OFFICIAL TITLE
AN INITIATIVE MEASURE

AMENDING TITLE 20, CHAPTER 1, ARIZONA REVISED STATUTES, BY ADDING ARTICLE 5; AMENDING SECTIONS 20-3111, 20-3112 AND 20-3113, ARIZONA REVISED STATUTES; AMENDING TITLE 20, CHAPTER 20, ARTICLE 2, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-3113.01; AMENDING SECTIONS 20-3114 AND 20-3115; AMENDING TITLE 23, CHAPTER 2, ARTICLE 8, ARIZONA REVISED STATUTES, BY ADDING SECTION 23-363.01; AMENDING TITLE 36, CHAPTER 25, ARIZONA REVISED STATUTES, BY ADDING ARTICLE 3; RELATING TO HEALTH CARE BILLING REFORM, MINIMUM WAGE FOR DIRECT CARE HOSPITAL WORKERS AND CONTROL OF HOSPITAL-ACQUIRED INFECTIONS.

TEXT OF PROPOSED AMENDMENT

Be it enacted by the People of the State of Arizona:

Section 1. Title 20, chapter 1, Arizona Revised Statutes, is amended by adding article 5, to read:

ARTICLE 5. PROHIBITION OF DISCRIMINATION BASED ON PREEXISTING CONDITIONS

20-192. Definitions

IN THIS ARTICLE, THE FOLLOWING TERMS ARE USED AS DEFINED:

1. "GROUP HEALTH PLAN" MEANS A PLAN COVERING EMPLOYEES OF AN EMPLOYER AS DEFINED IN SECTION 607(A) OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974.

2. "GROUP MARKET" MEANS THE HEALTH INSURANCE MARKET UNDER WHICH INDIVIDUALS OBTAIN HEALTH INSURANCE COVERAGE (DIRECTLY OR THROUGH ANY ARRANGEMENT) ON BEHALF OF THEMSELVES (AND THEIR DEPENDENTS) THROUGH A GROUP HEALTH PLAN MAINTAINED BY A LARGE OR SMALL EMPLOYER.

3. "HEALTH CARE INSURER" MEANS A DISABILITY INSURER, GROUP DISABILITY INSURER, BLANKET DISABILITY INSURER, HEALTH CARE SERVICES ORGANIZATION, HOSPITAL SERVICE CORPORATION, MEDICAL SERVICE CORPORATION OR HOSPITAL, MEDICAL, DENTAL AND OPTOMETRIC SERVICE CORPORATION.

4. "HEALTH CARE PLAN" MEANS ANY CONTRACTUAL ARRANGEMENT WHEREBY ANY HEALTH CARE SERVICES ORGANIZATION UNDERTAKES TO PROVIDE DIRECTLY OR TO ARRANGE FOR ALL OR A PORTION OF CONTRACTUALLY COVERED HEALTH CARE SERVICES AND TO PAY OR MAKE REIMBURSEMENT FOR ANY REMAINING PORTION OF THE HEALTH CARE SERVICES ON A PREPAID BASIS THROUGH INSURANCE OR OTHERWISE.

5. "HEALTH CARE SERVICES ORGANIZATION" MEANS ANY PERSON THAT UNDERTAKES TO CONDUCT ONE OR MORE HEALTH CARE PLANS. UNLESS THE CONTEXT OTHERWISE REQUIRES, HEALTH CARE SERVICES ORGANIZATION INCLUDES A PROVIDER-SPONSORED HEALTH CARE SERVICES ORGANIZATION.

6. "HEALTH INSURANCE COVERAGE":

(a) MEANS BENEFITS CONSISTING OF MEDICAL CARE (PROVIDED THROUGH INSURANCE SUBJECT TO THIS TITLE) UNDER ANY HOSPITAL OR MEDICAL SERVICE POLICY OR CERTIFICATE, HOSPITAL OR MEDICAL SERVICE PLAN CONTRACT OR HEALTH MAINTENANCE ORGANIZATION CONTRACT OFFERED BY A HEALTH CARE INSURER, WHETHER ON THE GROUP MARKET OR INDIVIDUAL MARKET.

(b) INCLUDES SHORT-TERM LIMITED DURATION INSURANCE.

7. "INDIVIDUAL MARKET" MEANS THE MARKET FOR HEALTH INSURANCE COVERAGE OFFERED TO INDIVIDUALS OTHER THAN IN CONNECTION WITH A GROUP HEALTH PLAN.

8. "MEDICAL CONDITION" MEANS ANY CONDITION, WHETHER PHYSICAL OR MENTAL, INCLUDING, BUT NOT LIMITED TO, ANY CONDITION RESULTING FROM ILLNESS, INJURY WHETHER OR NOT THE INJURY IS ACCIDENTAL, PREGNANCY OR CONGENITAL MALFORMATION.

9. "NETWORK PLAN" MEANS HEALTH CARE SERVICES THAT ARE PROVIDED BY A HEALTH CARE SERVICES ORGANIZATION UNDER WHICH THE FINANCING AND DELIVERY OF HEALTH CARE SERVICES ARE PROVIDED, IN WHOLE OR IN PART, THROUGH A DEFINED SET OF PROVIDERS UNDER CONTRACT WITH THE HEALTH CARE SERVICES ORGANIZATION.

10. "PREEXISTING CONDITION EXCLUSION" MEANS A LIMIT OR EXCLUSION OF BENEFITS RELATING TO A MEDICAL CONDITION BASED ON THE FACT THAT THE CONDITION WAS PRESENT BEFORE THE DATE OF ENROLLMENT FOR INSURANCE COVERAGE, REGARDLESS OF WHETHER ANY MEDICAL ADVICE, DIAGNOSIS, CARE OR TREATMENT WAS RECOMMENDED OR RECEIVED BEFORE THAT DATE.

11. "SHORT-TERM LIMITED DURATION INSURANCE" MEANS BENEFITS OFFERED BY A HEALTH CARE INSURER THAT HAS AN EXPIRATION DATE SPECIFIED IN THE CONTRACT THAT IS LESS THAN TWELVE MONTHS AFTER THE ORIGINAL EFFECTIVE DATE OF THE CONTRACT AND, TAKING INTO ACCOUNT RENEWALS OR EXTENSIONS, THAT HAS A DURATION OF NOT LONGER THAN THIRTY-SIX MONTHS.

12. "STATE EXCHANGE" MEANS AN AMERICAN HEALTH BENEFIT EXCHANGE ESTABLISHED BY THIS STATE PURSUANT TO 42 UNITED STATES CODE SECTION 18031.

20-192.01. Health insurance coverage; preexisting conditions

A HEALTH CARE INSURER OFFERING HEALTH INSURANCE COVERAGE IN THIS STATE SHALL NOT IMPOSE ANY PREEXISTING CONDITION EXCLUSION WITH RESPECT TO THE ISSUANCE, RENEWAL OR SCOPE OF BENEFITS PROVIDED IN SUCH COVERAGE.

20-192.02. Guaranteed issuance of coverage in the individual market and group market

A. SUBJECT TO SUBSECTIONS B THROUGH D OF THIS SECTION, A HEALTH CARE INSURER THAT OFFERS HEALTH INSURANCE COVERAGE IN THE INDIVIDUAL MARKET OR GROUP MARKET IN THIS STATE SHALL NOT DENY COVERAGE TO ANY EMPLOYER OR INDIVIDUAL IN THE APPLICABLE MARKET IN THIS STATE THAT APPLIES FOR SUCH COVERAGE.

