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September 28, 2018

VIA EMAIL AND U.S. MAIL

Mary E. Kosinski
Arizona Department of Insurance
100 N. 15th Ave., Suite 102
Phoenix, Arizona 85007-2624
Email: public_comments@azinsurance.gov

Dear Ms. Kosinski:

On behalf of Blue Cross Blue Shield of Arizona, I am submitting the attached comments on the Department of Insurance proposed rules adding Article 24, Out-of-Network Claim Dispute Resolution.

We have provided a redline draft of the rules with suggested revisions and explanatory comments.

Thank you for the opportunity to comment.

Sincerely,

Vista Thompson
Senior Counsel
Blue Cross Blue Shield of Arizona

5766.1

Comments and drafting suggestions from Blue Cross Blue Shield of Arizona

Article 24. Out-of-Network Claim Dispute Resolution

R20-6-2401. Definitions.

The definitions in A.R.S. § 20-3111 and this Section apply to this Article.

1. "Alternative Arbitrator" is ~~a person~~ an individual who is mutually agreeable to the health insurer and health care provider to act as ~~an A~~the arbitrator of a surprise out of network billing dispute, but ~~and~~ who is not contracted with the Department to conduct an arbitration. Department staff may not serve as an Alternative Arbitrator.

2. "Amount of the enrollee's cost sharing requirements" means the amount determined by the insurer prior to the dispute resolution process to be owed by the enrollee for copayment, coinsurance and deductible pursuant to the enrollee's health care policy.

3. "Arbitrator" has the same meaning as A.R.S. § 20-3111(2) and may include a mediator, Aarbitrator or other alternative dispute resolution professional. ~~An Arbitrator must be contracted with the Department~~ who is contracted with the Department to ~~conduct an~~ arbitrateion a surprise out of network billing dispute. Department staff may not serve as an Arbitrator.

4. "ARS 20-3113 Compliant Disclosure" means a written, dated document that contains the ~~following~~ all the information required by A.R.S. § 20-3113(A)(2):

~~4.~~5. A.R.S. 20-3113 Noncompliant Disclosure means a disclosure that: (a) is not dated; (b) is not in writing; or (c) is lacking one of the information elements required by A.R.S. § 20-3113(A)(2).

~~a. The name of the billing health care provider;~~

~~b. A statement that the health care provider is not a contracted provider;~~

~~c. The estimated total cost to be billed by the health care provider or the provider's representative for the health care services being provided;~~

~~d. A notice that the enrollee or the enrollee's authorized representative is not required to sign the ARS 20-3113 Disclosure to obtain health care services;~~

~~e.~~a. ~~A notice that if the enrollee or the enrollee's authorized representative signs the ARS 20-3113 Disclosure, they may have waived any rights to request arbitration of a qualifying surprise out-of-network bill.~~

~~5.~~6. "Balance bill" means the difference between the provider's billed amount and the allowed amount ~~paid by the insurer~~.

~~6.~~7. "Date of service" means the latest date on which the health care provider rendered a related health care service that is the subject of a qualifying surprise out-of-network

Commented [TV1]: This reference would not be capitalized because it is being used generically. Would not define the term with itself.

Commented [TV2]: This language appears to exclude Alternative Arbitrators. Revision suggested to explain that an arbitrator is one who has a contract, unlike the alternative arbitrator.

Commented [TV3]: Consider having definitions for compliant and non compliant

Commented [TV4]: Is it necessary to restate all the elements of the statute?

Commented [TV5]: The balance bill is typically the difference between the allowed amount and the billed charge. It will not necessarily be the amount actually paid by the insurer because the allowed amount will include member cost share amount.

To illustrate:
Billed Charge = $1000
Allowed amount = $600
Balance bill = $400
For a plan with a $100 copay, the plan would pay $500 of the allowed amount and the enrollee would pay $100 of the allowed amount.
The balance bill is only $400, so it is not accurate to say that the balance bill is the difference between the billed charge and the amount the insurer pays. In the situation where the entire allowed amount applies to deductible, the insurer may pay zero.

Recommend that the rules include a definition of allowed amount as follows: "The amount reimbursable for a covered service under the terms of the enrollee's benefit plan. The allowed amount includes both the amount payable by the insurer and the amount of the enrollee's cost sharing requirements. The allowed amount does not include the balance bill."

bill.

~~7.~~8. "Days" as used in this Article means calendar days unless specified as business days and does not include the day of the filing of a document.

~~8.~~9. "Department" means the Arizona Department of Insurance or an entity with which it contracts to ~~conduct~~ administer the out-of-network claim dispute resolution~~s~~ process.

