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**Out-of-Network Claim Dispute Resolution**

**Proposed Rules/Comments[[1]](#footnote-1)/Department Responses**

**Public Comment Hearing 11/1/2018**

**Article 24. Out-of-Network Claim Dispute Resolution**

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R20-6-2401. Definitions.

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

Current Language

**None.**

Comments

Recommend that the rules include a definition of allowed amount as follows:

“Allowed Amount” is 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. (BC/BS)

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ARS § 20-3115(H), in part, states:

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 healthcare provider.

The rule needs to specify that the “amount due to the healthcare provider is the allowed/scheduled amount that pertains to the healthcare service that was provided.” (DOI)

New Language or Response

1. “Allowed Amount” is 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.

Current Language

**1. “Alternative Arbitrator” is a person who is mutually agreeable to the health insurer and health care provider to act as an Arbitrator and who is not contracted with the Department to conduct an arbitration. Department staff may not serve as an Alternative Arbitrator.**

Comments

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

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The draft provides in R20-6-2401.1, a definition of “Alternative Arbitrator” that disallows an Arbitrator contracted with the Department to conduct an arbitration. This may unnecessarily prevent the insurer and health care provider to agree to use an Arbitrator with whom the Department has a contract as their alternative to the Arbitrator that the Department had proposed the parties use. Instead, I recommend amending the definition to say:

“Alternative Arbitrator” is a person who is mutually agreeable to the health insurer and health care provider to act as an Arbitrator. If the person is contracted with the State of Arizona to conduct arbitration proceedings, the provisions of that contract shall apply. Department staff may not serve as an Alternative Arbitrator. (DOI)

New Language or Response

2. “Alternative Arbitrator” is an individual who is mutually agreeable to the health insurer and health care provider to act as the arbitrator of a surprise out-of-network billing dispute. If the person is contracted with the State of Arizona to conduct arbitration proceedings, the provisions of that contract shall apply. Department staff may not serve as an Alternative Arbitrator.

Current Language

**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.**

Comments

The proposed definition of cost sharing requirements under (2) should include "out-of-network" in the context of coinsurance, copayment and deductible requirements. This would ensure consistency with the statutory provisions under A.R.S. S 20-3111 (5). (MEDNAX)

New Language or Response

3. “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 out-of-network copayment, coinsurance and deductible pursuant to the enrollee’s health care policy.

Current Language

**3. “Arbitrator” has the same meaning as A.R.S. § 20-3111(2) and may include a mediator, Arbitrator or other alternative dispute resolution professional. An Arbitrator must be contracted with the Department to conduct an arbitration. Department staff may not serve as an Arbitrator.**

Comments

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

New Language or Response

4. “Arbitrator” has the same meaning as A.R.S. § 20-3111(2) and may include a mediator, arbitrator or other alternative dispute resolution professional who is contracted with the Department to arbitrate a surprise out-of-network billing dispute. Department staff may not serve as an Arbitrator.

Current Language

**4. “ARS 20-3113 Disclosure” means a written, dated document that contains the following information:**

**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 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.**

Comments

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).

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 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. “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). (BC/BS)

New Language or Response

The Department declines to make the suggested change and will keep the current language.

5. “ARS 20-3113 Disclosure” means a written, dated document that contains the following information:

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 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.

Current Language

**5. “Balance bill” means the difference between the provider’s billed amount and the amount paid by the insurer.**

Comments

The definition of “Balance bill” does not take into account the amount owed by the enrollee for their cost share (copayment, coinsurance and deductible). It should read “Balance bill” means all charges that exceed the enrollee’s cost sharing requirements and the amount paid by the insurer. (DOI)

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5. “Balance bill” means the difference between the provider’s billed amount and the allowed amount ~~paid by the insurer~~.

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. (BC/BS)

New Language or Response

6. “Balance bill” means all charges that exceed the enrollee’s cost sharing requirements and the amount paid by the insurer.

Current Language

**6. “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 bill.**

Comments

No comments received.

New Language or Response

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 bill.

Current Language

**7. “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.**

Comments

CEP would recommend that the Definition of (7) “Days” means “business days unless specified as calendar days” rather than “calendar days unless specified as business days” which is currently contained in the ADOI draft proposed rules.

Our concern with the use of “calendar days” rather than “business days” is that during certain times of the year, including holidays, two weeks and one day (15 calendar days) may not be a sufficient time period for all of the affected parties to adequately receive notice and then respond in a timely manner. (CEP)

New Language or Response

The Department used this definition because one instance of “business days” is used at ARS § 20-3115(N) which implies that all other references to “days” are presumed to be calendar days.