B. A HEALTH CARE INSURER THAT OFFERS HEALTH INSURANCE COVERAGE IN THE GROUP MARKET OR INDIVIDUAL MARKET THROUGH A NETWORK PLAN MAY:

1. IN THE GROUP MARKET, LIMIT THE EMPLOYERS WHO MAY APPLY FOR SUCH COVERAGE TO THOSE WITH ELIGIBLE INDIVIDUALS WHO LIVE, WORK OR RESIDE WITHIN THE NETWORK PLAN'S SERVICE AREA.

2. WITHIN THE SERVICE AREA OF THE NETWORK PLAN, DENY COVERAGE TO OTHERWISE ELIGIBLE EMPLOYERS AND INDIVIDUALS ON DEMONSTRATING TO THE DIRECTOR THAT THE HEALTH CARE INSURER:

(a) LACKS THE CAPACITY TO DELIVER ADEQUATE SERVICES TO ANY ADDITIONAL ENROLLEES DUE TO ITS OBLIGATIONS TO EXISTING GROUP CONTRACT HOLDERS AND ENROLLEES; AND

(b) IS DENYING COVERAGE ON A NONDISCRIMINATORY BASIS, WITHOUT REGARD TO THE CLAIMS EXPERIENCE OR ANY HEALTH STATUS FACTORS OF SUCH INDIVIDUALS OR SUCH EMPLOYERS AND THEIR EMPLOYEES AND THEIR EMPLOYEES' DEPENDENTS.

C. A HEALTH CARE INSURER MAY DENY HEALTH INSURANCE COVERAGE IN THE GROUP MARKET OR INDIVIDUAL MARKET ON DEMONSTRATING TO THE DIRECTOR THAT THE HEALTH CARE INSURER:

1. DOES NOT HAVE THE FINANCIAL RESERVES NECESSARY TO UNDERWRITE ADDITIONAL COVERAGE; AND

2. IS DENYING COVERAGE ON A NONDISCRIMINATORY BASIS, WITHOUT REGARD TO THE CLAIMS EXPERIENCE OR ANY HEALTH STATUS FACTORS OF SUCH INDIVIDUALS OR SUCH EMPLOYERS AND THEIR EMPLOYEES AND THEIR EMPLOYEES' DEPENDENTS.

D. ON DENYING HEALTH INSURANCE COVERAGE PURSUANT TO SUBSECTION B, PARAGRAPH 2 OR SUBSECTION C, A HEALTH CARE INSURER MAY NOT OFFER COVERAGE IN THE GROUP MARKET OR INDIVIDUAL MARKET FOR A PERIOD OF ONE HUNDRED EIGHTY DAYS AFTER THE DATE SUCH COVERAGE IS DENIED.

20-192.03. Guaranteed renewability of coverage

A. SUBJECT TO SUBSECTION B OF THIS SECTION, EACH HEALTH CARE INSURER THAT OFFERS HEALTH INSURANCE COVERAGE IN THE INDIVIDUAL MARKET OR GROUP MARKET MUST RENEW OR CONTINUE IN FORCE SUCH COVERAGE AT THE OPTION OF THE PLAN SPONSOR OR THE INDIVIDUAL, AS APPLICABLE.

B. A HEALTH CARE INSURER MAY DECLINE TO RENEW OR MAY DISCONTINUE HEALTH INSURANCE COVERAGE OFFERED IN THE GROUP MARKET OR INDIVIDUAL MARKET ONLY IF SUCH NONRENEWAL OR DISCONTINUANCE IS BASED ON ONE OR MORE OF THE FOLLOWING GROUNDS FOR EXCEPTION:

1. THE PLAN SPONSOR OR INDIVIDUAL, AS APPLICABLE, HAS FAILED TO PAY PREMIUMS OR CONTRIBUTIONS IN ACCORDANCE WITH THE TERMS OF THE HEALTH INSURANCE COVERAGE OR THE ISSUER HAS NOT RECEIVED TIMELY PREMIUM PAYMENTS.

2. THE PLAN SPONSOR OR INDIVIDUAL, AS APPLICABLE, HAS PERFORMED AN ACT OR PRACTICE THAT CONSTITUTES FRAUD OR MADE AN INTENTIONAL MISREPRESENTATION OF MATERIAL FACT UNDER THE TERMS OF THE COVERAGE.

3. IN THE CASE OF A GROUP HEALTH PLAN, THE PLAN SPONSOR HAS FAILED TO COMPLY WITH A MATERIAL PLAN PROVISION RELATING TO EMPLOYER CONTRIBUTION OR GROUP PARTICIPATION RULES, PURSUANT TO APPLICABLE LAW.

4. THE ISSUER IS CEASING TO OFFER COVERAGE IN THE GROUP MARKET OR INDIVIDUAL MARKET IN ACCORDANCE WITH APPLICABLE LAW.

5. IN THE CASE OF A HEALTH CARE INSURER THAT OFFERS HEALTH INSURANCE COVERAGE IN THE MARKET THROUGH A NETWORK PLAN, THERE IS NO LONGER ANY ENROLLEE IN CONNECTION WITH SUCH PLAN WHO LIVES, RESIDES OR WORKS IN THE SERVICE AREA OF THE INSURER OR IN THE AREA FOR WHICH THE HEALTH CARE INSURER IS AUTHORIZED TO DO BUSINESS.

6. IN THE CASE OF HEALTH INSURANCE COVERAGE THAT IS MADE AVAILABLE IN THE SMALL OR LARGE GROUP MARKET ONLY THROUGH ONE OR MORE BONA FIDE ASSOCIATIONS, THE MEMBERSHIP OF AN EMPLOYER IN THE ASSOCIATION ON THE BASIS OF WHICH THE COVERAGE IS PROVIDED CEASES BUT ONLY IF SUCH COVERAGE IS TERMINATED UNDER THIS PARAGRAPH UNIFORMLY WITHOUT REGARD TO ANY HEALTH STATUS-RELATED FACTOR RELATING TO ANY COVERED INDIVIDUAL.

20-192.04. Rating restrictions

A. THE PREMIUM RATE CHARGED BY A HEALTH CARE INSURER FOR HEALTH INSURANCE COVERAGE OFFERED IN THE INDIVIDUAL MARKET OR SMALL GROUP MARKET, OR IN THE LARGE GROUP MARKET THROUGH A STATE EXCHANGE, MAY VARY BASED ONLY ON THE FOLLOWING FACTORS:

1. WHETHER SUCH PLAN OR COVERAGE COVERS AN INDIVIDUAL OR FAMILY.

2. GEOGRAPHIC RATING AREAS THAT ARE OR MAY BE ESTABLISHED BY THE DIRECTOR.

3. AGE, ACCORDING TO AGE BANDS THAT ARE OR MAY BE ESTABLISHED BY THE DIRECTOR, EXCEPT THAT SUCH RATE SHALL NOT VARY BY MORE THAN THREE TO ONE FOR ADULTS.

4. TOBACCO USE, EXCEPT THAT SUCH RATE SHALL NOT VARY BY MORE THAN 1.5 TO ONE, OR UNDER APPLICABLE FEDERAL LAW, WHICHEVER IS LOWER.

