State of South Dakota

NINETY-SECOND SESSION
LEGISLATIVE ASSEMBLY, 2017

947Y0400

HOUSE BILL NO. 1169

Introduced by: Representatives Haggar, Heinemann, Latterell, Peterson (Kent), Qualm, and Rhoden and Senators Greenfield (Brock), Curd, Maher, and Novstrup

FOR AN ACT ENTITLED, An Act to repeal, revise, and enact certain standards and other provisions relating to managed health care plans if the federal Patient Protection and Affordable Care Act is repealed.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF SOUTH DAKOTA:

Section 1. That §§ 58-17F-1 to 58-17F-21, inclusive, be repealed.

Section 2. That §§ 58-17G-1 to 58-17G-7, inclusive, be repealed.

Section 3. That §§ 58-17H-1 to 58-17H-49, inclusive, be repealed.

Section 4. That §§ 58-17I-1 to 58-17I-16, inclusive, be repealed.

Section 5. That § 58-1-24 be amended to read:

58-1-24. Terms used in §§ 58-1-25 and 58-18-87 mean:

(1) "Genetic information," information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. The term includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes;

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(2) "Genetic test," a test of human DNA, RNA, chromosomes, or genes performed in order to identify the presence or absence of an inherited variation, alteration, or mutation which is associated with predisposition to disease, illness, impairment, or other disorder. Genetic test does not mean a routine physical measurement; a chemical, blood, or urine analysis; a test for drugs or HIV infection; any test commonly accepted in clinical practice; or any test performed due to the presence of signs, symptoms, or other manifestations of a disease, illness, impairment, or other disorder;

(3) "Health carrier," any person who provides health insurance in this state. The term includes a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, a multiple employer welfare arrangement, a fraternal benefit contract, or any person providing a plan of health insurance subject to state insurance regulation;

(4) "Health insurance," insurance provided pursuant to chapters 58-17 (except disability income insurance), ~~58-17F, 58-17G, 58-17H, 58-17I~~ the provisions of this Act, 58-18 (except disability income insurance), 58-18B, 58-38, 58-40, and 58-41; and

(5) "Individual," an applicant for coverage or a person already covered by a health carrier.

Section 6. That § 58-17-143 be amended to read:

58-17-143. The board may, directly or indirectly, enter into preferred provider contracts to obtain discounts on goods or services from out-of-state providers. If health care goods or services are provided pursuant to a preferred provider contract and the goods or services are either not readily available in this state or are emergency services as defined by ~~§ 58-17H-1~~ section 38 of this Act, the provisions of that contract shall govern the reimbursement rate. The

payment by the risk pool for any services received from out-of-network providers in other states, other than emergency treatment as defined in ~~§ 58-17H-1~~ section 38 of this Act, is limited to one hundred fifteen percent of South Dakota's medicaid reimbursement. Emergency treatment, as defined in ~~§ 58-17H-1~~ section 38 of this Act, that is from an out-of-state provider that is an out-of-network provider, to the extent that such services are payable under the plan, may be reimbursed by the risk pool at an amount that does not exceed the amount determined to be reasonable by the plan administrator.

Section 7. That § 58-17D-2 be amended to read:

58-17D-2. A utilization review organization that conducts utilization reviews solely for property and casualty insurers in this state pursuant to policies issued in this state is not subject to ~~chapters 58-17F, 58-17G, 58-17H, and 58-17I~~ this Act except that any such utilization review organization shall register in the same manner as prescribed for utilization review organizations pursuant to ~~§§ 58-17H-35 to 58-17H-39, inclusive~~ this Act.

Section 8. That § 58-17E-9 be amended to read:

58-17E-9. Any discount medical plan organization that is not offered directly by a health carrier as provided by this chapter, shall register in a format as prescribed by the director and shall file reports and conduct business under the same standards as required of utilization review organizations in accordance with provisions of ~~§§ 58-17H-36 and 58-17H-37~~ sections 74 and 75 of this Act. No health carrier may offer or provide coverage through a person not registered but required to be registered pursuant to §§ 58-17E-9, 58-17E-39, 58-17E-41, and 58-17E-45, inclusive. Any plan or program that is registered pursuant to ~~§ 58-17F-16~~ section 31 of this Act is not required to maintain a separate registration pursuant to §§ 58-17E-9, 58-17E-39, 58-17E-41, and 58-17E-45, inclusive. Any plan or program of discounted goods or services that is offered by a health carrier in conjunction with a health benefit plan, as defined in §§ 58-18-42

and 58-17-66(9), a medicare supplement policy as defined in § 58-17A-1, or other insurance product that is offered by an authorized insurer and that is subject to the jurisdiction of the director is not required to be registered pursuant to §§ 58-17E-9, 58-17E-39, 58-17E-41, and 58-17E-45, inclusive.

Section 9. That § 58-33-93 be amended to read:

58-33-93. Terms used in §§ 58-33-93 to 58-33-116, inclusive, mean:

(1) "Admitted insurer," an insurer licensed to do an insurance business in this state including an entity authorized pursuant to § 58-18-88, a health maintenance organization or nonprofit hospital, or medical service corporation under the laws of this state;

(2) "Arrangement," a fund, trust, plan, program, or other mechanism by which a person provides, or attempts to provide, health care benefits;

(3) "Employee leasing arrangement," a labor leasing, staff leasing, employee leasing, professional employer organization, contract labor, extended employee staffing or supply, or other arrangement, under contract or otherwise, whereby one business or entity represents that it leases or provides its workers to another business or entity;

(4) "Employee welfare benefit plan" or "health benefit plan," a plan, fund, or program which is or was established or maintained by an employer or by an employee organization, or by both, to the extent that the plan, fund, or program is or was established or maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical or hospital care or benefits, or benefits in the event of sickness, accident, disability, death, or unemployment;

(5) "Fully insured," for the health care benefits or coverage provided or offered by or

through a health benefit plan or arrangement:

(a) An admitted insurer is directly obligated by contract to each participant to provide all of the coverage under the plan or arrangement; and

(b) The liability and responsibility of the admitted insurer to provide covered services or for payment of benefits is not contingent, and is directly to the individual employee, member, or dependent;

(6) "Licensee," a person that is, or that is required to be, licensed or registered under the laws of this state as a producer, third party administrator, insurer, or preferred provider organization;

(7) "MEWA," multiple employer welfare arrangement;

(8) "MEWA contact," the individual or position designated by the division to be the MEWA contact as identified on the division web site;

(9) "Nonadmitted insurer," an insurer not licensed to do insurance business in this state;

(10) "Preferred provider organization," an entity that engages in the business of offering a network of health care providers, whether or not on a risk basis, to employers, insurers, or any other person who provides a health benefit plan including a managed care contractor registered or required to be registered pursuant to ~~§ 58-17F-16~~ the provisions of this Act;

(11) "Producer," a person required to be licensed pursuant to chapter 58-30 of this state to sell, solicit, or negotiate insurance;

(12) "Professional employer organization," an arrangement, under contract or otherwise, whereby one business or entity represents that it co-employs or leases workers to another business or entity for an ongoing and extended, rather than a temporary or project-specific, relationship;

(13) "Third party administrator" or "administrator," has the meaning provided in chapter 58-29D.

Section 10. That § 58-37A-39 be amended to read:

58-37A-39. In addition to the provisions contained in this ~~chapter~~ Act, the following chapters and provisions of the South Dakota Code also apply to fraternal benefit societies, to the extent applicable and not in conflict with the express provisions of this chapter and the reasonable implications of this chapter:

(1) Chapter 47-6;

(2) Chapter 58-1;

(3) Chapter 58-2, with the exception of § 58-2-29;

(4) Chapter 58-3;

(5) Chapter 58-4;

(6) Chapter 58-5;

(7) Sections 58-6-8, 58-6-46, and 58-6-47;

(8) Chapters 58-15, 58-17, 58-17A, 58-17B, and 58-18;

(9) Chapter 58-29B;

(10) Chapter 58-30;

(11) Chapter 58-33;

(12) ~~Chapters 58-17F, 58-17G, 58-17H, 58-17I, and~~ Chapter 58-33A.

Section 11. That § 58-41-12 be amended to read:

58-41-12. The director shall determine whether the applicant for a certificate of authority has:

(1) Demonstrated the willingness and potential ability to assure that health care services will be provided in a manner to assure both the availability and accessibility of

adequate personnel and facilities consistent with the requirements of ~~chapter 58-17F~~ this Act;

(2) Arrangements, established in accordance with regulations promulgated by the director for an ongoing quality of health care assurance program consistent with the requirements of ~~chapter 58-17F~~ this Act, concerning health care processes and outcomes;

(3) A procedure, established in accordance with rules promulgated pursuant to chapter 1-26 by the director, to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the availability and accessibility of its services, and such other matters as may be reasonably required by the director; and

(4) Reasonable provisions for emergency and out-of-area health care services.

