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STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2016

A N A C T

RELATING TO INSURANCE - HEALTH CARE SERVICES - UTILIZATION REVIEW ACT

Introduced By: Representatives McKiernan, O'Brien, Almeida, Casey, and Bennett

Date Introduced: February 24, 2016

Referred To: House Corporations

It is enacted by the General Assembly as follows:

1 SECTION 1. Sections 23-17.12-2, 23-17.12-3, 23-17.12-4, 23-17.12-5, 23-17.12-6, 23-
2 17.12-7, 23-17.12-8, 23-17.12-8.1, 23-17.12-9, 23-17.12-10, 23-17.12-12, 23-17.12-13 and 23-
3 17.12-15 of the General Laws in Chapter 23-17.12 entitled "Health Care Services - Utilization
4 Review Act" are hereby amended to read as follows:

5 **23-17.12-2. Definitions. --** As used in this chapter, the following terms are defined as
6 follows:

7 (1) "Adverse determination" means a utilization review decision by a review agent not to
8 authorize a health care service. A decision by a review agent to authorize a health care service in
9 an alternative setting, a modified extension of stay, or an alternative treatment shall not constitute
10 an adverse determination if the review agent and provider are in agreement regarding the
11 decision. Adverse determinations include decisions not to authorize formulary and nonformulary
12 medication.

13 (2) "Appeal" means a subsequent review of an adverse determination upon request by a
14 patient or provider to reconsider all or part of the original decision.

15 (3) "Authorization" means the review agent's utilization review, performed according to
16 subsection 23-17.12-2(20), concluded that the allocation of health care services of a provider,
17 given or proposed to be given to a patient was approved or authorized.

18 (4) "Benefit determination" means a decision of the enrollee's entitlement to payment for
19 covered health care services as defined in an agreement with the payor or its delegate.

(5) "Certificate" means a certificate of registration granted by the director to a review agent.

(6) "Commissioner" means the health insurance commissioner appointed pursuant to §42-14.5-1.

~~(6)~~(7) "Complaint" means a written expression of dissatisfaction by a patient, or provider. The appeal of an adverse determination is not considered a complaint.

~~(7)~~(8) "Concurrent assessment" means an assessment of the medical necessity and/or appropriateness of health care services conducted during a patient's hospital stay or course of treatment. If the medical problem is ongoing, this assessment may include the review of services after they have been rendered and billed. This review does not mean the elective requests for clarification of coverage or claims review or a provider's internal quality assurance program except if it is associated with a health care financing mechanism.

~~(8) "Department" means the department of health.~~

~~(9) "Director" means the director of the department of health.~~

~~(10)~~(9) "Emergent health care services" has the same meaning as that meaning contained in the rules and regulations promulgated pursuant to chapter 12.3 of title 42 as may be amended from time to time and includes those resources provided in the event of the sudden onset of a medical, mental health, or substance abuse or other health care condition manifesting itself by acute symptoms of a severity (e.g. severe pain) where the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any body organ or part.

(10) "Office of the health insurance commissioner" or "OHIC" means the agency established under §42-14.5-1.

(11) "Patient" means an enrollee or participant in all hospital or medical plans seeking health care services and treatment from a provider.

(12) "Payor" means a health insurer, self-insured plan, nonprofit health service plan, health insurance service organization, preferred provider organization, health maintenance organization or other entity authorized to offer health insurance policies or contracts or pay for the delivery of health care services or treatment in this state.

(13) "Practitioner" means any person licensed to provide or otherwise lawfully providing health care services, including, but not limited to, a physician, dentist, nurse, optometrist, podiatrist, physical therapist, clinical social worker, or psychologist.

(14) "Prospective assessment" means an assessment of the medical necessity and/or appropriateness of health care services prior to services being rendered.

(15) "Provider" means any health care facility, as defined in § 23-17-2 including any mental health and/or substance abuse treatment facility, physician, or other licensed practitioners identified to the review agent as having primary responsibility for the care, treatment, and services rendered to a patient.

(16) "Retrospective assessment" means an assessment of the medical necessity and/or appropriateness of health care services that have been rendered. This shall not include reviews conducted when the review agency has been obtaining ongoing information.

(17) "Review agent" means a person or entity or insurer performing utilization review that is either employed by, affiliated with, under contract with, or acting on behalf of:

(i) A business entity doing business in this state;

(ii) A party that provides or administers health care benefits to citizens of this state, including a health insurer, self-insured plan, non-profit health service plan, health insurance service organization, preferred provider organization or health maintenance organization authorized to offer health insurance policies or contracts or pay for the delivery of health care services or treatment in this state; or

(iii) A provider.

(18) "Same or similar specialty" means a practitioner who has the appropriate training and experience that is the same or similar as the attending provider in addition to experience in treating the same problems to include any potential complications as those under review.

(19) "Urgent health care services" has the same meaning as that meaning contained in the rules and regulations promulgated pursuant to chapter 12.3 of title 42 as may be amended from time to time and includes those resources necessary to treat a symptomatic medical, mental health, or substance abuse or other health care condition requiring treatment within a twenty-four (24) hour period of the onset of such a condition in order that the patient's health status not decline as a consequence. This does not include those conditions considered to be emergent health care services as defined in subdivision (10).

(20) "Utilization review" means the prospective, concurrent, or retrospective assessment of the necessity and/or appropriateness of the allocation of health care services of a provider, given or proposed to be given to a patient. Utilization review does not include:

(i) Elective requests for the clarification of coverage; or

(ii) Benefit determination; or

(iii) Claims review that does not include the assessment of the medical necessity and appropriateness; or

(iv) A provider's internal quality assurance program except if it is associated with a

health care financing mechanism; or

(v) The therapeutic interchange of drugs or devices by a pharmacy operating as part of a licensed inpatient health care facility; or

(vi) The assessment by a pharmacist licensed pursuant to the provisions of chapter 19 of title 5 and practicing in a pharmacy operating as part of a licensed inpatient health care facility in the interpretation, evaluation and implementation of medical orders, including assessments and/or comparisons involving formularies and medical orders.

(21) "Utilization review plan" means a description of the standards governing utilization review activities performed by a private review agent.

(22) "Health care services" means and includes an admission, diagnostic procedure, therapeutic procedure, treatment, extension of stay, the ordering and/or filling of formulary or nonformulary medications, and any other services, activities, or supplies that are covered by the patient's benefit plan.

(23) "Therapeutic interchange" means the interchange or substitution of a drug with a dissimilar chemical structure within the same therapeutic or pharmacological class that can be expected to have similar outcomes and similar adverse reaction profiles when given in equivalent doses, in accordance with protocols approved by the president of the medical staff or medical director and the director of pharmacy.

23-17.12-3. General certificate requirements. -- (a) A review agent shall not conduct utilization review in the state unless ~~the department~~ OHIC has granted the review agent a certificate.

(b) Individuals shall not be required to hold separate certification under this chapter when acting as either an employee of, an affiliate of, a contractor for, or otherwise acting on behalf of a certified review agent.

(c) ~~The department~~ OHIC shall issue a certificate to an applicant that has met the minimum standards established by this chapter, and regulations promulgated in accordance with it, including the payment of any fees as required, and other applicable regulations of ~~the department~~ OHIC.

(d) A certificate issued under this chapter is not transferable, and the transfer of fifty percent (50%) or more of the ownership of a review agent shall be deemed a transfer.

(e) After consultation with the payors and providers of health care, ~~the department~~ OHIC shall adopt regulations necessary to implement the provisions of this chapter.

(f) The ~~director of health~~ commissioner is authorized to establish any fees for initial application, renewal applications, and any other administrative actions deemed necessary by the

~~director~~ commissioner to implement this chapter.

(g) The total cost of certification under this title shall be borne by the certified entities and shall be one hundred and fifty percent (150%) of the total salaries paid to the certifying personnel of ~~the department~~ OHIC ~~department~~ engaged in those certifications less any salary reimbursements and shall be paid to the ~~director~~ commissioner to and for the use of ~~the department~~ OHIC. That assessment shall be in addition to any taxes and fees otherwise payable to the state.

(h) The application and other fees required under this chapter shall be sufficient to pay for the administrative costs of the certificate program and any other reasonable costs associated with carrying out the provisions of this chapter.

(i) A certificate expires on the second anniversary of its effective date unless the certificate is renewed for a two (2) year term as provided in this chapter.

(j) Any systemic changes in the review agents operations relative to certification information on file shall be submitted to ~~the department~~ OHIC for approval within thirty (30) days prior to implementation.

23-17.12-4. Application process. -- (a) An applicant requesting certification or recertification shall:

(1) Submit an application provided by the ~~director~~ commissioner; and

(2) Pay the application fee established by the director through regulation and § 23-17.12-3(f).

(b) The application shall:

(1) Be on a form and accompanied by supporting documentation that the ~~director~~ commissioner requires; and

(2) Be signed and verified by the applicant.