B. WITH RESPECT TO FAMILY HEALTH INSURANCE COVERAGE, THE RATING VARIATIONS ALLOWED UNDER SUBSECTION A, PARAGRAPHS 3 AND 4 OF THIS SECTION, SHALL BE APPLIED BASED ON THE PORTION OF THE PREMIUM THAT IS ATTRIBUTABLE TO EACH COVERED FAMILY MEMBER.

Sec. 2. Heading change

The article heading of title 20, chapter 20, article 2, Arizona Revised Statutes, is changed from "OUT-OF-NETWORK CLAIM DISPUTE RESOLUTION" to "FAIR BILLING PRACTICES".

Sec. 3. Section 20-3111, Arizona Revised Statutes, is amended to read:

20-3111. Definitions

In this article, unless the context otherwise requires:

1. "AMBULANCE" MEANS ANY PUBLICLY OR PRIVATELY OWNED SURFACE VEHICLE THAT CONTAINS A STRETCHER AND NECESSARY MEDICAL EQUIPMENT AND SUPPLIES PURSUANT TO SECTION 36-2202 AND THAT IS ESPECIALLY DESIGNED AND CONSTRUCTED OR MODIFIED AND EQUIPPED TO BE USED, MAINTAINED OR OPERATED PRIMARILY FOR THE TRANSPORTATION OF INDIVIDUALS WHO ARE SICK, INJURED OR WOUNDED OR WHO REQUIRE MEDICAL MONITORING OR AID. AMBULANCE DOES NOT INCLUDE A SURFACE VEHICLE THAT IS OWNED AND OPERATED BY A PRIVATE SOLE PROPRIETOR, PARTNERSHIP, PRIVATE CORPORATION OR MUNICIPAL CORPORATION FOR THE EMERGENCY TRANSPORTATION AND IN-TRANSIT CARE OF ITS EMPLOYEES OR A VEHICLE THAT IS OPERATED TO ACCOMMODATE AN INCAPACITATED PERSON OR PERSON WITH A DISABILITY WHO DOES NOT REQUIRE MEDICAL MONITORING, CARE OR TREATMENT DURING TRANSPORT AND THAT IS NOT ADVERTISED AS HAVING MEDICAL EQUIPMENT AND SUPPLIES OR AMBULANCE ATTENDANTS.

2. "AMBULANCE SERVICE" MEANS A PERSON WHO OWNS OR OPERATES ONE OR MORE AMBULANCES.

~~1.~~ 3. "Arbitration" means a dispute resolution process in which an impartial arbitrator determines the dollar amount a health care provider is entitled to receive for payment of a surprise out-of-network bill.

~~2.~~ 4. "Arbitrator" means an impartial person who is appointed to conduct an arbitration.

5. "AVERAGE CONTRACTED RATE" MEANS THE AVERAGE OF THE COMMERCIAL CONTRACTED RATES PAID BY A HEALTH PLAN FOR THE SAME OR SIMILAR SERVICES IN THE GEOGRAPHIC AREA COVERED BY THE HEALTH PLAN DURING THE PRECEDING CALENDAR YEAR.

~~3.~~ 6. "Billing company" means any affiliated or unaffiliated company that is hired by a health care provider or health care facility to coordinate the payment of bills with health insurers and to generate or bill and collect payment from enrollees on the health care provider's or health care facility's behalf.

~~4.~~ 7. "Contracted provider" means a health care provider that has entered into a contract with a health insurer to provide health care services to the health insurer's enrollees at agreed on rates.

~~5.~~ 8. "Cost sharing requirements" means an enrollee's applicable ~~out-of-network~~ coinsurance, copayment and deductible requirements ~~under a health plan based on the adjudicated claim~~.

~~6.~~ 9. "Emergency services" has the same meaning prescribed in section 20-2801.

~~7.~~ 10. "Enrollee" means an individual who is eligible to receive benefits through a health plan.

11. "GEOGRAPHIC REGION" MEANS, AS TO THE PROVISIONS OF THIS ARTICLE REQUIRING A DETERMINATION OF THE AMOUNT MEDICARE REIMBURSES ON A FEE-FOR-SERVICE BASIS, THE REGION SPECIFIED FOR PHYSICIAN REIMBURSEMENT FOR MEDICARE FEE-FOR-SERVICE BY THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES.

~~8.~~ 12. "Health care facility" has the same meaning prescribed in section 36-437.

~~9.~~ 13. "Health care provider" means a person who is licensed, registered or certified as a health care professional under title 32 or a laboratory or durable medical equipment provider that furnishes services to a patient in a ~~network~~ HEALTH CARE facility and that separately bills the patient for the services.

~~10.~~ 14. "Health care services" means treatment, services, medications, tests, equipment, devices, durable medical equipment, laboratory services or supplies rendered or provided to an enrollee for the purpose of diagnosing, preventing, alleviating, curing or healing human disease, illness or injury.

~~11.~~ 15. "Health insurer" means a disability insurer, group disability insurer, blanket disability insurer, hospital service corporation or medical service corporation that provides health insurance in this state.

~~12.~~ 16. "Health plan" means a group or individual health plan that finances or furnishes health care services and that is issued by a health insurer.

~~13.~~ 17. "Network facility" means a health care facility that has entered into a contract with a health insurer to provide health care services to the health insurer's enrollees at agreed on rates.

18. "OUT-OF-NETWORK AMBULANCE" MEANS AN AMBULANCE OR AMBULANCE SERVICE THAT HAS NOT ENTERED INTO A CONTRACT WITH AN ENROLLEE'S HEALTH INSURER TO ATTEND OR TRANSPORT THE HEALTH INSURER'S ENROLLEES AT AGREED ON RATES.

19. "OUT-OF-NETWORK FACILITY" MEANS A HEALTH CARE FACILITY THAT HAS NOT ENTERED INTO A CONTRACT WITH AN ENROLLEE'S HEALTH INSURER TO PROVIDE HEALTH CARE SERVICES TO THE HEALTH INSURER'S ENROLLEES AT AGREED ON RATES.

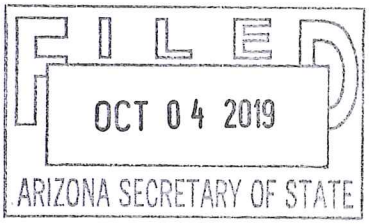
20. "OUT-OF-NETWORK PROVIDER" MEANS A HEALTH CARE PROVIDER THAT HAS NOT ENTERED INTO A CONTRACT WITH AN ENROLLEE'S HEALTH INSURER TO PROVIDE HEALTH CARE SERVICES TO THE HEALTH INSURER'S ENROLLEES AT AGREED ON RATES.

~~14.~~ 21. "Surprise out-of-network bill" ~~means a bill for a health care service that was provided in a network facility by a health care provider that is not a contracted provider and that meets one of the requirements listed~~ HAS THE SAME MEANING PRESCRIBED in section 20-3113.

Sec. 4. Section 20-3112, Arizona Revised Statutes, is amended to read:

20-3112. Applicability

This article does not apply to:
1. Health care services that are not covered by the enrollee's health plan.
2. Limited benefit coverage as defined in section 20-1137.



3. Charges for health care services that are subject to a direct payment agreement under section 32-3216 or 36-437.

~~4. Health plans that do not include coverage for out-of-network health care services, unless otherwise required by law.~~

~~5.~~ 4. State health and accident coverage for full-time officers and employees of this state and their dependents that is provided pursuant to title 38, chapter 4, article 4.