The Department will follow the guidance found at Title 1, A.R.S. regarding the computation of time.

**1-243. Computation of time**

A. Except as provided in subsection B, the time in which an act is required to be done shall be computed by excluding the first day and including the last day, unless the last day is a holiday, and then it is also excluded.

B. In cases in which notice of a decision by the state, any agency thereof or any political subdivision must be given to a petitioner and in which the petitioner must file a notice of appeal of such decision within a time certain of less than ten days, such time shall be computed starting with the day after the day during which the notice of decision is received by the petitioner by personal service or registered or certified mail.

**1-303. Last day for performance of act a holiday; effect**

When anything of a secular nature, other than a work of necessity or charity, is provided or agreed to be done upon a day named or within a time named, and the day or the last day thereof falls on a holiday, it may be performed on the next ensuing business day with effect as though performed on the appointed day.

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.

Current Language

**8. “Department” means the Arizona Department of Insurance or an entity with which it contracts to conduct out-of-network claim dispute resolutions.**

Comments

8. “Department” means the Arizona Department of Insurance or an entity with which it contracts to ~~conduct~~ administer the out-of-network claim dispute resolutions~~.~~ process.

Changed to reflect the fact that the DOI is not going to conduct arbitrations, and will be contracting with arbitrators, not a single entity. (BC/BS)

New Language or Response

9. “Department” means the Arizona Department of Insurance or an entity with which it contracts to administer the out-of-network claim dispute resolutions process.

Current Language

**9. “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 not be someone who represents the provider’s interests.**

Comments

9. “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. (BC/BS)

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The proposed rules fail to address what arrangements and accommodations will be made for members who do not speak English. Which party will bear the cost of an interpreter? Can the definition of "Enrollee's authorized representative" in R20-6-2401(9) be expanded to cover this possibility? (United)

New Language or Response

10. “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 shall not be someone who represents the provider’s interests. (BC/BS)

The Department will accommodate for disabilities. However, since the insurers may have an obligation under Federal law to provide interpreters, the enrollee or the insurer will have to provide an interpreter.

Current Language

**10. “Final resolution of a health care appeal” means that a member has exhausted the review process provided by Title 20, Chapter 15, Article 2.**

Comments

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.

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. (BC/BS)

New Language or Response

11. “Final resolution of a health care appeal” means that a member has a final decision under the review process provided by A.R.S. Title 20, Chapter 15, Article 2.

Current Language

**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 enrollee or the enrollee’s representative, the health insurer and the provider or the provider’s representative are parties to an Informal Settlement Teleconference.**

Comments

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~~. (BC/BS)

New Language or Response

12. “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.

Current Language

**None**

Comments

CEP would recommend that "Notification" be defined to mean:

* 1. email with a Return Receipt Requested in the form of an electronic copy of the recipient's signature;
	2. telephone notification with a certification from the caller that the enrollee, health insurer and health care provider received the call; or
	3. USPS certified mail with a Return Receipt requested in the form of a post card signed by the recipient.  Notice to all affected parties is a vital element throughout these statutes and without adequate notice, the dispute resolution process will not work as envisioned by the Legislature. (CEP)

New Language or Response

The Department declines to define “Notification.” Instead, the Department will develop a process that ensures that it has the correct contact and address information for each party to the IST and Arbitration.

Current Language

**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 the enrollee’s health plan:**

**d. The enrollee has resolved any health care appeal pursuant to Chapter 15, Article 2, 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:**

**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 20-3113 Disclosure:**

**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 did not provide the enrollee a written dated ARS 20-3113 Disclosure within a reasonable amount of time before the enrollee received the service;**

**v. 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 20-3113 Disclosure (“Disclosure”) and the enrollee or the enrollee’s authorized representative chose not to sign the Disclosure;**

**vi. 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 20-3113 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.**

Comments

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:

*(Comment: 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 network, that provider is still considered an out-of-network provider.)*

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

*(Comment: Federal law has broader definition of adverse benefit decision than AZ state law, and any appeal needs to be resolved before this process applies.)*

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:

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:

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 did not provide the enrollee ~~a written dated ARS~~ an A.R.S. § 20-3113 Compliant Disclosure within a reasonable amount of time before the enrollee received the service;

v. 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 Complaint Disclosure (“Disclosure”) and the enrollee or the enrollee’s authorized representative chose not to sign the Disclosure;

vi. 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 Complaint 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.

