AN ACT

ENTITLED, An Act to establish network adequacy standards, quality assessment and improvement requirements, utilization review and benefit determination requirements, and grievance procedures for managed health care plans, and to repeal certain standards for managed health care plans.

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

Section 1. That § 58-17C-1 to § 58-17C-103, inclusive, be repealed.

Section 2. Terms used in sections 2 to 21, inclusive, of this Act mean:

(1) "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;

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

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

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

(5) "Emergency medical condition," a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate 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 or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(6) "Emergency services," with respect to an emergency medical condition:

(a) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency condition; and

(b) Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities at a hospital to stabilize a patient;

(7) "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;

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

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

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

(11) "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;

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

(13) "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;

(14) "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;

(15) "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;

(16) "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;

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

(18) "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;

(19) "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;

(20) "Primary care professional," a participating health care professional designated by a health

carrier to supervise, coordinate or provide initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person; and

(21) "Secretary," the secretary of the Department of Health.

Section 3. Any managed care plan shall provide for the appointment of a medical director who has an unrestricted license to practice medicine. However, a managed care plan that specializes in a specific healing art shall provide for the appointment of 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 4. 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 and if no solicitation is made directly to the employees or dependents and if 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 non-covered 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 5. 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 a day, seven days a 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 6. 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 7. 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 8. The 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 9. In determining whether a health carrier has complied with any network adequacy provision of sections 2 to 21, inclusive, of this Act, the director shall give due consideration to the relative availability of healthcare providers in the service area and to the willingness of providers to join a network.

Section 10. The 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 2 to 21, inclusive, of this Act, 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 2 to 21, inclusive, of this Act.

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 section 5 of this Act do not apply to discounted fee-for-service only networks.

Section 11. Any health carrier offering a managed care plan shall satisfy all the following requirements:

(1) The 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 2 to 21, inclusive, of this Act, do not require the 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) The 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) The 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) The 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) The 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. If 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) The 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; and

(9) The 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 12. In any contractual arrangement between a health carrier and an intermediary, the following shall apply:

(1) The 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) The health carrier may 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) The 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 2 to 21, inclusive, of this Act; and

(7) The health carrier may, in the event of the intermediary's insolvency, 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 13. Any health carrier shall file with the director sample contract forms proposed for use with its participating providers and intermediaries. Any health carrier shall submit material changes to a sample contract that would affect a provision required by sections 2 to 21, inclusive, of this Act, or any rules promulgated pursuant to sections 2 to 21, inclusive, of this Act, 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 sixty 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 14. 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 15. 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, that a health carrier's access plan does not assure reasonable access to covered benefits, that a health carrier has entered into a contract that does not comply with sections 2 to 21, inclusive, of this Act, or that a health carrier has not complied with a provision of sections 2 to 21, inclusive, of this Act, 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 2 to 21, inclusive, of this Act.

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 16. Each managed care contractor, as defined in section 2 of this Act, shall register with the director prior to engaging in any managed care business in this state. The registration shall be in a format prescribed by the director. In prescribing the form or in carrying out other functions required by sections 16 to 20, inclusive, of this Act, the director shall consult with the secretary if applicable. The director or the secretary 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 17. Any managed care contractor 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 managed care contractor.

Section 18. The director or the secretary may request information from any managed care contractor at any time pertaining to its activities in this state. The managed care contractor shall respond to all requests for information within twenty days.

Section 19. No managed care contractor may engage in managed care activities in this state unless the managed care contractor is properly registered. The director may issue a cease and desist order against any managed care contractor which fails to comply with the requirements of sections 16 to 20, inclusive, of this Act, prohibiting the managed care contractor from engaging in managed care activities in this state.

Section 20. The director may require the payment of a fee in conjunction with the initial or annual registration of a managed care contractor not to exceed two hundred fifty dollars per registration. The fee shall be established by rules promulgated pursuant to chapter 1-26.

Section 21. 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 and to achieve the goals of sections 2 to 20, inclusive, of this Act, by ensuring adequate networks and by assuring quality of health care to the public that purchases network products. The rules may 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; and

(8) Record keeping.

