ARIZONA HOUSE OF REPRESENTATIVES

Fifty-sixth Legislature
Second Regular Session

HB 2444: grievance process; payment methods; report
Sponsor: Representative Montenegro, LD 29
Committee on Health & Human Services

Overview

Requires a health insurer to accept tangible checks as a form of acceptable payment and establishes reporting requirements for health care provider grievances.

History

Contracts to provide health care services

A contract between a health insurer and a health care provider that is issued, amended or renewed to provide health care services to the health insurer's enrollees may not restrict the method of payment from the health insurer to the health care provider in which the only acceptable payment method is a credit card payment.

If a health insurer initiates or changes payments to a health care provider using electronic funds transfer payments, including virtual credit card payments, the health insurer must do the following:

1) notify the health care provider if any fee is associated with a particular payment method;
2) advise the health care provider of the available methods of payment and provide clear instruction to the health care provider as to how to select an alternative payment method; and
3) remit or associate with each payment the explanation of benefits (A.R.S. § 20-241).

Grievances

Grievances are any written complaint that is subject to resolution through the insurer's internal system for resolving payment disputes and other contractual grievances with health care providers and submitted by a health care provider and received by the health care insurer. Grievances do not include: 1) complaints by a noncontracted provider regarding an insurer's decision to deny the noncontracted provider admission to the insurer's network; 2) complaints about an insurer's decision to terminate a health care provider from the insurer's network; and 3) complaints that are subject of a health care appeal.

Health care insurers are required to establish an internal system for resolving payment disputes and other contractual grievances with health care providers. Each health care insurer must provide a summary of all records of health care provider grievances received during the prior six months. The Director of the Department of Insurance and Financial Intuition (DIFI) may review the health care insurer's internal system and examine the health care insurer if the DIFI Director find's a significant number of grievances that have not been resolved (A.R.S. §§ 20-3101 and 20-3102).

Provisions

1. Requires a health insurer to accept tangible checks as a form of acceptable payment. (Sec. 1)
2. Asserts that a health care provider's decision to opt out of a method of payment remains in effect until they opt back in to the prior method of payment or a new contract is executed. (Sec. 1)
3. Requires the DIFI Director, annually on August 1, to post a report on DIFI's publicly accessible website information on health care provider grievances for the prior fiscal year. (Sec. 3)
4. Specifies that the report on health care provider grievances must include:
   a) the total number of grievances received;
   b) the average time to resolve a grievance; and
   c) the percentage of grievances where a health care insurer's decision was overturned. (Sec. 3)
5. Clarifies that this does not preclude a health care provider from collecting monies for a medical service that is not covered under the insurance policy or for the frequency of a medical service that is not covered under the insurance policy. (Sec. 3)
6. Expands the definition of *grievance* to include any delays in the timeliness of payments or payment denials. (Sec. 2)
7. Makes technical and conforming changes. (Sec. 1-4)

☐ Prop 105 (45 votes)	☐ Prop 108 (40 votes)	☐ Emergency (40 votes)	☐ Fiscal Note