Suggest that the Department consider listing indicia of reasonableness to help guide regulated parties. For example, in considering whether an ARS § 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. (BC/BS)

"Qualifying surprise out-of-network bill" (12)(d) we would like to clarify the tolling period. For purposes of determining the length of the tolling period, how will the Department calculate the days, weeks, or months between the time when the enrollee receives the provider's bill and institutes either a health care appeal or litigation? In other words, does the Department consider that the yearlong dispute resolution deadline begins to run on the date the healthcare appeal or litigation concludes, regardless of the length of time that elapsed before the member filed the action? (United)

New Language or Response

The Department accepts the BC/BS proposed change at R20-6-2401(12)(c) but declines to accept the remainder of the other proposed changes.

13. “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 to participate in the network that serves the enrollee’s health plan:

d. The enrollee has resolved any health care appeal pursuant to Chapter 15, Article 2, 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:

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 20-3113 Disclosure:

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 did not provide the enrollee a written dated ARS 20-3113 Disclosure within a reasonable amount of time before the enrollee received the service;

v. 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 20-3113 Disclosure (“Disclosure”) and the enrollee or the enrollee’s authorized representative chose not to sign the Disclosure;

vi. 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 20-3113 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.

In response to the United comment, the Department will consider that the yearlong dispute resolution deadline begins to run on the date the healthcare appeal or litigation concludes.

Additional General Comments on R20-6-2401:

Comment

Wonder if “telephonically” needs to be defined to include web-based conferences and other means of communication that are not conducted in person. (DOI)

New Language or Response

“Telephonically” does not need to be defined. The term “teleconference” is broad enough to encompass web-based conferences and other means of communication.

R20-6-2402. Request for Arbitration.

Current Language

**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.**

Comments

No comments received.

Current Language

**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 Chapter 15, Article 2, ARS, 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.**

Comments

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. (BC/BS)

New Language or Response

The Department accepts the first proposed change but rejects the reference to applicable federal law.

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, 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.

Current Language

**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 Title 20, Chapter 15, Article 2.**

Comments

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. (BC/BS)

(C)(1) CEP would recommend that the notification requirement include:

* 1. an email with a Return Receipt requested in the form of an electronic copy of the recipient's signature;
	2. telephone notification with a certification from the caller that the enrollee, health insurer and health care provider received the call; or
	3. USPS certified mail with a Return Receipt requested in the form of a postcard signed by the recipient.

If the decision is made not to add a new definition under R20-6-2401 for "Notification, then these notification requirements need to be included in this section. Once again, to ensure that the affected parties are actually notified so that the dispute resolution process can proceed. (CEP)

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The language in (C)(1) and (2) and (D), "Evaluation of the Request for Arbitration by the Department," suggests that the Department's notification to enrollees, insurers, and providers will be by "mail." We believe that, given the tight deadlines set forth in (E), these notices should be sent electronically. We urge the Department to strike the words "mail" and "send" and replace them with "provide." "Provide" is a generic term and will not constrain the Department to either electronic or post office delivered mail. (United)

We urge the Department to configure its internal processes to accept a new/additional E-mail address from insurers. Insurers should have the option to use an E-mail that is separate and distinct from the address to which the Department currently sends consumer complaints about issues that do not necessarily involve non-surprise billing complaints. Doing so will allow insurers to efficiently and accurately route notices from the Department that either schedule the A.R.S. § 20-3114(B) Informal Settlement Teleconference, or request additional information pursuant to A.R.S. 820-3115(C)(3) and R20-6-2402(D). This will aid insurers in complying with the 15-day deadline set forth in A.R.S. § 20-3115(C)(3)(a) and A.A.C. R20-6-2402(E). Allowing the use of a dedicated Email address will also satisfy the requirements of A.R.S. S 20-3115(A) that the Department "develop a simple, fair, efficient and cost-effective arbitration procedure for surprise out-of-network bill disputes." (United)

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R20-6-2402 C.1 stipulates that when a surprise out-of-network bill qualifies for an Informal Settlement Conference (ISC), that notification be mailed by the DOI to the enrollee, health insurer and healthcare provider. The primary and collective goal for all parties involved should be the settlement of a qualifying out-of-network bill prior to or during the ISC. Therefore, it is in the best interest of the DOI, the enrollee, health insurer and healthcare provider that each participant be successfully notified so they can prepare for and participate in a productive, informal teleconference.