Section 22. Terms used in sections 22 to 27, inclusive, of this Act, mean:

(1) "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;

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

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

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

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

(6) "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;

(7) "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;

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

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

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

(11) "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;

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

(13) "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;

(14) "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;

(15) "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;

(16) "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;

(17) "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;

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

(19) "Quality improvement," the effort to improve the processes and outcomes related to the provision of care within the health plan; and

(20) "Secretary," the secretary of the Department of Health.

Section 23. Any 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 22 to 27, inclusive, of this Act.

Section 24. Any 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 23 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 shall 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 25. 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 22 to 27, inclusive, of this Act, the carrier may, at the discretion of the director and secretary, be deemed to have met the applicable requirements.

Section 26. The Division of Insurance shall separately monitor complaints regarding managed care policies.

Section 27. 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 and to achieve the goals of sections 22 to 26, inclusive, of this Act, by assuring quality of health care to the public that purchases network products. The rules may include:

(1) Definition of terms;

(2) Contents of reports and filings;

(3) Record keeping;

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

(5) Quality assurance plans or quality improvement plans or both.

Section 28. Terms used in sections 28 to 74, inclusive, of this Act, mean:

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

(a) A determination by a health carrier or the carrier's 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 the carrier's designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan;

(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; or

(d) A rescission of coverage determination;

(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 sections 28 to 74, inclusive, of this Act, 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 the carrier's 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) "Clinical peer," a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure, or treatment under review;

(7) "Clinical review criteria," the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by the health carrier to determine the medical necessity and appropriateness of health care services;

(8) "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;

(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) "Emergency medical condition," a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate 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 or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(14) "Emergency services," with respect to an emergency medical condition:

(a) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency condition; and

(b) Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities at a hospital to stabilize a patient;

(15) "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;

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

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

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

(19) "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;

(20) "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;

(21) "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;

(22) "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;

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

(24) "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;

(25) "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;

(26) "Rescission," a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. The term does not include a cancellation or discontinuance of coverage under a health benefit plan if:

(a) The cancellation or discontinuance of coverage has only a prospective effect; or

(b) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage;

(27) "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;

(28) "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;

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

(30) "Stabilized," with respect to an emergency medical condition, that no material deterioration of the condition is likely, with reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, with respect to a pregnant woman, the woman has delivered, including the placenta;

(31) "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

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

Section 29. The provisions of sections 28 to 74, inclusive, of this Act, apply to any health carrier that provides or performs utilization review services. The requirements of sections 28 to 74, inclusive, of this Act, also apply to any designee of the health carrier or utilization review organization that performs utilization review functions on the carrier's behalf.

Section 30. If conducting utilization review or making a benefit determination for emergency services, a health carrier that provides benefits for services in an emergency department of a hospital shall comply with the provisions of sections 30 to 38, inclusive, of this Act. 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 even if the emergency services are provided on an out–of-network basis. A health carrier shall cover emergency services whether the health care provider furnishing the services is a participating provider with respect to such services. If the emergency services are provided out-of-network, the services shall be covered without imposing any

administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from network providers. Emergency services are provided out-of-network by complying with the cost sharing requirements set forth in sections 32 to 35, inclusive, of this Act, and without regard to any other term or condition of coverage other than the exclusion of or coordination of benefits, an affiliation or waiting periods as permitted under section 2704 of the Public Health Service Act, as amended to January 1, 2011, or cost sharing requirements as set forth in sections 31 to 35, inclusive, of this Act.

Section 31. Coverage of in-network emergency services are subject to applicable copayments, coinsurance, and deductibles.

Section 32. Cost-sharing requirements for out-of-network emergency services expressed as a copayment amount or coinsurance rate imposed with respect to a covered person cannot exceed the cost-sharing requirement imposed with respect to a covered person if the services were provided in-network.

Section 33. Notwithstanding section 32 of this Act, a covered person may be required to pay, in addition to the in-network cost-sharing, the excess of the amount the out-of-network provider charges over the amount the health carrier is required to pay pursuant to this section.