Section 12. That the code be amended by adding a NEW SECTION to read:

Terms used in this Act mean:

(1) "Adverse determination," any of the following:

(a) A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request by a covered person for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit;

(b) The denial, reduction, termination, or failure to provide or make payment in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan; or

(c) Any prospective review or retrospective review determination that denies, reduces, terminates, or fails to provide or make payment, in whole or in part, for a benefit;

(2) "Ambulatory review," utilization review of health care services performed or provided in an outpatient setting;

(3) "Authorized representative," a person to whom a covered person has given express written consent to represent the covered person for purposes of this chapter, a person authorized by law to provide substituted consent for a covered person, a family member of the covered person or the covered person's treating health care professional if the covered person is unable to provide consent, or a health care professional if the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional. For any urgent care request, the term includes a health care professional with knowledge of the covered person's medical condition;

(4) "Case management," a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions;

(5) "Certification," a determination by a health carrier or its designee utilization review organization that a request for a benefit under the health carrier's health benefit plan has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level

of care, and effectiveness;

(6) "Closed plan," a managed care plan or health carrier that requires covered persons to use participating providers under the terms of the managed care plan or health carrier and does not provide any benefits for out-of-network services except for emergency services;

(7) "Concurrent review," utilization review conducted during a patient's hospital stay or course of treatment in a facility or other inpatient or outpatient health care setting;

(8) "Consumer," someone in the general public who may or may not be a covered person or a purchaser of health care, including employers;

(9) "Covered benefits" or "benefits," those health care services to which a covered person is entitled under the terms of a health benefit plan;

(10) "Covered person," a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

(11) "Director," the director of the Division of Insurance;

(12) "Discharge planning," the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility;

(13) "Discounted fee for service," a contractual arrangement between a health carrier and a provider or network of providers under which the provider is compensated in a discounted fashion based upon each service performed and under which there is no contractual responsibility on the part of the provider to manage care, to serve as a gatekeeper or primary care provider, or to provide or assure quality of care. A contract between a provider or network of providers and a health maintenance organization is not a discounted fee for service arrangement;

(14) "Emergency medical condition," the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy;

(15) "Emergency services," health care items and services furnished or required to evaluate and treat an emergency medical condition;

(16) "Facility," an institution providing health care services or a health care setting, including hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation, and other therapeutic health settings;

(17) "Grievance," a written complaint, or oral complaint if the complaint involves an urgent care request, submitted by or on behalf of a covered person regarding:

(a) Availability, delivery, or quality of health care services;

(b) Claims payment, handling, or reimbursement for health care services;

(c) Any other matter pertaining to the contractual relationship between a covered person and the health carrier.

A request for an expedited review need not be in writing;

(18) "Health benefit plan," a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services;

(19) "Health care professional," a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with state law;

(20) "Health care provider" or "provider," a health care professional or a facility;

(21) "Health care services," services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease;

(22) "Health carrier," an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the director, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits, or health services;

(23) "Health indemnity plan," a health benefit plan that is not a managed care plan or health carrier;

(24) "Intermediary," a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network;

(25) "Managed care contractor," a person who establishes, operates, or maintains a network of participating providers; or contracts with an insurance company, a hospital or medical service plan, an employer, an employee organization, or any other entity providing coverage for health care services to operate a managed care plan or health carrier;

(26) "Managed care entity," a licensed insurance company, hospital or medical service plan, health maintenance organization, or an employer or employee organization, that operates a managed care plan or a managed care contractor. The term does not include a licensed insurance company unless it contracts with other entities to provide a network of participating providers;

(27) "Managed care plan," a plan operated by a managed care entity that provides for the financing or delivery of health care services, or both, to persons enrolled in the plan through any of the following:

(a) Arrangements with selected providers to furnish health care services;

(b) Explicit standards for the selection of participating providers; or

(c) Financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan;

(28) "Necessary information," includes the results of any face-to-face clinical evaluation or second opinion that may be required;

(29) "Network," the group of participating providers providing services to a health carrier;

(30) "Open plan," a managed care plan or health carrier other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan or health carrier;

(31) "Participating provider," a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly, from the health carrier;

(32) "Prospective review," utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a health carrier's requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision;

(33) "Quality assessment," the measurement and evaluation of the quality and outcomes of medical care provided to individuals, groups, or populations;

(34) "Quality improvement," the effort to improve the processes and outcomes related to

the provision of care within the health plan;

(35) "Retrospective review," any review of a request for a benefit that is not a prospective review request, which does not include the review of a claim that is limited to veracity of documentation, or accuracy of coding, or adjudication for payment;

(36) "Second opinion," an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the medical necessity and appropriateness of the initial proposed health care service;

(37) "Secretary," the secretary of the Department of Health;

(38) "Stabilized," with respect to an emergency medical condition, that no material deterioration of the condition is likely, with reasonable medical probability, to result or occur before an individual can be transferred;

(39) "Utilization review," a set of formal techniques used by a managed care plan or utilization review organization to monitor and evaluate the medical necessity, appropriateness, and efficiency of health care services and procedures including techniques such as ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, and retrospective review; and

(40) "Utilization review organization," an entity that conducts utilization review other than a health carrier performing utilization review for its own health benefit plans.

Section 13. That the code be amended by adding a NEW SECTION to read:

A managed care plan shall appoint a medical director who has an unrestricted license to practice medicine. However, a managed care plan that specializes in a specific healing art shall appoint a director who has an unrestricted license to practice in that healing art. The director is

responsible for oversight of treatment policies, protocols, quality assurance activities, and utilization management decisions of the managed care plan.

Section 14. That the code be amended by adding a NEW SECTION to read:

Nothing in section 13 of this Act applies to dental only, vision only, accident only, school accident, travel, or specified disease plans or plans that primarily provide a fixed daily, fixed occurrence, or fixed per procedure benefit without regard to expenses incurred.

Section 15. That the code be amended by adding a NEW SECTION to read:

This section and section 17 of this Act apply to any health carrier who offers a managed care plan as defined in this Act.

Section 16. That the code be amended by adding a NEW SECTION to read:

Any health carrier shall provide to any prospective enrollee written information describing the terms and conditions of the plan. If the plan is described orally, easily understood, truthful, objective terms shall be used. The written information need not be provided to any prospective enrollee who makes inquiries of a general nature directly to a carrier. In the solicitation of group coverage to an employer, a carrier is not required to provide the written information required by this section to individual employees or their dependents if no solicitation is made directly to the employees or dependents and no request to provide the written information to the employees or dependents is made by the employer. All written plan descriptions shall be readable, easily understood, truthful, and in an objective format. The format shall be standardized among each plan that a health carrier offers so that comparison of the attributes of the plans is facilitated. The following specific information shall be communicated:

(1) Coverage provisions, benefits, and any exclusions by category of service, provider, and if applicable, by specific service;

(2) Any and all authorization or other review requirements, including preauthorization

review, and any procedures that may lead the patient to be denied coverage for or not be provided a particular service;

(3) The existence of any financial arrangements or contractual provisions with review companies or providers of health care services that would directly or indirectly limit the services offered, restrict referral, or treatment options;

(4) Explanation of how plan limitations impact enrollees, including information on enrollee financial responsibility for payment of coinsurance or other noncovered or out-of-plan services;

(5) A description of the accessibility and availability of services, including a list of providers participating in the managed care network and of the providers in the network who are accepting new patients, the addresses of primary care physicians and participating hospitals, and the specialty of each provider in the network; and

(6) A description of any drug formulary provisions in the plan and the process for obtaining a copy of the current formulary upon request. There shall be a process for requesting an exception to the formulary and instructions as to how to request an exception to the formulary.

Section 17. That the code be amended by adding a NEW SECTION to read:

Nothing in this section or section 15 of this Act apply to dental only, vision only, accident only, school accident, travel, or specified disease plans or plans that primarily provide a fixed daily, fixed occurrence, or fixed per procedure benefit without regard to expenses incurred. The provisions of section 15 of this Act § 58-17C-6 only apply to oral or written communications specifically designed to elicit an application for insurance.

Section 18. That the code be amended by adding a NEW SECTION to read:

This section to section 37 of this Act, inclusive, apply to all health carriers that offer

managed care plans.

Section 19. That the code be amended by adding a NEW SECTION to read:

A health carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four hours per day, seven days per week. Sufficiency shall be determined in accordance with the requirements of this section, and may be established by reference to any reasonable criteria used by the carrier, including: provider-covered person ratios by specialty; primary care provider-covered person ratios; geographic accessibility; waiting times for appointments with participating providers; hours of operation; and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

Section 20. That the code be amended by adding a NEW SECTION to read:

In any case where the health carrier has an insufficient number or type of participating provider to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the director.

Section 21. That the code be amended by adding a NEW SECTION to read:

The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of covered persons.

Section 22. That the code be amended by adding a NEW SECTION to read:

A health carrier shall monitor, on an ongoing basis, the ability, clinical capacity, and legal authority of its providers to furnish all contracted benefits to covered persons. In the case of

capitated plans, the health carrier shall also monitor the financial capability of the provider.