We respectfully request this ISC notification not be solely limited to U.S. mail and that it additionally include email and telephone notification options to provide greater flexibility to the DOI. Furthermore, we suggest language be included to ensure that the DOI makes a reasonable attempt to confirm notification was received to ensure the likelihood of full participation by the enrollee, health insurer and healthcare provider in the Informal Settlement Conference, and mitigate the need for arbitration. (ARMA/AOMA)

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We also believe that adequate and appropriate notice of a qualifying surprise out-of-network bill settlement conference and arbitration be provided. While we are supportive of the flexibility of allowing a provider to determine who should present them in the process the provider of services, a billing representative or other administrative staff) it is important that sufficient time be provided between the notice and the proposed settlement conference to allow the appropriate person to be available for the conference. (AZNA/AZANA/NP/Nurse-Midwives)

New Language or Response

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 notify 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 notify the enrollee of 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.

The Department will remove the phrase “mail a notification” and replace it with “notify” to facilitate other means of notification other than U.S. mail. The Department will also will develop a process that ensures that it has the correct contact and address information for each party to the IST and Arbitration.

Current Language

**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 the enrollee, health insurer, health care provider or health care provider’s billing company.**

Comments

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. (BC/BS)

New Language or Response

The Department declines to make the proposed change.

Current Language

**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 to respond to the Department’s Request for Additional Information.**

Comments

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. (BC/BS)

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While section E (response time for DOI's request for additional information) is consistent with A.R.S. S 20-3115(C), we are concerned that the proposed fifteen (15) days does not provide enough time for providers to comply with the statute and proposed rule. Our recommendation here would be to extend the number of days to thirty (30) or even forty-five (45) to better enable providers to comply with these provisions. We would like to work with and encourage the department to amend this provision during the upcoming 2019 legislative session. Also, we believe that under (F)(2) "...billing company fail to respond..." should be edited to "...billing company fails to respond..." (MEDNAX)

New Language or Response

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.

Current Language

**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 fail to respond to the Department’s Request for Additional Information, the Department shall deem that the enrollee’s Request for Arbitration qualifies for arbitration.**

Comments

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 fail~~ 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.

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. (BC/BS)

New Language or Response

The Department declines to make the proposed changes.

Current Language

**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.**

**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.**

Comments

No comments received.

R20-6-2403. Informal Settlement Teleconference.

Current Language

**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).**

Comments

The language in (A), (B), and (E), "Deadline to arrange the Informal Settlement Teleconference," "Notice of Informal Settlement Teleconference," and "Consequence of non-participation in the Informal Settlement Teleconference" suggests that the Department's notification to enrollees, insurers, and providers will be by mail. As addressed above, we believe that the Department should give the parties the option to receive these notices electronically. We urge the Department to strike "mailing" and "send' and replace them with generic terms such as "the original notification" and "provide." Doing so helps ensure "a simple, fair, efficient and cost-effective arbitration procedure for surprise out-of-network bill disputes" within the meaning of A.R.S. § 20-3115(A). (United)

New Language or Response

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 notifying the enrollee that the enrollee’s Request for Arbitration qualifies for Arbitration required by Section R20-6-2402(C)(1).

Current Language

**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.**

Comments

Would it be permissible for the parties to resolve the matter before the Informal Settlement Teleconference described in A.R.S. 20-3114(B) and R20-6-2403? (United)

Will the Department give any consideration to input from the parties in scheduling the Informal Settlement Teleconference before it sends the notice described in R20-62403(B)? (United)

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Deadline to Arrange Informal Settlement Conference: R20-6-2403 A. requires the DOI to arrange an ISC "within 30 days" of mailing the notification to the enrollee that a request for arbitration has qualified. We respectfully request that a timeframe be affixed to this process to ensure all parties receive timely notice within a specified timeframe (e.g. no more than 2-3 days following the arbitration qualification notification) that the ISC has been scheduled. And, we respectfully request that adequate advance time (of at least 7 days) be allotted to ensure that the ISC is not being imposed on the parties at the last moment.

We are extremely concerned about the consequences on busy physicians (and their other patients) of receiving inadequate notice, and potentially being compelled to postpone/reschedule critical patient visits, diagnostic procedures, surgeries, etc. in order to participate in an ISC. If our goal is to incentivize the use of the ISC as much as possible (as we believe it should be), the scheduling and notification processes must be user-friendly for all parties involved.