"Enrollee's authorized representative" means a person to whom an enrollee has given express written consent to represent the enrollee, the enrollee's parent or legal guardian, a person appointed by the court to act on behalf of the enrollee or the enrollee's legal representative. An enrollee's authorized representative ~~may~~ shall not be someone who represents the provider's interests.

~~9.~~10. "Final resolution of a health care appeal" means that a member has ~~exhausted~~ a final decision under the review process provided by A.R.S. Title 20, Chapter 15, Article 2.

~~10.~~11. "Informal Settlement Teleconference" means a teleconference arranged by the Department that is held to settle the enrollee's qualifying surprise out-of-network bill prior to an Arbitration being scheduled. The parties to the Informal Settlement Teleconference are: (a) the enrollee or the enrollee's authorized representative; (b) the health insurer; and (c) the provider or the provider's representative. ~~are parties to an Informal Settlement Teleconference~~.

~~11.~~12. "Qualifying surprise out-of-network bill" is a surprise out-of-network bill that is disputed by the enrollee and:

a. Is for health services covered by the enrollee's health plan;

b. Is for health services provided in a network facility;

c. Is for health services performed by a provider who is not contracted ~~with~~to participate in the network that serves the enrollee's health plan:

d. The enrollee has resolved any health care appeal pursuant to A.R.S. Title 20, Chapter 15, Article 2 and applicable federal law such as 45 CFR 147.136, ~~ARS~~ that the enrollee may have had against the insurer following the health insurer's initial adjudication of the claim;

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

f. 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 $1,000.00; and

g. One of the following applies:

Commented [TV6]: Changed to reflect the fact that the DOI is not going to conduct arbitrations, and will be contracting with arbitrators, not a single entity.

Commented [TV7]: Revised because an enrollee may decide not to exhaust. The process could go all the way to OAH external appeal or even to judicial review. Simply need a final decision.

Commented [TV8]: Suggest restructuring to avoid ambiguity from not having a comma before "and"

Commented [TV9]: Because insurers have narrow networks, it is possible for a provider to be contracted for some networks but not others. If a provider is not contracted to participate in the enrollee's specific network, that provider is still considered an out of network provider.

Commented [TV10]: Revised for consistency with reference above.

Commented [TV11]: Federal law has broader definition of adverse benefit decision than AZ state law, and any appeal needs to be resolved before this process applies.

i. The bill is for emergency services, including under circumstances described by A.R.S. § 20-2803(A);

ii. The bill is for health care services directly related to the emergency services that are provided during an inpatient admission to any network facility;

iii. The bill is for a health care service that was not provided in the case of an emergency and the health care provider or provider's representative did not provide the enrollee a ~~written dated ARS~~ A.R.S. § 20-3113 Compliant Disclosure:

The bill is for a health care service that was not provided in the case of an emergency and the health care provider or provider's representative did not provide the enrollee an ~~written dated ARS~~ A.R.S. § 20-3113 Compliant Disclosure within a reasonable amount of time before the enrollee received the service;

iv. . The bill is for a health care service that was not provided in the case of an emergency and the health care provider or provider's representative provided the enrollee a ~~written dated ARS~~ A.R.S. § 20-3113 Compliant Disclosure ("Disclosure") and the enrollee or the enrollee's authorized representative chose not to sign the Disclosure;

v. The bill is for a health care service that was not provided in the case of an emergency, ~~an~~d the health care provider or provider's representative provided the enrollee a written dated ~~ARS~~ A.R.S. §20-3113 Compliant Disclosure ("Disclosure"), and the enrollee or the enrollee's authorized representative signed the Disclosure but the amount actually billed to the enrollee is greater than the estimated cost provided in the signed Disclosure.

Commented [TV12]: Suggest that the Department consider listing indicia of reasonableness to help guide regulated parties. For example,

In considering whether an A.R.S. § 20-3113 Disclosure was timely provided to an enrollee, the Department will consider all relevant information, including but not limited to:
--the period of time between the date the surgery was scheduled and the date of the surgery
-the enrollee's medical condition and the urgency of the procedure
-the circumstances under which the disclosure was delivered to the enrollee
-etc.

R20-6-2402. Request for Arbitration.

A Request for Arbitration. An enrollee may request dispute resolution of a surprise out-of-network bill by filing a timely Request for Arbitration with the Department on a Request for Arbitration form available on the Department's website.