(c) Before the certificate expires, a certificate may be renewed for an additional two (2) years.

(d) If a completed application for recertification is being processed by ~~the department~~ OHIC, a certificate may be continued until a renewal determination is made.

(e) In conjunction with the application, the review agent shall submit information that the ~~director~~ commissioner requires including:

(1) A request that the state agency regard specific portions of the standards and criteria or the entire document to constitute " trade secrets" within the meaning of that term in § 38-2-2(4)(i)(B);

(2) The policies and procedures to ensure that all applicable state and federal laws to

protect the confidentiality of individual medical records are followed;

(3) A copy of the materials used to inform enrollees of the requirements under the health benefit plan for seeking utilization review or pre-certification and their rights under this chapter, including information on appealing adverse determinations;

(4) A copy of the materials designed to inform applicable patients and providers of the requirements of the utilization review plan;

(5) A list of the third party payors and business entities for which the review agent is performing utilization review in this state and a brief description of the services it is providing for each client; and

(6) Evidence of liability insurance or of assets sufficient to cover potential liability.

(f) The information provided must demonstrate that the review agent will comply with the regulations adopted by the ~~director~~ commissioner under this chapter.

23-17.12-5. General application requirements. -- An application for certification or recertification shall be accompanied by documentation to evidence the following:

(1) The requirement that the review agent provide patients and providers with a summary of its utilization review plan including a summary of the standards, procedures and methods to be used in evaluating proposed or delivered health care services;

(2) The circumstances, if any, under which utilization review may be delegated to any other utilization review program and evidence that the delegated agency is a certified utilization review agency delegated to perform utilization review pursuant to all of the requirements of this chapter;

(3) A complaint resolution process consistent with subsection 23-17.12-2(6) and acceptable to ~~the department~~ OHIC, whereby patients, their physicians, or other health care providers may seek resolution of complaints and other matters of which the review agent has received written notice;

(4) The type and qualifications of personnel (employed or under contract) authorized to perform utilization review, including a requirement that only a practitioner with the same license status as the ordering practitioner, or a licensed physician or dentist, is permitted to make a prospective or concurrent adverse determination;

(5) The requirement that a representative of the review agent is reasonably accessible to patients, patient's family and providers at least five (5) days a week during normal business in Rhode Island and during the hours of the agency's review operations;

(6) The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records are followed;

(7) The policies and procedures regarding the notification and conduct of patient interviews by the review agent;

(8) The requirement that no employee of, or other individual rendering an adverse determination for, a review agent may receive any financial incentives based upon the number of denials of certification made by that employee or individual;

(9) The requirement that the utilization review agent shall not impede the provision of health care services for treatment and/or hospitalization or other use of a provider's services or facilities for any patient;

(10) Evidence that the review agent has not entered into a compensation agreement or contract with its employees or agents whereby the compensation of its employees or its agents is based upon a reduction of services or the charges for those services, the reduction of length of stay, or utilization of alternative treatment settings; provided, nothing in this chapter shall prohibit agreements and similar arrangements; and

(11) An adverse determination and internal appeals process consistent with § 23-17.12-9 and acceptable to ~~the department~~ OHIC, whereby patients, their physicians, or other health care providers may seek prompt reconsideration or appeal of adverse determinations by the review agent.

23-17.12-6. Denial, suspension, or revocation of certificate. -- (a) ~~The department~~ OHIC may deny a certificate upon review of the application if, upon review of the application, it finds that the applicant proposing to conduct utilization review does not meet the standards required by this chapter or by any regulations promulgated pursuant to this chapter.

(b) ~~The department~~ OHIC may revoke a certificate and/or impose reasonable monetary penalties not to exceed five thousand dollars ($5,000) per violation in any case in which:

(1) The review agent fails to comply substantially with the requirements of this chapter or of regulations adopted pursuant to this chapter;

(2) The review agent fails to comply with the criteria used by it in its application for a certificate; or

(3) The review agent refuses to permit examination by the ~~director~~ commissioner to determine compliance with the requirements of this chapter and regulations promulgated pursuant to the authority granted to the ~~director~~ commissioner in this chapter; provided, however, that the examination shall be subject to the confidentiality and " need to know" provisions of subdivisions 23-17.12-9(c)(4) and (5). These determinations may involve consideration of any written grievances filed with ~~the department~~ OHIC against the review agent by patients or providers.

(c) Any applicant or certificate holder aggrieved by an order or a decision of ~~the~~

~~department~~ OHIC made under this chapter without a hearing may, within thirty (30) days after notice of the order or decision, make a written request to ~~the department~~ OHIC for a hearing on the order or decision pursuant to § 42-35-15.

(d) The procedure governing hearings authorized by this section shall be in accordance with §§ 42-35-9 -- 42-35-13 as stipulated in § 42-35-14(a). A full and complete record shall be kept of all proceedings, and all testimony shall be recorded but need not be transcribed unless the decision is appealed pursuant to § 42-35-15. A copy or copies of the transcript may be obtained by any interested party upon payment of the cost of preparing the copy or copies. Witnesses may be subpoenaed by either party.

23-17.12-7. Judicial review. -- Any person who has exhausted all administrative remedies available to him or her within ~~the department~~ OHIC, and who is aggrieved by a final decision of ~~the department~~ OHIC under § 23-17.12-6, is entitled to judicial review pursuant to §§ 42-35-15 and 42-35-16.

23-17.12-8. Waiver of requirements. -- (a) Except for utilization review agencies performing utilization review activities to determine the necessity and/or appropriateness of substance abuse and mental health care, treatment or services, ~~the department~~ OHIC shall waive all the requirements of this chapter, with the exception of those contained in §§ 23-17.12-9, (a)(1)-(3), (5), (6), (8), (b)(1)-(6), and (c)(2)-(6), 23-17.12-12, and 23-17.12-14, for a review agent that has received, maintains and provides evidence to ~~the department~~ OHIC of accreditation from the utilization review accreditation commission (URAC) or other organization approved by the ~~director~~ commissioner. The waiver shall be applicable only to those services that are included under the accreditation by the utilization review accreditation commission or other approved organization.

(b) ~~The department~~ OHIC shall waive the requirements of this chapter only when a direct conflict exists with those activities of a review agent that are conducted pursuant to contracts with the state or the federal government or those activities under other state or federal jurisdictions.

(c) The limitation in subsection 23-17.12-8(b) notwithstanding, ~~the department~~ OHIC may waive or exempt all or part of the requirements of this chapter by mutual written agreement with a state department or agency when such waiver or exemption is determined to be necessary and appropriate to the administration of a health care related program. ~~The department~~ OHIC shall promulgate such regulations as deemed appropriate to implement this provision.

23-17.12-8.1. Variance of statutory requirements.. -- (a) ~~The department~~ OHIC is authorized to issue a statutory variance from one or more of the specific requirements of this

chapter to a review agent where it determines that such variance is necessary to permit the review agent to evaluate and address practitioner billing and practice patterns when the review agent believes in good faith that such patterns evidence the existence of fraud or abuse. Any variance issued by ~~the department~~ OHIC pursuant to this section shall be limited in application to those services billed directly by the practitioner. Prior to issuing a statutory variance ~~the department~~ OHIC shall provide notice and a public hearing to ensure necessary patient and health care provider protections in the process. Statutory variances shall be issued for a period not to exceed one year and may be subject to such terms and conditions deemed necessary by ~~the department~~ OHIC.

(b) On or before January 15th of each year, ~~the department~~ OHIC shall issue a report to the general assembly summarizing any review agent activity as a result of a waiver granted under the provisions of this section.

23-17.12-9. Review agency requirement for adverse determination and internal appeals. -- (a) The adverse determination and appeals process of the review agent shall conform to the following:

(1) Notification of a prospective adverse determination by the review agent shall be mailed or otherwise communicated to the provider of record and to the patient or other appropriate individual as follows:

(i) Within fifteen (15) business days of receipt of all the information necessary to complete a review of non-urgent and/or non-emergent services;

(ii) Within seventy-two (72) hours of receipt of all the information necessary to complete a review of urgent and/or emergent services; and

(iii) Prior to the expected date of service.

(2) Notification of a concurrent adverse determination shall be mailed or otherwise communicated to the patient and to the provider of record period as follows:

(i) To the provider(s) prior to the end of the current certified period; and

(ii) To the patient within one business day of making the adverse determination.

(3) Notification of a retrospective adverse determination shall be mailed or otherwise communicated to the patient and to the provider of record within thirty (30) business days of receipt of a request for payment with all supporting documentation for the covered benefit being reviewed.

(4) A utilization review agency shall not retrospectively deny authorization for health care services provided to a covered person when an authorization has been obtained for that service from the review agent unless the approval was based upon inaccurate information

material to the review or the health care services were not provided consistent with the provider's submitted plan of care and/or any restrictions included in the prior approval granted by the review agent.