We understand that the scheduling of ISCs will be a new and challenging responsibility for the staff of the DOI. And we understand that a representative may substitute for the physician at the ISC. However, we foresee that in many cases the physician’s representative (likely to be a layperson not trained in medicine or familiar with the patient’s care) would be more of a placeholder than a meaningful participant. If the treating physician cannot participate personally, this could negatively affect the quality of the ISC and the ability of the parties to have a meaningful and productive discussion towards a fair resolution of the surprise billing issue. Therefore, we respectfully urge that practical steps be taken by the DOI to help ensure, where reasonably possible, that the ISC scheduling process is realistic and workable with due recognition of today’s extremely busy physician practice environment. (ARMA/AOMA)

Scheduling Flexibility for Informal Settlement Conference & Arbitration: 20-6-2403 B. requires the DOI to notify the parties of the date, time and call-in number for the Informal Settlement Conference. We recognize it would be challenging for the DOI to find a suitable date and time for everyone to participate. However, as noted before, if the date and time chosen is not conducive for participation it will severely undermine the goal of resolving these disputes amicably through the ISC process.

In a similar vein to our comments above, we respectfully request the ability of the enrollee, health insurer, and provider to work independently of the DOl to schedule an alternative date and time that is agreeable to all parties. We also ask that the DOI please be considerate of the impact of scheduling ISCs during peak physician practice hours to avoid or minimize disruption to patient access to care, e.g. hospital surgeries, on-call coverage in hospitals, etc. (ARMA/AOMA)

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We echo the sentiments expressed in the ARMA and AOMA letter regarding the flexibility of scheduling for the settlement conference and arbitration. (AZNA/AZANA/NP/Nurse-Midwives)

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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. (BC/BS)

New Language or Response

The Department sees no statutory impediment preventing the parties from settling the qualifying surprise out-of-network bill at any time during this process as long as the Department is promptly notified of the settlement.

The Department will make every effort to try to schedule a date and time for the Informal Settlement Teleconference that is mutually agreeable to all the parties.

The Department declines to adopt the change proposed by BC/BS.

B. Notice of Informal Settlement Teleconference. At least 14 days prior to the scheduled date, 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.

Current Language

**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.**

Comments

Informal Settlement Teleconference Under (C) the department may want to consider the consequences of what happens if there is a dispute regarding an enrollee's cost sharing requirements being inaccurate as submitted by the health insurer. (MEDNAX)

New Language or Response

No changes.

Current Language

**D. Consequences of non-participation in the Informal Settlement Teleconference. If a party fails to participate in the 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 who shall immediately schedule the Arbitration. The non-participating party shall pay the entire cost of the Arbitration.**

**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.**

Comments

D. Consequences of non-participation in the Informal Settlement Teleconference. If a party fails to participate in the ~~Information~~ Informal 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 ~~who~~ which shall ~~immediately~~ promptly schedule the Arbitration. The non-participating party shall pay the entire cost of the Arbitration.

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. (BC/BS)

New Language or Response

D. Consequences of non-participation in the Informal Settlement Teleconference. If a party fails to participate in the Informal 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 shall promptly schedule the Arbitration. The non-participating party shall pay the entire cost of the Arbitration.

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.

Current Language

**E. One-time opportunity for the enrollee to reschedule the Informal Settlement Teleconference. In the event 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.**

Comments

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. (BC/BS)

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Section (E) is inconsistent with A.R.S. 20-3114 (B). The statute provides that request for rescheduling be "within fourteen days after the first scheduled informal settlement teleconference." Section (E) under this proposed regulation requires rescheduling to occur "within 14 days of the original Informal Settlement Teleconference mailing date found on the Department's Notice of Informal Settlement Teleconference." (MEDNAX)

New Language or Response

E. One-time opportunity for the enrollee to reschedule the Informal Settlement Teleconference. 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 after the originally scheduled Informal Settlement Teleconference. Failure to submit a request to the Department to reschedule the Informal Settlement Teleconference within the 14 day period terminates the enrollee’s Request for Arbitration.

Current Language

**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.**

Comments

Will the Department provide a standardized form for the Notification to the Department after the Informal Settlement Teleconference required by R20-6-2403(F)(1)? If the Department declines to provide a standardized form, will an electronic mail message be permissible for the R20-6-2403(F)(1) notification? (United)

New Language or Response

Yes. The Department plans to provide a standardized form which may be available through a portal.

Current Language

**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.**

Comments

No comments received.

Current Language

**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).**

Comments

Finally, under (H) we believe that "L" in reference to A.R.S. § 20-3102 should be deleted or changed. (MEDNEX)

New Language or Response

The Department declines to make the suggested change and will keep the current language.