Section 23. That the code be amended by adding a NEW SECTION to read:

In determining whether a health carrier has complied with any network adequacy provision of sections 18 to 37 of this Act, inclusive, the director shall give due consideration to the relative availability of health care providers in the service area and to the willingness of providers to join a network.

Section 24. That the code be amended by adding a NEW SECTION to read:

A health carrier shall file with the director, in a manner and form defined by rules promulgated pursuant to chapter 1-26 by the director, an access plan meeting the requirements of sections 18 to 37 of this Act, inclusive, for each of the managed care plans that the carrier offers in this state. The carrier shall prepare an access plan prior to offering a new managed care plan, and shall annually update an existing access plan. The access plan shall describe or contain at least the following:

(1) The health carrier's network;

(2) The health carrier's procedures for making referrals within and outside its network;

(3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in managed care plans;

(4) The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;

(5) The health carrier's method of informing covered persons of the plan's services and features, including the plan's grievance procedures and its procedures for providing and approving emergency and specialty care;

(6) The health carrier's system for ensuring the coordination and continuity of care for

covered persons referred to specialty physicians, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(7) The health carrier's process for enabling covered persons to change primary care professionals;

(8) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transferred to other providers in a timely manner; and

(9) Any other information required by the director to determine compliance with the provisions of sections 18 to 37 of this Act, inclusive.

The provisions of subdivisions (2), (4), (6), (7), and (8), of this section, and the provisions regarding primary care provider-covered person ratios and hours of operation in § 58-I 7C-8 do not apply to discounted fee-for-service only networks.

Section 25. That the code be amended by adding a NEW SECTION to read:

A health carrier offering a managed care plan shall satisfy all the following requirements:

(1) A health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on services;

(2) In no event may a participating provider collect or attempt to collect from a covered person any money owed to the provider by the health carrier nor may the provider have any recourse against covered persons for any covered charges in excess of the

copayment, coinsurance, or deductible amounts specified in the coverage, including covered persons who have a health savings account;

(3) The provisions of sections 18 to 37 of this Act, inclusive, do not require a health carrier, its intermediaries or the provider networks with which they contract, to employ specific providers or types of providers that may meet their selection criteria, or to contract with or retain more providers or types of providers than are necessary to maintain an adequate network;

(4) A health carrier shall notify participating providers of the providers' responsibilities with respect to the health carrier's applicable administrative policies and programs, including payment terms, utilization review, quality assessment, and improvement programs, grievance procedures, data reporting requirements, confidentiality requirements, and any applicable federal or state programs;

(5) A health carrier may not prohibit or penalize a participating provider from discussing treatment options with covered persons irrespective of the health carrier's position on the treatment options, from advocating on behalf of covered persons within the utilization review or grievance processes established by the carrier or a person contracting with the carrier or from, in good faith, reporting to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare;

(6) A health carrier shall contractually require a provider to make health records available to the carrier upon request but only those health records necessary to process claims, perform necessary quality assurance or quality improvement programs, or to comply with any lawful request for information from appropriate state authorities. Any person that is provided records pursuant to this section shall

maintain the confidentiality of such records and may not make such records available to any other person who is not legally entitled to the records;

(7) A health carrier and participating provider shall provide at least sixty days written notice to each other before terminating the contract without cause. If a provider is terminated without cause or chooses to leave the network, upon request by the provider or the covered person and upon agreement by the provider to follow all applicable network requirements, the carrier shall permit the covered person to continue an ongoing course of treatment for ninety days following the effective date of contract termination. In the event of a covered person that has entered a second trimester of pregnancy at the time of contract termination as specified in this section, the continuation of network coverage through that provider shall extend to the provision of postpartum care directly related to the delivery;

(8) A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments, or deductibles from covered persons pursuant to the evidence of coverage or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for noncovered services;

(9) A health carrier shall establish a mechanism by which the participating providers may determine in a timely manner whether or not a person is covered by the carrier.

Section 26. That the code be amended by adding a NEW SECTION to read:

In any contractual arrangement between a health carrier and an intermediary, the following shall apply:

(1) A health carrier's ultimate statutory responsibility to monitor the offering of covered benefits to covered persons shall be maintained whether or not any functions or duties are contractually delegated or assigned to the intermediary;

(2) A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the carrier's covered persons;

(3) A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty days prior written notice from the health carrier;

(4) If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons;

(5) An intermediary shall maintain the books, records, financial information, and documentation of services provided to covered persons and preserve them for examination pursuant to chapter 58-3;

(6) An intermediary shall allow the director access to the intermediary's books, records, financial information, and any documentation of services provided to covered persons, as necessary to determine compliance with sections 18 to 37 of this Act, inclusive;

(7) A health carrier shall have the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services.

Section 27. That the code be amended by adding a NEW SECTION to read:

A health carrier shall file with the director sample contract forms proposed for use with its participating providers and intermediaries. A health carrier shall submit material changes to a

sample contract that would affect a provision required by sections 18 to 37 of this Act, inclusive, or any rules promulgated pursuant to sections 18 to 37 of this Act, inclusive, to the director for approval thirty days prior to use. Changes in provider payment rates, coinsurance, copayments, or deductibles, or other plan benefit modifications are not considered material changes for the purpose of this section. If the director takes no action within thirty days after submission of a material change to a contract by a health carrier, the change is deemed approved. The health carrier shall maintain provider and intermediary contracts and provide copies to the division or department upon request.

Section 28. That the code be amended by adding a NEW SECTION to read:

The execution of a contract by a health carrier does not relieve the health carrier of its liability to any person with whom it has contracted for the provision of services, nor of its responsibility for compliance with the law or applicable regulations. Any contract shall be in writing and subject to review by the director, if requested.

Section 29. That the code be amended by adding a NEW SECTION to read:

In addition to any other remedies permitted by law, if the director determines that a health carrier has not contracted with enough participating providers to assure that covered persons have accessible health care services in a geographic area, or that a health carrier's access plan does not assure reasonable access to covered benefits, or that a health carrier has entered into a contract that does not comply with sections 18 to 37 of this Act, inclusive, or that a health carrier has not complied with a provision of sections 18 to 37 of this Act, inclusive, the director may institute a corrective action that shall be followed by the health carrier, or may use any of the director's other enforcement powers to obtain the health carrier's compliance with sections 18 to 37 of this Act, inclusive.

Section 30. That the code be amended by adding a NEW SECTION to read:

The director may, after consultation with the secretary, promulgate pursuant to chapter 1-26 reasonable rules to protect the public in its purchase of network health insurance products, achieve the goals of sections 18 to 37 of this Act, inclusive, by ensuring adequate networks and by assuring quality of health care to the public that purchases network products. The rules include:

(1) Definition of terms;

(2) Provider/covered person ratios;

(3) Geographic access requirements;

(4) Accessibility of care;

(5) Contents of reports and filings;

(6) Notification requirements;

(7) Selection criteria;

(8) Recordkeeping;

(9) Setting of quality criteria based upon type of network; and

(10) Quality assurance/quality improvement plans.

Section 31. That the code be amended by adding a NEW SECTION to read:

Each managed care contractor, as defined in section 12 of this Act, shall register with the director prior to engaging in any managed care business in this state. The registration is subject to the provisions of sections 73 to 77 of this Act, inclusive, and any applicable rules promulgated pursuant to those sections.

Section 32. That the code be amended by adding a NEW SECTION to read:

A health carrier that provides managed care plans shall develop and maintain the infrastructure and disclosure systems necessary to measure the quality of health care services provided to covered persons on a regular basis and appropriate to the types of plans offered by

the health carrier. A health carrier shall:

(1) Utilize a system designed to assess the quality of health care provided to covered persons and appropriate to the types of plans offered by the health carrier. The system shall include systematic collection, analysis, and reporting of relevant data in accordance with statutory and regulatory requirements. The level of quality assessment activities undertaken by a health plan may vary based on the plan's structure with the least amount of quality assessment activities required being those plans which are open and the provider network is simply a discounted fee for service preferred provider organization; and

(2) File a written description of the quality assessment program with the director in the prescribed general format, which shall include a signed certification by a corporate officer of the health carrier that the filing meets the requirements of sections 18 to 37 of this Act, inclusive.

Section 33. That the code be amended by adding a NEW SECTION to read:

A health carrier that issues a closed plan, or a combination plan having a closed component, shall, in addition to complying with the requirements of section 32 of this Act develop and maintain the internal structures and activities necessary to improve the quality of care being provided. Quality improvement activities for a health carrier subject to the requirements of this section should involve:

(1) Developing a written quality improvement plan designed to analyze both the processes and outcomes of the health care delivered to covered persons;

(2) Establishing an internal system to implement the quality improvement plan and to specifically identify opportunities to improve care and using the findings of the system to improve the health care delivered to covered persons; and

(3) Assuring that participating providers have the opportunity to participate in developing, implementing, and evaluating the quality improvement system.

The health carrier shall provide a copy of the quality improvement plan to the director or secretary, if requested.

