

ARIZONA

According to *Nahom v. Scottsdale Mem. Hosp.*, 180 Ariz. 548, 885 P.2d 1113 (App. 1994), the courts hold that injured patients are third-party beneficiaries to the health insurer-medical provider contracts and, therefore, prohibit "balance billing" based on the terms of that contract. Article 20-1072 reiterates that an enrollee cannot be held liable to the provider or hospital for any amounts owed by insurer. However, this ruling and statute only pertain to participating providers. Like many states, Arizona has no law prohibiting non-participating providers from balance billing.

The relevant chapters of Health Care Services Organizations (Article 9) are attached. Portions of these chapters refer to balance billing by participating providers, access to emergency care and what information a health plan must disclose to enrollees. They seem to indicate that an insurer is not required to pay an out-of-network provider providing covered services at an in-network facility at the same rate as an in-network provider. But rather, each organization and plan offered by that organization may have different stipulations regarding this action, and must specify the terms and conditions to its enrollees in disclosure forms.

However, according to Emergency Services Access (Chapter 20-2803), a health care services plan shall not deny coverage for emergency services provided to the plan's enrollee due to a provider's failure to obtain prior authorization from the plan if the provider could not determine the patient's enrollment in a particular plan due to the patient's physical condition, or if the patient's enrollment information was not available from the plan at the time of the provider's contact. This portion of the chapter may be construed to mean that in a situation where a patient receives care at an in-network facility by an out-of-network provider, and due to the patient's condition, the provider is unable to verify enrollment status, the insurer cannot deny coverage.

20-1072. Nonliability of enrollees for provider or hospital charges; penalty

A. Every written contract between a health care services organization and a provider or hospital shall set forth that if the organization fails to pay for covered health care services as set forth in the enrollee's evidence of coverage or contract the enrollee is not liable to the provider or hospital for any amounts owed by the organization and the provider or hospital shall not bill or otherwise attempt to collect from the enrollee the amount owed by the organization.

B. If the written contract between the contracting provider or hospital and the organization fails to contain the required prohibition stated in subsection A, the enrollee is not liable to the contracting provider or hospital for any amounts owed by the organization.

C. No contracting provider or agent, trustee or assignee of the contracting provider or hospital may maintain an action at law against an enrollee to collect any amounts owed by the organization for which the enrollee is not liable to the contracting provider under subsection A.

D. Nothing in this section impairs the right of a provider or hospital to charge, collect from, attempt to collect from or maintain an action at law against an enrollee for any of the following:

1. Copayment or coinsurance amounts.
2. Health care services not covered by the organization, including out of area claims that are not paid by an organization on behalf of an enrollee.
3. Health care services rendered after the termination of the contract between the health care services organization and the provider or hospital, unless the health care services were rendered during confinement in an inpatient facility and the confinement began prior to the date of termination, or unless the provider has assumed post-termination treatment obligations under the contract.

E. Nothing in this section prohibits an enrollee from seeking health care services from a contracting or noncontracting provider or hospital and accepting financial responsibility for these services.

F. No provider or hospital may charge an enrollee of a health care services organization more than the amount the provider or hospital contracted to charge the enrollee pursuant to the provider's contract or hospital's contract with the health care services organization.

G. Nothing in this section prohibits any person from informing an enrollee of either the cost of health care services performed or the status of any bill submitted to an organization in connection with health care services provided to an enrollee. Any information provided to an enrollee pursuant to this subsection shall include a statement that the information is not a bill and is for the enrollee's information only. The statement shall include the following disclosure prominently displayed at the top of the page in all capital letters: "Do not pay this statement. This is not a bill. The information provided below is for information purposes only."

H. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization.

I. The director shall impose a penalty against any health care provider or hospital in violation of this section of up to three times the amount of the provider or hospital charges at issue.

J. The director shall investigate any complaint filed pursuant to this section and enforce the requirements of this section.

20-1076. Health care plans; disclosure form; enrollee notification

A. Each health care services organization that offers a health care plan to the public shall provide disclosure forms as required by this section. The disclosure form shall be in a form prescribed by the director and shall include the following:

1. A separate roster of plan primary care physicians who are licensed pursuant to title 32, chapter 13, 17 or 29, including the physician's degree and practice specialty, the year first licensed to practice medicine and, if different, the year initially licensed to practice in Arizona.

2. In concise and specific terms:

(a) The full premium cost of the plan.

(b) Any copayment, coinsurance or deductible requirements that an enrollee or the enrollee's family may incur in obtaining coverage under the plan and any reservation by the plan to change premiums.

(c) The health care benefits to which an enrollee would be entitled. The disclosure shall state where and in what manner an enrollee may obtain services, including the procedures for selecting or changing primary care physicians and the locations of hospitals and outpatient treatment centers that are under contract with the health care services organization.

3. Any limitations of the services, kinds of service, benefits and exclusions that apply to the plan. A description of limitations shall include:

(a) Procedures for emergency room, nighttime or weekend visits and referrals to specialist physicians.

(b) Whether services received outside the plan are covered and in what manner they are covered.

(c) Procedures an enrollee must follow, if any, to obtain prior authorization for services.

(d) The circumstances under which prior authorization is required for emergency medical care and a statement as to whether and where the plan provides twenty-four hour emergency services.