Additional General Comments on R20-6-2403

Comment

When an informal teleconference is initiated, will the Department secure written permission from the enrollee to discuss PHI? (Aetna)

Response

No. The Department will make it clear to the enrollee that PHI may be discussed. The health care insurer and provider are subject to HIPAA as either covered entities or business associates.

Comment

Is the subject of the informal telephone conference limited to a payment dispute or could the conference also include discussion about policies and medical appropriateness utilized during the appeal process? (Aetna)

Response

The Department’s role is to arrange the informal settlement teleconference (IST). It has no opinion as to what can be discussed at the IST. However, the parties should keep in mind that the purpose of the IST is to try to resolve the surprise out-of-network bill to avoid arbitration.

Comment

Insurers are required to provide documentation during or before the telephone conference. Will the Department provide a form standardizing the required documents for the teleconference? (Aetna)

Response

No. ARS § 20-3115(E) instructs the health insurer to provide to the parties the enrollee’s cost sharing requirements under the enrollee’s health plan based on the adjudicated claim.

Comment

In the event of a successful Informal Settlement Teleconference or (if permissible) settlement prior to the Informal Settlement Teleconference, we advocate that the rule require a signed settlement agreement between the insurer and the provider. I have enclosed a copy of the settlement agreement we currently use for a similar program in Texas, in the event that the Department would like to base a form of it. In lieu of a required signed settlement agreement, we propose that the rule require that the notification of settlement required by R20-6-2403(F)(2) include language in that the provider shall not bill the enrollee. (United)

Response

The Department will review this agreement and proscribe a form.

Comments

The Department will make outreach to the insurer for additional information (if needed), and provide notification of a request for an informal teleconference. How will the Department contact the insurer? Likewise, the insurer will provide notification to the Department of the outcome of an informal teleconference. How will the insurer provide the necessary notifications to the Department? Aetna suggests use of a secure web portal or a designated email box. (Aetna)

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According to 20-3115(A) (C1 and 3) (E) (F) (G), Conduct of Arbitration Proceedings, Department will notify parties during stages of the Arbitration process. Please advise the methodology the Department will utilize to issue notification to Issuers for all stages of Arbitration. (ACH)

Response

The Department will obtain appropriate contact information from all the parties to an IST and Arbitration. In addition, the Department is exploring configuring a secure portal.

R20-6-2404. Arbitrators.

Current Language

**A. Contracted entities. The Department shall contract with one or more entities to provide Arbitrators. The Department must have a list of at least three Arbitrators to assign to Arbitrations.**

Comments

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 a list of at least three Arbitrators to assign to Arbitrations. (BC/BS)

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Add to R20-6-2404(A) the following sentence: The Department shall publish the list of contracted entities and a list of each entity’s qualified Arbitrators on its website. (DOI)

The draft provides in R20-6-2404.A requires the Department to have a list of at least three arbitrators to assign. However, I believe the Department actually needs at least four, one as an initial Department appointee, and then three that the Department can propose in the event the first appointed arbitrator is rejected by the health care provider or insurer. (DOI)

New Language or Response

ARS § 20-105 defines a “person” to include an individual or an entity.

A. Contracted entities. The Department shall contract with one or more persons to provide Arbitrators. The Department must have a list of at least four Arbitrators to assign to Arbitrations. The Department shall publish the list of contracted entities and a list of each entity’s qualified Arbitrators on its website.

Current Language

**B. Arbitrator Qualifications. Any entity contracting with the Department must be able to provide Arbitrators who possess at least three years of experience in health care services claims.**

Comments

B. Arbitrator Qualifications. Any individual Arbitrator or entity contracting with the Department must have or be able to provide Arbitrators who possess ~~at least three years of experience in health care services claims.~~ the following:

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 individual is not considered impartial if the individual has, within the 3 years preceding the arbitration, has 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. (BC/BS)

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R20-6-2404 B & D. stipulates the qualifications of arbitrators, and the appointment and selection process by the health insurer and provider. There are no provisions in the proposed rules to require disclosure of any of the qualifications and background of the arbitrators under consideration. At a minimum the health insurer and healthcare provider should be informed of each arbitrator’s requisite health care services claims experience and work history (e.g., has the arbitrator been employed by health insurers or healthcare providers?).

In addition, absent a fee schedule (or limits on the arbitrators’ fees), we respectfully suggest there should be a required disclosure of each arbitrator’s services and proposed fees to allow cost considerations to be considered in the arbitrator selection process. (ARMA/AOMA)

New Language or Response

The Department has included these qualifications in its RFP. The Arbitrator’s responses will be available on the Arizona Procurement portal.