Section 34. That the code be amended by adding a NEW SECTION to read:

Nothing in sections 18 to 37 of this Act, inclusive, applies to health carrier's plans that do not contain provider networks or to dental only, vision only, accident only, school accident, travel, or specified disease plans or plans that primarily provide a fixed daily, fixed occurrence, or fixed per procedure benefit without regard to expenses incurred.

Section 35. That the code be amended by adding a NEW SECTION to read:

If the director and secretary find that the requirements of any private accrediting body meet the requirements of network adequacy, quality assurance, or quality improvement as set forth in sections 18 to 37 of this Act, inclusive, the carrier may, at the discretion of the director and secretary, be deemed to have met the applicable requirements.

Section 36. That the code be amended by adding a NEW SECTION to read:

Nothing in sections 18 to 37 of this Act, inclusive, applies to health carriers that only offer individual policies if:

(1) The policy does not use an individual or group to determine where or when services will be rendered, the course of treatment, or who will provide the services;

(2) The policy does not require pre-authorization for services provided under the policy; and

(3) The difference in policy benefits does not exceed ten percent whether an insured used a participating provider or nonparticipating provider.

Section 37. That the code be amended by adding a NEW SECTION to read:

The Division of Insurance shall separately monitor complaints regarding managed care for any policy that is exempt pursuant to section 36 of this Act.

Section 38. That the code be amended by adding a NEW SECTION to read:

A health carrier shall cover emergency services necessary to screen and stabilize a covered person and may not require prior authorization of such services if a prudent layperson would have reasonably believed that an emergency medical condition existed. With respect to care obtained from a noncontracting provider within the service area of a managed care plan, a health carrier shall cover emergency services necessary to screen and stabilize a covered person and may not require prior authorization of such services if a prudent layperson would have reasonably believed that use of a contracting provider would result in a delay that would worsen the emergency, or if a provision of federal, state, or local law requires the use of a specific provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a participating provider.

A health carrier shall cover emergency services if the plan, acting through a participating provider or other designated representative of the health carrier, has authorized the provision of emergency services.

Section 39. That the code be amended by adding a NEW SECTION to read:

If a participating provider or other designated representative of a health carrier authorizes emergency services, the health carrier may not subsequently retract its authorization after the emergency services have been provided, or reduce payment for an item or service furnished in reliance on approval, unless the approval was based on a material misrepresentation about the covered person's health condition made by the provider of emergency services.

Section 40. That the code be amended by adding a NEW SECTION to read:

Coverage of emergency services is subject to any contract coverage limits, applicable

copayments, coinsurance, and deductibles.

Section 41. That the code be amended by adding a NEW SECTION to read:

For immediately required post-evaluation or post-stabilization services, a health carrier shall provide access to a designated representative twenty-four hours a day, seven days a week, to facilitate review, or otherwise provide coverage with no financial penalty to the covered person.

Section 42. That the code be amended by adding a NEW SECTION to read:

A covered person shall have access to emergency services twenty-four hours a day, seven days a week to treat emergency medical conditions that require immediate medical attention.

Section 43. That the code be amended by adding a NEW SECTION to read:

Nothing in sections 38 to 44 of this Act, inclusive, applies to dental only, vision only, accident only, school accident, travel, or specified disease plans or plans that primarily provide a fixed daily, fixed occurrence, or fixed per procedure benefit without regard to expenses incurred.

Section 44. That the code be amended by adding a NEW SECTION to read:

If the director of the Division of Insurance and the secretary of the Department of Health find that the requirements of any private accrediting body meet the requirements of coverage of emergency medical services as set forth in sections 38 to 44 of this Act, inclusive, the health carrier may, at the discretion of the director and secretary, be deemed to have met the applicable requirements.

Section 45. That the code be amended by adding a NEW SECTION to read:

This section to section 68 of this Act, inclusive, apply to any health carrier that provides or performs utilization review services. The requirements of this section to section 68 of this Act, inclusive, also apply to any designee of the health carrier or utilization review organization that performs utilization review functions on the carrier's behalf.

Section 46. That the code be amended by adding a NEW SECTION to read:

A health carrier is responsible for monitoring all utilization review activities carried out by, or on behalf of, the health carrier and for ensuring that all requirements of sections 45 to 68 of this Act, inclusive, and applicable rules are met. The health carrier shall also ensure that appropriate personnel have operational responsibility for the conduct of the health carrier's utilization review program.

Section 47. That the code be amended by adding a NEW SECTION to read:

If a health carrier contracts to have a utilization review organization or other entity perform the utilization review functions required by sections 45 to 68 of this Act, inclusive, or applicable rules, the director shall hold the health carrier responsible for monitoring the activities of the utilization review organization or entity with which the health carrier contracts and for ensuring that the requirements of sections 45 to 68 of this Act, inclusive, and applicable rules are met.

Section 48. That the code be amended by adding a NEW SECTION to read:

A health carrier that requires a request for benefits under the covered person's health plan to be subjected to utilization review shall implement a written utilization review program that describes all review activities, both delegated and nondelegated for:

(1) The filing of benefit requests;

(2) The notification of utilization review and benefit determinations; and

(3) The review of adverse determinations in accordance with sections 69 to 72 of this Act, inclusive.

The program document shall describe the following:

(1) Procedures to evaluate the medical necessity, appropriateness, efficacy, or efficiency of health care services;

(2) Data sources and clinical review criteria used in decision-making;

(3) Mechanisms to ensure consistent application of review criteria and compatible decisions;

(4) Data collection processes and analytical methods used in assessing utilization of health care services;

(5) Provisions for assuring confidentiality of clinical and proprietary information;

(6) The organizational structure that periodically assesses utilization review activities and reports to the health carrier's governing body; and

(7) The staff position functionally responsible for day-to-day program management.

A health carrier shall prepare an annual summary report in the format specified of its utilization review program activities and file the report, if requested, with the director and the secretary of the Department of Health.

Section 49. That the code be amended by adding a NEW SECTION to read:

A utilization review program shall use documented clinical review criteria that are based on sound clinical evidence and are evaluated periodically to assure ongoing efficacy. A health carrier may develop its own clinical review criteria, or it may purchase or license clinical review criteria from qualified vendors. A health carrier shall make available its clinical review criteria upon request to authorized government agencies including the Division of Insurance and the Department of Health.

Section 50. That the code be amended by adding a NEW SECTION to read:

Qualified licensed health care professionals shall administer the utilization review program and oversee review decisions. Any adverse determination shall be evaluated by an appropriately licensed and clinically qualified health care provider.

Section 51. That the code be amended by adding a NEW SECTION to read:

A health carrier shall issue utilization review and benefit determinations in a timely manner

pursuant to the requirements of sections 45 to 68 of this Act, inclusive. A health carrier shall have a process to ensure that utilization reviewers apply clinical review criteria in conducting utilization review consistently.

Section 52. That the code be amended by adding a NEW SECTION to read:

For purposes of calculating the time periods within which a determination is required to be made for prospective and retrospective reviews, the time period within which the determination is required to be made begins on the date the request is received by the health carrier in accordance with the health carrier's procedures established pursuant to section 48 of this Act. If the time period for making the determination for a prospective or retrospective review is extended due to the covered person or, if applicable, the covered person's authorized representative's failure to submit the information necessary to make the determination, the time period for making the determination shall be tolled from the date on which the health carrier sends the notification of the extension to the covered person or, if applicable, the covered person's authorized representative until the earlier of: the date on which the covered person or, if applicable, the covered person's authorized representative responds to the request for additional information or the date on which the specified information was to have been submitted. If the covered person or the covered person's authorized representative fails to submit the information before the end of the period of the extension, as specified in sections 61 to 63 of this Act, inclusive, the health carrier may deny the certification of the requested benefit.

Section 53. That the code be amended by adding a NEW SECTION to read:

A health carrier shall routinely assess the effectiveness and efficiency of its utilization review program.

Section 54. That the code be amended by adding a NEW SECTION to read:

A health carrier's data system shall be sufficient to support utilization review program

activities and to generate management reports to enable the health carrier to monitor and manage health care services effectively.

Section 55. That the code be amended by adding a NEW SECTION to read:

If a health carrier delegates any utilization review activities to a utilization review organization, the health carrier shall maintain adequate oversight, which shall include:

(1) A written description of the utilization review organization's activities and responsibilities, including reporting requirements;

(2) Evidence of formal approval of the utilization review organization program by the health carrier; and

(3) A process by which the health carrier evaluates the performance of the utilization review organization.

Section 56. That the code be amended by adding a NEW SECTION to read:

A health carrier shall coordinate the utilization review program with other medical management activity conducted by the carrier, such as quality assurance, credentialing, provider contracting data reporting, grievance procedures, processes for assessing member satisfaction, and risk management.

Section 57. That the code be amended by adding a NEW SECTION to read:

A health carrier shall provide covered persons and participating providers with access to its review staff by a toll-free number or collect call telephone line.

Section 58. That the code be amended by adding a NEW SECTION to read:

When conducting utilization review, the health carrier shall collect only the information necessary, including pertinent clinical information, to make the utilization review or benefit determination.