~~6.~~ 5. A self-funded or self-insured employee benefit plan if the regulation of that plan is preempted by the employee retirement income security act of 1974 (P.L. 93-406; 88 Stat. 829; 29 United States Code section 1144(b)).

Sec. 5. Section 20-3113, Arizona Revised Statute, is amended to read:

20-3113 Surprise out-of-network bills and ambulance balance bills prohibited

~~A. A bill for a health care service that was provided in a network facility by a health care provider that is not a contracted provider must meet one of the following requirements to qualify as a surprise out-of-network bill:~~

~~1. The bill was for emergency services, including under circumstances described by section 20-2803, subsection A and health care services directly related to the emergency services that are provided during an inpatient admission to any network facility.~~

~~2. The bill was for a health care service that was not provided in the case of an emergency and the health care provider or the provider's representative did not provide to the enrollee, or did not provide to the enrollee within a reasonable amount of time before the enrollee received the services, a written dated disclosure that contained the following information:~~

~~(a) Notice that contains the name of the billing health care provider and that states the health care provider is not a contracted provider.~~

~~(b) The estimated total cost to be billed by the health care provider or the provider's representative.~~

~~(c) Notice that the enrollee or the enrollee's authorized representative is not required to sign the disclosure to obtain medical care but if the enrollee or the enrollee's representative signs the disclosure, the enrollee may have waived any rights to dispute resolution under this article.~~

~~3. The bill was for a health care service that was not provided in the case of an emergency and the enrollee received the disclosure prescribed in paragraph 2 of this subsection, but the enrollee or the enrollee's authorized representative chose not to sign the disclosure.~~

A. ANY BILL IN VIOLATION OF THE FOLLOWING REQUIREMENTS IS A "SURPRISE OUT-OF-NETWORK BILL":

1. WHEN AN ENROLLEE RECEIVES HEALTH CARE SERVICES AT THE ENROLLEE'S NETWORK FACILITY BUT THE SERVICES ARE RENDERED BY AN OUT-OF-NETWORK PROVIDER, THE ENROLLEE SHALL NOT BE CHARGED OR OWE AN AMOUNT MORE THAN THE COST SHARING REQUIREMENT THAT THE ENROLLEE WOULD HAVE OWED FOR RECEIVING THE SAME SERVICES FROM A CONTRACTED PROVIDER.

2. WHEN AN ENROLLEE RECEIVES EMERGENCY SERVICES AT AN OUT-OF-NETWORK FACILITY, THE ENROLLEE SHALL NOT BE CHARGED OR OWE AN AMOUNT GREATER THAN THE COST SHARING REQUIREMENT THAT THE ENROLLEE WOULD HAVE OWED FOR RECEIVING THE SAME SERVICES AT A NETWORK FACILITY BY A CONTRACTED PROVIDER.

3. WHEN AN ENROLLEE IS ATTENDED OR TRANSPORTED BY AN OUT-OF-NETWORK AMBULANCE, THE ENROLLEE SHALL NOT BE CHARGED OR OWE AN AMOUNT GREATER THAN THE COST SHARING REQUIREMENT THAT THE ENROLLEE WOULD HAVE OWED FOR RECEIVING THE SAME SERVICES BY AN IN-NETWORK AMBULANCE.

B. WHEN AN ENROLLEE IS ATTENDED OR TRANSPORTED BY AN IN-NETWORK AMBULANCE, THE ENROLLEE SHALL NOT BE DIRECTLY CHARGED OR OWE AN AMOUNT GREATER THAN THE ENROLLEE'S COST SHARING REQUIREMENTS, IN ADDITION TO WHICH THE AMBULANCE OR AMBULANCE SERVICE MAY BE REIMBURSED BY THE ENROLLEE'S INSURER AT THE AGREED ON RATES.

C. IF A HEALTH CARE PROVIDER, HEALTH CARE FACILITY OR AMBULANCE SERVICE RECEIVES MORE IN PAYMENT FROM AN ENROLLEE THAN THE COST SHARING AMOUNTS ALLOWED BY THIS SECTION, THE HEALTH CARE PROVIDER, HEALTH CARE FACILITY OR AMBULANCE SERVICE SHALL REFUND ANY OVERPAYMENT TO THE ENROLLEE WITHIN THIRTY CALENDAR DAYS AFTER RECEIVING PAYMENT FROM THE ENROLLEE. IF THE HEALTH CARE PROVIDER, HEALTH CARE FACILITY OR AMBULANCE SERVICE DOES NOT REFUND ANY OVERPAYMENT TO THE ENROLLEE WITHIN THIRTY CALENDAR DAYS, INTEREST SHALL ACCRUE AT THE RATE OF TEN PERCENT EACH YEAR BEGINNING WITH THE DATE PAYMENT WAS RECEIVED FROM THE ENROLLEE. A HEALTH CARE PROVIDER, HEALTH CARE FACILITY OR AMBULANCE SERVICE SHALL AUTOMATICALLY INCLUDE IN THE REFUND TO THE ENROLLEE ALL INTEREST THAT HAS ACCRUED PURSUANT TO THIS SUBSECTION WITHOUT REQUIRING THE ENROLLEE TO SUBMIT A REQUEST FOR THE INTEREST AMOUNT.

D. ANY COST SHARING PAID BY THE ENROLLEE FOR SERVICES DESCRIBED IN SUBSECTION A OF THIS SECTION SHALL COUNT TOWARD ANY DEDUCTIBLE OR OUT-OF-POCKET LIMIT IN THE SAME MANNER AS THE ENROLLEE'S COST SHARING REQUIREMENTS FOR SERVICES FROM A CONTRACTED PROVIDER, NETWORK FACILITY OR IN-NETWORK AMBULANCE.

~~B.~~ E. Notwithstanding any provision of this article, a health insurer and any health plan offered by a health insurer shall comply with chapter 17, article 1 of this title.

Sec. 6.Title 20, chapter 20, article 2, Arizona Revised Statutes, is amended by adding section 20-3113.01 to read:

20-3113.01 Fair payment standards.

A. WHEN AN ENROLLEE RECEIVES HEALTH CARE SERVICES AT THE ENROLLEE'S NETWORK FACILITY BUT THE SERVICES ARE RENDERED BY AN OUT-OF-NETWORK PROVIDER, THE HEALTH INSURER SHALL REIMBURSE THE HEALTH CARE PROVIDER THE GREATER OF THE AVERAGE CONTRACTED RATE, OR ONE HUNDRED TWENTY-FIVE PERCENT OF THE AMOUNT MEDICARE REIMBURSES ON A FEE-FOR-SERVICE BASIS FOR THE SAME OR SIMILAR SERVICES IN THE GEOGRAPHIC REGION IN WHICH THE SERVICES WERE RENDERED.

B. WHEN AN ENROLLEE RECEIVES EMERGENCY SERVICES AT AN OUT-OF-NETWORK FACILITY, THE HEALTH INSURER SHALL REIMBURSE THE HEALTH CARE FACILITY OR HEALTH CARE PROVIDER THE GREATER OF THE AVERAGE CONTRACTED RATE, OR ONE HUNDRED TWENTY-FIVE PERCENT OF THE AMOUNT MEDICARE REIMBURSES ON A FEE-FOR-SERVICE BASIS FOR THE SAME OR SIMILAR SERVICES IN THE GEOGRAPHIC REGION IN WHICH THE SERVICES WERE RENDERED.