B. Deadline for filing a Request for Arbitration with the Department. A Request for Arbitration must be received by the Department within one year after the date of service listed on the surprise out-of-network bill. If the enrollee filed a health care appeal pursuant to A.R.S. Title 20, Chapter 15, Article 2, ~~ARS,~~ or applicable federal law, the one year deadline is tolled from the date the enrollee filed the health care appeal to the date of the final resolution of the appeal.

C. Evaluation of the Request for Arbitration by the Department. Within 15 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 is a qualifying surprise out-of-network bill and mail a notification to the enrollee, health insurer and health care provider that the Request for Arbitration qualifies for Arbitration;

2. Determine that the surprise out-of-network bill is not a qualifying surprise out-of-network bill and mail a notification to the enrollee that states the reason for the Department's determination;

3. Determine that the Request for Arbitration is incomplete, or

4. Return the Request for Arbitration to the enrollee without making a determination if the enrollee's request should instead be filed as a health care appeal within the meaning of A.R.S. Title 20, Chapter 15, Article 2.

D. Request for additional information for an incomplete Request for Arbitration. If the Department determines that the Request for Arbitration is incomplete, the Department may send a written request for additional information to any one or more of the following: ~~the~~ enrollee, health insurer, health care provider or health care provider's billing company.

E. Time to respond to the Department's Request for Additional Information. The enrollee, health insurer, health care provider or the health care provider's billing company shall have 15 days from the date of the request to respond to the Department's Request for Additional Information.

F. Failure to respond to the Department's Request for Additional Information.

1. If the enrollee fails to respond to the Department's Request for Additional Information, the Department shall deny the enrollee's Request for Arbitration.

2. If ~~either the health insurer or the health care provider or health care provider's billing company~~ any other party fails to respond to the Department's Request for Additional Information, the Department shall deem that the enrollee's Request for Arbitration qualifies for arbitration.

~~2.~~3. If the Department has not received a response within the 15-day period, the Department shall either notify the parties of dismissal or send a notice qualifying the request for the arbitration process.

G. Receipt of Additional Information. Upon receipt of the additional information requested by the Department under subsection (D) of this Section, the Department shall determine, within seven days, whether the enrollee's Request for Arbitration qualifies for Arbitration and send the notice required under subsection (C)(1) or subsection (C)(2) of this Section, whichever applies.

H. Final Determination. The Department's determination whether an enrollee's Request for Arbitration qualifies for Arbitration is a final decision and not an appealable agency action within the meaning of A.R.S. § 41-1092(3). A claim that is the subject of a qualifying surprise out-of-network bill is not subject to the timely payment of claims law during the pendency of the Arbitration.

Commented [TV13]: This process is supposed to be efficient and cost effective. We think that email should be used as an alternate means of communication so long as the member has an email address. The Department could require insurers to have a designated email contact for inquiries related to this process, and could also require a provider to designate one.

Commented [TV14]: Recommend email as an alternative

Commented [TV15]: Could be email

Commented [TV16]: Revised to be more concise

Commented [TV17]: Need to fill in the process gap.

I. Enrollee's payment responsibility.

1. Notwithstanding any informal settlement or Arbitrator's Final Written Decision, the enrollee is responsible for only the following:

a. The amount of the enrollee's cost sharing requirements; and

b. Any amount received by the enrollee from the enrollee's health insurer as payment for the health care services at issue in a qualifying surprise out-of-network bill.

2. A health care provider may not issue, either directly or indirectly through its billing company, any additional balance bill to the enrollee for the same health care services.

R20-6-2403. Informal Settlement Teleconference.

A. Deadline to arrange the Informal Settlement Teleconference. Upon a determination that an enrollee has made a Request for Arbitration that qualifies for Arbitration, the Department shall arrange an Informal Settlement Teleconference between the parties within 30 days of mailing the notification that the enrollee's Request for Arbitration qualifies for Arbitration required by Section R20-6-2402(C)(1).

B. Notice of Informal Settlement Teleconference. The Department shall send a Notice of Informal Settlement Teleconference to the enrollee, the enrollee's authorized representative, the health insurer, the health care provider and the health care provider's representative informing them of the date, time and call-in number for the Informal Settlement Teleconference. Any party may, for good cause, request that the teleconference be rescheduled for a different date by sending the Department a written request with an explanation of the good cause.

Commented [TV18]: Suggest Email as an option.

C. Health Insurer documentation. On or before the Informal 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 qualifying surprise out-of-network bill.