(e) The circumstances under which the plan may retroactively deny coverage for emergency medical treatment and nonemergency medical treatment that had prior authorization under the plan's written policies.

(f) A statement regarding whether or not plan providers must comply with any specified numbers, targeted averages or maximum durations of patient visits. If any of these are required of plan providers, the disclosure shall state the specific requirements.

(g) The procedures to be followed by an enrollee for consulting a physician other than the primary care physician, and whether the enrollee's physician, the plan's medical director or a committee must first authorize the referral.

(h) The necessity of repeating prior authorization if the specialist care is continuing.

(i) Whether a point of service option is available, and if so, how it is structured.

4. Grievance procedures for claim or treatment denials, dissatisfaction with care and access to care issues.

5. Subject to section 20-1057.02, a response to whether a plan physician is restricted to prescribing drugs from a plan list or plan formulary and the extent to which an enrollee will be reimbursed for costs of a drug that is not on a plan list or plan formulary.

6. A response to whether plan provider compensation programs include any incentives or penalties that are intended to encourage plan providers to withhold services or minimize or avoid referrals to specialists. If these types of incentives or penalties are included, the health care services organization shall provide a concise description of them. The health care services organization may also include, in a separate section, a concise explanation or justification for the use of these incentives or penalties.

7. A description of the health care services organization's continuity of care policies pursuant to section 20-1057.04.

8. A statement that the disclosure form is a summary only, and that the plan evidence of coverage should be consulted to determine governing contractual provisions.

B. A health care services organization shall not disseminate a completed disclosure form until the form is submitted to the director. For purposes of this section, a health care services organization is not required to submit to the director its separate roster of plan physicians or any roster updates.

C. On request, a health care services organization shall provide the information required under subsection A of this section to all employers who are considering participating in a health care plan that is offered by the health care services organization or to an employer that is considering renewal of a plan that is provided by the health care services organization.

D. An employer shall provide to its eligible employees the disclosures required under subsection A of this section no later than the initiation of any open enrollment period or at least ten days before any employee enrollment deadline that is not associated with an open enrollment period.

E. An employer shall not execute a contract with a health care services organization until the employer receives the information required under subsection A of this section.

F. Nothing in this section provides any private right or cause of action to or on behalf of any enrollee, prospective enrollee, employer or other person, whether a resident or nonresident of this state. This section provides solely an administrative remedy to the director of the department of insurance for any violation of this section or any related rule.

G. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization.

20-2803. Emergency services access; prior authorization; requirements

A. A health care services plan shall provide coverage for an initial medical screening examination and any immediately necessary stabilizing treatment required by the emergency medical treatment and active labor act (P.L. 99-272; 100 Stat. 164; 42 United

States Code section 1395dd) without prior authorization by the plan, subject to applicable copayments, coinsurance and deductibles.

B. A health care services plan shall provide coverage for emergency ambulance services without prior authorization, subject to applicable copayment, coinsurance and deductibles.

C. A provider shall not deny, limit or otherwise restrict a patient's access to medically necessary emergency services based on the patient's enrollment in a health care services plan.

D. A health care services plan may require as a condition of coverage prior authorization for health care services arising after the initial medical screening examination and immediately necessary stabilizing treatment. Prior authorization is granted unless denied or direction of the enrollee's care is initiated by the plan within a reasonable period of time after the plan receives the prior authorization request. If direction of care instructions are received from the plan after more than a reasonable period of time has elapsed, the treating provider or providers shall comply with the late instructions to the extent feasible, except that a health care services plan remains responsible for coverage of medically necessary care given and substantially completed before the late instructions were received.

E. A health care services plan that requires prior authorization under subsection C shall provide twenty-four hour access by telephone or facsimile for enrollees and providers to request prior authorization for medically necessary care after the initial medical screening examination and any immediately necessary stabilizing treatment. Plan personnel shall have access to a physician when necessary to make determinations regarding prior authorization.

F. A health care services plan that gives prior authorization for specific care by a provider shall not rescind or modify the authorization after the provider renders the authorized care in good faith and pursuant to the authorization.

G. A hospital emergency department shall make reasonable efforts to promptly contact the health care services plan for prior authorization for continuing treatment, specialty consultations, transfer arrangements or other appropriate care for an enrollee. A health care services plan shall not deny coverage for emergency services provided to the plan's enrollee due to a provider's failure to obtain prior authorization from the plan if the provider could not determine the patient's enrollment in a particular plan due to the patient's physical condition, or if the patient's enrollment information was not available from the plan at the time of the provider's contact.

H. If the health care services plan and the provider disagree on the medical necessity of specific emergency services for an enrollee, except for emergency services provided outside the geographic service area of the plan, medical personnel representing the plan shall make necessary arrangements to assume the care of the enrollee within a reasonable period of time after the disagreement arises. If the health care services plan fails to assume the care of the enrollee as provided by this subsection, the plan shall not deny coverage for medically necessary emergency services provided to the enrollee due to lack of prior authorization.

I. If within a reasonable period of time after receiving a request from a hospital emergency department for a specialty consultation a health care services plan fails to identify an appropriate specialist who is available and willing to assume the care of the enrollee, the emergency department may arrange for medically necessary emergency services by any appropriate specialist, and the plan shall not deny coverage for these services due to lack of prior authorization. A health care services plan shall not require prior authorization for specialty care emergency services for treatment of any immediately life threatening medical condition.