C. WHEN AN ENROLLEE IS ATTENDED OR TRANSPORTED BY AN OUT-OF-NETWORK AMBULANCE, THE HEALTH INSURER SHALL REIMBURSE THE AMBULANCE OR AMBULANCE SERVICE THE GREATER OF THE AVERAGE CONTRACTED RATE OR THE RATE SET BY THE DEPARTMENT OF HEALTH SERVICES PURSUANT TO TITLE 36, CHAPTER 21.1, ARTICLE 2.

Sec. 7. Section 20-3114, Arizona Revised Statutes, is amended to read:

20-3114. Dispute resolution; settlement teleconference; arbitration; surprise out-of-network bills

A. An enrollee who has received a surprise out-of-network bill and who disputes the amount of the bill may seek dispute resolution of the bill by filing a request for arbitration with the department not later than one year after the date of service noted in the surprise out-of-network bill, except as otherwise provided in this section, if ~~all of~~ the following apply:

1. The enrollee has resolved any health care appeal pursuant to chapter 15, article 2 of this title that the enrollee may have had against the health insurer following the health insurer's initial adjudication of the claim. The one-year time period for requesting arbitration is tolled from the date that the enrollee files a health care appeal until the date of final resolution of the appeal.

2. The enrollee has not instituted a civil lawsuit or other legal action against the insurer or health care provider related to the same surprise out-of-network bill or the health care services provided.

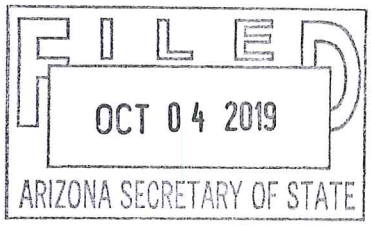
3. The amount of the surprise out-of-network bill ~~for which the enrollee is responsible~~ for all related health care services provided by the health care provider whether contained in one or multiple bills, after deduction of the enrollee's cost sharing requirements and the insurer's allowable reimbursement, is at least one thousand dollars.

B. If an enrollee requests dispute resolution of a surprise out-of-network bill, the enrollee or the enrollee's authorized representative shall participate in an informal settlement teleconference and may participate in the arbitration of the bill. If the enrollee or enrollee's authorized representative fails to attend the informal settlement teleconference, the conference shall be terminated and the enrollee, within fourteen days after the first scheduled informal settlement teleconference, may request that the department reschedule the informal settlement teleconference. If the enrollee does not request that the department reschedule the informal settlement teleconference, the enrollee forfeits the right to arbitrate the surprise out-of-network bill. The health care provider or the provider's representative and the health insurer shall participate in the informal settlement teleconference and the arbitration.

~~C. An enrollee may not seek dispute resolution of a bill if the enrollee or the enrollee's authorized representative signed the disclosure prescribed in section 20-3113, subsection A, paragraph 2 and the amount actually billed to the enrollee is less than or equal to the estimated total cost provided in the disclosure.~~

Sec. 8. Section 20-3115, Arizona Revised Statutes, is amended to read:

20-3115. Conduct of arbitration proceedings



A. The department shall develop a simple, fair, efficient and cost-effective arbitration procedure for surprise out-of-network bill disputes and specify time frames, standards and other details of the arbitration proceeding, including procedures for scheduling and notifying the parties of the settlement teleconference required by subsection E of this section. The department shall contract with one or more entities to provide arbitrators who are qualified under section 20-3116 for this process. Department staff may not serve as arbitrators.

B. An enrollee may request arbitration of a surprise out-of-network bill by submitting a request for arbitration to the department on a form prescribed by the department, which shall include contact, billing and payment information regarding the surprise out-of-network bill and any other information the department believes is necessary to confirm that the bill qualifies for arbitration. The form shall be made available on the department's website.

C. Within fifteen days after receipt of a request for arbitration, the department shall do one of the following:

1. Determine that the surprise out-of-network bill qualifies for arbitration under this article and notify the enrollee, health insurer and health care provider that the request qualifies.

2. Determine that the surprise out-of-network bill does not qualify for arbitration under this article and notify the enrollee that the surprise out-of-network bill does not qualify and state the reason for the determination.

3. If the department cannot determine whether the surprise out-of-network bill qualifies for arbitration, request in writing any additional information from the enrollee, health insurer or health care provider or its billing company that is needed to determine whether the surprise out-of-network bill qualifies for arbitration and all of the following apply:

(a) The enrollee, health insurer or health care provider or its billing company shall respond to the department's request for additional information within fifteen days after the date of the department's request.

(b) Within seven days after receipt of the additional requested information, the department shall determine whether the surprise out-of-network bill qualifies for arbitration and send the notices required under this subsection.

(c) If the health insurer or health care provider or its billing company fails to respond within the time frame specified in subdivision (a) of this paragraph to a department request for information, the department shall deem the request for arbitration as eligible for arbitration. If the enrollee fails to respond within the time frame specified in subdivision (a) of this paragraph, the request for arbitration is denied.

D. The determination by the department of whether a surprise out-of-network bill qualifies for arbitration is a final and binding decision with no right of appeal to the department. The department's determination is solely an administrative remedy and does not bar any private right or cause of action for or on behalf of any enrollee, provider or other person. The court shall decide the matter, including any interpretation of statute or rule, without deference to any previous determination that may have been made on the question by the department.

E. In an effort to settle the surprise out-of-network bill before arbitration, the department shall arrange an informal settlement teleconference within thirty days after the department sends the notices required by this section. The department is not a party to and may not participate in the informal settlement teleconference. As part of the settlement teleconference the health insurer shall provide to the parties the enrollee's cost sharing requirements under the enrollee's health plan based on the adjudicated claim. The insurer shall notify the department whether the informal settlement teleconference resulted in settlement of the disputed surprise out-of-network bill and, if settlement was reached, notify the department of the terms of the settlement within seven days.

F. If after proper notice from the department or contracted entity either the health insurer or health care provider or the provider's representative fails to participate in the teleconference, the other party may notify the department to immediately initiate arbitration and the nonparticipating party shall be required to pay the total cost of the arbitration.

G. On receipt of notice that the dispute has not settled or that a party has failed to participate in the teleconference, the department shall appoint an arbitrator and shall notify the parties of the arbitration and the appointed arbitrator. The department's notice shall specify whether one party is responsible for the total cost of the arbitration pursuant to subsection F of this section. The ~~health insurer and health care provider~~ PARTIES must agree on the arbitrator and may mutually agree to use an arbitrator who is not on the department's list. If ~~either the health insurer or health care provider~~ ANY PARTY objects to the arbitrator, and the parties are unable to agree on a mutually acceptable alternative arbitrator, the department or contracted entity shall randomly assign ~~three~~ FOUR arbitrators. The ENROLLEE, health insurer and the health care provider shall each strike one arbitrator, and the last arbitrator shall conduct the arbitration unless there are two OR MORE arbitrators remaining, in which case the department or contracted entity shall randomly assign the arbitrator.

H. Before the arbitration:

1. The enrollee shall pay or make arrangements in writing to pay the health care provider the total amount of the enrollee's cost sharing requirements that is due for the health care services that are the subject of the surprise out-of-network bill as stated by the health insurer in the settlement teleconference.

2. The enrollee shall pay any amount that has been received by the enrollee from the enrollee's health insurer as payment for the out-of-network health care services that were provided by the health care provider.

3. If a health insurer pays for out-of-network health care services directly to a health care provider, the health insurer that has not remitted its payment for the out-of-network health care services shall remit the amount due to the health care provider.