(5) Any notice of an adverse determination shall include:

(i) The principal reasons for the adverse determination, to include explicit documentation of the criteria not met and/or the clinical rationale utilized by the agency's clinical reviewer in making the adverse determination. The criteria shall be in accordance with the agency criteria noted in subsection 23-17.12-9(d) and shall be made available within the first level appeal timeframe if requested unless otherwise provided as part of the adverse determination notification process;

(ii) The procedures to initiate an appeal of the adverse determination, including the name and telephone number of the person to contract with regard to an appeal;

(iii) The necessary contact information to complete the two-way direct communication defined in subdivision 23-17.12-9(a)(7); and

(iv) The information noted in subdivision 23-27.12-9(a)(5)(i)(ii)(iii) for all verbal notifications followed by written notification to the patient and provider(s).

(6) All initial retrospective adverse determinations of a health care service that had been ordered by a physician, dentist or other practitioner shall be made, documented and signed consistent with the regulatory requirements which shall be developed by the department with the input of review agents, providers and other affected parties.

(7) ~~A level one~~ An internal appeal decision of an adverse determination shall not be made until an appropriately qualified and licensed review physician, dentist or other practitioner has spoken to, or otherwise provided for, an equivalent two-way direct communication with the patient's attending physician, dentist, other practitioner, other designated or qualified professional or provider responsible for treatment of the patient concerning the medical care, with the exception of the following:

(i) When the attending provider is not reasonably available;

(ii) When the attending provider chooses not to speak with agency staff;

(iii) When the attending provider has negotiated an agreement with the review agent for alternative care; and/or

(iv) When the attending provider requests a peer to peer communication prior to the adverse determination, the review agency shall then comply with subdivision 23-17.12-9(c)(1) in responding to such a request. Such requests shall be on the case specific basis unless otherwise arranged for in advance by the provider.

(8) All initial, prospective and concurrent adverse determinations of a health care service that had been ordered by a physician, dentist or other practitioner shall be made, documented and signed by a licensed practitioner with the same licensure status as the ordering practitioner or a licensed physician or dentist. This does not prohibit appropriately qualified review agency staff from engaging in discussions with the attending provider, the attending provider's designee or appropriate health care facility and office personnel regarding alternative service and treatment options. Such a discussion shall not constitute an adverse determination provided though that any change to the provider's original order and/or any decision for an alternative level of care must be made and/or appropriately consented to by the attending provider or the provider's designee responsible for treating the patient.

(9) The requirement that, upon written request made by or on behalf of a patient, any adverse determination and/or appeal shall include the written evaluation and findings of the reviewing physician, dentist or other practitioner. The review agent is required to accept a verbal request made by or on behalf of a patient for any information where a provider or patient can demonstrate that a timely response is urgent.

(b) The review agent shall conform to the following for the appeal of an adverse determination:

(1) The review agent shall maintain and make available a written description of the appeal procedure by which either the patient or the provider of record may seek review of determinations not to authorize a health care service. The process established by each review agent may include a reasonable period within which an appeal must be filed to be considered and that period shall not be less than sixty (60) days.

(2) The review agent shall notify, in writing, the patient and provider of record of its decision on the appeal as soon as practical, but in no case later than fifteen (15) or twenty-one (21) business days if verbal notice is given within fifteen (15) business days after receiving the required documentation on the appeal.

(3) The review agent shall also provide for an expedited appeals process for emergency or life threatening situations. Each review agent shall complete the adjudication of expedited appeals within two (2) business days of the date the appeal is filed and all information necessary to complete the appeal is received by the review agent.

(4) All ~~first level~~ internal appeals of determinations not to authorize a health care service that had been ordered by a physician, dentist, or other practitioner shall be made, documented, and signed by a licensed practitioner with the same licensure status as the ordering practitioner or a licensed physician or a licensed dentist.

(5) ~~All second level appeal decisions shall be made, signed, and documented by a licensed practitioner in the same or a similar general specialty as typically manages the medical condition, procedure, or treatment under discussion.~~

(6) The review agent shall maintain records of written appeals and their resolution, and shall provide reports as requested by ~~the department~~ OHIC.

(c) The review agency must conform to the following requirements when making its adverse determination and appeal decisions:

(1) The review agent must assure that the licensed practitioner or licensed physician is reasonably available to review the case as required under subdivision 23-17.12-9(a)(7) and shall conform to the following:

(i) Each agency peer reviewer shall have access to and review all necessary information as requested by the agency and/or submitted by the provider(s) and/or patients;

(ii) Each agency shall provide accurate peer review contact information to the provider at the time of service, if requested, and/or prior to such service, if requested. This contact information must provide a mechanism for direct communication with the agency's peer reviewer;

(iii) Agency peer reviewers shall respond to the provider's request for a two-way direct communication defined in subdivision 23-17.12-9(a)(7)(iv) as follows:

(A) For a prospective review of non-urgent and non-emergent health care services, a response within one business day of the request for a peer discussion;

(B) For concurrent and prospective reviews of urgent and emergent health care services, a response within a reasonable period of time of the request for a peer discussion; and

(C) For retrospective reviews, prior to the ~~first level~~ internal appeal decision.

(iv) The review agency will have met the requirements of a two-way direct communication, when requested and/or as required prior to the first level of appeal, when it has made two (2) reasonable attempts to contact the attending provider directly.

(v) Repeated violations of this section shall be deemed to be substantial violations pursuant to § 23-17.12-14 and shall be cause for the imposition of penalties under that section.

(2) No reviewer at any level under this section shall be compensated or paid a bonus or incentive based on making or upholding an adverse determination.

(3) No reviewer under this section who has been involved in prior reviews of the case under appeal or who has participated in the direct care of the patient may participate as the sole reviewer in reviewing a case under appeal; provided, however, that when new information has been made available ~~at the first level of~~ for the internal appeal, then the review may be conducted

by the same reviewer who made the initial adverse determination.

(4) A review agent is only entitled to review information or data relevant to the utilization review process. A review agent may not disclose or publish individual medical records or any confidential medical information obtained in the performance of utilization review activities. A review agent shall be considered a third party health insurer for the purposes of § 5-37.3-6(b)(6) of this state and shall be required to maintain the security procedures mandated in § 5-37.3-4(c).

(5) Notwithstanding any other provision of law, the review agent, ~~the department~~ OHIC, and all other parties privy to information which is the subject of this chapter shall comply with all state and federal confidentiality laws, including, but not limited to, chapter 37.3 of title 5 (Confidentiality of Health Care Communications and Information Act) and specifically § 5-37.3-4(c), which requires limitation on the distribution of information which is the subject of this chapter on a " need to know" basis, and § 40.1-5-26.

(6) ~~The department~~ OHIC may, in response to a complaint that is provided in written form to the review agent, review an appeal regarding any adverse determination, and may request information of the review agent, provider or patient regarding the status, outcome or rationale regarding the decision.

(d) The requirement that each review agent shall utilize and provide upon request, by Rhode Island licensed hospitals and the Rhode Island Medical Society, in either electronic or paper format, written medically acceptable screening criteria and review procedures which are established and periodically evaluated and updated with appropriate consultation with Rhode Island licensed physicians, hospitals, including practicing physicians, and other health care providers in the same specialty as would typically treat the services subject to the criteria as follows:

(1) Utilization review agents shall consult with no fewer than five (5) Rhode Island licensed physicians or other health care providers. Further, in instances where the screening criteria and review procedures are applicable to inpatients and/or outpatients of hospitals, the medical director of each licensed hospital in Rhode Island shall also be consulted. Utilization review agents who utilize screening criteria and review procedures provided by another entity may satisfy the requirements of this section if the utilization review agent demonstrates to the satisfaction of the ~~director~~ commissioner that the entity furnishing the screening criteria and review procedures has complied with the requirements of this section.

(2) Utilization review agents seeking initial certification shall conduct the consultation for all screening and review criteria to be utilized. Utilization review agents who have been

certified for one year or longer shall be required to conduct the consultation on a periodic basis for the utilization review agent's highest volume services subject to utilization review during the prior year; services subject to the highest volume of adverse determinations during the prior year; and for any additional services identified by the ~~director~~ commissioner.

(3) Utilization review agents shall not include in the consultations as required under paragraph (1) of this subdivision, any physicians or other health services providers who have financial relationships with the utilization review agent other than financial relationships for provisions of direct patient care to utilization review agent enrollees and reasonable compensation for consultation as required by paragraph (1) of this subdivision.

(4) All documentation regarding required consultations, including comments and/or recommendations provided by the health care providers involved in the review of the screening criteria, as well as the utilization review agent's action plan or comments on any recommendations, shall be in writing and shall be furnished to ~~the department~~ OHIC on request. The documentation shall also be provided on request to any licensed health care provider at a nominal cost that is sufficient to cover the utilization review agent's reasonable costs of copying and mailing.

