# *ARIZONA STATE SENATE*

***Fifty-Third Legislature, First Regular Session***

**AMENDED**

FACT SHEET FOR S.B. 1441

~~insurers; health providers; claim mediation~~

(NOW: insurers; health providers; claims arbitration)

Purpose

Allows an enrollee of a health plan who has received a surprise out-of-network bill (bill) and who disputes the amount of the bill to seek dispute resolution of the bill, provided that certain criteria are met.

Background

The term *balance billing*, also known as *surprise billing*, refers to situations where an enrollee receives a medical bill from a health care provider (provider) who does not belong to their health insurer's (insurer) provider network, typically for medical services that are rendered at an in-network health care facility. In such situations, the enrollee is charged by the out-of-network provider for an amount in excess of that which is reimbursable under the enrollee's health plan for the specific medical services rendered. Participating providers within a health plan's provider network are generally prohibited from balance billing a patient under their respective contracts with the plan.

The National Association of Insurance Commissioners (NAIC) *Health Benefit Plan Network Access and Adequacy Model Act*, adopted in 2015, defines *balance billing* as the practice of a provider billing for the difference between the provider's charge and the insurer's allowed amount. All 50 states and the District of Columbia have balance billing laws in place. These laws, however, vary widely in terms of their applicability and scope. Under current Arizona law, for instance, no provider or hospital may charge an enrollee or a health care services organization (organization) more than the amount the provider or hospital contracted to charge the enrollee pursuant to that provider or hospital's contract with the organization (A.R.S. § 20-1072).

A number of states, including Colorado, Connecticut, Florida, Illinois, Indiana and Texas, have enacted laws specifically limiting balance billing by out-of-network providers under certain circumstances.

The fiscal impact to the state General Fund associated with this legislation is unknown.

Provisions

***Dispute Resolution Process***

1. Allows an enrollee who has received a bill and who disputes the amount of the bill to seek dispute resolution if all of the following apply:

   a) the enrollee has resolved any health care appeal that the enrollee may have had against the insurer following the insurer's initial adjudication of the claim;
   b) the amount of the bill for which the enrollee is responsible after deduction of the enrollee's cost sharing requirements and the insurer's allowable reimbursement is at least $1,000; and
   c) the enrollee received the bill.

2. Requires the Arizona Department of Insurance (Department) to develop a simple, fair, efficient and cost-effective arbitration procedure for bill disputes and specify time frames, standards and other details of the arbitration proceeding.

3. Allows the Department to contract with one or more entities to provide qualified arbitrators for the purpose of the arbitration process. *Department staff may not serve as arbitrators.*

4. Requires a person to do the following in order to qualify as an arbitrator:
   a) have at least three years of experience in health care services claims; and
   b) comply with any other qualifications established by the Department.

5. Allows the enrollee to request arbitration of a bill by submitting a request for arbitration to the Department on a Department-prescribed form (form), which must include the following:
   a) contact, billing and payment information regarding the bill; and
   b) any other information the Department believes is necessary to confirm that the bill qualifies for arbitration.

6. Requires the form to be made available on the Department's website.

7. Requires the Department, on receipt of the request for arbitration, to notify the insurer and provider regarding the request.

8. Requires the Department, in an effort to settle the bill before arbitration, to arrange an informal settlement teleconference (teleconference) within 30 days after the Department receives the request for arbitration.

9. Requires the insurer, as part of the teleconference, to provide the enrollee's cost sharing requirements under the enrollee's health plan based on the adjudicated claim to the parties involved.

10. Requires the parties involved to notify the Department of the results of the teleconference.

11. Requires the enrollee to participate in the teleconference and allows the enrollee the option of participating in the arbitration.

12. Requires the insurer and provider or their representative to participate in both the teleconference and the arbitration.

13. Specifies that if either the insurer or provider or their representative fails to participate in the teleconference, then the other party may notify the Department to immediately initiate arbitration with the nonparticipating party being required to pay the total cost of the arbitration.

14. Requires the Department, upon receipt of notice that the dispute has not been settled or that a party has failed to participate in the teleconference, to appoint an arbitrator and to notify the parties of the arbitration and the appointed arbitrator.