I. Arbitration of any surprise out-of-network bill shall be conducted telephonically unless otherwise agreed by all of the required participants.

J. Arbitration of the surprise out-of-network bill shall take place with or without the enrollee's participation.

K. The arbitrator shall determine the amount the health care provider is entitled to receive as payment for the health care services. The arbitrator shall allow each party to provide information the arbitrator reasonably determines to be relevant in evaluating the surprise out-of-network bill~~, including the following information:~~ CONSISTENT WITH SECTION 20-3113.

~~1. The average contracted amount that the health insurer pays for the health care services at issue in the county where the health care services were performed.~~

~~2. The average amount that the health care provider has contracted to accept for the health care services at issue in the county where the services were performed.~~

~~3. The amount that medicare and medicaid pay for the health care services at issue.~~

~~4. The health care provider's direct pay rate for the health care services at issue, if any, under section 32-3216.~~

~~5. Any information that would be evaluated in determining whether a fee is reasonable under title 32 and not excessive for the health care services at issue, including the usual and customary charges for the health care services at issue performed by a health care provider in the same or similar specialty and provided in the same geographic area.~~

~~6. Any other reliable databases or sources of information on the amount paid for the health care services at issue in the county where the services were performed.~~

L. Except on the agreement of the parties participating in the arbitration, the arbitration shall be conducted within one hundred twenty days after the department's notice of arbitration.

M. Except on the agreement of the parties participating in the arbitration, the arbitration may not last more than four hours.

N. The arbitrator shall issue a final written decision within ten business days following the arbitration hearing. The arbitrator shall provide a copy of the decision to the enrollee, the health insurer and the health care provider or its billing company or authorized representative.

O. All pricing information provided by health insurers and health care providers in connection with the arbitration of a surprise out-of-network bill is confidential and may not be disclosed by the arbitrator or any other party participating in the arbitration or used by anyone, other than the providing party, for any purpose other than to resolve the surprise out-of-network bill.

P. All information received by the department or contracted entity in connection with an arbitration is confidential and may not be disclosed by the department or contracted entity to any person other than the arbitrator.

Q. A claim that is the subject of an arbitration request is not subject to article 1 of this chapter during the pendency of the arbitration. A health insurer shall remit its portion of the payment resulting from the informal settlement teleconference or the amount awarded by the arbitrator within thirty days after resolution of the claim.

R. A claim that is reprocessed by an insurer as a result of a settlement, arbitration decision or other action under this article is not in violation of section 20-3102, subsection L.

S. Notwithstanding any informal settlement or the arbitrator's decision under this article, the enrollee is responsible for only the amount ~~of the enrollee's cost sharing requirements and any amount received by the enrollee from the enrollee's health insurer as payment for the out-of-network health care services that were provided by the health care provider~~ PERMITTED BY SECTION 20-3113, and the health care provider may not issue, either directly or through its billing company, any additional balance bill to the enrollee related to the health care service that was the subject of the informal settlement teleconference or arbitration.

T. Unless all the parties otherwise agree or unless required by subsection F of this section, the health insurer and the health care provider shall share the costs of the arbitration equally, and the enrollee is not responsible for any portion of the cost of the arbitration. The health insurer and health care provider shall make payment arrangements with the arbitrator for their respective share of the costs of the arbitration.

Sec. 9. Title 23, chapter 2, article 8 Arizona Revised Statutes, is amended by adding section 23-363.01, to read:

23-363.01. Minimum Wage Rates for Direct Care Hospital Workers; Definitions

A. EXISTING DIRECT CARE HOSPITAL WORKERS

1. BEGINNING ON THE EFFECTIVE DATE OF THIS SECTION, THE MINIMUM WAGE FOR EACH EXISTING DIRECT CARE HOSPITAL WORKER SHALL BE FIVE PERCENT GREATER THAN THE EXISTING DIRECT CARE HOSPITAL WORKER'S WAGE RATE IN THE PREVIOUS YEAR, WHICH IS THE HIGHEST HOURLY RATE OF BASE WAGES (OR, IF THE WORKER IS PAID ON A SALARY BASIS, THE EQUIVALENT BASE HOURLY RATE) THAT WAS PAID TO THE EXISTING DIRECT CARE HOSPITAL WORKER IN THE YEAR BEFORE THE EFFECTIVE DATE OF THIS SECTION. THIS WAGE INCREASE ESTABLISHES THE NEW MINIMUM RATE OF PAY FOR THE EXISTING DIRECT CARE HOSPITAL WORKER, WHICH SHALL REMAIN IN EFFECT FOR THE FULL CALENDAR YEAR UNTIL THE NEXT WAGE INCREASE IS DUE PURSUANT TO THIS SECTION, UNTIL THE EMPLOYER RAISES WAGES PURSUANT TO SUBSECTION C OF THIS SECTION OR UNTIL THE EXISTING DIRECT CARE HOSPITAL WORKER IS NO LONGER EMPLOYED, WHICHEVER OCCURS FIRST.

2. FOLLOWING THE WAGE INCREASE MADE ON THE EFFECTIVE DATE OF THIS SECTION, THE MINIMUM WAGE FOR EXISTING DIRECT CARE HOSPITAL WORKERS SHALL BE INCREASED BY FIVE PERCENT EACH JANUARY 1 FOR THE FOLLOWING THREE YEARS.

B. NEWLY HIRED DIRECT CARE HOSPITAL WORKERS. THE MINIMUM WAGE FOR ANY NEWLY HIRED DIRECT CARE HOSPITAL WORKER MUST BE NO LESS THAN THE MINIMUM WAGE PAID TO ANY OTHER DIRECT CARE HOSPITAL WORKER WITH THE SAME JOB CLASSIFICATION OR WITH EQUIVALENT JOB RESPONSIBILITIES AND DUTIES AT THAT COVERED HOSPITAL.

C. ALL DIRECT CARE HOSPITAL WORKERS

1. AN EMPLOYER MAY INCREASE BASE WAGES FOR DIRECT CARE HOSPITAL WORKERS ABOVE THE REQUIRED MINIMUM WAGE AT ANY TIME BUT MAY NOT REDUCE BASE WAGES BELOW THE REQUIRED MINIMUM WAGE AMOUNT ESTABLISHED PURSUANT TO THIS SECTION.

2. BEGINNING THE FIFTH YEAR AFTER THE EFFECTIVE DATE OF THIS SECTION, NO FURTHER DIRECT CARE HOSPITAL WORKER MINIMUM WAGE INCREASES SHALL BE REQUIRED BY OPERATION OF THIS SECTION, BUT DIRECT CARE HOSPITAL WORKERS' BASE WAGES MUST REMAIN EQUAL TO OR GREATER THAN THEIR BASE WAGES AS OF DECEMBER 31 OF THE FOURTH YEAR AFTER THE EFFECTIVE DATE OF THIS SECTION.

3. COVERED HOSPITALS SHALL ENSURE THAT ALL DIRECT CARE HOSPITAL WORKERS WHO WORK AT THAT COVERED HOSPITAL ARE COMPENSATED UNDER THE REQUIREMENTS OF THIS SECTION, REGARDLESS OF WHETHER THE DIRECT CARE HOSPITAL WORKER IS EMPLOYED BY THE COVERED HOSPITAL OR BY ANOTHER EMPLOYER.