Section 59. That the code be amended by adding a NEW SECTION to read:

Compensation to persons providing utilization review services for a health carrier may not contain incentives, direct or indirect, for these persons to make inappropriate review decisions. Compensation to any such persons may not be based, directly or indirectly, on the quantity or type of adverse determinations rendered.

Section 60. That the code be amended by adding a NEW SECTION to read:

A health carrier shall maintain written procedures pursuant to this Act for making standard utilization review and benefit determinations on requests submitted to the health carrier by covered persons or their authorized representatives for benefits and for notifying covered persons and their authorized representatives of its determinations with respect to these requests within the specified time frames required under this Act. If a period of time is extended as permitted by this Act, due to a claimant's failure to submit information necessary to decide a prospective, retrospective, or disability claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information

Section 61. That the code be amended by adding a NEW SECTION to read:

For prospective review determinations, other than allowed by this section, a health carrier shall make the determination and notify the covered person or, if applicable, the covered person's authorized representative of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than fifteen days after the date the health carrier receives the request. If the determination is an adverse determination, the health carrier shall make the notification of the adverse determination in accordance with section 64 of this Act.

The time period for making a determination and notifying the covered person or, if applicable, the covered person's authorized representative of the determination pursuant to this

section may be extended once by the health carrier for up to fifteen days, if the health carrier:

(1) Determines that an extension is necessary due to matters beyond the health carrier's control; and

(2) Notifies the covered person or, if applicable, the covered person's authorized representative, prior to the expiration of the initial fifteen-day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

If the extension is necessary due to the failure of the covered person or the covered person's authorized representative to submit information necessary to reach a determination on the request, the notice of extension shall specifically describe the required information necessary to complete the request; and give the covered person or, if applicable, the covered person's authorized representative at least forty-five days from the date of receipt of the notice to provide the specified information.

If the health carrier receives a prospective review request from a covered person or the covered person's authorized representative that fails to meet the health carrier's filing procedures, the health carrier shall notify the covered person or, if applicable, the covered person's authorized representative of this failure and provide in the notice information on the proper procedures to be followed for filing a request. This notice shall be provided as soon as possible, but in no event later than five days following the date of the failure. The health carrier may provide the notice orally or, if requested by the covered person or the covered person's authorized representative, in writing. The provisions only apply in a case of failure that is a communication by a covered person or the covered person's authorized representative that is received by a person or organizational unit of the health carrier responsible for handling benefit matters and is a communication that refers to a specific covered person, a specific medical

condition or symptom, and a specific health care service, treatment, or provider for which certification is being requested.

Section 62. That the code be amended by adding a NEW SECTION to read:

For concurrent review determinations, if a health carrier has certified an ongoing course of treatment to be provided over a period of time or number of treatments:

(1) Any reduction or termination by the health carrier during the course of treatment before the end of the period or number treatments, other than by health benefit plan amendment or termination of the health benefit plan, shall constitute an adverse determination; and

(2) The health carrier shall notify the covered person of the adverse determination in accordance with section 64 of this Act at a time sufficiently in advance of the reduction or termination to allow the covered person or, if applicable, the covered person's authorized representative to file a grievance to request a review of the adverse determination pursuant to sections 89 to 111 of this Act, inclusive, and obtain a determination with respect to that review of the adverse determination before the benefit is reduced or terminated.

The health care service or treatment that is the subject of the adverse determination shall be continued without liability to the covered person until the covered person has been notified of the determination by the health carrier with respect to the internal review request made pursuant to sections 89 to 111 of this Act, inclusive.

Section 63. That the code be amended by adding a NEW SECTION to read:

For retrospective review determinations, a health carrier shall make the determination within a reasonable period of time, but in no event later than thirty days after the date of receiving the benefit request.

In the case of a certification, the health carrier may notify in writing the covered person and the provider rendering the service.

If the determination is an adverse determination, the health carrier shall provide notice of the adverse determination to the covered person or, if applicable, the covered person's authorized representative in accordance with section 64 of this Act. The time period for making a determination and notifying the covered person or, if applicable, the covered person's authorized representative of the determination pursuant to this section may be extended once by the health carrier for up to fifteen days, provided the health carrier:

(1) Determines that an extension is necessary due to matters beyond the health carrier's control; and

(2) Notifies the covered person or, if applicable, the covered person's authorized representative, prior to the expiration of the initial thirty-day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

If the extension under this section is necessary due to the failure of the covered person or, if applicable, the covered person's authorized representative to submit information necessary to reach a determination on the request, the notice of extension shall specifically describe the required information necessary to complete the request; and give the covered person or, if applicable, the covered person's authorized representative at least forty-five days from the date of receipt of the notice to provide the specified information.

Section 64. That the code be amended by adding a NEW SECTION to read:

Any notification of an adverse determination under this section shall, in a manner which is designed to be understood by the covered person, set forth:

(1) The specific reason or reasons for the adverse determination;

(2) A reference to the specific plan provision on which the determination is based;

(3) A description of additional material or information necessary for the covered person to complete the benefit request, including an explanation of why the material or information is necessary to complete the request;

(4) A description of the health carrier's grievance procedures established pursuant to sections 89 to 111 of this Act, inclusive, including time limits applicable to those procedures;

(5) If the health carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

(6) If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

(7) If applicable, instructions for requesting:

(a) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination, as provided in subdivision (5) of this section; or

(b) The written statement of the scientific or clinical rationale for the adverse

determination, as provided in subdivision (6) of this section; and

(8) A statement explaining the right of the covered person, as appropriate, to contact the Division of Insurance at any time for the assistance or, upon completion of the health carrier's grievance procedure process as provided under sections 89 to 111 of this Act, inclusive, to file a civil suit in a court of competent jurisdiction.

A health carrier may provide the notice required under this section in writing electronically.

Section 65. That the code be amended by adding a NEW SECTION to read:

In the certificate of coverage or member handbook provided to covered persons, a health carrier shall include a clear and comprehensive description of its utilization review procedures, including the procedures for obtaining review of adverse determinations, and a statement of rights and responsibilities of covered persons with respect to those procedures. A health carrier shall include a summary of its utilization review and benefit determination procedures in materials intended for prospective covered persons. A health carrier shall print on its membership cards a toll-free telephone number to call for utilization review and benefit decisions.

Section 66. That the code be amended by adding a NEW SECTION to read:

Nothing in sections 45 to 68 of this Act, inclusive, applies to dental only, vision only, accident only, school accident, travel, or specified disease plans or plans that primarily provide a fixed daily, fixed occurrence, or fixed per procedure benefit without regard to expenses incurred.

Section 67. That the code be amended by adding a NEW SECTION to read:

If the director of the Division of Insurance and the secretary of the Department of Health find that the requirements of any private accrediting body meet the requirements of utilization review as set forth in sections 45 to 68 of this Act, inclusive, the health carrier may, at the

discretion of the director and secretary, be deemed to have met the applicable requirements.

Section 68. That the code be amended by adding a NEW SECTION to read:

The director may, after consultation with the secretary of the Department of Health, promulgate rules, pursuant to chapter 1-26, to carry out the provisions of sections 45 to 68 of this Act, inclusive. The rules shall be designed to afford the public timely administration of utilization review and to assure that utilization review decisions are made in a fair and clinically acceptable manner. The rules may include the following:

(1) Definition of terms;

(2) Timing, form, and content of reports;

(3) Application of clinical criteria as it relates to utilization review;

(4) Written determinations; and

(5) Utilization review procedures.

Section 69. That the code be amended by adding a NEW SECTION to read:

Each health carrier shall establish and maintain a grievance system, approved by the director after consultation with the secretary of the Department of Health, which may include an impartial mediation provision, to provide reasonable procedures for the resolution of grievances initiated by any enrollee concerning the provision of health care services. Mediation may be made available to enrollees unless an enrollee elects to litigate a grievance prior to submission to mediation. No medical malpractice damage claim is subject to arbitration under sections 60 to 72 of this Act, inclusive. Each health carrier shall provide that if a grievance is filed which requires a review of services authorized to be provided by a practitioner or if a grievance is filed which requires a review of treatment which has been provided by a practitioner, the review shall include a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

Section 70. That the code be amended by adding a NEW SECTION to read:

The health carrier shall maintain records of grievances filed with it and shall submit to the director a summary report at such times and in such format as the director may require. The grievances involving other persons shall be referred to such persons with a copy to the director.

Section 71. That the code be amended by adding a NEW SECTION to read:

The health carrier shall maintain a record of each grievance filed with it for five years, and the director and the secretary of health shall have access to the records.

Section 72. That the code be amended by adding a NEW SECTION to read:

The director, in consultation with the secretary of health, shall promulgate rules, pursuant to chapter 1-26, to establish time frames relative to the filing of grievances, the disposition of grievances, and the response to the aggrieved person. Rules may also be promulgated covering definition of terms, grievance procedures, and content of reports.