15. Specifies that the insurer and provider must agree on the arbitrator.

16. Requires the Department or contracted entity, in the instance that the insurer or provider objects to the arbitrator, to randomly assign five arbitrators. *Of the five arbitrators assigned, the insurer and the provider would each be required to strike two arbitrators with the last arbitrator remaining conducting the arbitration.*

17. Requires the following to occur before arbitration:
    a) the enrollee pays or makes arrangements in writing to pay to the provider the total amount of the enrollee's cost sharing due for the services contained in the bill;
    b) the enrollee pays any amount received from the enrollee's insurer as payment for the out-of-network services that were rendered by the provider; and
    c) if the insurer pays for out-of-network services directly to a provider, then the insurer that has not remitted its payment for such services remits the amount due to the provider.

18. Requires arbitration of any bill to be conducted in the county in which the health care services giving rise to the bill were rendered and allows the arbitration to be conducted telephonically on the agreement of all of the participants.

19. Requires the arbitration of the bill to take place with or without the enrollee's participation.

20. Requires the arbitrator to determine the amount the provider is entitled to receive as payment for the health care services, laboratory services or durable medical equipment.

21. Requires the arbitrator to allow each party to provide information the arbitrator reasonably determines to be relevant in evaluating the bill, including the following:
    a) the average contracted amount that the insurer pays for the health care services at issue in the county where the services were performed;
    b) the average amount that the provider has contracted to accept for the health care services at issue in the county where the services were performed;
    c) the amount that Medicare and Medicaid pay for the health care services at issue;
    d) the provider's direct pay rate, if any;
    e) any information that would be evaluated in determining whether a fee is reasonable and not excessive for the health care services at issue, including the usual and customary charges for health care services at issue that were:
        i) performed by a provider in the same or similar specialty; and
        ii) provided in the same geographical area; and
    f) 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.

22. Requires the arbitration to be conducted within 120 days after the Department's notice of arbitration, except on the agreement of the parties participating in the arbitration.

23. Prohibits the arbitration from lasting more than four hours, except on the agreement of the parties participating in the arbitration.

24. Requires the arbitrator to issue a final written decision within 10 business days following the arbitration hearing.

25. Requires the arbitrator to provide a copy of the decision to the enrollee, the insurer and the provider or its billing company or authorized representative.

26. Specifies that all pricing information provided by insurers and providers in connection with the arbitration of a bill is confidential and may not be disclosed by the arbitrator or any other party participating in the arbitration.

27. Exempts a claim that is the subject of an arbitration request from being subject to A.R.S. Title 20, Chapter 20, Article 1, pertaining to the timely payment of health care provider claims, while the arbitration is pending.

28. Requires an insurer to remit its portion of the payment resulting from the teleconference or the amount awarded by the arbitrator within 30 days of resolution of the claim.

29. Stipulates that the enrollee, notwithstanding any informal settlement of the arbitrator's decision with respect to the bill, is responsible for only the amount of the enrollee's cost sharing requirements and any amount received by the enrollee from the enrollee's insurer as payment for out-of-network services that were rendered by the provider.

30. Prohibits a provider from issuing, either directly or through its billing company, any additional balance bill to the enrollee related to the health care service, laboratory service or durable medical equipment that was the subject of the teleconference or arbitration.

31. Requires the insurer and provider to share the costs of the arbitration equally, unless all parties otherwise agree.

32. Specifies that the enrollee is not responsible for any portion of the cost of the arbitration.

***Notice of Rights to Dispute Resolution***

33. Requires the Department, in conjunction with the appropriate health care boards, to prescribe a notice that outlines an enrollee's rights to dispute a bill.

34. Requires insurers to include the above notice in each explanation of benefits or other similar claim adjudication notice that is:
    a) issued to enrollees; and
    b) involves covered services rendered by a non-contracted provider.

35. Requires a provider, their representative or billing company, upon being contacted by the enrollee, to provide written notice as prescribed by the Department to the enrollee, informing them of the dispute resolution process.

36. Requires the Department to post information on its website for health care consumers regarding:
    a) what constitutes a bill;
    b) how to try to avoid a bill; and
    c) how the dispute resolution process may be used to resolve a bill.

### *Annual Report on Disputed Bills*

37. Requires the Department, beginning on or before December 31, 2019 and by each December 31 thereafter, to report on the resolution of disputed bills.

38. Requires the report to include the following information:
    a) the total number of inquiries regarding dispute resolution of bills;
    b) the total number of requests that did not qualify for dispute resolution and the reasons why the disputed bills did not qualify;
    c) the number of requests that qualified for dispute resolution;
    d) the most common requests for dispute resolution by provider specialty area and health care service;
    e) the number of requests for dispute resolution by geographic area in this state;
    f) the most common requests for dispute resolution based on the type of health care facility in which the health care services were provided;
    g) the number of requests for dispute resolution that were settled during a teleconference and arbitration;
    h) the number of times an insurer, provider or their representative or an enrollee failed to attend the teleconference;
    i) the average percentage by which disputed bills were reduced from the initially billed amount; and
    j) any additional information that the Department determines is relevant in evaluating the effectiveness of the dispute resolution process.

