PRESS RELEASE

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2000-24
For Immediate Release
December 28, 2000

New Law Establishing Timely Pay Requirements and Grievance Provisions for Health Care Providers Takes Effect Jan. 1

Arizona Insurance Director Charles R. Cohen said the Insurance Department is prepared to begin administering a new law that provides time limits and procedures for health insurers to pay providers and resolve provider grievances.

The timely pay and grievance law is part of House Bill 2600, or the Managed Care Accountability Act, which the Arizona Legislature enacted in 2000. The timely pay and grievance provisions of the Act apply to all health insurers, not just managed care plans. The law, which goes into effect January 1, 2001, does not apply to AHCCCS, Medicare fee-for-service, county health system, workers compensation or self-insured employer claims.

According to Cohen, this new legislation is an important, positive step toward addressing concerns of providers regarding their right to be paid in a timely manner and to have their disputes with insurers resolved fairly and expeditiously.

“The Arizona Legislature, and particularly the primary sponsor of HB 2600, Rep. Barbara Leff, are to be commended for enacting this important new law,” Cohen said. “It not only gives health care providers important new rights, it gives the Insurance Department critical tools for monitoring network adequacy and financial solvency of health insurers.”

Under the new law, health insurers generally must approve or deny a “clean” or complete claim from a provider within 30 days, and must pay interest on late payments at a 10 percent annual rate, unless a different rate is specified in the contract between the provider and insurer. The insurer’s obligation to pay interest may not be waived.

The law limits the kind of supporting information insurers can request from providers, and prevents insurers or providers from seeking adjustments of payments more than one year after the payment was made.

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The grievance provisions of the law require all health insurers to establish an internal grievance system for resolving disputes with contracted and non-contracted providers. The Insurance Department is requiring all health insurers to make their grievance policies available to providers and to provide the Department with the name of a grievance contact person.

The law also requires insurers to file semi-annual reports with the Department summarizing their grievance records. The reports will be public records under state law. The Department will use the reports, along with other information, to assess whether particular insurers are generally complying with the timely pay and grievance laws, and to analyze whether they appear to have problems in related areas, like financial solvency and network adequacy, which require targeted regulatory attention.

The Department has also established form and content requirements for an insurer's semi-annual grievance reports. These requirements include the number and types of grievances filed, the types of resolution, the average number of days to resolution and the average amount in dispute per payment grievance.

The Insurance Department has established a Provider Information Line at (602) 912-8468 to provide information to providers about the timely pay and grievance laws. The Department also has information available on its Internet web site at www.state.az.us/id including a comprehensive bulletin ("Circular Letter 2000-15") recently issued by Director Cohen to health insurers regarding their compliance requirements, and a timely pay and grievances pamphlet that summarizes the new law and how it will be administered.

While the law greatly strengthens providers' rights to timely payment, it does not give the Insurance Department the authority or resources to adjudicate individual claims or resolve disputes between insurers and providers. Providers who have payment or contract disputes with insurers should submit written grievances directly to the insurer. Grievances should not be submitted to the Insurance Department. If providers contact the Department for help with particular claims or grievances, the Department will refer them to each insurer's designated grievance contact person.

"It is important for providers to understand that while the new law requires insurers to have procedures and systems in place to address their timely payment complaints and other contractual disputes, it does not make the Insurance Department into a court to resolve those disputes or a collection agency to pursue payment," Cohen said. "The Department will fulfill its responsibility to assure that insurers put these systems into place, but it is still up to providers to pursue payment and grievances on their own behalf."

Director Cohen plans to integrate this new scheme for timely payment of providers with the regulatory framework the Department is developing under another piece of 2000 legislation. Senate Bill 1330 transferred regulatory oversight for HMO quality assurance and network adequacy from the Department of Health Services to the Insurance Department, effective July 1, 2001. Cohen said issues pertaining to timely payment of providers are highly related to an insurer's network stability and financial solvency, and will mesh naturally in the new oversight program.