A health carrier complies with the requirements of this section if it provides payment of emergency services provided by an out-of-network provider in an amount not less than the greatest of the following:

(1) The amount negotiated with in-network providers for emergency services, excluding any in-network copayment or coinsurance imposed with respect to the covered person;

(2) The amount of the emergency service calculated using the same method the plan uses to determine payments for out-of-network services, but using the in-network cost-sharing provisions instead of the out-of-network cost-sharing provisions; or

(3) The amount that would be paid under Medicare for the emergency services, excluding any in-network copayment or coinsurance requirements.

Section 34. For capitated or other health benefit plans that do not have a negotiated per-service amount for in-network providers, subdivision (1) of section 33 of this Act does not apply.

Section 35. If a heath benefit plan has more than one negotiated amount for in-network providers for a particular emergency service, the amount in subdivision (1) of section 33 of this Act is the median of these negotiated amounts.

Section 36. Any cost-sharing requirement other than a copayment or coinsurance requirement, such as a deductible or out-of-pocket maximum, may be imposed with respect to emergency services provided out-of-network if the cost-sharing requirement generally applies to out-of-network benefits. A deductible may be imposed with respect to out-of-network emergency services only as part of a deductible that generally applies to out-of-network benefits. If an out-of-pocket maximum generally applies to out-of-network benefits, that out-of-network maximum applies to out-of-network emergency services.

Section 37. 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 38. If the director and the secretary find that the requirements of any private accrediting body meet the requirements of coverage of emergency medical services as set forth in sections 29 to 37, inclusive, of this Act, the health carrier may, at the discretion of the director and secretary, be deemed to have met the applicable requirements.

Section 39. 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 28 to 74,

inclusive, of this Act, 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 40. If a health carrier contracts to have a utilization review organization or other entity perform the utilization review functions required by sections 28 to 74, inclusive, of this Act, 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 28 to 74, inclusive, of this Act, and applicable rules, are met.

Section 41. 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 the filing of benefit requests, the notification of utilization review and benefit determinations, and the review of adverse determinations in accordance with sections 75 to 87, inclusive, of this Act.

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. A health carrier shall maintain records for a minimum of six years of all benefit requests and claims and notices associated with utilization review and benefit determinations made in accordance with sections 52 to 57, inclusive, and sections 65 to 73, inclusive, of this Act. The health carrier shall make the records available for examination by covered persons and the director upon request.

Section 42. 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 43. 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 44. A health carrier shall issue utilization review and benefit determinations in a timely manner pursuant to the requirements of sections 52 to 57, inclusive, and sections 65 to 73, inclusive, of this Act. A health carrier shall have a process to ensure that utilization reviewers apply clinical review criteria in conducting utilization review consistently.

If a health carrier fails to strictly adhere to the requirements of sections 52 to 57, inclusive, and sections 65 to 73, inclusive, of this Act, with respect to making utilization review and benefit determinations of a benefit request or claim, the covered person shall be deemed to have exhausted the provisions of sections 22 to 74, inclusive, of this Act, and may take action regardless of whether

the health carrier asserts that the carrier substantially complied with the requirements of sections 52 to 57, inclusive, and sections 65 to 73, inclusive, of this Act, as applicable, or that any error it committed was de minimus.

Any covered person may file a request for external review in accordance with rules promulgated by the director. In addition to the external review rights a covered person is entitled to pursue any available remedies under state or federal law on the basis that the health carrier failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

Section 45. Any health carrier shall routinely assess the effectiveness and efficiency of its utilization review program.

Section 46. Any 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 47. 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 48. Each 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 49. Each 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 50. If conducting a utilization review, the health carrier shall collect only the information necessary, including pertinent clinical information, to make the utilization review or benefit determination.

Section 51. In conducting utilization review, the health carrier shall ensure that the review is conducted in a manner to ensure the independence and impartiality of the individuals involved in making the utilization review or benefit determination.

In ensuring the independence and impartially of individuals involved in making the utilization review or benefit determination, no health carrier may make decisions regarding hiring, compensation, termination, promotion, or other similar matters based upon the likelihood that the individual will support the denial of benefits.

Section 52. A health carrier shall maintain written procedures pursuant to sections 28 to 74, inclusive, of 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 sections 28 to 74, inclusive, of this Act. If a period of time is extended as permitted by sections 28 to 74, inclusive, of 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 53. For any prospective review determination, 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 57 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 54. 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 57 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 75 to 87, inclusive, of this Act, 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 75 to 87, inclusive, of this Act.

