

ARIZONA'S MANAGED CARE ACCOUNTABILITY ACT: MEANINGFUL REFORM OR COSTLY REGULATION?

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The Arizona Legislature recently concluded its 44th Legislature, Second Regular Session. One of the major pieces of legislation enacted was H.B. 2600, the Managed Care Accountability Act.¹

Governor Jane Hull refused to sign the bill but allowed it to become law without her signature on March 23, 2000.² The bill will take effect on July 18, 2000, but its provisions apply to policies issued or renewed beginning on January 1, 2001.³ The legislation covers a wide range of issues and directly affects how health insurers, hospital and medical service corporations and HMOs will do business in Arizona in the future.

In recent years, Arizona has been on the forefront of states enacting various health care reforms. Arizona's Accountable Health Plan Act,⁴ together with the enactment of the health care appeals law,⁵ demonstrated the Legislature's resolve to address consumer problems relating to assuring a minimum level of benefits and providing a mechanism to challenge denials of coverage. H.B. 2600 follows closely the public policy evidenced by the two earlier enactments.

While H.B. 2600 imposes a wide range of regulations on the health insurance industry, the most controversial aspect of the legislation clearly was the establishment of health care insurer liability based upon Arizona's existing insurer bad faith standards. A health care insurer, for purposes of the imposition of liability, is defined as "a disability insurer, group disability insurer, blanket disability insurer, health care services organization (HMO), hospital service corporation, medical service corporation or hospital and medical service corporation (Blue Cross & Blue Shield-type organizations)."⁶ Essentially, the Act imposes liability upon a health care insurer for damages caused to the insurer's enrollee by the insurer's delay in authorizing or failure to authorize a request for medically necessary health care services covered under the health care plan or by the denial of payment of benefits covered under the plan, if both:

1. The health care insurer did not have a reasonable basis for delaying the authorization of health care services or the denial of payment of benefits; and
2. The health care insurer knew it was without a reasonable basis for such action or failed to perform an adequate investigation to determine whether its action was reasonable.⁷

Essentially, this new statutory cause of action adopts existing Arizona bad faith standards and applies them to insurer decisions regarding failure to authorize health care services or the denial of covered benefits.⁸ It does provide, as Arizona law recognizes in bad faith cases, that an insurer is not liable if its conduct was inadvertent or unintentional. In other words, a mistake as opposed to acting with conscious disregard for the enrollee's interest, will not result in liability under the Act.

Interestingly, there is a prior notification requirement in the law relating to the enrollee's notice of intent to file suit.⁹ That section requires the enrollee to either complete the health care appeals process in its totality or provide written notice to the health care insurer at least 30 days before filing suit, stating the enrollee's intention to file suit and setting forth the basis therefor.

The Bill also contains a less obvious liability provision. It requires an insurer's medical director to make denials of preauthorized requests for services in writing if the denial is based on medical necessity.¹⁰ This creates a liability issue because Arizona case law holds that an insurance company medical director is practicing medicine when he denies a preauthorization request.¹¹ The new provision also requires the insurer to provide a copy of the denial to the requesting provider and maintain a copy for Department of Insurance review.¹²

Other key provisions of the legislation prohibit any person regulated by the Arizona insurance laws from terminating a contract with a health care professional solely because the provider advocates for a patient or assists a patient in

requesting a reconsideration of the denial.¹³ H.B. 2600 creates a new system of regulation over third party intermediaries, which are defined as entities assuming business risk through a written contract with health care insurers, HMOs and hospital and medical service corporations.¹⁵ It creates bonding and cash deposit requirements to cover benefits payable under the contract and allows a health care provider that does not receive payment for services within 90 days to sue to collect on the bond or deposit.

H.B. 2600 prohibits financial incentive arrangements between health care professionals and insurers that induce the provider to deny or reduce covered medically necessary care for a specific condition.¹⁵ This prohibition, however, does not apply to per diem or per case payments, diagnostic-related grouping payments, capitation payments or shared risk arrangements as long as such payment mechanisms are not related to specific medical decisions.

Although operating under the rubric of reform, the Act requires benefit insurers and HMOs to cover chiropractic services through network providers with a minimum of 12 self-referral visits per year.¹⁶ This provision clearly relates less to managed care accountability than to the political persuasiveness of the chiropractic lobbying effort.

The Act includes detailed regulations regarding formulary and non-formulary drugs.¹⁷ Insurers must disclose the use of a formulary and describe how the insurer decides to add or remove drugs from its formulary. It requires insurers to create a process for providers to request authorization for formulary or non-formulary drugs during non-business hours and maintain a system for providers to request medically necessary non-formulary drugs. It also prohibits insurers from excluding an insured's drug for a 60-day period after the insurer's notification to the pharmacy that it has removed the formulary drug from its list.

There are comprehensive provisions assuring continuity of care.¹⁸ These include requiring an insurer to allow a new insured whose doctor is not part of the network to continue treating with the provider for 30 days if the insurer has a life-threatening condition or for up to six weeks if the insured is in the third trimester of a pregnancy. The bill requires an insurer that terminates a provider for reasons other than incompetence or unprofessional conduct, to allow that provider's patients to continue treating with the provider for life-threatening conditions and advanced pregnancies.

While much of the legislation contains comprehensive regulatory requirements, one section attempts to lighten the administrative burden on insurers and HMOs. Under current law, the Arizona Department of Insurance has the option of requiring prior approval of any life and disability insurer advertising.¹⁹ In practice, the Department always requires preapproval. The law explicitly requires preapproval of HMO advertising.²⁰ H.B. 2600 changes the regulation of advertising and permits HMOs and life and health insurers to simply file advertisements with the Department before using the ads.²¹ There is no prior approval requirement. The Director is given cease and desist authority and can impose penalties if the ad is false or misleading. The Director must provide at least five days notice before issuing a cease and desist order prohibiting the use of the advertising.

