has not received any response providing the requested information in subsection C of this section from the applicant after thirty calendar days, the HEALTH insurer may deem the application withdrawn AND COMMUNICATE THE WITHDRAWAL OF THE APPLICATION TO THE APPLICANT WITHIN SEVEN CALENDAR DAYS.

F. IF AT ANY TIME DURING THE APPLICATION PROCESS THE HEALTH INSURER TOLLS THE TIME PERIOD SPECIFIED IN SECTION 20-3453 WHILE WAITING FOR ADDITIONAL INFORMATION FROM THE APPLICANT, THE HEALTH INSURER SHALL ACKNOWLEDGE RECEIPT OF THE ADDITIONAL INFORMATION NOT LATER THAN SEVEN CALENDAR DAYS AFTER THE HEALTH INSURER RECEIVES THE ADDITIONAL INFORMATION. THE HEALTH INSURER SHALL PROVIDE ALL NOTIFICATIONS TO THE APPLICANT IN THIS SUBSECTION IN WRITING OR BY ELECTRONIC MEANS.

G. A HEALTH INSURER MAY NOT TOLL THE TIME PERIOD SPECIFIED IN SECTION 20-3453 MORE THAN THREE TIMES. IF, AFTER THE THIRD TOLL, A HEALTH

INSURER HAS NOT RECEIVED A RESPONSE FROM THE APPLICANT THAT INCLUDES THE REQUESTED INFORMATION AS PRESCRIBED IN SUBSECTION C OF THIS SECTION WITHIN THIRTY CALENDAR DAYS, THE HEALTH INSURER MAY DEEM THE APPLICATION WITHDRAWN AND SHALL INFORM THE APPLICANT OF THE WITHDRAWAL WITHIN SEVEN CALENDAR DAYS.

~~F.~~ H. On receipt of a complete CREDENTIALING application, a health insurer must send the applicant a proposed contract that is complete and ready for execution by the parties.

~~G.~~ I. A health insurer that enters into a delegated credentialing agreement with a licensed health care facility or that participates in a health insurer credentialing alliance with equivalent or higher standards than as prescribed in this section is deemed to be in compliance with the requirements of this section.

Sec. 4. Repeal

Section 20-3456, Arizona Revised Statutes, is repealed.

Sec. 5. Title 20, chapter 27, article 1, Arizona Revised Statutes, is amended by adding a new section 20-3456, to read:

20-3456. Covered services; claims; payment; liability; notice

A. A PROVIDER MAY RECEIVE PAYMENT FROM A HEALTH INSURER PURSUANT TO THIS SECTION FOR SERVICES THAT WERE PROVIDED FROM THE DATE THAT WAS INCLUDED ON THE NOTICE OF COMPLETE CREDENTIALING APPLICATION TO THE DATE THE PROVIDER'S NETWORK PARTICIPATION CONTRACT IS EXECUTED. A HEALTH INSURER SHALL PROCESS A PROVIDER'S CLAIM AS AN IN-NETWORK CLAIM AND PAY THE CLAIM IF ALL OF THE FOLLOWING APPLY:

1. THE PROVIDER HAS APPLIED FOR CREDENTIALING WITH THE HEALTH INSURER AND RENDERS A COVERED SERVICE TO AN INDIVIDUAL WHO IS AN ELIGIBLE HEALTH PLAN MEMBER ON THE DATE OF SERVICE.

2. THE PROVIDER RENDERS THE SERVICE ON OR AFTER THE DATE ON WHICH THE HEALTH INSURER NOTIFIED THE PROVIDER THAT THE APPLICATION WAS A COMPLETE CREDENTIALING APPLICATION.

3. THE PROVIDER DOES NOT SUBMIT THE CLAIM UNTIL AFTER THE PROVIDER HAS A FULLY EXECUTED NETWORK PARTICIPATION CONTRACT WITH THE HEALTH INSURER FOR THE MEMBER'S HEALTH PLAN NETWORK AND THE HEALTH INSURER HAS APPROVED THE PROVIDER'S CREDENTIALS.

B. IF A CLAIM IS SUBMITTED WITHIN ONE YEAR AFTER THE DATE OF SERVICE, A HEALTH INSURER MAY NOT DENY A PROVIDER'S CLAIM THAT IS SUBMITTED IN COMPLIANCE WITH THIS SECTION ON THE BASIS THAT THE CLAIM WAS NOT SUBMITTED WITHIN THE CONTRACTUALLY REQUIRED TIME PERIOD.

C. THIS SECTION DOES NOT REQUIRE A HEALTH INSURER TO REIMBURSE THE APPLICANT AT THE IN-NETWORK RATE FOR ANY COVERED MEDICAL SERVICES PROVIDED BY THE APPLICANT IF THE APPLICANT'S CREDENTIALING APPLICATION IS NOT APPROVED OR THE HEALTH CARE PROVIDER IS UNWILLING TO CONTRACT WITH THE INSURER ON MUTUALLY ACCEPTABLE TERMS.

D. WITHIN A REASONABLE PERIOD BEFORE A HEALTH CARE PROVIDER PROVIDES SERVICE TO A PATIENT IN A NETWORK FACILITY, A HEALTH CARE PROVIDER OR THE HEALTH CARE PROVIDER'S REPRESENTATIVE SHALL PROVIDE A

WRITTEN, DATED DISCLOSURE THAT INFORMS THE PATIENT OF ALL OF THE FOLLOWING:

1. THE NAME OF THE BILLING HEALTH CARE PROVIDER.

2. THE TOTAL ESTIMATED COST TO BE BILLED BY THE HEALTH CARE PROVIDER OR THE HEALTH CARE PROVIDER'S REPRESENTATIVE.

3. A STATEMENT THAT THE HEALTH CARE PROVIDER IS NOT CREDENTIALED AND IS NOT A [~~CONTRACT~~] [CONTRACTED] PROVIDER.

Sec. 6. Section 20-3459, Arizona Revised Statutes, is amended to read:

20-3459. Civil immunity; enforcement; civil penalty

A. A health insurer that complies in good faith with the requirements of this chapter is immune from civil liability for the purposes of reviewing and approving a credentialing application.

B. A HEALTH INSURER THAT DOES NOT CREDENTIAL A PROVIDER IS NOT SUBJECT TO CIVIL LIABILITY FOR ANY ACT OR OMISSION OF THE PROVIDER IN RENDERING SERVICES TO A HEALTH INSURER'S MEMBER.

~~B.~~ C. The director shall enforce this chapter. A health insurer that fails to comply with this chapter or with any rules adopted pursuant to this chapter is subject to the civil penalties prescribed in section 20-456.

~~C.~~ D. On receipt of multiple complaints of violations of this chapter by a health insurer from applicants or participating providers, the director shall conduct an examination of the health insurer pursuant to section 20-156, 20-831 or 20-1058, as applicable to the specific insurer.

Sec. 7. Effective date

This act is effective from and after March 31, 2026.

Enroll and engross to conform
Amend title to conform

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