(5) Utilization review agents may utilize non-Rhode Island licensed physicians or other health care providers to provide the consultation as required under paragraph (1) of this subdivision, when the utilization review agent can demonstrate to the satisfaction of the ~~director~~ commissioner that the related services are not currently provided in Rhode Island or that another substantial reason requires such approach.

(6) Utilization review agents whose annualized data reported to ~~the department~~ OHIC demonstrate that the utilization review agent will review fewer than five hundred (500) such requests for authorization may request a variance from the requirements of this section.

23-17.12-10. External appeal requirements. -- (a) In cases where the ~~second level of~~ internal appeal to reverse an adverse determination is unsuccessful, the review agent shall provide for an external appeal by an unrelated and objective appeal agency, selected by the ~~director~~ commissioner. The ~~director~~ commissioner shall promulgate rules and regulations including, but not limited to, criteria for designation, operation, policy, oversight, and termination of designation as an external appeal agency. The external appeal agency shall not be required to be certified under this chapter for activities conducted pursuant to its designation.

(b) The external appeal shall have the following characteristics:

(1) The external appeal review and decision shall be based on the medical necessity for the health care or service and the appropriateness of service delivery for which authorization has

been denied.

(2) Neutral physicians, dentists, or other practitioners in the same or similar general specialty as typically manages the health care service shall be utilized to make the external appeal decisions.

(3) Neutral physicians, dentists, or other practitioners shall be selected from lists:

(i) Mutually agreed upon by the provider associations, insurers, and the purchasers of health services; and

(ii) Used during a twelve (12) month period as the source of names for neutral physician, dentist, or other practitioner reviewers.

(4) The neutral physician, dentist, or other practitioner may confer either directly with the review agent and provider, or with physicians or dentists appointed to represent them.

(5) Payment for the appeal fee charged by the neutral physician, dentist, or other practitioner shall be shared equally between the two (2) parties to the appeal; provided, however, that if the decision of the utilization review agent is overturned, the appealing party shall be reimbursed by the utilization review agent for their share of the appeal fee paid under this subsection.

(6) The decision of the external appeal agency shall be binding; however, any person who is aggrieved by a final decision of the external appeal agency is entitled to judicial review in a court of competent jurisdiction.

23-17.12-12. Reporting requirements. -- (a) ~~The department~~ OHIC shall establish reporting requirements to determine if the utilization review programs are in compliance with the provisions of this chapter and applicable regulations.

(b) By November 14, 2014, the ~~department~~ Rhode Island department of health shall report to the general assembly regarding hospital admission practices and procedures and the effects of such practices and procedures on the care and wellbeing of patients who present behavioral healthcare conditions on an emergency basis. The report shall be developed with the cooperation of the department of behavioral healthcare, developmental disabilities, and hospitals and of the department of children, youth, and families, and shall recommend changes to state law and regulation to address any necessary and appropriate revisions to ~~the department's~~ OHIC's regulations related to utilization review based on the Federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the Patient Protection and Affordable Care Act, Pub. L. 111-148, and the state's regulatory interpretation of parity in insurance coverage of behavioral healthcare. These recommended or adopted revisions to ~~the department's~~ OHIC's regulations shall include, but not be limited to:

(1) Adverse determination and internal appeals, with particular regard to the time necessary to complete a review of urgent and/or emergent services for patients with behavioral health needs;

(2) External appeal requirements;

(3) The process for investigating whether insurers and agents are complying with the provisions of chapter 17.12 of title 23 in light of parity in insurance coverage for behavioral healthcare, with particular regard to emergency admissions; and

(4) Enforcement of the provisions of chapter 17.12 of title 23 in light of insurance parity for behavioral healthcare.

23-17.12-13. Lists. -- The ~~director~~ commissioner shall periodically provide a list of private review agents issued certificates and the renewal date for those certificates to all licensed health care facilities and any other individual or organization requesting the list.

23-17.12-15. Annual report. -- The ~~director~~ commissioner shall issue an annual report to the governor and the general assembly concerning the conduct of utilization review in the state. The report shall include a description of utilization programs and the services they provide, an analysis of complaints filed against private review agents by patients or providers and an evaluation of the impact of utilization review programs on patient access to care.

SECTION 2. Section 23-17.13-3 of the General Laws in Chapter 23-17.13 entitled "Health Care Accessibility and Quality Assurance Act" is hereby amended to read as follows:

23-17.13-3. Certification of health plans. -- (a) Certification process.

(1) Certification.

(i) The director shall establish a process for certification of health plans meeting the requirements of certification in subsection (b).

(ii) The director shall act upon the health plan's completed application for certification within ninety (90) days of receipt of such application for certification.

(2) Review and recertification. - To ensure compliance with subsection (b), the director shall establish procedures for the periodic review and recertification of qualified health plans not less than every five (5) years; provided, however, that the director may review the certification of a qualified health plan at any time if there exists evidence that a qualified health plan may be in violation of subsection (b).

(3) Cost of certification. - The total cost of obtaining and maintaining certification under this title and compliance with the requirements of the applicable rules and regulations are borne by the entities so certified and shall be one hundred and fifty percent (150%) of the total salaries paid to the certifying personnel of the department engaged in those certifications less any salary

reimbursements and shall be paid to the director to and for the use of the department. That assessment shall be in addition to any taxes and fees otherwise payable to the state.

(4) Standard definitions. - To help ensure a patient's ability to make informed decisions regarding their health care, the director shall promulgate regulation(s) to provide for standardized definitions (unless defined in existing statute) of the following terms in this subdivision, provided, however, that no definition shall be construed to require a health care entity to add any benefit, to increase the scope of any benefit, or to increase any benefit under any contract:

(i) Allowable charge;

(ii) Capitation;

(iii) Co-payments;

(iv) Co-insurance;

(v) Credentialing;

(vi) Formulary;

(vii) Grace period;

(viii) Indemnity insurance;

(ix) In-patient care;

(x) Maximum lifetime cap;

(xi) Medical necessity;

(xii) Out-of-network;

(xiii) Out-patient;

(xiv) Pre-existing conditions;

(xv) Point of service;

(xvi) Risk sharing;

(xvii) Second opinion;

(xviii) Provider network;

(xix) Urgent care.

(b) Requirements for certification. - The director shall establish standards and procedures for the certification of qualified health plans that conduct business in this state and who have demonstrated the ability to ensure that health care services will be provided in a manner to assure availability and accessibility, adequate personnel and facilities, and continuity of service, and has demonstrated arrangements for ongoing quality assurance programs regarding care processes and outcomes; other standards shall consist of, but are not limited to, the following:

(1) Prospective and current enrollees in health plans must be provided information as to the terms and conditions of the plan consistent with the rules and regulations promulgated under

chapter 12.3 of title 42 so that they can make informed decisions about accepting and utilizing the health care services of the health plan. This must be standardized so that customers can compare the attributes of the plans, and all information required by this paragraph shall be updated at intervals determined by the director. Of those items required under this section, the director shall also determine which items shall be routinely distributed to prospective and current enrollees as listed in this subsection and which items may be made available upon request. The items to be disclosed are:

(i) Coverage provisions, benefits, and any restriction or limitations on health care services, including but not limited to, any exclusions as follows: by category of service, and if applicable, by specific service, by technology, procedure, medication, provider or treatment modality, diagnosis and condition, the latter three (3) of which shall be listed by name.

(ii) Experimental treatment modalities that are subject to change with the advent of new technology may be listed solely by the broad category " Experimental Treatments" . The information provided to consumers shall include the plan's telephone number and address where enrollees may call or write for more information or to register a complaint regarding the plan or coverage provision.

(2) Written statement of the enrollee's right to seek a second opinion, and reimbursement if applicable.

(3) Written disclosure regarding the appeals process described in § 23-17.12-1 et seq. and in the rules and regulations for the utilization review of care services, promulgated by the ~~department of health~~ office of the health insurance commissioner, the telephone numbers and addresses for the plan's office which handles complaints as well as for the office which handles the appeals process under § 23-17.12-1 et seq. and the rules and regulations for the utilization of health.

(4) Written statement of prospective and current enrollees' right to confidentiality of all health care record and information in the possession and/or control of the plan, its employees, its agents and parties with whom a contractual agreement exists to provide utilization review or who in any way have access to care information. A summary statement of the measures taken by the plan to ensure confidentiality of an individual's health care records shall be disclosed.

(5) Written disclosure of the enrollee's right to be free from discrimination by the health plan and the right to refuse treatment without jeopardizing future treatment.

(6) Written disclosure of a plan's policy to direct enrollees to particular providers. Any limitations on reimbursement should the enrollee refuse the referral must be disclosed.

(7) A summary of prior authorization or other review requirements including

preauthorization review, concurrent review, post-service review, post-payment review and any procedure that may lead the patient to be denied coverage for or not be provided a particular service.