Section 55. For retrospective review determinations, the 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 57 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 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 56. 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 41 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 53 and 55 of this Act, the health carrier may deny the certification of the requested benefit.

Section 57. 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) Information sufficient to identify the benefit request or claim involved, including the date of service, if applicable, the health care provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in denying the benefit request or claim;

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

(4) 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;

(5) A description of the health carrier's grievance procedures established pursuant to sections 75 to 87, inclusive, of this Act, including time limits applicable to those procedures;

(6) 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;

(7) 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;

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

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

(9) A statement explaining the availability of and 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

75 to 87, inclusive, of this Act, to file a civil suit in a court of competent jurisdiction.

If the adverse determination is a rescission, the health carrier shall provide, in addition to any applicable disclosures required under section 57 of this Act, clear identification of the alleged fraudulent practice or omission or the intentional misrepresentation of material fact, an explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact, and the effective date of the rescission.

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

If the adverse determination is a rescission, the health carrier shall provide advance notice of the rescission determination required by rules promulgated by the director, in addition to any applicable disclosures required under this section.

The health carrier shall provide clear identification of the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact.

The health carrier shall provide an explanation as to why the act, practice, or omission was fraudulent or was an intentional misrepresentation of a material fact.

The health carrier shall provide notice that the covered person or the covered person's authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file a grievance to request a review of the adverse determination to rescind coverage pursuant to sections 75 to 88, inclusive of this Act.

The health carrier shall provide a description of the health carrier's grievance procedures established pursuant to Section 75 to 88, inclusive, of this Act, including any time limits applicable to those procedures.

The health carrier shall provide the date when the advance notice ends and the date back to which the coverage will be retroactively rescinded.

Section 58. 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 59. If the director and the secretary find that the requirements of any private accrediting body meet the requirements of utilization review as set forth in sections 28 to 74, inclusive, of this Act, the health carrier may, at the discretion of the director and secretary, be deemed to have met the applicable requirements.

Section 60. 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. In prescribing the form or in carrying out other functions required sections 60 to 64, inclusive, of this Act, the director shall consult with the secretary if applicable. The director or the secretary 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 61. 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 62. The director or the secretary 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 63. A utilization review organization may not engage in utilization review in this state unless the utilization review organization is properly registered. The director may issue a cease and desist order against any utilization review organization which fails to comply with the requirements of sections 60 to 64, inclusive, of this Act, prohibiting the utilization review organization from engaging in utilization review activities in this state.

Section 64. The director 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 65. Each health carrier shall establish written procedures, in accordance with sections 65 to 73, inclusive, of this Act, 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 66. 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 67. If the benefit request involves a prospective review urgent care request, the provisions of section 66 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 68. 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 twenty-fours 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 73 of this Act.

Section 69. 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 66 and 67 of this Act.

Section 70. 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 69 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 57 of this Act.

Section 71. 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 73 of this Act.

Section 72. For purposes of calculating the time periods within which a determination is required to be made under sections 68 to 70, inclusive, of this Act, 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 41of this Act for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

Section 73. If a health carrier's determination with respect to sections 65 to 72, inclusive, of this Act, 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) Information sufficient to identify the benefit request or claim involved, including the date of service, if applicable, the health care provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning;

(2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in denying the benefit request or claim;

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

(4) 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;

(5) A description of the health carrier's internal review procedures established pursuant to sections 75 to 87, inclusive, of this Act, including any time limits applicable to those procedures;

(6) A description of the health carrier's expedited review procedures established pursuant to sections 84 to 88, inclusive, of this Act;

(7) 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;

(8) 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;

(9) 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 (7) of this section; or

(b) The written statement of the scientific or clinical rationale for the adverse determination in accordance with subdivision (8) of this section; and

(10) A statement explaining the availability of and 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 75 to 87, inclusive, of this Act, 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 74. The director may, after consultation with the secretary, promulgate rules, pursuant to chapter 1-26, to carry out the provisions of sections 28 to 73, inclusive, of this Act. The rules shall provide for a timely administration of utilization review by the public and 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.

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 as amended to January 1, 2011.