The health care appeals laws were also significantly amended. In addition to the medical director liability provisions discussed above, the law distinguishes between medical necessity appeals and coverage reviews.²² Medical necessity appeals continue to be decided with the use of consulting physicians; whereas, coverage appeals proceed directly to an external independent review level under which the Director ultimately decides the coverage issue. In order to obtain an expedited review, the enrollee must show that waiting for informal reconsideration of formal appeal is "likely to cause a significant negative change in the member's medical condition."²³ Accordingly, expedited appeal in the Health Care Appeals Act was created.²⁴ It requires the utilization review agent who denies the claim on an expedited review to inform the policyholder of his right to expedited appeal. The provider must immediately appeal to the UR agent and within three business days of receipt, a specialist in the licensed field relating to the appeal, employed by the UR agent, must re-review the expedited appeal and render a decision.

The last major area addressed by the Managed Care Accountability Act relates to the timely payment of claims.²⁵ For purposes of this section, a health care insurer includes health insurers, HMOs, dental service corporations, prepaid dental plans, optometric service corporations and hospital and medical service corporations. Essentially, the Act requires an insurer to approve or deny a "clean claim" within 30 days of receipt thereof. A "clean claim" is a claim that can be processed without obtaining additional information from the provider or a third party.²⁶ The insurer must pay interest if it fails to pay a clean claim within 30 days. To the extent the insurer requires additional information before

approving or denying a clean claim, it must make the request within 30 days of receiving the claim and specifically state the reasons for the request. Thereafter, the insurer must approve or deny the claim within 30 days after receiving the information. If approved, the insurer must pay the claim within 30 days or pay interest in addition thereto.

As one can see, the Managed Care Accountability Act is an all-encompassing effort at reforming the managed care system from the standpoint of making it more responsive to consumers and health care providers who disagree with authorization or claim decisions. While the net result undoubtedly will provide greater remedies within a more expedited time frame for claim review and decision-making, the Act certainly will create a host of concerns and administrative hurdles for the managed care industry. The creation of a bad faith statutory remedy, while intended to encourage thoughtful and reasonable claims decisions, could have the effect of dramatically increasing the exposure of health care insurers. A complicated health care appeals process coupled with the statutory bad faith exposure undoubtedly can result in pitfalls for the unwary, which ultimately result in higher costs that get passed along to the premium payers. In a sense, the good intention that led to the Act's passage may well create a costly bureaucratic and litigation morass that may negatively impact the health care market in the State.

Endnotes

1. *See* 2000 Ariz. Sess. Laws 37.
2. Letter from Ariz. Governor Jane Dee Hull to House Speaker Jeff Groscost (March 23, 2000) (on file with author).
3. *See* Ariz. Const., Art. IV, Pt. 1, § 1; 2000 Ariz. Sess. Laws 37, § 38.
4. *See* A.R.S. § 20-2301 et seq.
5. *See* A.R.S. § 20-2530 et seq.
6. *See* 2000 Ariz. Sess. Laws 37, § 35 (A.R.S. § 20-3151(2)).
7. *See* 2000 Ariz. Sess. Laws 37, § 35 (A.R.S. § 20-3153).
8. *See Clearwater v. State Farm Mutual Automobile Ins. Co.*, 164 Ariz. 256, 792 P.2d 719 (1990); *Noble v. National American Life Insurance Co.*, 128 Ariz. 188, 624 P.2d 866 (1981).
9. *See* Ariz. Sess. Laws 37, § 35 (A.R.S. § 20-3155).
10. *See* 2000 Ariz. Sess. Laws 37, § 28 (A.R.S. § 20-2510(B)).
11. *See Murphy v. Bd. of Medical Examiners*, 190 Ariz. 441, 949 P.2d 530 (App. 1997).
12. *See* 2000 Ariz. Sess. Laws 37, § 28 (A.R.S. § 20-2510(B)).
13. *See* 2000 Ariz. Sess. Laws 37, §§ 1, 5, 10 & 17 (A.R.S. § 20-118, 20-826, 20-934 & 20-1061).
14. *See* 2000 Ariz. Sess. Laws 37, § 2 (A.R.S. § 20-120).
15. *See* 2000 Ariz. Sess. Laws 37, §§ 7, 10 & 11 (A.R.S. §§ 20-833, 20-934 & 20-1061).
16. *See* 2000 Ariz. Sess. Laws 37, §§ 16 & 17 (A.R.S. §§ 20-1057.03 & 20-936.03).
17. *See* 2000 Ariz. Sess. Laws 37, §§ 8, 11 & 16 (A.R.S. §§ 20-841.06, 20-936.02 & 20-1057.02).
18. *See* 2000 Ariz. Sess. Laws 37, §§ 8, 11 & 16 (A.R.S. §§ 20-841.06, 20-936.04 & 20-1057.04).

19. *See* A.R.S. § 20-1110.
20. *See* A.R.S. § 20-1057(D).
21. *See* 2000 Ariz. Sess. Laws 37, §§ 5, 14, 15 & 21 (A.R.S. §§ 20-826, 20-1018, 20-1057 & 20-1110).
22. *See* 2000 Ariz. Sess. Laws 37, § 29 (A.R.S. § 20-2533).
23. 2000 Ariz. Sess. Laws 37, § 30 (A.R.S. § 20-2534).
24. *See id.*
25. *See* 2000 Ariz. Sess. Laws 37, § 34 (A.R.S. § 20-3102).
26. *See* 2000 Ariz. Sess. Laws 37, § 34 (A.R.S. § 20-3101).