D. Consequences of non-participation in the Informal Settlement Teleconference. If a party fails to participate in the Informal ~~Information~~ Settlement Teleconference, it shall be subject to the following consequences:

1. If the health insurer, provider or provider's representative fails to participate in an Informal Settlement Teleconference scheduled by the Department, the participating party may notify the Department, which ~~who~~ shall ~~immediately~~ promptly schedule the Arbitration. The non-participating party shall pay the entire cost of the Arbitration.

Commented [TV19]: Seems unlikely to be immediate.

2. If the enrollee or the enrollee's authorized representative fails to participate in the original Informal Settlement Teleconference, the original Informal Settlement Teleconference is terminated.

3. If the enrollee or the enrollee's authorized representative fails to participate in a rescheduled Informal Settlement Teleconference, the enrollee's Request for Arbitration is terminated.

E. One-time opportunity for the enrollee to reschedule the Informal Settlement Teleconference. ~~In the event~~ If the enrollee or the enrollee's representative fails to participate in the Informal Settlement Teleconference originally scheduled by the Department, the enrollee may request that the Department reschedule the Informal Settlement Conference. The enrollee's request to reschedule must be received by the Department within 14 days of the original Informal Settlement Teleconference mailing date found on the Department's Notice of Informal Settlement Teleconference. Failure to submit a request to the Department to reschedule the Informal Settlement Teleconference within 14 days terminates the enrollee's Request for Arbitration.

F. Notification to the Department after the Informal Settlement Teleconference. : Within seven days after the date of the Informal Settlement Teleconference, the health insurer shall:

1. Notify the Department whether a settlement was reached between the parties; and

2. If a settlement was reached, notify the Department of the terms of the settlement on a form prescribed by the Department.

G. Failure to settle. If the parties fail to settle the qualifying surprise out-of-network bill at the Informal Settlement Teleconference, the Department shall arrange for the Arbitration.

H. Settlement. If the parties settle the qualifying surprise out-of-network bill at the Informal Settlement Teleconference, the health insurer shall remit its portion of the payment to the health care provider within 30 days after the Informal Settlement Teleconference. A claim that is reprocessed by a health insurer as a result of informal settlement is not in violation of A.R.S. § 20-3102(L).

R20-6-2404. Arbitrators.

A. Contracted entities. The Department shall contract with one or more entities to provide Arbitrators. The Department may also contract with individual arbitrators. The Department must have at least three Arbitrators to assign to Arbitrations.

B. Arbitrator Qualifications. Any individual Arbitrator or entity contracting with the Department must have or be able to provide Arbitrators who possess the following qualifications:

1. at least three years of experience in evaluating the reasonableness of health care services claims and reimbursement levels;
2. The background and experience to be impartial and free of conflicts of interest. An

Commented [TV20]: Why does it have to be an entity? Individual arbitrators should also be able to respond to the procurement RFP. We think the options should be robust, and should not be limited to arbitrators available only through a single entity.

Commented [TV21]: We think the rules need to elaborate on the type of claims expertise that is needed. Someone who has experience processing health claims is not going to have expertise in evaluating whether billed and paid reimbursement is fair for the service rendered.

individual is not considered impartial if the individual has, within the 3 years preceding the arbitration, had a business or employment relationship with an insurer or provider, or served as an officer or director, within the three years prior to the arbitration

B.C. Alternative Arbitrators. A health insurer and provider may mutually agree to use an Alternative Arbitrator by notifying the Department that they have elected not to use a Department appointed Arbitrator. if either the health insurer or the health care provider objects to an Arbitrator appointed by the Department.

C.D. Appointment of an Arbitrator.

1. The Department shall appoint an Arbitrator for each Arbitration unless the health insurer and health care provider have notified the Department of an Alternative Arbitrator.

2. If the health insurer and health care provider have not agreed on an Alternative Arbitrator and do not agree to the Arbitrator appointed by the Department, they shall either:

3.

4. Mutually agree to use an Alternative Arbitrator; or

pParticipate in the following procedure:

i. The Department shall assign three Arbitrators.

ii. The health insurer shall strike one Arbitrator.

iii. The health care provider shall strike one Arbitrator.

iv. If one Arbitrator remains, the Department shall appoint the remaining Arbitrator to the Arbitration. If the health insurer and health care provider strike the same Arbitrator, the Department shall randomly assign the Arbitrator from the remaining two Arbitrators.

Commented [TV22]: There should not be a requirement that a party first objects. Insurer and provider may simply choose to have someone who they agree is qualified.