Section 75. Terms used in sections 75 to 88, inclusive, of this Act, mean:

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

(a) A determination by a health carrier or the carrier's 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 the carrier's designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan;

(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; or

(d) A rescission of coverage determination;

(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 sections 75 to 88, inclusive, of this Act, 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 the carrier's 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) "Clinical peer," a physician or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically

manages the medical condition, procedure, or treatment under review;

(7) "Clinical review criteria," written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by the health carrier to determine the medical necessity and appropriateness of health care services;

(8) "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;

(9) "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;

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

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

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

(13) "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;

(14) "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;

(15) "Emergency medical condition," a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate 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 or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(16) "Emergency services," with respect to an emergency medical condition:

(a) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency condition; and

(b) Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities at a hospital to stabilize a patient;

(17) "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;

(18) "Final adverse determination," an adverse determination that as been upheld by the health carrier at the completion of the internal appeals process applicable pursuant to sections 79 to 87, inclusive, of this Act, or an adverse determination that with respect to which the internal appeals process has been deemed exhausted in accordance with section 78 of this Act;

(19) "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; or

(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;

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

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

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

(23) "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;

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

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

(29) "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;

(30) "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;

(31) "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;

(32) "Rescission," a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect. The term does not include a cancellation or discontinuance of coverage under a health benefit plan if:

(a) The cancellation or discontinuance of coverage has only a prospective effect; or

(b) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage;

(33) "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;

(34) "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;

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

(36) "Stabilized," with respect to an emergency medical condition, that no material deterioration of the condition is likely, with reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, with respect to a pregnant woman, the woman has delivered, including the placenta;

(37) "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

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

Section 76. Each health carrier shall maintain in a register written records to document all

grievances received including the notices and claims associated with the grievances during a calendar year. A request for a first level review of a grievance involving an adverse determination shall be processed in compliance with sections 79 to 83, inclusive, of this Act, and is required to be included in the register. For each grievance the register shall contain 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 77. Each 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 78 of this Act;

(2) The number of covered lives;

(3) The total number of grievances;

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

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

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

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

Section 78. Except as specified in sections 75 to 88, inclusive, of this Act, each health carrier shall use written procedures for receiving and resolving grievances from covered persons, as provided in sections 79 to 83, inclusive, of this Act. If a health carrier fails to strictly adhere to the requirements of sections 79 to 82, inclusive, or sections 84 to 87, inclusive, of this Act, with respect to receiving and resolving grievances involving an adverse determination, the covered person shall be deemed to have exhausted the provisions of sections 75 to 88, inclusive, of this Act, and may take action regardless of whether the health carrier asserts that the carrier substantially complied with the requirements of sections 79 to 82, inclusive, or sections 84 to 87, inclusive, of this Act, or that any error the carrier committed was de minimus.

A covered person may file a request for external review in accordance with rules promulgated by the director. In addition a covered person is entitled to pursue any available remedies under state or federal law on the basis that the health carrier failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

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 79 to 83, inclusive, of this Act. 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 sections 75 to 88, inclusive, of 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 76 and 77 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 sections 75 to 88, inclusive, 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 79. Within one hundred eighty days after the date of receipt of a notice of an adverse determination sent pursuant to sections 28 to 74, inclusive, of this Act, any 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. In providing for a first level review under this section, the health carrier shall ensure that the review conducted in a manner under this section to ensure the independence and impartiality of the individuals involved in making the first level review decision. In ensuring the independence and impartiality of individuals involved in making the first level review decision, no health carrier may make decisions related to such individuals regarding hiring, compensation, termination, promotion or other similar matters based upon the likelihood that the individual will support the denial of benefits.

The health carrier shall designate one or more health care providers who have appropriate training and experience in the field of medicine involved in the medical judgment to evaluate the adverse determination. No health care provider may have been involved in the initial adverse determination. In conducting the review, a reviewer 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 80. No covered person has the right to attend, or to have a representative in attendance, at the first level review. However, the covered person or, if applicable, the covered person's authorized representative may:

(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 81. 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 79 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 79 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 78 of this Act for filing a request, without regard to whether all of the information necessary to make the determination accompanies the filing.