(8) Any health plan that operates a provider incentive plan shall not enter into any compensation agreement with any provider of covered services or pharmaceutical manufacturer pursuant to which specific payment is made directly or indirectly to the provider as an inducement or incentive to reduce or limit services, to reduce the length of stay or the use of alternative treatment settings or the use of a particular medication with respect to an individual patient, provided however, that capitation agreements and similar risk sharing arrangements are not prohibited.

(9) Health plans must disclose to prospective and current enrollees the existence of financial arrangements for capitated or other risk sharing arrangements that exist with providers in a manner described in paragraphs (i), (ii), and (iii):

(i) "This health plan utilizes capitated arrangements, with its participating providers, or contains other similar risk sharing arrangements;

(ii) This health plan may include a capitated reimbursement arrangement or other similar risk sharing arrangement, and other financial arrangements with your provider;

(iii) This health plan is not capitated and does not contain other risk sharing arrangements."

(10) Written disclosure of criteria for accessing emergency health care services as well as a statement of the plan's policies regarding payment for examinations to determine if emergency health care services are necessary, the emergency care itself, and the necessary services following emergency treatment or stabilization. The health plan must respond to the request of the treating provider for post-stabilization treatment by approving or denying it as soon as possible.

(11) Explanation of how health plan limitations impact enrollees, including information on enrollee financial responsibility for payment for co-insurance, co-payment, or other non-covered, out-of-pocket, or out-of-plan services. This shall include information on deductibles and benefits limitations including, but not limited to, annual limits and maximum lifetime benefits.

(12) The terms under which the health plan may be renewed by the plan enrollee, including any reservation by the plan of any right to increase premiums.

(13) Summary of criteria used to authorize treatment.

(14) A schedule of revenues and expenses, including direct service ratios and other statistical information which meets the requirements set forth below on a form prescribed by the

director.

(15) Plan costs of health care services, including but not limited to all of the following:

(i) Physician services;

(ii) Hospital services, including both inpatients and outpatient services;

(iii) Other professional services;

(iv) Pharmacy services, excluding pharmaceutical products dispensed in a physician's office;

(v) Health education;

(vi) Substance abuse services and mental health services.

(16) Plan complaint, adverse decision, and prior authorization statistics. This statistical data shall be updated annually:

(i) The ratio of the number of complaints received to the total number of covered persons, reported by category, listed in paragraphs (b)(15)(i) -- (vi);

(ii) The ratio of the number of adverse decisions issued to the number of complaints received, reported by category;

(iii) The ratio of the number of prior authorizations denied to the number of prior authorizations requested, reported by category;

(iv) The ratio of the number of successful enrollee appeals to the total number of appeals filed.

(17) Plans must demonstrate that:

(i) They have reasonable access to providers, so that all covered health care services will be provided. This requirement cannot be waived and must be met in all areas where the health plan has enrollees;

(ii) Urgent health care services, if covered, shall be available within a time frame that meets standards set by the director.

(18) A comprehensive list of participating providers listed by office location, specialty if applicable, and other information as determined by the director, updated annually.

(19) Plans must provide to the director, at intervals determined by the director, enrollee satisfaction measures. The director is authorized to specify reasonable requirements for these measures consistent with industry standards to assure an acceptable degree of statistical validity and comparability of satisfaction measures over time and among plans. The director shall publish periodic reports for the public providing information on health plan enrollee satisfaction.

(c) Issuance of certification.

(1) Upon receipt of an application for certification, the director shall notify and afford

1 the public an opportunity to comment upon the application.

2 (2) A health care plan will meet the requirements of certification, subsection (b) by
3 providing information required in subsection (b) to any state or federal agency in conformance
4 with any other applicable state or federal law, or in conformity with standards adopted by an
5 accrediting organization provided that the director determines that the information is substantially
6 similar to the previously mentioned requirements and is presented in a format that provides a
7 meaningful comparison between health plans.

8 (3) All health plans shall be required to establish a mechanism, under which providers,
9 including local providers participating in the plan, provide input into the plan's health care policy,
10 including technology, medications and procedures, utilization review criteria and procedures,
11 quality and credentialing criteria, and medical management procedures.

12 (4) All health plans shall be required to establish a mechanism under which local
13 individual subscribers to the plan provide input into the plan's procedures and processes regarding
14 the delivery of health care services.

15 (5) A health plan shall not refuse to contract with or compensate for covered services an
16 otherwise eligible provider or non-participating provider solely because that provider has in good
17 faith communicated with one or more of his or her patients regarding the provisions, terms or
18 requirements of the insurer's products as they relate to the needs of that provider's patients.

19 (6) (i) All health plans shall be required to publicly notify providers within the health
20 plans' geographic service area of the opportunity to apply for credentials. This notification
21 process shall be required only when the plan contemplates adding additional providers and may
22 be specific as to geographic area and provider specialty. Any provider not selected by the health
23 plan may be placed on a waiting list.

24 (ii) This credentialing process shall begin upon acceptance of an application from a
25 provider to the plan for inclusion.

26 (iii) Each application shall be reviewed by the plan's credentialing body.

27 (iv) All health plans shall develop and maintain credentialing criteria to be utilized in
28 adding providers from the plans' network. Credentialing criteria shall be based on input from
29 providers credentialed in the plan and these standards shall be available to applicants. When
30 economic considerations are part of the decisions, the criteria must be available to applicants.
31 Any economic profiling must factor the specialty utilization and practice patterns and general
32 information comparing the applicant to his or her peers in the same specialty will be made
33 available. Any economic profiling of providers must be adjusted to recognize case mix, severity
34 of illness, age of patients and other features of a provider's practice that may account for higher

1 than or lower than expected costs. Profiles must be made available to those so profiled.

2 (7) A health plan shall not exclude a provider of covered services from participation in 3 its provider network based solely on:

4 (i) The provider's degree or license as applicable under state law; or

5 (ii) The provider of covered services lack of affiliation with, or admitting privileges at a 6 hospital, if that lack of affiliation is due solely to the provider's type of license.

7 (8) Health plans shall not discriminate against providers solely because the provider 8 treats a substantial number of patients who require expensive or uncompensated medical care.

9 (9) The applicant shall be provided with all reasons used if the application is denied.

10 (10) Plans shall not be allowed to include clauses in physician or other provider contracts 11 that allow for the plan to terminate the contract " without cause" ; provided, however, cause shall 12 include lack of need due to economic considerations.

13 (11) (i) There shall be due process for non-institutional providers for all adverse 14 decisions resulting in a change of privileges of a credentialed non-institutional provider. The 15 details of the health plan's due process shall be included in the plan's provider contracts.

16 (ii) A health plan is deemed to have met the adequate notice and hearing requirement of 17 this section with respect to a non-institutional provider if the following conditions are met (or are 18 waived voluntarily by the non-institutional provider):

19 (A) The provider shall be notified of the proposed actions and the reasons for the 20 proposed action.

21 (B) The provider shall be given the opportunity to contest the proposed action.

22 (C) The health plan has developed an internal appeals process that has reasonable time 23 limits for the resolution of an internal appeal.

24 (12) If the plan places a provider or provider group at financial risk for services not 25 provided by the provider or provider group, the plan must require that a provider or group has met 26 all appropriate standards of the department of business regulation.

27 (13) A health plan shall not include a most favored rate clause in a provider contract.

28 SECTION 3. Section 27-18-77 of the General Laws in Chapter 27-18 entitled "Accident 29 and Sickness Insurance Policies" is hereby amended to read as follows:

30 **27-18-77. Internal and external appeal of adverse benefit determinations. --** (a) The 31 commissioner shall adopt regulations to implement standards and procedures with respect to 32 internal claims and appeals of adverse benefit determinations, and with respect to external appeals 33 of adverse benefit determinations.

34 (b) ~~The regulations adopted by the commissioner shall apply only to those adverse~~

~~benefit determinations which are not subject to the jurisdiction of the department of health pursuant to R.I. Gen. Laws § 23-17.12 et seq. (Utilization Review Act).~~

(c) This section shall not apply to insurance coverage providing benefits for: (1) hospital confinement indemnity; (2) disability income; (3) accident only; (4) long term care; (5) Medicare supplement; (6) limited benefit health; (7) specified disease indemnity; (8) sickness or bodily injury or death by accident or both; and (9) other limited benefit policies. This section also shall not apply to grandfathered health plans.

SECTION 4. Section 27-19-67 of the General Laws in Chapter 27-19 entitled "Nonprofit Hospital Service Corporations" is hereby amended to read as follows:

27-19-67. Internal and external appeal of adverse benefit determinations. -- (a) The commissioner shall adopt regulations to implement standards and procedures with respect to internal claims and appeals of adverse benefit determinations, and with respect to external appeals of adverse benefit determinations.