R20-6-2405. Before the Arbitration

A. Enrollee's duties. Before the Arbitration, the enrollee shall:

1. Pay, or make written arrangements in writing to pay, to the health care provider the amount stated by the health insurer in the Informal Settlement Teleconference which shall be the total amount of the enrollee's cost sharing requirements due for the health care services that are the subject of the qualifying surprise out-of- network bill.

2. Pay to the health care provider any amount that the enrollee has received from the health insurer as payment for the health care services that are the subject of the qualifying surprise out-of-network bill.

B. Health insurer's duties. Before the Arbitration, the health insurer shall:

1. Remit any amount due to the health care provider if the health care insurer

pays for out-of-network services directly to health care providers and the health insurer has not remitted any amounts due.

R20-6-2406. The Arbitration.

A. Conduct of Arbitration. An Arbitration of a qualifying out-of-network surprise bill shall be conducted:

1. Telephonically unless the parties agree otherwise;

2. With or without the enrollee's participation;

3. Within 120 days after the Department's Notice of Arbitration unless agreed otherwise by the parties; and

4. For a maximum duration of four hours unless agreed otherwise by the parties.

B. Arbitrator's Determination. The Arbitrator or Alternative Arbitrator shall determine the amount the health care provider is entitled to receive as payment for the health care services that are the subject of the qualifying surprise out-of-network bill.

C. Allowable Evidence. The Arbitrator or Alternative Arbitrator shall allow each party to provide relevant information for evaluating the qualifying surprise out-of-network bill including:

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

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 health care provider performed the services;

3. The amount 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 A.R.S. § 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; and

6. Any other reliable sources of information, including databases, that provide the amount paid for the health care services at issue in the county where the health care provider performed the services.

D. Final Written Decision. Within 10 business days following the Arbitration, the Arbitrator or Alternative Arbitrator shall issue a Final Written Decision and provide a copy to the enrollee, the health insurer, the health care provider, the health care

provider's billing company (if applicable) and the health care provider's authorized representative (if applicable).

E. Payment of the claim. The health insurer shall remit its portion of ~~the~~any remaining payment awarded by the Arbitrator or Alternative Arbitrator to the health care provider within 30 days of the date of the Final Written Decision. A claim that is reprocessed by a health insurer as a result of the Arbitration is not in violation of A.R.S. § 20-3102(L).

F. Payment of the Costs of Arbitration. The health insurer and health care provider shall make payment arrangements with the Arbitrator or Alternative Arbitrator for their respective share of the costs of the Arbitration. The respective share of the costs of Arbitration are determined as follows:

1. The enrollee is not responsible for any portion of the cost of the Arbitration.

2. The health insurer and the health care provider shall share the costs of the Arbitration equally unless one of the following exceptions applies:

a. The health insurer and health care provider agree to share the costs of the Arbitration in non-equal portions.

b. The health insurer pays the entire cost of the Arbitration for failing to participate in the Informal Settlement Teleconference after receiving proper notice from the Department.

c. The health care provider or the health care provider's representative pays the entire cost of the Arbitration for failing to participate in the Informal Settlement Teleconference after receiving proper notice from the Department.

G. Confidentiality. In connection with the Arbitration of a qualifying surprise out-of-network bill, all of the following apply:

1. All pricing information provided by a health insurer or health care provider is confidential.

2. Pricing information provided by a health insurer or health care provider may not be disclosed by the Arbitrator, Alternative Arbitrator or any other party participating in the Arbitration.

3. Pricing information provided by a health insurer or health care provider may not be used by anyone, except the party providing the information, for any purpose other than to resolve the qualifying surprise out-of-network bill.

4. All information received by the Department in connection with the Arbitration is confidential and ~~may~~shall not be disclosed to any person except the Arbitrator or Alternative Arbitrator.

~~4.~~5. The Department shall mark information received in connection with an Arbitration as confidential and take appropriate measures to ensure privacy and security of the information.

Commented [TV23]: We are concerned about inadvertent disclosure of this highly proprietary information and think the DOI needs to take all precautions to assure confidentiality.

H. Arbitrator's Report. At the conclusion of each Arbitration, the Arbitrator shall produce a report to the Department that contains the following information:

1. Date of Arbitration:

2. Date the Arbitrator issued the Final Written Decision;

3. Whether the parties settled the qualifying surprise out-of-network bill during the Arbitration without a decision by the Arbitrator ;

4. The initial amount billed by the health care provider;

5. The total payment amount awarded to the health care provider, with a breakdown of the following three amounts: insurer portion of insurer's allowed amount, enrollee cost share, and balance bill; and

6. Any other information the Department may request an Arbitrator to report prior to an Arbitration.