Section 73. That the code be amended by adding a NEW SECTION to read:

Any utilization review organization which engages in utilization review activities in this state shall register with the Division of Insurance prior to conducting business in this state. The registration shall be in a format prescribed by the director of the Division of Insurance. In prescribing the format or in carrying out other functions required under sections 73 to 77 of this Act, inclusive, the director shall consult with the secretary of the Department of Health if applicable. The director or the secretary of health may require that the following information be submitted:

(1) Information relating to its actual or anticipated activities in this state;

(2) The status of any accreditation designation it holds or has sought;

(3) Information pertaining to its place of business, officers, and directors;

(4) Qualifications of review staff; and

(5) Any other information reasonable and necessary to monitor its activities in this state.

Section 74. That the code be amended by adding a NEW SECTION to read:

Any utilization review organization which has previously registered in this state shall, on or before July first of each year, file with the Division of Insurance any changes to the initial or subsequent annual registration for the utilization review organization.

Section 75. That the code be amended by adding a NEW SECTION to read:

The director or the secretary of health may request information from any utilization review organization at any time pertaining to its activities in this state. The utilization review organization shall respond to all requests for information within twenty days.

Section 76. That the code be amended by adding a NEW SECTION to read:

A utilization review organization may not engage in utilization review in this state unless the utilization review organization is properly registered. The director of the Division of Insurance may issue a cease and desist order against any utilization review organization which fails to comply with the requirements of sections 73 to 77 of this Act, inclusive, prohibiting the utilization review organization from engaging in utilization review activities in this state.

Section 77. That the code be amended by adding a NEW SECTION to read:

The director of the Division of Insurance may require the payment of a fee in conjunction with the initial or annual registration of a utilization review organization not to exceed two hundred fifty dollars per registration. The fee shall be established by rules promulgated pursuant to chapter 1-26.

Section 78. That the code be amended by adding a NEW SECTION to read:

The provisions of sections 69 to 77 of this Act, inclusive, apply to all individual and group policies, plans, certificates, or contracts that allow for the use of managed care or utilization review.

Section 79. That the code be amended by adding a NEW SECTION to read:

For the purposes of this Act, the term, urgent care request, means a request for a health care service or course of treatment with respect to which the time periods for making a nonurgent care request determination:

(1) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

(2) In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

Except as provided in subdivision (1), in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any request that a physician with knowledge of the covered person's medical condition determines is an urgent care request within the meaning of subdivisions (1) and (2) shall be treated as an urgent care request.

Section 80. That the code be amended by adding a NEW SECTION to read:

A health carrier shall establish written procedures in accordance with sections 80 to 88 of this Act, inclusive, for receiving benefit requests from covered persons or their authorized representatives and for making and notifying covered persons or their authorized representatives of expedited utilization review and benefit determinations with respect to urgent care requests and concurrent review urgent care requests.

Section 81. That the code be amended by adding a NEW SECTION to read:

For an urgent care request, unless the covered person or the covered person's authorized representative has failed to provide sufficient information for the health carrier to determine

whether, or to what extent, the benefits requested are covered benefits or payable under the health carrier's health benefit plan, the health carrier shall notify the covered person or, if applicable, the covered person's authorized representative of the health carrier's determination with respect to the request, whether or not the determination is an adverse determination, as soon as possible, taking into account the medical condition of the covered person, but in no event later than seventy-two hours after the date of the receipt of the request by the health carrier. If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with section 88 of this Act.

Section 82. That the code be amended by adding a NEW SECTION to read:

If the covered person or, if applicable, the covered person's authorized representative has failed to provide sufficient information for the health carrier to make a determination, the health carrier shall notify the covered person or, if applicable, the covered person's authorized representative either orally or, if requested by the covered person or the covered person's authorized representative, in writing of this failure and state what specific information is needed as soon as possible, but in no event later than twenty-four hours after receipt of the request.

Section 83. That the code be amended by adding a NEW SECTION to read:

If the benefit request involves a prospective review urgent care request, the provisions of section 82 of this Act apply only in the case of a failure that:

(1) Is a communication by a covered person or, if applicable, the covered person's authorized representative that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and

(2) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service treatment, or provider for which approval is being requested.

Section 84. That the code be amended by adding a NEW SECTION to read:

The health carrier shall provide the covered person or, if applicable, the covered person's authorized representative a reasonable period of time to submit the necessary information, taking into account the circumstances, but in no event less than forty-eight hours after the date of notifying the covered person or the covered person's authorized representative of the failure to submit sufficient information, as provided in sections 82 and 83 of this Act.

Section 85. That the code be amended by adding a NEW SECTION to read:

The health carrier shall notify the covered person or, if applicable, the covered person's authorized representative of its determination with respect to the urgent care request as soon as possible, but in no event more than forty-eight hours after the earlier of:

(1) The health carrier's receipt of the requested specified information; or

(2) The end of the period provided for the covered person or, if applicable, the covered person's authorized representative to submit the requested specified information.

If the covered person or the covered person's authorized representative fails to submit the information before the end of the period of the extension, as specified in section 84 of this Act, the health carrier may deny the certification of the requested benefit. If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with section 64 of this Act.

Section 86. That the code be amended by adding a NEW SECTION to read:

For concurrent review urgent care requests involving a request by the covered person or the covered person's authorized representative to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least twenty-four hours prior to the expiration of the prescribed period of time or number of treatments, the health carrier shall make a determination with respect to the request and notify the covered person or,

if applicable, the covered person's authorized representative of the determination, whether it is an adverse determination or not, as soon as possible, taking into account the covered person's medical condition but in no event more than twenty-four hours after the date of the health carrier's receipt of the request. If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with section 64 of this Act. The provisions of sections 81 to 85 of this Act, inclusive, apply to concurrent review urgent care requests.

Section 87. That the code be amended by adding a NEW SECTION to read:

For purposes of calculating the time periods within which a determination is required to be made under sections 81 to 86 of this Act, inclusive, the time period within which the determination is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established pursuant to section 48 of this Act for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

Section 88. That the code be amended by adding a NEW SECTION to read:

If a health carrier's determination with respect to sections 81 to 86 of this Act, inclusive, is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with this section. A notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:

(1) The specific reason or reasons for the adverse determination;

(2) A reference to the specific plan provisions on which the determination is based;

(3) A description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;

(4) A description of the health carrier's internal review procedures established pursuant to sections 89 to 111 of this Act, inclusive, including any time limits applicable to those procedures;

(5) A description of the health carrier's expedited review procedures established pursuant to sections 80 to 88 of this Act, inclusive;

(6) If the health carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either in specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

(7) If the adverse determination is based on a medical necessity or experimental or investigation treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

(8) If applicable, instructions for requesting:

(a) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination in accordance with subdivision (6) of this section; or

(b) The written statement of the scientific or clinical rationale for the adverse determination in accordance with subdivision (7) of this section; and

(9) A statement explaining the right of the covered person, as appropriate to contact the

Division of Insurance at any time for assistance or, upon completion of the health carrier's grievance procedure process as provided under sections 89 to 111 of this Act, inclusive, to file a civil suit in a court of competent jurisdiction.

A health carrier may provide the notice required under this section orally, in writing or electronically. If notice of the adverse determination is provided orally, the health carrier shall provide written or electronic notice of the adverse determination within three days following the oral notification.

Section 89. That the code be amended by adding a NEW SECTION to read:

A health carrier shall maintain in a register written records to document all grievances received during a calendar year. A request for a first level review of a grievance involving an adverse determination shall be processed in compliance sections 92 to 95 of this Act, inclusive, but is not required to be included in the register. A request for an additional voluntary review of a grievance involving an adverse determination that may be conducted pursuant to sections 101 to 107 of this Act, inclusive, shall be included in the register. For each grievance the register shall contain, at a minimum, the following information:

(1) A general description of the reason for the grievance;

(2) The date received;

(3) The date of each review or, if applicable, review meeting;

(4) Resolution at each level of the grievance, if applicable;

(5) Date of resolution at each level, if applicable; and

(6) Name of the covered person for whom the grievance was filed.

The register shall be maintained in a manner that is reasonably clear and accessible to the director. A health carrier shall retain the register compiled for a calendar year for five years.

Section 90. That the code be amended by adding a NEW SECTION to read:

A health carrier shall submit to the director, at least annually, a report in the format specified by the director. The report shall include for each type of health benefit plan offered by the health carrier:

(1) The certificate of compliance required by section 91 of this Act;

(2) The number of covered lives;

(3) The total number of grievances;

(4) The number of grievances for which a covered person requested an additional voluntary grievance review pursuant to sections 101 to 107 of this Act, inclusive;

(5) The number of grievances resolved at each level, if applicable, and their resolution;

(6) The number of grievances appealed to the director of which the health carrier has been informed;

(7) The number of grievances referred to alternative dispute resolution procedures or resulting in litigation; and

(8) A synopsis of actions being taken to correct problems identified.