(b) ~~The regulations adopted by the commissioner shall apply only to those adverse benefit determinations which are not subject to the jurisdiction of the department of health pursuant to R.I. Gen. Laws § 23-17.12 et seq. (Utilization Review Act).~~

(c) This section shall not apply to insurance coverage providing benefits for: (1) Hospital confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5) Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or bodily injury or death by accident or both; and (9) Other limited benefit policies. This section also shall not apply to grandfathered health plans.

SECTION 5. Section 27-20-63 of the General Laws in Chapter 27-20 entitled "Nonprofit Medical Service Corporations" is hereby amended to read as follows:

27-20-63. Internal and external appeal of adverse benefit determinations. -- (a) The commissioner shall adopt regulations to implement standards and procedures with respect to internal claims and appeals of adverse benefit determinations, and with respect to external appeals of adverse benefit determinations.

(b) ~~The regulations adopted by the commissioner shall apply only to those adverse benefit determinations which are not subject to the jurisdiction of the department of health pursuant to R.I. Gen. Laws § 23-17.12 et seq. (Utilization Review Act).~~

(c) This section shall not apply to insurance coverage providing benefits for: (1) Hospital confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5) Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or bodily injury or death by accident or both; and (9) Other limited benefit policies. This section also

shall not apply to grandfathered health plans.

SECTION 6. Section 27-41-80 of the General Laws in Chapter 27-41 entitled "Health Maintenance Organizations" is hereby amended to read as follows:

27-41-80. Internal and external appeal of adverse benefit determinations. -- (a) The commissioner shall adopt regulations to implement standards and procedures with respect to internal claims and appeals of adverse benefit determinations, and with respect to external appeals of adverse benefit determinations.

(b) ~~The regulations adopted by the commissioner shall apply only to those adverse benefit determinations within the jurisdiction of the department of health pursuant to R.I. Gen. Laws § 23-17.12 et seq. (Utilization Review Act).~~

(c) This section shall not apply to insurance coverage providing benefits for: (1) Hospital confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5) Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or bodily injury or death by accident or both; and (9) Other limited benefit policies. This section also shall not apply to grandfathered health plans.

SECTION 7. Title 27 of the General Laws entitled "INSURANCE" is hereby amended by adding thereto the following chapter:

CHAPTER 81

THE HEALTH BENEFIT PLAN NETWORK ACCESS AND ADEQUACY ACT

27-81-1. Title. -- This act shall be known and may be cited as the "Health Benefit Plan Network Access and Adequacy Act".

27-81-2. Purpose. -- The purpose and intent of this chapter are to:

(1) Establish standards for the creation and maintenance of networks by health carriers;

(2) Assure the adequacy, accessibility, and transparency of health care services offered under a network plan by:

(i) Establishing requirements for written agreements between health carriers offering network plans and participating providers regarding the standards, terms and provisions under which the participating provider will provide covered benefits to covered persons; and

(ii) Requiring health carriers to maintain and follow access plans that consist of policies and procedures for assuring the ongoing sufficiency of provider networks consistent with §27-81-5, including any requirements related to its availability to the public.

27-81-3. Definitions. -- For purposes of this chapter:

(1) "Authorized representative" means:

(i) A person to whom a covered person has given express written consent to represent the

1 covered person;

2 (ii) A person authorized by law to provide substituted consent for a covered person; or

3 (iii) The covered person's treating health care professional only when the covered person

4 is unable to provide consent or a family member of the covered person.

5 (2) "Commissioner" means the Rhode Island office of the health insurance commissioner.

6 (3) "Covered benefits" or " benefits" means those health care services to which a covered person

7 is entitled under the terms of a health benefit plan.

8 (4) "Covered person" means a policyholder, subscriber, enrollee or other individual

9 participating in a health benefit plan.

10 (5) "Economic credentialing" means the use of economic criteria unrelated to quality of

11 care or professional competency in determining an individual's qualifications for initial or

12 continuing participation in a network.

13 (6) "Emergency medical condition" means a medical condition manifesting itself by acute

14 symptoms of sufficient severity (including severe pain) so that a prudent layperson, who

15 possesses an average knowledge of health and medicine, could reasonably expect the absence of

16 immediate medical attention to result in a condition:

17 (i) Placing the health of the individual, or, with respect to a pregnant woman, her unborn

18 child, in serious jeopardy;

19 (ii) Constituting a serious impairment to bodily functions; or

20 (iii) Constituting a serious dysfunction of any bodily organ or part.

21 (7) "Emergency services" means with respect to an emergency medical condition:

22 (i) A medical or mental health screening examination that is within the capability of the

23 emergency department of a hospital, including ancillary services routinely available to the

24 emergency department to evaluate the emergency medical condition; and

25 (ii) Any further medical or mental health examination and treatment to the extent they are

26 within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

27 (8) "Essential community provider" or " ECP" means a provider that:

28 (i) Serves predominantly low-income, medically underserved individuals, including a

29 health care provider defined in §340B(a)(4) of the Public Health Service Act; or

30 (ii) Is described in §1927(c)(l)(D)(i)(IV) of the Social Security Act, as set forth by §221

31 of Pub.L.111-8.

32 (9) "Facility" means an institution providing physical, mental or behavioral health care

33 services or a health care setting, including, but not limited to, hospitals and other licensed

34 inpatient centers, ambulatory surgical centers, nursing homes, hospices, home health agencies,

1 residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and
2 other therapeutic health settings.
3 (10) "Facility-based professionals" means those health care professionals that typically
4 provide their services in a facility setting.
5 (11) "Health benefit plan" means a policy, contract, certificate or agreement entered into,
6 offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of
7 the costs of physical, mental or behavioral health care services.
8 (12) "Health care professional" means a physician or other health care practitioner
9 licensed, accredited or certified to perform specified physical, mental or behavioral health care
10 services consistent with state law.
11 (13) "Health care provider" or " provider" means a health care professional, a pharmacy
12 or a facility.
13 (14) "Health care services" means services for the diagnosis, prevention, treatment, cure
14 or relief of a physical, mental or behavioral health condition, illness, injury or disease, including
15 mental health and substance use disorders.
16 (15) "Health carrier" means an entity subject to the insurance laws and regulations of this
17 state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or
18 enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of
19 health care services, including a nonprofit service corporation, a health maintenance organization,
20 an entity offering a policy of accident and sickness insurance, or any other entity providing a plan
21 of health insurance, health benefits or health services.
22 (16) "Health maintenance organization" means a health maintenance organization as
23 defined in chapter 41 of title 27.
24 (17) "Intermediary" means a person authorized to negotiate and execute provider
25 contracts with health carriers on behalf of health care providers or on behalf of a network.
26 (18) "Network" means the group or groups of participating providers providing services
27 under a network plan.
28 (19) "Network plan" means a health benefit plan that either requires a covered person to
29 use, or creates incentives, including financial incentives, for a covered person to use health care
30 providers managed, owned, under contract with or employed by the health carrier.
31 (20) "Nonprofit service corporation" means a nonprofit hospital service corporation as
32 defined in chapter 19 of title 27 or a nonprofit medical service corporation as defined in chapter
33 20 of title 27.
34 (21) "Participating provider" means a provider who, under a contract with the health

1 carrier or with its contractor or subcontractor, has agreed to provide health care services to
2 covered persons with an expectation of receiving payment, other than coinsurance, copayments or
3 deductibles, directly or indirectly from the health carrier.
4 (22) "Person" means an individual, a corporation, a partnership, an association, a joint
5 venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any
6 combination of the foregoing.
7 (23) "Primary care" means health care services for a range of common physical, mental
8 or behavioral health conditions provided by a physician or non-physician primary care
9 professional.
10 (24) "Primary care professional" means a participating health care professional,
11 designated by the health carrier to supervise, coordinate or provide initial care or continuing care
12 to a covered person, and who may be required by the health carrier to initiate a referral for
13 specialty care and maintain supervision of health care services rendered to the covered person.
14 (25)(i) "Specialist" means a health care professional who:
15 (A) Focuses on a specific area of physical, mental or behavioral health or a group of
16 patients; and
17 (B) Has successfully completed required training and is recognized by the department of
18 health to provide specialty care;
19 (ii) "Specialist" includes a subspecialist who has additional training and recognition
20 above and beyond their specialty training.
21 (26) "Specialty care" means advanced medically necessary care and treatment of specific
22 physical, mental or behavioral health conditions or those health conditions which may manifest in
23 particular ages or subpopulations, that are provided by a specialist, preferably in coordination
24 with a primary care professional or other health care professional.
25 (27) "Telemedicine" or "telehealth" means health care services provided through
26 telecommunications technology by a health care professional who is at a location other than
27 where the covered person is located.
28 (28) "Tier" means to structure a network that identifies and groups some or all types of
29 providers and facilities into specific groups to which different provider reimbursement, covered
30 person cost-sharing or provider access requirements, or any combination thereof, apply for the
31 same services.
32 (29) "To stabilize" means with respect to an emergency medical condition, to provide
33 such medical treatment of the condition as may be necessary to assure, within a reasonable
34 medical probability, that no material deterioration of the condition is likely to result from or occur

