KUTAKROCK

August 3, 2020

Stop Surprise Billing and Patient Protections Act Summary

On July 6, 2020 several unions filed a ballot proposition for the 2020 Election titled the Stop Surprise Billing and Patient Protections Act (the "Initiative"). The Initiative addresses four policy issues. It restricts the ability of health insurers to apply preexisting condition limitations on their plans. It bootstraps a new surprise medical billing statute on the existing arbitration system. It establishes a new "minimum wage" for all non-executive/physician hospital employees which will increase hospital employee salaries by 20% over time. Finally, it statutorily establishes a new infection control regulatory system on hospitals. The language of the Initiative can be found here.

The purpose of this memorandum is to highlight some of the areas of the Initiative which we believe may have a detrimental impact on the operations of major medical carriers and of insurers selling short-term and limited benefit coverage. The following is a general summary of the key insurance-related provisions. We have attempted to highlight areas where existing law and the Initiative are inconsistent and may create confusion or create conflicting requirements for insurers.

Pre-existing Condition Limitations: The drafters did not utilize the traditional approach to modifying existing statutory regulations governing major medical carriers by individually modifying the disability insurer, group disability insurance, hospital service corporations, healthcare services organization and accountable health plan statutes. Instead, the drafters created new definitions in A.R.S. § 20-192. As a result, if the Initiative passes, it appears there will be conflicts between existing statutes and the Initiative language.

One of the areas of potential concern is the new restrictions on use of the pre-existing conditions on short-term limited duration insurance. In the new A.R.S. § 20-192, the Initiative defines "HEALTH INSURANCE COVERAGE" as follows:

> "(a) MEANS BENEFITS CONSISTING OF MEDICAL CARE (PROVIDED THROUGH INSURANCE SUBJECT TO THIS TITLE) UNDER ANY HOSPITAL OR MEDICAL SERVICE POLICY OR CERTIFICATE, HOSPITAL OR MEDICAL SERVICE PLAN CONTRACT OR HEALTH MAINTENANCE ORGANIZATION CONTRACT OFFERED BY HEALTH CARE INSURER, WHETHER ON THE GROUP MARKET OR INDIVIDUAL MARKET.
>
> (b) INCLUDES SHORT-TERM LIMITED DURATION INSURANCE"

The Initiative utilizes a definition that is different from the current definition of short-term limited duration insurance in A.R.S. 20-1384. The Initiative defines short-term limited duration insurance as:

> "BENEFITS OFFERED BY A HEALTH CARE INSURER THAT HAS AN EXPIRATION DATE SPECIFIED IN THE CONTRACT THAT IS LESS THAN TWELVE MONTHS AFTER THE ORIGINAL EFFECTIVE DATE OF THE CONTRACT AND TAKING INTO ACCOUNT RENEWALS OR EXTENSIONS THAT HAS A DURATION OF NOT LONGER THAN THIRTY-SIX MONTHS."

The current definition of short-term limited duration insurance in A.R.S. 1384(C)(2) was not modified, which provides:

> "Short-term limited duration insurance means health insurance coverage that is offered by a health care insurer, that is not subject to state health coverage mandates in this title, that has an expiration date specified in the contract that is less than twelve months after the original effective date of the contract and, taking into account renewals or extensions, that has a duration of no longer than thirty-six months."

In addition, the Initiative does not modify A.R.S. § 20-1379, which provides for the guaranteed availability of coverage and limits pre-existing coverage exclusions. Of particular note, this statute currently makes it clear, in subsection (U)(17), that short-term limited duration insurance is excluded from its guaranteed issuance and renewal provisions:

> "'Short-term limited duration insurance' has the same meaning prescribed in section 20-1384 and is not intended or marketed as health insurance coverage subject to guaranteed issuance or guaranteed renewal provisions of the laws of this state but that is creditable coverage within the meaning of this section and section 20-2301"

The current statutory definition of short-term limited duration insurance is inconsistent with the treatment of short-term policies in the Initiative. As a result, if the Initiative passes there will be two differing regulatory regimes governing short-term limited duration policies, creating confusion over whether those policies are subject to state health coverage mandates, and over guaranteed issuance and renewability requirements. The Initiative also did not modify the definition of "limited benefit coverage" under A.R.S. § 20-1137(B), and this potentially creates additional confusion.

Out-of-Network Bills: The Initiative significantly modifies current surprise billing statutes. The current law provides for an informal settlement conference and arbitration for surprise bills over $1,000. To be eligible, the insured is required to first arrange to pay the provider the amounts required under the insured's applicable cost-sharing requirements. The insured is required to participate in an informal settlement conference before seeking arbitration managed by Department of Insurance and Financial Institutions (DIFI), and the insured is held harmless for costs in excess of the insured's cost-sharing amount.

Under the Initiative, healthcare services organizations ("HCSOs") are newly required to participate in the surprise billing program, but the manner in which the drafters included HCSOs may have a much broader impact on the ability of health plans to design their networks. Specifically, the Initiative strikes A.R.S. § 20-3112(4), which excludes from the current out-of-network dispute resolution process "[h]ealth plans that do not include coverage for out-of-network health care services, unless otherwise required by law."

The purpose of this exclusion is to recognize that certain health insurance plans, such as those offered by HCSOs, only provide coverage for services provided by contracted or in-network providers unless otherwise required by law. Under existing law, an insured who chooses to receive care from a non-contracted provider would be responsible for the entire cost of the services provided or a higher out-of-network cost-sharing requirement. The Initiative drafters' decision to strike A.R.S. § 20-3312 (4) in effect negates those insurance contract provisions that limit coverage to services received by in-network providers. By bringing such claims back within the scope of the surprise billing dispute resolution process, the Initiative would limit the enrollee's financial exposure to only their typical in-network cost-sharing requirements, and force the insurer to pay for what are currently non-covered services.

The Initiative also includes new payment criteria for resolving out-of-network disputes. Under new A.R.S. § 20-3113.01, insurers would be required to reimburse (a) out-of-network providers at in-network facilities, and (b) emergency services received at out-of-network facilities, at the higher of the average in-network rate or 125% of Medicare Fee for Service Rates. The insurer can only make the insured responsible for their in-network cost-sharing responsibility, regardless of whether the provider is in-network or out-of-network. Further, the underlying statute still limits the surprise out-of-network dispute resolution process to provider bills that exceed $1,000. As a result, it is unclear whether, for insureds who receive services from out-of-network providers for less than $1,000, insurers would also have to cover those services as well. The Initiative drafters also expanded the surprise billing statute to apply to ground ambulance services, even though Arizona is a rate-regulated state, and commercial insurers are required to reimburse the providers at the regulated rate.

Please let a member of our Insurance Regulatory and Government Affairs team know if you have any questions regarding the Initiative.