Section 91. That the code be amended by adding a NEW SECTION to read:

Except as specified in this Act, a health carrier shall use written procedures for receiving and resolving grievances from covered persons, as provided in sections 92 to 107 of this Act, inclusive. A health carrier shall file with the director a copy of the procedures required under this section, including all forms used to process requests made pursuant to sections 92 to 107 of this Act, inclusive. Any subsequent material modifications to the documents also shall be filed. The director may disapprove a filing received in accordance with this section that fails to comply with this Act or applicable rules. In addition, a health carrier shall file annually with the director, as part of its annual report required by sections 89 and 90 of this Act, a certificate of compliance stating that the health carrier has established and maintains, for each of its health

benefit plans, grievance procedures that fully comply with the provisions of this Act. A description of the grievance procedures required under this section shall be set forth in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to covered persons. The grievance procedure documents shall include a statement of a covered person's right to contact the Division of Insurance for assistance at any time. The statement shall include the telephone number and address of the Division of Insurance.

Section 92. That the code be amended by adding a NEW SECTION to read:

Within one hundred eighty days after the date of receipt of a notice of an adverse determination sent pursuant to the provisions of this Act, a covered person or the covered person's authorized representative may file a grievance with the health carrier requesting a first level review of the adverse determination. The health carrier shall provide the covered person with the name address, and telephone number of a person or organizational unit designated to coordinate the first level review on behalf of the health carrier. The health carrier shall designate a health care provider or providers who have appropriate training and experience in the field of medicine involved in the medical judgement to evaluate the adverse determination. No health care provider or providers may have been involved in the initial adverse determination. In conducting the review, the reviewer or reviewers shall take into consideration all comments, documents, records, and other information regarding the request for services submitted by the covered person or the covered person's authorized representative, without regard to whether the information was submitted or considered in making the initial adverse determination.

Section 93. That the code be amended by adding a NEW SECTION to read:

No covered person has the right to attend, or to have a representative in attendance, at the first level review, but the covered person or, if applicable, the covered person's authorized

representative is entitled to:

(1) Submit written comments, documents, records, and other material relating to the request for benefits for the review or reviewers to consider when conducting the review; and

(2) Receive from the health carrier, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the covered person's request for benefits. A document, record, or other information shall be considered relevant to a covered person's request for benefits if the document, record, or other information:

(a) Was relied upon in making the benefit determination;

(b) Was submitted, considered, or generated in the course of making the adverse determination, without regard to whether the document, record, or other information was relied upon in making the benefit determination;

(c) Demonstrates that, in making the benefit determination, the health carrier, or its designated representatives consistently applied required administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons; or

(d) Constitutes a statement of policy or guidance with respect to the health benefit plan concerning the denied health care service or treatment for the covered person's diagnosis, without regard to whether the advice or statement was relied upon in making the benefit determination.

The health carrier shall make the provisions of this section known to the covered person or, if applicable, the covered person's authorized representative within three working days after the date of receipt of the grievance.

Section 94. That the code be amended by adding a NEW SECTION to read:

A health carrier shall notify and issue a decision in writing or electronically to the covered person or, if applicable, the covered person's authorized representative within the following time frames:

(1) With respect to a grievance requesting a first level review of an adverse determination involving a prospective review request, the health carrier shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition, but no later than thirty days after the date of the health carrier's receipt of the grievance requesting the first level review made pursuant to section 92 of this Act; or

(2) With respect to a grievance requesting a first level review of an adverse determination involving a retrospective review request, the health carrier shall notify and issue a decision within a reasonable period of time but no later than sixty days after the date of the health carrier's receipt of the grievance requesting the first level review made pursuant to section 92 of this Act.

For purposes of calculating the time periods within which a determination is required to be made and notice provided under this section, the time period shall begin on the date the grievance requesting the review is filed with the health carrier in accordance with the health carrier's procedures established pursuant to section 91 of this Act for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

Section 95. That the code be amended by adding a NEW SECTION to read:

The decision issued pursuant to section 94 of this Act shall set forth in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized

representative and include the following:

(1) The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);

(2) A statement of the reviewers' understanding of the covered person's grievance;

(3) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position;

(4) A reference to the evidence or documentation used as the basis for the decision;

(5) For a decision involving an adverse determination:

(a) The specific reason or reasons for the adverse determination;

(b) A reference to the specific plan provisions on which the determination is based;

(c) A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant, as the term, relevant, is defined in section 93 of this Act, to the covered person's benefit request;

(d) If the health carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

(e) If the adverse determination is based on a medical necessity or experimental

or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request; and

(f) If applicable, instructions for requesting:

(i) A copy of the rule, guideline, protocol. or other similar criterion relied upon in making the adverse determination, as provided in subsection (d) of this section; or

(ii) The written statement of the scientific or clinical rationale for the determination, as provided in subsection (e) of this section;

(6) If applicable, a statement indicating:

(a) A description of the process to obtain an additional voluntary review of the first level review decision involving an adverse determination, if the covered person wishes to request a voluntary second level review pursuant to section 94 of this Act;

(b) The written procedures governing the voluntary review, including any required time frame for the review; and

(c) The covered person's right to bring a civil action in a court of competent jurisdiction;

(7) If applicable, the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state insurance director."; and

(8) Notice of the covered person's right to contact the Division of Insurance for

assistance at any time, including the telephone number and address of the Division of Insurance.

Section 96. That the code be amended by adding a NEW SECTION to read:

A health carrier shall establish written procedures for a standard review of a grievance that does not involve an adverse determination. The procedures shall permit a covered person or the covered person's authorized representative to file a grievance that does not involve an adverse determination with the health carrier under sections 97 to 100 of this Act, inclusive.

Section 97. That the code be amended by adding a NEW SECTION to read:

No covered person has the right to attend, or to have a representative in attendance at the standard review, but the covered person or the covered person's authorized representative is entitled to submit written material for the person or persons designated by the carrier pursuant to section 98 of this Act to consider when conducting the review. The health carrier shall make the provisions of this section known to the covered person or, if applicable, the covered person's authorized representative within three working days after the date of receiving the grievance.

Section 98. That the code be amended by adding a NEW SECTION to read:

Upon receipt of the grievance, a health carrier shall designate a person or persons to conduct the standard review of the grievance. The health carrier may not designate the same person or persons to conduct the standard review of the grievance that denied the claim or handled the matter that is the subject of the grievance. The health carrier shall provide the covered person or, if applicable, the covered person's authorized representative with the name, address, and telephone number of a person designated to coordinate the standard review on behalf of the health carrier.

Section 99. That the code be amended by adding a NEW SECTION to read:

The health carrier shall notify in writing the covered person or, if applicable, the covered

person's authorized representative of the decision within twenty working days after the date of receipt of the request for a standard review of a grievance filed pursuant to section 97 of this Act. The time frame for notification may be varied subject to the following:

(1) Subject to subdivision (2) of this section, if, due to circumstances beyond the carrier's control, the health carrier cannot make a decision and notifies the covered person or, if applicable, the covered person's authorized representative pursuant to this section within twenty working days, the health carrier may take up to an additional ten working days to issue a written decision; and

(2) A health carrier may extend the time for making and notifying the covered person or, if applicable, the covered person's authorized representative in accordance with subdivision (1) of this section, if, on or before the twentieth working day after the date of receiving the request for a standard review of a grievance, the health carrier provides written notice to the covered person or, if applicable, the covered person's authorized representative of the extension and the reasons for the delay.

Section 100. That the code be amended by adding a NEW SECTION to read:

The written decision issued pursuant to section 99 of this Act shall contain:

(1) The titles and qualifying credentials of the person or persons participating in the standard review process (the reviewers);

(2) A statement of the reviewers' understanding of the covered person's grievance;

(3) The reviewers' decision in clear terms and the contract basis in sufficient detail for the covered person to respond further to the health carrier's position;

(4) A reference to the evidence or documentation used as the basis for the decision;

(5) If applicable, a statement indicating:

(a) A description of the process to obtain an additional review of the standard

review decision if the covered person wishes to request a voluntary second level review pursuant to section 94 of this Act; and

(b) The written procedures governing the voluntary review, including any required time frame for the review; and

(6) Notice of the covered person's right, at any time to contact the Division of Insurance, including the telephone number and address of the Division of Insurance.

Section 101. That the code be amended by adding a NEW SECTION to read:

A health carrier that offers managed care plans shall establish a voluntary review process for its managed care plans to give those covered persons who are dissatisfied with the first level review decision made pursuant to sections 79 to 95 of this Act, inclusive, or who are dissatisfied with the standard review decision made pursuant to sections 96 to 100 of this Act, inclusive, the option to request an additional voluntary review, at which the covered person or the covered person's authorized representative has the right to appear in person at the review meeting before designated representatives of the health carrier. This section does not apply to health indemnity plans.

A health carrier required by this section to establish a voluntary review process shall provide covered persons or their authorized representatives with notice pursuant to subdivision (6) of section 95 or subdivision (5) of section 100 of this Act, as appropriate, of the option to file a request with the health carrier for an additional voluntary review of the first level review decision received under sections 92 to 95 of this Act, inclusive, or the standard review decision received under sections 96 to 100 of this Act, inclusive.