Section 82. Prior to issuing a decision in accordance with the timeframes provided in section 81 of this Act, the health carrier shall provide free of charge to covered person, or the covered person's authorized representative, any new or additional evidence, relied upon or generated by the health carrier, or at the direction of the health carrier, in connection with the grievance sufficiently in advance of the date the decision is required to be provided to permit the covered person, or the covered person's authorized representative, a reasonable opportunity to respond prior to that date.

Before the health carrier issues or provides notice of a final adverse determination in accordance with the timeframes provided in section 81 of this Act that is based on new or additional rationale, the health carrier shall provide the new or additional rationale to the covered person, or the covered

person's authorized representative, free of charge as soon as possible and sufficiently in advance of the date the notice of final adverse determination is to be provided to permit the covered person, or the covered person's authorized representative a reasonable opportunity to respond prior to that date.

Section 83. The decision issued pursuant to section 81 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 any person participating in the first level review process (the reviewer);

(2) Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider, if applicable, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(3) A statement of the reviewer's understanding of the covered person's grievance;

(4) The reviewer's 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;

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

(6) For a first level review decision issued pursuant to section 81 of this Act that upholds the grievance denial:

(a) The specific reason or reasons for the final internal adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in reaching the denial;

(b) The 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 80 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 final 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 final 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 final 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 final 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;

(7) If applicable, a statement indicating:

(a) A description of the procedures for obtaining an independent external review of the final adverse determination pursuant to rules promulgated by the director; and

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

jurisdiction;

(8) 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.";

(9) 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 84. Each 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.

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

Section 85. 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 86. 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 87 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 78 of this Act for filing a request, without regard to whether all of the information necessary to make the determination accompanies the filing.

Section 87. A notification of a decision under sections 84 to 87, inclusive, of this Act, 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 any person participating in the expedited review process (the reviewer);

(2) Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider, if applicable, the claim amount, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(3) A statement of the reviewer's understanding of the covered person's grievance;

(4) The reviewer's 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;

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

(6) If the decision involves a final adverse determination, the notice shall provide:

(a) The specific reason or reasons for the final adverse determination, including the

denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in reaching the denial;

(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 final 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 describing the procedures for obtaining an independent external review of the adverse determination pursuant to rules promulgated by the director;

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

(i) 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

(j) 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 88. The director, in consultation with the secretary, 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 89. For the purposes of sections 2 to 21, inclusive, of this Act, the term, health benefit plan, means 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. The term includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.

The term does not include coverage only for accident, or disability income insurance, or any

combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, specified in federal regulations issued pursuant to Public Law No. 104-191, as amended to January 1, 2011, under which benefits for medical care are secondary or incidental to other insurance benefits.

The term does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or other similar, limited benefits specified in federal regulations issued pursuant to Public Law No. 104-191, as amended to January 1, 2011.

The term does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor: coverage only for a specified disease or illness; or hospital indemnity or other fixed indemnity insurance.

The term does not include the following if offered as a separate policy, certificate, or contract of insurance: medicare supplemental health insurance as defined under Section 882(g)(1) of the Social Security Act, as amended to January 1, 2011; coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)), as amended to January 1, 2011; or similar supplemental coverage provided to coverage under a group health plan.

Section 90. For the purposes of sections 22 to 27, inclusive, of this Act, the term, health benefit plan, means 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. The term includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.

The term does not include coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, specified in federal regulations issued pursuant to Public Law No. 104-191, as amended to January 1, 2011, under which benefits for medical care are secondary or incidental to other insurance benefits.

The term does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or other similar, limited benefits specified in federal regulations issued pursuant to Public Law No. 104-191, as amended to January 1, 2011.

The term does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor: coverage only for a specified disease or illness; or hospital indemnity or other fixed indemnity insurance.

The term does not include the following if offered as a separate policy, certificate, or contract of insurance: medicare supplemental health insurance as defined under Section 882(g)(1) of the Social Security Act, as amended to January 1, 2011; coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)), as amended to January 1, 2011; or similar supplemental coverage provided to coverage under a group health plan.

Section 91. For the purposes of sections 28 to 74, inclusive, of this Act, the term, health benefit plan, means 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. The term includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.

The term does not include coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, specified in federal regulations issued pursuant to Public Law No. 104-191, as amended to January 1, 2011, under which benefits for medical care are secondary or incidental to other insurance benefits.