1 during the transfer of the individual from a facility, or, with respect to an emergency birth with no
2 complications resulting in a continued emergency, to deliver the child and the placenta.
3 (30) "Transfer" means the movement, including the discharge, of an individual outside a
4 hospital's facilities at the direction of any person employed by, or affiliated or associated, directly
5 or indirectly, with the hospital, but does not include the movement of an individual who:
6 (i) Has been declared dead; or
7 (ii) Leaves the facility without the permission of any such person.
8 **27-81-4. Applicability and scope. --** This chapter applies to all health carriers that offer
9 network plans.
10 **27-81-5. Network adequacy. --** (a)(1) A health carrier providing a network plan shall
11 maintain a network that is sufficient in numbers and types of appropriate providers, including
12 those that serve predominantly low-income, medically underserved populations, to assure that all
13 covered services to covered persons, including children and adults, will be accessible without
14 unreasonable travel or delay.
15 (2) For purposes of networks that are tiered, network adequacy shall be determined
16 through evaluation of the lowest cost-sharing tier.
17 (3) Covered persons shall have access to emergency services twenty-four (24) hours per
18 day, seven (7) days per week .
19 (4) The commissioner may consider accreditation by a nationally recognized private
20 accrediting entity with established and maintained standards that, at a minimum, are substantially
21 similar to or exceed the standards required under this chapter, when determining if a network
22 meets some or all of this chapter's requirements; however, accreditation shall not be used as a
23 delegation of regulatory authority in determining network adequacy and may not be used as a
24 substitute for regulatory oversight:
25 (i) Should the commissioner use accreditation as an additional regulatory tool in
26 determining compliance with the standards required under this chapter, the accrediting entity
27 should make available to the commissioner and the public its current standards to demonstrate
28 that the entity's standards meet or exceed the requirements set forth in this chapter; and
29 (ii) The private accrediting entity or health carrier shall provide the commissioner with
30 documentation that the health carrier and its networks have been accredited by the entity and
31 make the underlying accreditation files available to the commissioner upon request.
32 (b) The commissioner shall determine sufficiency in accordance with the requirements of
33 this section, and may establish sufficiency by reference to any reasonable criteria, which may
34 include, but shall not be limited to:

1 (1) Provider-covered person ratios by specialty, including facility-based professional-
2 covered person ratios;
3 (2) Primary care professional-covered person ratios;
4 (3) Geographic accessibility of providers, including primary care professionals,
5 specialties, hospitals and facility-based professionals;
6 (4) Geographic variation and population dispersion;
7 (5) Waiting times for an appointment with participating providers;
8 (6) Hours of operation;
9 (7) The ability of the network to meet the needs of covered persons, which may include
10 low income persons, children and adults with serious, chronic or complex health conditions or
11 physical or mental disabilities or persons with limited English proficiency; and
12 (8) The volume of technological and specialty care services available to serve the needs
13 of covered persons requiring technologically advanced or specialty care services.
14 (c) The commissioner shall conduct periodic surveys of covered persons and providers to
15 help inform the monitoring of network adequacy and shall make the result publicly available.
16 (d)(1) A health carrier shall have a process to assure that a covered person obtains a
17 covered benefit at an in-network level of benefits, including an in-network level of cost-sharing,
18 from a non-participating provider, or shall make other arrangements acceptable to the
19 commissioner when:
20 (i) The health carrier has a sufficient network, but does not have a type of participating
21 provider available to provide the covered benefit to the covered person or it does not have a
22 participating provider available to provide the covered benefit to the covered person without
23 unreasonable travel or delay; or
24 (ii) The health carrier has an insufficient number or type of participating provider
25 available to provide the covered benefit to the covered person without unreasonable travel or
26 delay.
27 (2) The health carrier shall specify and inform covered persons of the process a covered
28 person may use to request access to obtain a covered benefit from a non-participating provider as
29 provided in subsection (d)(1) of this section when:
30 (i) The covered person is diagnosed with a condition or disease that requires specialized
31 health care services or medical services; and
32 (ii) The health carrier:
33 (A) Does not have a participating provider of the required specialty with the professional
34 training and expertise to treat or provide health care services for the condition or disease; or

(B) Cannot provide reasonable access to a participating provider with the required specialty with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable travel or delay.

(3) The health carrier shall treat the health care services the covered person receives from a non-participating provider pursuant to subsection (d)(2) of this section as if the services were provided by a participating provider, including counting the covered person's cost-sharing for such services toward the maximum out-of-pocket limit applicable to services obtained from participating providers under the health benefit plan.

(4) The process described under subsections (d)(l) and (d)(2) of this section shall ensure that requests to obtain a covered benefit from a non-participating provider are addressed in a timely fashion appropriate to the covered person's condition.

(5) The health carrier shall have a system in place that documents all requests to obtain a covered benefit from a non-participating provider under this subsection and shall provide this information to the commissioner upon request.

(6) The process established in this subsection is not intended to be used by health carriers as a substitute for establishing and maintaining a sufficient provider network in accordance with the provisions of this chapter nor is it intended to be used by covered persons to circumvent the use of covered benefits available through a health carrier's network delivery system options.

(7) Nothing in this section prevents a covered person from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims grievance and appeals processes.

(e)(1) A health carrier shall establish and maintain adequate arrangements to ensure covered persons have reasonable access to participating providers located near their home or business address. In determining whether the health carrier has complied with this provision, the commissioner shall give due consideration to the relative availability of health care providers with the requisite expertise and training in the service area under consideration.

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

(f)(1) Beginning January l, 2017, a health carrier shall file with the commissioner, in a manner and form defined by rule or regulation of the commissioner, an access plan meeting the requirements of this chapter for each of the network plans the carrier offers in the state;

(2)(i) The health carrier may request the commissioner to deem sections of the access plan as proprietary or confidential, and such sections shall not be made public. The health carrier

1 shall make the access plans, absent any proprietary or confidential information, as determined by
2 the commissioner, available online, at its business premises, and to any person upon request.
3 (ii) For the purposes of this subsection, information is proprietary or confidential if
4 revealing the information would cause the health carrier's competitors to obtain valuable business
5 information;
6 (3) The health carrier shall prepare an access plan prior to offering a new network plan,
7 and shall notify the commissioner of any material change to any existing network plan within
8 fifteen (15) business days after the change occurs. The health carrier shall include in the notice to
9 the commissioner a reasonable timeframe within which it will submit to the commissioner for
10 approval or file with the commissioner, as appropriate, an update to an existing access plan. For
11 the purpose of this subsection, "material change" means any change to the network or covered
12 person population that impacts the ability of the network to satisfy the requirements of this
13 chapter;
14 (4) The access plan shall describe or contain at least the following:
15 (i) The factors used by the health carrier to build its provider network, including a
16 description of the network and the criteria used to select and tier providers;
17 (ii) The health carrier's procedures for making and authorizing referrals within and
18 outside its network, if applicable;
19 (iii) The health carrier's process for monitoring and assuring on an ongoing basis the
20 sufficiency of the network to meet the health care needs of populations that enroll in network
21 plans;
22 (iv) The factors used by the health carrier to build its provider network, including a
23 description of the network and the criteria used to select and/or tier providers;
24 (v) The health carrier's efforts to address the needs of covered persons, including, but not
25 limited to, children and adults, including those with limited English proficiency or illiteracy,
26 diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic or
27 complex medical conditions. This includes the carrier's efforts, when appropriate, to include
28 various types of ECPs in its network;
29 (vi) The health carrier's methods for assessing the health care needs of covered persons
30 and their satisfaction with services;
31 (vii) The health carrier's method of informing covered persons of the plan's covered
32 services and features, including, but not limited to:
33 (A) The plan's grievance and appeals procedures;
34 (B) Its process for choosing and changing providers;