4. AN EMPLOYER MAY NOT OFFSET THE MINIMUM WAGE REQUIREMENTS ESTABLISHED BY THIS SECTION BY REDUCING BENEFITS, PAID LEAVE, SHIFT DIFFERENTIALS, PREMIUMS, OR OTHER COMPENSATION PAID TO A DIRECT CARE HOSPITAL WORKER, INCLUDING NEWLY HIRED DIRECT CARE HOSPITAL WORKERS.

D. FOR THE PURPOSES OF THIS SECTION:

1. "BASE WAGES" MEANS MONETARY COMPENSATION THAT IS DUE TO AN EMPLOYEE BY REASON OF EMPLOYMENT, INCLUDING AN EMPLOYEE'S COMMISSIONS, BUT NOT TIPS, GRATUITIES, PAID LEAVE OR BENEFITS.

2. "COVERED HOSPITAL" MEANS ANY GENERAL HOSPITAL OR RURAL GENERAL HOSPITAL IN THIS STATE, AS DEFINED IN RULE OR ANY SATELLITE FACILITY LICENSED UNDER A GENERAL HOSPITAL'S OR RURAL GENERAL HOSPITAL'S LICENSE PURSUANT TO SECTION 36-422, OTHER THAN A HOSPITAL OR FACILITY OPERATED BY THE FEDERAL GOVERNMENT, THIS STATE, A COUNTY OR A SPECIAL HEALTH CARE DISTRICT ESTABLISHED PURSUANT TO TITLE 48, CHAPTER 31.

3. "DIRECT CARE HOSPITAL WORKER" MEANS ANY NONMANAGERIAL WORKER WHO IS EMPLOYED TO WORK AT OR BY A COVERED HOSPITAL TO PROVIDE DIRECT PATIENT CARE AND SERVICES DIRECTLY SUPPORTING PATIENT CARE, INCLUDING BUT NOT LIMITED TO NURSES, AIDES, TECHNICIANS, JANITORIAL AND HOUSEKEEPING STAFF, FOOD SERVICES WORKERS, AND NONMANAGERIAL ADMINISTRATIVE STAFF. "DIRECT CARE HOSPITAL WORKER" DOES NOT INCLUDE A PHYSICIAN LICENSED PURSUANT TO TITLE 32.

4. "EXISTING DIRECT CARE HOSPITAL WORKER" MEANS ANY DIRECT CARE HOSPITAL WORKER WHO IS EMPLOYED AS OF DECEMBER 31 OF THE YEAR PRECEDING THE DATE ANY MINIMUM WAGE INCREASE IS DUE PURSUANT TO THIS SECTION.

Sec. 10. Title 36, Chapter 25, Arizona Revised Statutes, is amended by adding a new article 3 to read:

ARTICLE 3. HOSPITAL-ACQUIRED INFECTION CONTROL.

36-2421. Definitions

IN THIS ARTICLE, THE FOLLOWING TERMS ARE USED AS DEFINED:

1. "COVERED HOSPITAL" MEANS ANY GENERAL HOSPITAL OR RURAL GENERAL HOSPITAL IN THIS STATE, AS DEFINED IN RULE, OR ANY SATELLITE FACILITY LICENSED UNDER A GENERAL HOSPITAL'S OR RURAL GENERAL HOSPITAL'S LICENSE PURSUANT TO SECTION 36-422, OTHER THAN A HOSPITAL OR FACILITY OPERATED BY THE FEDERAL GOVERNMENT, THIS STATE, A COUNTY OR A SPECIAL HEALTH CARE DISTRICT ESTABLISHED PURSUANT TO TITLE 48, CHAPTER 31.

2. "DEPARTMENT" MEANS THE DEPARTMENT OF HEALTH SERVICES, OR ANY SUCCESSOR AGENCY WITH SIMILAR AUTHORITY AND RESPONSIBILITIES.

3. "HOSPITAL-ACQUIRED INFECTION STANDARD" INCLUDES ALL OF THE FOLLOWING:

(a) A CLASSIFICATION BY THE CENTERS FOR DISEASE CONTROL AND PREVENTION OF "NO DIFFERENT THAN THE NATIONAL BENCHMARK" OR "BETTER THAN THE NATIONAL BENCHMARK" FOR ANY OF THE FOLLOWING TYPES OF HOSPITAL-ACQUIRED INFECTIONS, AS OF THE MOST RECENT DATA COLLECTION PERIOD REPORTED IN THE HOSPITAL COMPARE DATA PUBLISHED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES:

(i) *CLOSTRIDIUM DIFFICILE.*

(ii) CENTRAL LINE-ASSOCIATED BLOODSTREAM INFECTION.

(iii) CATHETER-ASSOCIATED URINARY TRACT INFECTIONS.

(iv) SURGICAL SITE INFECTIONS.

(v) METHICILLIN-RESISTANT *STAPHYLOCOCCUS AUREUS.*

(b) IF THE CENTERS FOR DISEASE CONTROL AND PREVENTION AND CENTERS FOR MEDICARE AND MEDICAID SERVICES CEASE TO TRACK AND PROVIDE COMPARISONS OF ANY OF THE HOSPITAL-ACQUIRED INFECTIONS PRESCRIBED IN SUBDIVISION (a) OF THIS PARAGRAPH, ANY APPROPRIATE ALTERNATIVE STANDARD THAT THE DEPARTMENT DEFINES.

(c) IF THE CENTERS FOR DISEASE CONTROL AND PREVENTION AND CENTERS FOR MEDICARE AND MEDICAID SERVICES TRACK AND COMPARE OTHER HEALTH CARE-ASSOCIATED DISEASES AND ORGANISMS TO NATIONAL BENCHMARKS, INCLUDING OTHER MULTIDRUG RESISTANT BACTERIA, A CLASSIFICATION OF "NO DIFFERENT THAN THE NATIONAL BENCHMARK" OR "BETTER THAN THE NATIONAL BENCHMARK" FOR THOSE ADDITIONAL DISEASES AND ORGANISMS, AS OF THE MOST RECENT DATA COLLECTION PERIOD REPORTED IN THE HOSPITAL COMPARE DATA PUBLISHED BY CENTERS FOR MEDICARE AND MEDICAID SERVICES.

36-2422. Hospital-Acquired Infections; standard; reduction; annual report; posting; fees; fund; civil penalty

A. COVERED HOSPITALS SHALL MEET THE HOSPITAL-ACQUIRED INFECTION STANDARD.

B. IN JANUARY OF EACH YEAR, EACH COVERED HOSPITAL SHALL ASSESS WHETHER, FOR THE PREVIOUS YEAR, IT WAS IN COMPLIANCE WITH THE HOSPITAL-ACQUIRED INFECTION STANDARD, AND SHALL REPORT ON ITS PERFORMANCE TO THE DEPARTMENT ON OR BEFORE FEBRUARY 1 OF THAT YEAR. THE REPORT SHALL INCLUDE ALL DATA SUFFICIENT FOR THE DEPARTMENT TO CONFIRM THAT THE COVERED HOSPITAL MET THE HOSPITAL-ACQUIRED INFECTION STANDARD FOR THE RELEVANT PERIOD. THE COVERED HOSPITAL MUST EXPLAIN WHY ANY CATEGORY OF HOSPITAL COMPARE DATA FOR THE RELEVANT PERIOD IS REPORTED AS NOT AVAILABLE. COVERED HOSPITALS SHALL PROVIDE ANY FOLLOW-UP INFORMATION REQUESTED BY THE DEPARTMENT WITHIN THIRTY DAYS AFTER THE REQUEST.