The term does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or other similar, limited benefits specified in federal regulations issued pursuant to Public Law No. 104-191, as amended to January 1, 2011.

The term does not include the following benefits if the benefits are provided under a separate

policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor: coverage only for a specified disease or illness; or hospital indemnity or other fixed indemnity insurance.

The term does not include the following if offered as a separate policy, certificate, or contract of insurance: medicare supplemental health insurance as defined under Section 882(g)(1) of the Social Security Act, as amended to January 1, 2011; coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)), as amended to January 1, 2011; or similar supplemental coverage provided to coverage under a group health plan.

Section 92. For the purposes of sections 28 to 74, inclusive, 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) of this section, 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) of this section shall be treated as an urgent care request.

Section 93. For the purposes of sections 75 to 88, inclusive, of this Act, the term, health benefit plan, means 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. The term includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.

The term does not include coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage, specified in federal regulations issued pursuant to Public Law No. 104-191, as amended to January 1, 2011, under which benefits for medical care are secondary or incidental to other insurance benefits.

The term does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or other similar, limited benefits specified in federal regulations issued pursuant to Public Law No. 104-191, as amended to January 1, 2011.

The term does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan

sponsor: coverage only for a specified disease or illness; or hospital indemnity or other fixed indemnity insurance.

The term does not include the following if offered as a separate policy, certificate, or contract of insurance: medicare supplemental health insurance as defined under Section 882(g)(1) of the Social Security Act, as amended to January 1, 2011; coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)), as amended to January 1, 2011; or similar supplemental coverage provided to coverage under a group health plan.

Section 94. For the purposes of sections 75 to 88, inclusive, 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) of this section, 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) of this section shall be treated as an urgent care request.

Section 95. That § 58-1-24 be amended to read as follows:

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;

(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), sections 2 to 94, inclusive, 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 96. That § 58-17-143 be amended to read as follows:

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 section 28 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 section 28 of this Act, is limited to one hundred fifteen percent of South Dakota's medicaid reimbursement. Emergency treatment, as defined in section 28 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 97. That § 58-17D-2 be amended to read as follows:

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 this Act except that any such utilization review organization shall register in the same manner as prescribed for utilization review organizations pursuant to sections 60 to 64, inclusive, of this Act.

Section 98. That § 58-17E-9 be amended to read as follows:

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 sections 61 to 62, inclusive, 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 section 16 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 99. That § 58-33-93 be amended to read as follows:

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 section 16 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 100. That § 58-37A-39 be amended to read as follows:

58-37A-39. In addition to the provisions contained in this chapter, 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) Sections 2 to 94, inclusive, of this Act, and chapter 58-33A.

Section 101. That § 58-41-12 be amended to read as follows:

58-41-12. Upon receipt of an application for issuance of a certificate of authority, the director shall forthwith transmit copies of such application and accompanying documents to the secretary. The secretary 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 sections 2 to 21, inclusive, of this Act;

(2) Arrangements, established in accordance with regulations promulgated by the secretary for an ongoing quality of health care assurance program consistent with the requirements of sections 2 to 21, inclusive, of this Act, concerning health care processes and outcomes;

(3) A procedure, established in accordance with regulations promulgated by the secretary, 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 secretary; and

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

An Act to establish network adequacy standards, quality assessment and improvement requirements, utilization review and benefit determination requirements, and grievance procedures for managed health care plans, and to repeal certain standards for managed health care plans.

I certify that the attached Act originated in the

SENATE as Bill No. 38

_____
Secretary of the Senate

_____
President of the Senate

Attest:

_____
Secretary of the Senate

_____
Speaker of the House

Attest:

_____
Chief Clerk

Senate Bill No. 38
File No. ____
Chapter No. _____

Received at this Executive Office this _____ day of _____ ,

20____ at _____ M.

By _____
for the Governor

The attached Act is hereby approved this _____ day of _____ , A.D., 20___

_____
Governor

STATE OF SOUTH DAKOTA,
ss.
Office of the Secretary of State

Filed _____ , 20___
at _____ o'clock __ M.

_____
Secretary of State

By _____
Asst. Secretary of State