39. Requires the Department to submit the report to the Governor, the President of the Senate and the Speaker of the House of Representatives and to provide a copy of the report to the Secretary of State.

### *Miscellaneous*

40. Requires that a bill for a health care service, laboratory service or durable medical equipment that was provided in a network facility by a provider that is not a contracted provider meet one of the following requirements in order to qualify as being surprise out-of-network:
    a) the bill was for a health care service, laboratory service or durable medical equipment that was provided in the case of an emergency and services directly related to the emergency that are provided during an inpatient admission to any network facility;
    b) the bill was not for a health care service, laboratory service or durable medical equipment that was provided in the case of an emergency and the provider or their representative did not provide to the enrollee a written disclosure containing the following information within a reasonable period of time:
        i) notice that the provider is not a contracted provider;

   - ii) the estimated total cost to be billed by the provider or their representative;
   - iii) notice that if the enrollee or the enrollee's authorized representative signs the disclosure, then the enrollee may have waived any rights to dispute resolution; or
 - c) the bill was not for a health care service, laboratory service or durable medical equipment that was provided in the case of an emergency and the enrollee received the above disclosure, but the enrollee or their authorized representative chose not to sign the disclosure.

41. Prohibits an enrollee from seeking arbitration of a bill if:
    a) the enrollee or their authorized representative signed the above disclosure; and
    b) the amount actually billed to the enrollee is less than or equal to the estimated total cost provided in the disclosure.

42. Specifies that the provisions of this legislation do not apply to the following:
    a) health care services that are not covered by the enrollee's plan;
    b) limited benefit coverage as defined in statute;
    c) charges for health care services or durable medical equipment subject to a direct payment agreement;
    d) plans that do not include coverage for out-of-network health care services, unless otherwise required by law; and
    e) state health and accident coverage for full-time officers and employees of the state of Arizona and their dependents.

43. Defines various terms.

44. Makes technical changes.

45. Becomes effective on January 1, 2019.

<u>Amendments Adopted by Committee</u>

1. Adopted the strike-everything amendment.

2. Removes a patient disclosure requirement for health care facilities with respect to estimated cost for services to be rendered to an enrollee and the provider not having a contract with the enrollee's insurer.

3. Removes certain penalties for providers and health care facilities with respect to not following enrollee disclosure requirements or failing to attend or participate in an arbitration.

4. Clarifies enrollee payment responsibility with respect to a bill.

5. Makes technical changes.

Amendments Adopted by Committee of the Whole

1. Specifies criteria that qualify a bill for health care, laboratory or durable medical equipment services as being surprise out-of-network.

2. Specifies an instance when an enrollee would not be eligible for arbitration.

3. Adds a requirement for enrollee participation with respect to a teleconference.

4. Adds a requirement for a nonparticipating party to pay the cost of the arbitration for nonparticipation in the teleconference.

5. Adds an enrollee cost sharing agreement requirement that would occur prior to the arbitration.

6. Reduces the period of time in which an arbitration has to occur.

7. Prohibits balance billing an enrollee once a bill claim is resolved.

8. Modifies definitions.

9. Makes technical changes.

10. Adds a delayed effective date.

Amendments Adopted by the House of Representatives

1. Modifies the criteria that must be met in order for dispute resolution of a bill to occur.

2. Modifies arbitrator qualifications.

3. Specifies information that is to be included in the form submitted when requesting arbitration.

4. Adds additional requirements with respect to a teleconference.

5. Further specifies what must occur prior to arbitration.

6. Requires a notice to be provided to an enrollee, informing them of their rights to dispute resolution.

7. Adds an annual Department reporting requirement for disputed bills.

8. Further specifies what the provisions of the legislation do not apply to.

9. Modifies definitions.

10. Makes technical changes.

| Senate Action | | | | House Action | | | |
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| FIN | 2/15/17 | DPA/SE | 7-0-0 | BI | 3/20/17 | DPA | 5-2-0-1 |
| 3rd Read | 3/01/17 | | 25-5-0 | 3rd Read | 4/19/17 | | 40-19-0 |

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