1 (C) Its process for updating its provider directories for each of its network plans;
2 (D) A statement of health care services offered, including those services offered through
3 the preventive care benefit, if applicable; and
4 (E) Its procedures for covering and approving emergency, urgent and specialty care, if
5 applicable;
6 (viii) The health carrier's system for ensuring the coordination and continuity of care for
7 covered persons referred to specialty physicians, for covered persons using ancillary services,
8 including social services and other community resources, and for ensuring appropriate discharge
9 planning;
10 (ix) The health carrier's process for enabling covered persons to change primary care
11 professionals, if applicable;
12 (x) The health carrier's proposed plan for providing continuity of care in the event of
13 contract termination between the health carrier and any of its participating providers, or in the
14 event of the health carrier's insolvency or other inability to continue operations. The description
15 shall explain how covered persons will be notified of the contract termination, or the health
16 carrier's insolvency or other cessation of operations, and transitioned to other providers in a
17 timely manner;
18 (xi) The health carrier's process for monitoring access to physician specialist services in
19 emergency room care, anesthesiology, radiology, hospitalist care and pathology/laboratory
20 services at their participating hospitals; and
21 (xii) Any other information required by the commissioner to determine compliance with
22 the provisions of this chapter.
23 **27-81-6. Requirements for health carriers and participating providers. --** (a)(1)
24 Health carrier selection standards for selecting and tiering, as applicable, of participating
25 providers shall be developed for providers and each health care professional specialty:
26 (2) The standards shall be used in determining the selection and tiering of participating
27 providers by the health carrier, and its intermediaries with which it contracts;
28 (3)(i) Selection and tiering criteria shall not be established in a manner:
29 (A) That would allow a health carrier to discriminate against high-risk populations by
30 excluding and tiering providers because they are located in geographic areas that contain
31 populations or providers presenting a risk of higher than average claims, losses or health care
32 services utilization; or
33 (B) That would exclude providers because they treat or specialize in treating populations
34 presenting a risk of higher than average claims, losses or health care services utilization; or

(C) That would allow a health carrier to economically credential a provider;

(ii) Selection and tiering criteria must include a quality component that carries equal or greater weight than other components of the selection and tiering criteria;

(iii) A health carrier shall make its standards for selecting and tiering, as applicable, participating providers available for approval by the commissioner. A description in plain language of the standards the health carrier uses for selecting and tiering, as applicable, shall be available to the public.

(b)(i) A health carrier and participating provider shall provide at least sixty (60) days written notice to each other before the provider is removed or leaves the network without cause or the health carrier moves the provider to another tier within the network;

(ii) The health carrier shall make a good faith effort to provide written notice of a provider's removal from or leaving the network within thirty (30) days of receipt or issuance of a notice provided in accordance with subsection §27-81-5(f)(4)(x) of this section to all covered persons who are patients seen on a regular basis by the provider being removed from or leaving the network, irrespective of whether it is for cause or without cause;

(iii) When the provider being removed from or leaving the network is a primary care professional, all covered persons who are patients of that primary care professional shall also be notified. When the provider either gives or receives the notice in accordance with subsection §27-81-5(f)(4)(x) of this section, the provider shall supply the health carrier with a list of those patients of the provider that are covered by a plan of the health carrier;

(iv) Each contract between a health carrier and a participating provider shall provide that termination of contract does not release the health carrier from the obligation of continuing to reimburse a physician or provider providing medically necessary treatment at the time of termination to a covered person who has a condition regarding which the treating physician or health care provider believes that discontinuing care by the treating physician or provider could cause harm to the covered person; and

(A) The physician or provider requests that the covered person be permitted to continue treatment under the physician's or provider's care;

(B) The physician or provider agrees to accept the same reimbursement from the health carrier for that covered person as provided under the contract between the physician or the provider; and

(C) The physician or provider agrees not to seek payment from the covered person of any amount for which the covered person would not be responsible if the physician or provider were still a participating provider.

(c) A contract between a health carrier and a provider shall not contain provisions that conflict with the provisions contained in the network plan or the requirements of this chapter.

(d)(i)(A) At the time the contract is signed, a health carrier and, if appropriate, an intermediary shall timely notify a participating provider of all provisions and other documents incorporated by reference in the contract;

(B) While the contract is in force, the carrier shall notify a participating provider of any changes to those provisions or documents that would result in material changes in the contract ninety (90) days prior to the implementation of the changes and allow a provider to reject those changes without terminating the existing contract;

(ii) A health carrier shall timely inform a provider of the provider's network participation status on any health benefit plan in which the carrier has included the provider as a participating provider at least ninety (90) days before placing the provider in the network.

27-81-7. Provider directories. -- (a)(1)(i) A health carrier shall post online a current provider directory for each of its network plans with the information and search functions described in §27-81-7(c);

(ii) In making a directory available online, the carrier shall ensure that the general public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number.

(2)(i) The health carrier shall update each network plan provider directory at least monthly;

(ii) The health carrier shall periodically audit at least a reasonable sample size of its provider directories for accuracy and retain documentation of such an audit to be made available to the commissioner upon request.

(3) A health carrier shall provide a print copy of a current provider directory with the information described in §27-81-7(b) upon request of a covered person or a prospective covered person.

(4) For each network plan, a health carrier shall include in plain language in both the electronic and print directory, the following general information:

(i) A description of the criteria the carrier has used to build its provider network;

(ii) If applicable, a description of the criteria the carrier has used to tier providers, and in which tier each provider is placed for the network;

(iii) If applicable, how the carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital or other type of facility in the network which tier each is placed, for example, by name, symbols or grouping, in order for a covered

person or a prospective covered person to be able to identify the provider tier;

(iv) If applicable, note that authorization or referral may be required to access some providers; and

(v) Identification regarding the breadth of each network.

(5)(i) A health carrier shall make it clear for both its electronic and print directories what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this state.

(ii) The health carrier shall include in both its electronic and print directories a customer service email address and telephone number or electronic link that covered persons or the general public may use to notify the health carrier of inaccurate provider directory information.

(6) For the pieces of information required pursuant to §§27-81-7(b), (c) and (d) in a provider directory pertaining to a health care professional, a hospital or a facility other than a hospital, the health carrier shall make available through the directory the source of the information and any limitations, if applicable.

(7) A provider directory, whether in electronic or print format, shall accommodate the communication needs of individuals with disabilities, and include a link to or information regarding available assistance for persons with limited English proficiency.

(b) The health carrier shall make available through an electronic provider directory, for each network plan, the information under this subsection in a searchable format:

(1) For health care professionals:

(i) Name;

(ii) Gender;

(iii) Participating office location(s);

(iv) Specialty, if applicable;

(v) Medical group affiliations, if applicable;

(vi) Facility affiliations, if applicable;

(vii) Participating facility affiliations, if applicable;

(viii) Languages spoken other than English, if applicable; and

(ix) Whether accepting new patients.

(2) For hospitals:

(i) Hospital name;

(ii) Hospital type (e.g. general acute care. children's cancer, rehab, etc.);

(iii) Participating hospital locations; and

(iv) Hospital accreditation status.

(3) For facilities other than hospitals, by type:

(i) Facility name;

(ii) Facility type;

(iii) Types of services performed; and

(iv) Participating facility location(s).

(c) For the electronic provider directories, for each network plan, a health carrier shall include the information required under §27-81-7(b) and additionally:

(1) For health care professionals:

(i) Contact information;

(ii) Board certification(s); and

(iii) Languages spoken other than English by clinical staff, if applicable.

(2) For hospitals: Telephone number; and

(3) For facilities other than hospitals: Telephone number.

27-81-8. Enforcement. -- (a) If the commissioner determines that a health carrier has not contracted with a sufficient number of participating providers to ensure that covered persons have accessible health care services in a geographic area, or that a health carrier's network access plan does not ensure reasonable access to covered benefits, or that a health carrier has entered into a contract that does not comply with this chapter, or that a health carrier has not complied with a provision of this chapter, the commissioner shall require a modification to the access plan or institute a corrective action plan, as appropriate, that shall be followed by the health carrier, or may use any of the commissioner's other enforcement powers to obtain the health carrier's compliance with this chapter.

(b) The commissioner will not act to arbitrate, mediate or settle disputes regarding a decision not to include a provider in a network plan or in a provider network or regarding any other dispute between a health carrier, its intermediaries or one or more providers arising under or by reason of a provider contract or its termination.

27-81-9. Regulations. -- The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this chapter. The regulations shall be subject to review in accordance with chapter 35 of title 42.

27-81-10. Severability. -- If any provision of this chapter, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the chapter, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

27-81-11. Effective date. -- This chapter shall be effective January 1, 2017.

1 (1) All provider and intermediary contracts in effect on January 1, 2017, shall comply
2 with this chapter no later than eighteen (18) months after January 1, 2017. The commissioner may
3 extend the eighteen (18) month period of compliance for an additional period not to exceed six
4 (6) months if the health carrier demonstrates good cause for an extension.
5 (2) A new provider or intermediary contract that is issued or put in force on or after July
6 1, 2017, shall comply with this chapter.
7 (3) A provider contract or intermediary contract not described in subsections (1) or (2) of
8 this section shall comply with this chapter no later than eighteen (18) months after January 1,
9 2017.
10 SECTION 8. This act shall take effect on January 1, 2017.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N   A C T

RELATING TO INSURANCE - HEALTH CARE SERVICES - UTILIZATION REVIEW ACT

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1 This act would transfer the responsibilities related to utilization review from the
2 department of health to the office of the health insurance commissioner. This act would also
3 establish criteria by which the office of the health insurance commissioner shall review and
4 regulate the adequacy of health plan networks.
5 This act would take effect on January 1, 2017.

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