B. Arbitrator Qualifications. Any person contracting with the Department must be able to provide Arbitrators who possess at least three years of experience in health care services claims.

Current Language

**C. Alternative Arbitrators. A health insurer and provider may mutually agree to use an Alternative Arbitrator if either the health insurer or the health care provider objects to an Arbitrator appointed by the Department.**

Comments

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~~. (BC/BS)

New Language or Response

The Department declines to incorporate this proposed change. The procedure has been determined by the statute (see ARS § 20-3115(G)). The statute requires that the Department first appoint an Arbitrator.

Current Language

**D. Appointment of an Arbitrator.**

**1. The Department shall appoint an Arbitrator for each Arbitration.**

**2. If the health insurer and health care provider do not agree to the Arbitrator appointed by the Department, they shall either:**

**a. Mutually agree to use an Alternative Arbitrator; or**

**b. Participate 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.**

**v. If the health insurer and health care provider strike the same Arbitrator, the Department shall randomly assign the Arbitrator from the remaining two Arbitrators.**

Comments

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~~:

a. Mutually agree to use an Alternative Arbitrator; or

~~b~~.a. Participate 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.

v. If the health insurer and health care provider strike the same Arbitrator, the Department shall randomly assign the Arbitrator from the remaining two Arbitrators. (BC/BS)

New Language or Response

The Department declines to incorporate this proposed change. The procedure has been determined by the statute (see ARS § 20-3115(G)). The statute requires that the Department first appoint an Arbitrator.

Additional General Comments on R20-6-2404:

Comment

We would recommend a cap of $400 placed on arbitration costs unless both parties agree. It makes little economic sense to the affected parties to have an $800 arbitration cost on a disputed bill of only $1,100. (CEP)

Response

The Department lacks the authority to fix prices for arbitration costs. The Department is in the process of issuing a RFP for arbitration services. Contracts will be awarded by the Department keeping in mind that the procedure shall be cost-effective.

Comment

We would like the rule amended to provide that when the Department provides the three arbitrator candidates pursuant to R20-6-2404, the Department also provide information about the arbitrators' rates with their contact information. (United)

Response

The arbitrator’s rates and contact information will be available on the Arizona Procurement portal.

Comments

B. & D. stipulates the qualifications of arbitrators, and the appointment and selection process by the health insurer and provider. There are no provisions in the proposed rules to require disclosure of any of the qualifications and background of the arbitrators under consideration. At a minimum the health insurer and healthcare provider should be informed of each arbitrator's requisite health care services claims experience and work history (e.g., has the arbitrator been employed by health insurers or healthcare providers?).

In addition, absent a fee schedule (or limits on the arbitrators' fees), we respectfully suggest there should be a required disclosure of each arbitrator's services and proposed fees to allow cost considerations to be considered in the arbitrator selection process. (ARMA/AOMA)

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We echo the sentiments expressed in the ARMA and AOMA letter regarding . . . as well as the qualification and fees for arbitrators. We believe their proposals regarding the qualifications and fees are good suggestions. (AZNA/AZANA/NP/Nurse-Midwives)

Response

Information about Arbitrators contracted with the Department will be available on the Arizona Procurement portal.

R20-6-2405. Before the Arbitration.

Current Language

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

**1. Pay or make 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.**

Comments

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. (BC/BS)

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We believe that under (A) the department should specify what would happen if the enrollee failed to pay or make arrangements to pay the appropriate cost sharing requirements. This is not addressed in the statute and would be an excellent opportunity under rulemaking here to so specify. (MEDNAX)

New Language or Response

The Department declines to incorporate the proposed changes.

The Department’s RFP requires the Arbitrator to make the determination that the enrollee has paid the provider before the Arbitration can be held.

Current Language

**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.**

Comments

No comments received.

Additional General Comments on R20-6-2405:

Comment

There appears to be punctuation missing from the heading R20-6-2405. Before the Arbitration. (United)

Response

R20-6-2405. Before the Arbitration.

R20-6-2406. The Arbitration.

Current Language

**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.**

Comments

No comments received.

Current Language

**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.**

Comments

R20-6-2406. The Arbitration In (C) (2), we would specify that this amount does not include Medicaid and Medicare because they are addressed in (C) (3). (MEDNAX)

New Language or Response

The Department declines to incorporate the proposed changes.

Current Language

**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).**

Comments

No comments received.

