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# REVISED STATUTE:
# ARIZONA'S SURPRISE OUT-OF-NETWORK MEDICAL BILL


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In an attempt to protect consumers from "surprise medical bills" the Arizona legislature recently passed Senate Bill 1445 into law as Article 2 of Title 20, Chapter 20 of the Arizona revised statutes. This legislation provides recourse through alternative dispute resolution for balances owed to out of network healthcare provider. The process outlined in Article 2 is managed by the Arizona Department of Insurance ("the department") and brings the patient ("enrollee"), the insurance company, and the provider – or their respective representatives – to the negotiating table to settle out of network claim disputes.

This article provides a general overview of Article 2 and the duties it imposes on the parties. It is important to understand that the effect of this bill is to arrive at a fair settlement between the insurer and the provider. The provider is not attempting to show what it is entitled to collect from the enrollee, but rather what the provider is entitled to collect from the insurer. Article 2 makes clear that the enrollee will only ever be liable for his or her cost share.

## SURPRISE MEDICAL BILL

To qualify as a "surprise medical bill" the bill must meet a number of criteria listed in Section 20-3113. First, the services must have been provided at an in-network hospital by an out-of-network provider. According to Article 2, providers who would qualify include health care professionals, laboratories, and durable medical equipment providers.

The services must also meet one of several additional qualifications:

- The services were rendered during an emergency or during an inpatient stay directly related to an emergency.
- The services are not related to an emergency, and the provider fails to provide the enrollee with a written, dated disclosure.
- The services are not related to an emergency, and the enrollee chooses not to sign the provided disclosure.

## WRITTEN DISCLOSURE REQUIREMENTS

An out-of-network provider is required to provide an enrollee with a written, dated disclosure to avoid a bill qualifying as a surprise medical bill. Section 20-3113 requires the disclosure to contain three elements. First, the disclosure must name the provider and state that the provider is not contracted. Second, the disclosure must include an estimate of the total cost to be billed by the provider. Third, the disclosure must state that the enrollee is not required to sign the disclosure to obtain medical care, but if they do sign, they may have waived any rights to dispute resolution under Article 2.

The written dated disclosure requirement is problematic in a couple of ways. First, the onus for delivering the disclosure statement is on the non-participating provider, but such providers may be largely dependent on the facility's administrative infrastructure to coordinate care. Under the statute, facilities have no incentive to ensure the enrollee receives the written disclosure, and the affected providers may very well not have the access to the patient necessary to deliver such a disclosure.

Additionally, the patient has no incentive to sign the disclosure. On the contrary, the disclosure must state that the enrollee "is not required to sign the disclosure

to obtain medical care." This language creates a catch-22 for providers. The provider may not balance bill the enrollee unless the enrollee signs the disclosure, but the provider must render care even if the enrollee refuses to sign. It is unlikely that the legislature intended this result, but we can only await clarification either from the legislature or the courts.

## ADDITIONAL THRESHOLD REQUIREMENTS

Even if the bill qualifies as a surprise medical bill, the enrollee must still satisfy some additional requirements to be eligible for alternative dispute resolution. Article 2 states that "all of the following" must apply. First, the bill must be greater than $1000 after deducting the patient's cost share. Second, the patient must have already resolved an appeal with the insurer. Third, the enrollee must submit the request for arbitration within one year of receiving the surprise bill; however, the time period is tolled while the enrollee exercises his or her appeal rights with the insurer. Finally, the enrollee cannot have sued either the insurer or the provider in relation to the same bill or the services billed.

The statute is not clear as to how to calculate the tolled period. The department has stated that it will consider the deadline to "begin to run on the date the healthcare appeal or litigation concludes." This rule appears contrary to the plain language of the statute. The statute is clear that the deadline begins to run from the date the enrollee receives the bill, not when the appeal is resolved. Also, there is no toll period applied to litigation. If the enrollee has "instituted a civil lawsuit or other legal action against the insurer or healthcare provider related to the same surprise out-of-network bill or the health care services provided," then they may not avail themselves of the Article 2 dispute process.

An enrollee also may not seek dispute resolution if the enrollee signed the statutory disclosure and the amount billed is less than or equal to the estimated amount on the disclosure. Before arbitration, the enrollee must participate in an informal teleconference with the insurer and the provider, but the enrollee does not have to participate in the actual arbitration.

The enrollee must pay his cost share prior to arbitration. The cost share does not have to be paid before requesting the alternative dispute process, but if the request is approved, it must be paid, or at least payment arrangements must be agreed to, before the arbitration can take place. The insurer, also, must pay to the provider it's out-of-network benefit to the provider prior to arbitration. In short, all amounts agreed to be paid must be paid prior to arbitrating the disputed amount.

## PREPARING FOR ARBITRATION

It is left up to the Department of Insurance to develop a "simple, fair, efficient, and cost-effective" arbitration procedure. The enrollee must contact the department to request arbitration. The department is then responsible for determining if the bill qualifies for arbitration. The department must make this determination quickly, as it is required to notify the insurer and the provider within 15 days if the bill qualifies.

If the department cannot determine whether the bill qualifies on the basis of the information provided, it must request additional information within the 15-day time period. That information may be requested from the enrollee, the insurer, or the provider, who must respond to the request within 15 days. If an insurer or provider fails to respond to information requests timely, the department will deem the bill eligible for arbitration. If the enrollee fails to respond timely, it will deny the request for arbitration. After the additional information is received, the department has an additional seven days to review the information and make a determination.

Prior to arbitration, the department will arrange an informal teleconference between the parties, but the department may not participate in the teleconference. The insurer is tasked with reporting back to the department whether the conference resulted in a settlement. If either the insurer or provider fail to participate in the teleconference, the case moves immediately to arbitration, and the nonparticipating party must pay the total cost of the arbitration; otherwise, the cost of arbitration is shared between the insurer and provider.

At this point, the department will appoint an arbitrator. If the parties do not agree to the appointed

arbitrator, the department will appoint three arbitrators and the health insurer and provider will each strike one. The remaining arbitrator will preside.

## THE ARBITRATION PROCESS

Arbitrations must be conducted within 120 days of the notice of arbitration. The arbitration will be conducted by teleconference, may not last longer than four hours, and the arbitrator must issue a decision within 10 days of the arbitration. The insurer must pay any outstanding amount within 30 days of resolution. Some of these requirements can be modified by the agreement of the parties, but in no case can the enrollee be billed for any amount beyond his or her cost share.

The arbitrator's job is to determine the amount the health care provider is entitled to receive from the insurer. The arbitrator should allow any information to be presented that is relevant to making that determination. Such information could include Medicare and Medicaid allowed amounts, an insurer's usual and customary charge rate, the provider's average contractual rate, and other data. Both the arbitrator and the department are obligated to keep any information revealed to them confidential, so the parties can feel comfortable making their case without compromising their sensitive pricing information.

While ambiguities in the legislation may cause some complications, the alternative dispute process is generally clear and will likely assist all parties concerned in a fair resolution to out-of-network claims resulting from non-contracted provider care. If non-contracted providers wish to avoid the arbitration process, obtaining signed disclosures from enrollees will be key. Although participating facilities have no express duty under Article 2, the facility will often be in the best position to ensure that enrollees are served by participating providers when possible. In the current healthcare marketplace, where stakeholders are increasingly pressured to collaborate for better clinical and fiscal outcomes, limiting patient exposure to out-of-network bills is a need that will only grow more urgent.