C. THE DEPARTMENT MAY TAKE ANY ACTION NECESSARY TO REDUCE THE INCIDENCE OF HOSPITAL-ACQUIRED INFECTIONS, INCLUDING TAKING ANY ACTION TO ENFORCE THE PROVISIONS OF THIS ARTICLE AND TO ADDRESS COVERED HOSPITALS' NONCOMPLIANCE WITH THE HOSPITAL-ACQUIRED INFECTION STANDARD.

D. THE DEPARTMENT SHALL PROMPTLY MAKE SUCH CHANGES IN AND ADDITIONS TO RULES AS ARE NECESSARY TO FULLY IMPLEMENT THIS SECTION. REGULATORY ACTIONS THE DEPARTMENT MAY TAKE TO ADDRESS NONCOMPLIANCE WITH THE HOSPITAL-ACQUIRED INFECTION STANDARD INCLUDE BUT ARE NOT LIMITED TO THE FOLLOWING:

1. REQUIRING INSPECTIONS OF COVERED HOSPITALS TO IDENTIFY PRACTICES CONTRIBUTING TO INFECTION PROBLEMS.

2. RECOMMENDING OR REQUIRING STAFFING STANDARDS TO ADDRESS INFECTION PROBLEMS.

3. COORDINATING WITH LOCAL HEALTH DEPARTMENTS TO IDENTIFY AND ADDRESS INFECTION PROBLEMS SPECIFIC TO LOCALITIES.

4. DEVELOPING TRAINING OR LICENSING STANDARDS INTENDED TO REDUCE INFECTION RATES.

E. THE DEPARTMENT MAY AUDIT ANY COVERED HOSPITAL FOR COMPLIANCE WITH THIS ARTICLE. THE DEPARTMENT SHALL NOTIFY THE COVERED HOSPITAL TO BE AUDITED IN WRITING AT LEAST SEVEN DAYS BEFORE THE DATE OF THE AUDIT. THE COVERED HOSPITAL TO BE AUDITED SHALL MAKE AVAILABLE FOR INSPECTION AND COPYING AT ALL REASONABLE TIMES ITS OWN BOOKS AND RECORDS, AS WELL AS THOSE OF ANY AFFILIATE OR RELATED ENTITY AS IS RELEVANT. A COVERED HOSPITAL MAY NOT REFUSE TO ALLOW AN AUDIT AFTER A LAWFUL REQUEST BY THE DEPARTMENT.

F. EACH COVERED HOSPITAL SHALL PUBLICLY POST CLEAR AND EASILY COMPREHENSIBLE INFORMATION REGARDING ITS COMPLIANCE OR NONCOMPLIANCE WITH THE HOSPITAL-ACQUIRED INFECTION STANDARD FOR THE CURRENT REPORTED YEAR AND THE THREE PRECEDING YEARS. IF THE HOSPITAL COMPARE DATA FOR THAT COVERED HOSPITAL IS REPORTED AS NOT AVAILABLE, THE COVERED HOSPITAL SHALL PROVIDE A CLEAR EXPLANATION OF WHY. SUCH INFORMATION SHALL BE POSTED ON THE COVERED HOSPITAL'S PUBLIC WEBSITE AND IN CONSPICUOUS, CLEARLY VISIBLE LOCATIONS NEAR EACH PUBLIC ENTRANCE OF THE ESTABLISHMENT OR IN OTHER CONSPICUOUS LOCATIONS IN CLEAR VIEW OF THE PUBLIC AND EMPLOYEES WHERE SIMILAR NOTICES ARE CUSTOMARILY POSTED.

G. EACH COVERED HOSPITAL SHALL MAINTAIN RECORDS FOR AT LEAST FOUR YEARS SHOWING COMPLIANCE WITH THE REQUIREMENTS OF THIS ARTICLE.

H. THE DEPARTMENT SHALL IMPOSE A FIRST YEAR ANNUAL FEE OF $2,000 ON EACH COVERED HOSPITAL TO RECOVER THE COSTS OF ADMINISTERING THIS ARTICLE. THE DEPARTMENT MAY ADJUST THIS FEE AS NECESSARY BASED ON ACTUAL COSTS YEAR TO YEAR. THE DEPARTMENT SHALL ESTABLISH THE REDUCTIONS OF HOSPITAL-ACQUIRED INFECTIONS FUND AND SHALL DEPOSIT THE FEES COLLECTED PURSUANT TO THIS SECTION IN THE FUND.

I. THE DEPARTMENT SHALL IMPOSE A CIVIL PENALTY ON COVERED HOSPITALS THAT VIOLATE THIS ARTICLE OR ANY RULE ADOPTED BY THE DEPARTMENT PURSUANT TO THIS ARTICLE. THE PENALTY IS $500 PER VIOLATION. EACH DAY THAT A VIOLATION OCCURS CONSTITUTES A SEPARATE VIOLATION. ACTIONS TO ENFORCE THE COLLECTION OF THESE PENALTIES SHALL BE BROUGHT IN THE NAME OF THIS STATE BY THE DEPARTMENT, THE ATTORNEY GENERAL OR THE COUNTY ATTORNEY IN THE JUSTICE COURT OR THE SUPERIOR COURT IN THE COUNTY IN WHICH THE VIOLATION OCCURRED. THESE PENALTIES SHALL BE DEPOSITED IN THE REDUCTIONS OF HOSPITAL-

ACQUIRED INFECTIONS FUND ESTABLISHED PURSUANT TO THIS SECTION AND SHALL BE USED FOR THE COSTS OF ENFORCING THIS ARTICLE. INTEREST ON PENALTIES AND ON ALL OTHER MONETARY RELIEF SHALL ACCRUE AT THE RATE OF TEN PERCENT EACH YEAR.

36-2423. Reductions of Hospital-Acquired Infections Fund

A. THE REDUCTIONS OF HOSPITAL-ACQUIRED INFECTIONS FUND IS ESTABLISHED CONSISTING OF ALL MONIES COLLECTED PURSUANT TO SECTION 36-2420. THE DIRECTOR SHALL ADMINISTER THE FUND.

B. THE DIRECTOR SHALL USE FUND MONIES EACH FISCAL YEAR TO RECOVER THE COSTS OF ADMINISTERING THIS ARTICLE.

C. MONIES IN THE FUND:

1. DO NOT REVERT TO THE STATE GENERAL FUND.

2. ARE EXEMPT FROM THE PROVISIONS OF SECTION 35-190 RELATING TO LAPSING OF APPROPRIATIONS.

3. ARE CONTINUOUSLY APPROPRIATED.

Sec. 11. Conflicts with federal law

This act shall not be interpreted or applied so as to create any power or duty in conflict with federal law.

Sec. 12. Severability

If a provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act that can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Sec. 13. Saving clause

This act does not affect rights and duties that matured, penalties that were incurred and proceedings that were begun before the effective date of this act.

Sec. 14. Legal defense

The People of Arizona desire that this initiative, if approved by the voters, be defended if it is challenged in court. They therefore declare that the political committee registered to circulate petitions and campaign in support of the adoption of this initiative, or any one or more of its officers, has standing to defend this initiative on behalf of and as the agent of the People of Arizona in any legal action brought to challenge the validity of this initiative.

Sec. 15. Short Title

This act may be cited as the "Stop Surprise Billing and Protect Patients Act".