Section 102. That the code be amended by adding a NEW SECTION to read:

Upon receipt of a request for an additional voluntary review, the health carrier shall send notice to the covered person or, if applicable, the covered person's authorized representative of

the covered person's right to:

(1) Request the opportunity to appear in person before a review panel of the health carrier's designated representatives within five working days after the date of receipt of the notice;

(2) Receive from the health carrier, upon request, copies of all documents, records, and other information that is not confidential or privileged relevant to the covered person's request for benefits;

(3) Present the covered person's case to the review panel;

(4) Submit written comments, documents, records, and other material relating to the request for benefits for the review panel to consider when conducting the review both before and, if applicable, at the review meeting;

(5) If applicable, ask questions of any representative of the health carrier on the review panel; and

(6) Be assisted or represented by an individual of the covered person's choice.

The covered person's right to a fair review may not be made conditional on the covered person's appearance at the review.

Section 103. That the code be amended by adding a NEW SECTION to read:

With respect to a voluntary review of a first level review decision made pursuant to sections 92 to 95 of this Act, inclusive, a health carrier shall appoint a review panel to review the request. In conducting the review, the review panel shall take into consideration all comments, documents, records, and other information regarding the request for benefits submitted by the covered person or the covered person's authorized representative pursuant to section 102 of this Act, without regard to whether the information was submitted or considered in reaching the first level review decision. The decision of the panel is legally binding on the health carrier.

Except for an individual who was involved with the first level review decision who may be a member of the panel or appear before the panel to present information or anser questions, a majority of the panel shall be comprised of individuals who were not involved in the first level review decision made pursuant to sections 92 to 95 of this Act, inclusive.

The health carrier shall ensure that a majority of the individuals conducting the additional voluntary review of the first level review decision made pursuant to sections 92 to 95 of this Act, inclusive, are health care professionals who have appropriate expertise. If a reviewing health care professional with the expertise required by this section is not reasonably available and there has been a denial of a health care service, the reviewing health care professional is only ineligible to review decisions if the professional meets both of the following criteria:

(1) The professional is a provider in the covered person's health benefit plan; and

(2) The professional has financial interest in the outcome of the review.

Section 104. That the code be amended by adding a NEW SECTION to read:

With respect to a voluntary review of a standard review decision made pursuant to sections 96 to 100 of this Act, inclusive, a health carrier shall appoint a review panel to review the request. The decision of the panel is legally binding on the health carrier.

An employee or representative of the health carrier who was involved with the standard review decision may be a member of the panel or appear before the panel to present information or answer questions. A majority of the panel shall be comprised of employees or representatives of the health carrier who were not involved in the standard review decision made pursuant to sections 96 to 100 of this Act, inclusive.

Section 105. That the code be amended by adding a NEW SECTION to read:

If a covered person or the covered person's authorized representative requests the opportunity to appear in person before the review panel appointed pursuant to sections 103 and

104 of this Act, the procedures for conducting the review shall include the following provisions:

(1) The review panel shall schedule and hold a review meeting within forty-five working days after the date of receipt of the request;

(2) The covered person or, if applicable, the covered person's authorized representative shall be notified in writing at least fifteen working days in advance of the date of the review meeting;

(3) The health carrier shall not unreasonably deny a request for postponement of the review made by the covered person or the covered person's authorized representative; and

(4) The review meeting shall be held during regular business hours at a location reasonably accessible to the covered person or, if applicable, the covered person's authorized representative.

In any case in which a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person or, if applicable, the covered person's authorized representative the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology.

If the health carrier desires to have an attorney present to represent the interests of the health carrier, the health carrier shall notify the covered person or, if applicable, the covered person's authorized representative at least fifteen working days in advance of the date of the review meeting that an attorney will be present and that the covered person may wish to obtain legal representation of his or her own.

The review panel shall issue a written decision, as provided in section 107 of this Act, to the covered person or, if applicable, the covered person's authorized representative within five working days of completing the review meeting.

Section 106. That the code be amended by adding a NEW SECTION to read:

If the covered person or, if applicable, the covered person's authorized representative does not request the opportunity to appear in person before the review panel within the specified timeframe provided under subdivision (1) of section 102 of this Act, the review panel shall issue a decision and notify the covered person or, if applicable, the covered person's authorized representative of the decision, as provided in section 107 of this Act, in writing or electronically, within forty-five working days after the earlier of:

(1) The date the covered person or the covered person's authorized representative notifies the health carrier of the covered person's decision not to request the opportunity to appear in person before the review panel; or

(2) The date on which the covered person's or the covered person's authorized representative's opportunity to request to appear in person before the review panel expires pursuant to subdivision (1) of section 102 of this Act.

For purposes of calculating the time periods within which a decision is required to be made and notice provided under this section and section 105 of this Act, the time period shall begin on the date the request for additional voluntary review is filed with the health carrier in accordance with the health carrier's procedures established pursuant to section 91 of this Act for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

Section 107. That the code be amended by adding a NEW SECTION to read:

A decision issued pursuant to sections 105 and 107 of this Act shall include:

(1) The titles and qualifying credentials of the members of the review panel;

(2) A statement of the review panel's understanding of the nature of the grievance and all pertinent facts;

(3) The rationale for the review panel's decision;

(4) A reference to evidence or documentation considered by the review panel in making that decision;

(5) In cases concerning a grievance involving an adverse determination, the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; and

(6) Notice of the covered person's right to contact the Division of Insurance for assistance at any time, including the telephone number and address of the Division of Insurance.

Section 108. That the code be amended by adding a NEW SECTION to read:

A health carrier shall establish written procedures for the expedited review of urgent care requests of grievances involving an adverse determination. In addition, a health carrier shall provide expedited review of a grievance involving an adverse determination with respect to concurrent review urgent care requests involving an admission, availability of care, continued stay, or health care service for a covered person who has received emergency services, but has not been discharged from a facility. The procedures shall allow a covered person or the covered person's authorized representative to request an expedited review under this section orally or in writing.

A health carrier shall appoint an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. The clinical peer or peers may not have been involved in making the initial adverse determination.

Section 109. That the code be amended by adding a NEW SECTION to read:

In an expedited review that is not an initial determination for benefits, all necessary

information, including the health carrier's decision, shall be transmitted between the health carrier and the covered person or, if applicable, the covered person's authorized representative by telephone, facsimile, or the most expeditious method available.

Section 110. That the code be amended by adding a NEW SECTION to read:

An expedited review decision, that is not an initial determination for benefits, shall be made and the covered person or, if applicable, the covered person's authorized representative shall be notified of the decision in accordance with section 111 of this Act as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two hours after the date of receipt of the request for the expedited review. If the expedited review is of a grievance involving an adverse determination with respect to a concurrent review urgent care request, the service shall be continued without liability to the covered person until the covered person has been notified of the determination.

For purposes of calculating the time periods within which a decision is required to be made under this section, the time period within which the decision is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established pursuant to section 91 of this Act for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

Section 111. That the code be amended by adding a NEW SECTION to read:

A notification of a decision under sections 108 to 111 of this Act, inclusive, shall, in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized representative, set forth the following:

(1) The titles and qualifying credentials of the person or persons participating in the expedited review process (the reviewers);

(2) A statement of the reviewers' understanding of the covered person's grievance;

(3) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position;

(4) A reference to the evidence or documentation used as the basis for the decision;

(5) If the decision involves an adverse determination, the notice shall provide:

(a) The reasons for the adverse determination;

(b) A reference to the specific plan provisions on which the determination is based;

(c) A description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;

(d) If the health carrier relied upon an internal rule, guideline, protocol, or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol, or other similar criterion or a statement that a specific rule, guideline, protocol, or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the covered person upon request;

(e) If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

(f) If applicable, instructions for requesting:

(i) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination as provided in subsection (d) of this section; or

(ii) The written statement of the scientific or clinical rationale for the adverse determination as provided in subsection (e) of this section;

(g) A statement indicating the covered person's right to bring a civil action in a court of competent jurisdiction; and

(h) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state insurance director."; and

(i) A notice of the covered person's right to contact the Division of Insurance for assistance at any time, including the telephone number and address of the Division of Insurance.

A health carrier may provide the notice required under this section orally, in writing, or electronically. If notice of the adverse determination is provided orally, the health carrier shall provide written or electronic notice of the adverse determination within three days following the date of the oral notification.

Section 112. That the code be amended by adding a NEW SECTION to read:

The provisions of sections 51 to 111 of this Act, inclusive, do not apply to any Medicare supplement policies or certificates subject to the provisions of chapter 58-17A.

Section 113. That the code be amended by adding a NEW SECTION to read:

The director may promulgate rules, pursuant to chapter 1-26, pertaining to claims for group disability income plans. The rules shall be consistent with applicable federal requirements

included in 29 CFR Part 2560.

Section 114. That the code be amended by adding a NEW SECTION to read:

If the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, is repealed, the provisions of this Act take effect on the date the repeal is effective.