Current Language

**E. Payment of the claim. The health insurer shall remit its portion of the 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).**

Comments

Also under (E) of this proposed section the "L" in reference to A.R.S. $3102 should be deleted or changed (see also reference under R20-6-2403 above). (MEDNAX)

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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). (BC/BS)

New Language or Response

The Department declines to incorporate the proposed changes.

Current Language

**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.**

Comments

No comments received.

Current Language

**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 not be disclosed to any person except the Arbitrator or Alternative Arbitrator.**

Comments

Further we believe that (G)(2) should be more specific in terms of to whom disclosure may not be disclosed by adding "those outside of the arbitration" or similar language. Even further, (G)(3) should be combined with (G)(2) to read more consistent with A.R.S. $20-3115 (O) by including "other than to resolve the surprise out-of-network bill." (MEDNAX)

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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.

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.

We are concerned about inadvertent disclosure of this highly proprietary information and think the DOI needs to take all precautions to assure confidentiality. (BC/BS)

New Language or Response

The Department declines to incorporate the proposed changes.

The Department is not a party to the Arbitration and will not obtain any of the documents or information shared at the Arbitration. The Department has included the confidentiality requirements in the RFP for the Arbitrators.

Current Language

**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;**

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

**5. The payment amount awarded to the health care provider; and**

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

Comments

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. (BC/BS)

New Language or Response

The Department declines to incorporate the proposed changes.

Additional General Comments on R20-6-2406:

Comment

If the parties settle the qualifying out-of-network bill at the Informal Settlement Teleconference, insurers are required to process the claim within 30 days after the conference call. Aetna recognizes that an EOB will be issued. What other notice requirements, if any, are insurers required to make after a settlement is reached? (Aetna)

Response

Notice to the Department is required. Please see ARS § 20-3115(E).

Additional General Comments

Comment

We find that clarity is needed in regards to Section 20-3113 A2 (non-ER scenarios) and 20-3113 A3 (non ER scenarios and enrollee refused to sign disclosure) and whether or not these requirements apply to HMO and/ or EPO products and plans. If the requirements do apply to HMO/ EPO products, what type of health plans does "20-3112 Applicability #4" apply to? (ACH)

Response

This is a comment about the statutory scheme.

Comment

20-3114(A)(3), Dispute resolution; settlement teleconference; arbitration; surprise out-of-network bills, states amount of out-of-network bill enrollee is responsible is for all related health care services provided by a health care provider whether contained in one or multiple bills. Please explain what is included in all related health care services. Is the date span of an inpatient stay for services rendered by the same provider considered all related health care services? Is all related health care services solely limited to (1) date of service and not a span of dates? (ACH)

Response

This is a comment about the statutory scheme.

Comment

Finally, we would recommend that the Arizona Department of Insurance establish an out-of-network dispute resolution process review committee consisting of at least one representative from the health insurer industry and the health care provider industry to meet quarterly with the ADOI for at least two years after the effective date of these Rules. This committee would review the arbitration process and make recommendations for changes if deemed necessary to ensure that the process is working fairly for all parties. (CEP)

Response

The Department declines to implement this suggestion at this time.

Comment

We request that when the proposed rules are adopted and published as final regulations, the Department explicitly state that a health care provider, provider's representative, or billing company may fulfill the requirement to notify a patient of the dispute resolution process under Arizona Revised Statute $ 20-3117(C) by directing the patient to the relevant section of the Department's website in its written and/or electronic communication with the patient. Permitting health care providers, their representatives, and billing companies to direct the patient to the Department's language at its source will ensure that patients receive the most up-to-date information regarding their rights under state law. It will also reduce the burden on health care providers, their representatives, and billing companies as they seek to provide the most accurate information possible. (ZOTEK)

Response

The Department is exploring a secure portal where this type of information can be obtained.

1. Commenters are: Aetna, America’s Health Insurance Plans (AHIP), Arizona College of Emergency Physicians (CEP), Arizona Complete Heath (ACH), Arizona Department of Insurance (DOI), Arizona Medical Association/Arizona Osteopathic Medical Association (ARMA/AOMA), Arizona Nurses Association/Arizona Association of Nurse Anesthetists/Arizona Nurse Practitioner Council/American College of Nurse-Midwives (AZNA/AZANA/NP/Nurse-Midwives), Association of Air Medical Services, Blue Cross Blue Shield of Arizona (BC/BS), MEDNAX, UnitedHealthcare (United), and ZOTEC. [↑](#footnote-ref-1)