

UTILIZATION REVIEW AND BENEFIT DETERMINATION MODEL ACT

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Section 1. Title

This Act shall be known and may be cited as the Utilization Review and Benefit Determination Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act in regulation form. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as regulations.

Section 2. Purpose and Intent

This Act establishes standards and criteria for the structure and operation of utilization review and benefit determination processes designed to facilitate ongoing assessment and management of health care services.

Section 3. Definitions

For purposes of this Act:

- A. (1) “Adverse determination” means:
 - (a) A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier’s health benefit plan upon application of any utilization review technique does not meet the health carrier’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;
 - (b) The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person’s eligibility to participate in the health carrier’s health benefit plan; or
 - (c) Any prospective review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit.
- (2) “Adverse determination” includes a rescission of coverage determination.

Drafting Note: The federal Department of Labor’s claims procedure final regulation (DOL final rule), as published in the *Federal Register*, Nov. 21, 2000, which establishes standards for the processing of claims under group health plans, uses the term “adverse benefit determination.” This model act uses the term “adverse determination.” The NAIC has chosen to continue to use the term “adverse determination” in this model act instead of using the DOL final rule’s term “adverse benefit determination” because the term “adverse determination” is referenced in several other NAIC model acts in addition to this model act. If the terminology were changed, this would necessitate revising several NAIC model acts to reflect this change in terminology. The definition of “adverse determination” in Subsection A has been revised, however, to be consistent with the DOL final rule’s definition for the term “adverse benefit determination.” The definition of “adverse determination” has been revised to include rescission of coverage determinations, as provided in the interim final rules on internal claims and appeals and external review processes, published in the *Federal Register*, July 23, 2010.

- B. “Ambulatory review” means utilization review of health care services performed or provided in an outpatient setting.
- C. “Authorized representative” means:
 - (1) A person to whom a covered person has given express written consent to represent the covered person for purposes of this Act;
 - (2) A person authorized by law to provide substituted consent for a covered person;
 - (3) A family member of the covered person or the covered person’s treating health care professional when the covered person is unable to provide consent;
 - (4) A health care professional when the covered person’s health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional; or
 - (5) In the case of an urgent care request, a health care professional with knowledge of the covered person’s medical condition.
- D. “Case management” means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.
- E. “Certification” means a determination by a health carrier or its designee utilization review organization that a request for a benefit under the health carrier’s health benefit plan has been reviewed and, based on the information provided, satisfies the health carrier’s requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.
- F. “Clinical peer” means a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

Drafting Note: States may wish to define “clinical peer” more broadly to include a health care professional who has demonstrable expertise to review a case, whether or not the reviewing professional is in the same or similar specialty as the health care professional who made the initial decision.

- G. “Clinical review criteria” means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health carrier to determine the medical necessity and appropriateness of health care services.
- H. “Commissioner” means the commissioner of insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term “commissioner” appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

- I. “Concurrent review” means utilization review conducted during a patient’s stay or course of treatment in a facility, the office of a health care professional or other inpatient or outpatient health care setting.

Drafting Note: The DOL final rule, which was unchanged by the interim final rules on internal claims and appeals and external review processes published in the *Federal Register*, July 23, 2010, uses the term “concurrent claim” instead of “concurrent review.” The DOL final rule does not define “concurrent claim.” However, given the use of the term in the substantive provisions of the DOL final rule and the way the term is used substantively in this model, the definition of “concurrent review,” as defined in Subsection I, is consistent with the term “concurrent claim.”

- J. “Covered benefits” or “benefits” means those health care services to which a covered person is entitled under the terms of a health benefit plan.
- K. “Covered person” means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.
- L. “Discharge planning” means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.
- M. “Emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

Drafting Note: The definition of “emergency medical condition” has been revised to reflect the definition of that term in the interim final rules on emergency services published in the *Federal Register* June 28, 2010.

- N. “Emergency services” means, with respect to an emergency medical condition:
 - (1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
 - (2) Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at a hospital, to stabilize a patient.

Drafting Note: The definition of “emergency services” has been revised to reflect the definition of that term in the interim final rules on emergency services published in the *Federal Register* June 28, 2010.

- O. “Facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.
- P. (1) “Health benefit plan” means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

Drafting Note: The Patient Protection and Affordable Care Act (Affordable Care Act) uses the term “health insurance coverage.” “Health benefit plan,” as defined in this model act, is intended to be consistent with the definition of “health insurance coverage” contained in HIPAA. Paragraphs (2), (3), (4), and (5) below track the language of HIPAA that addresses “excepted benefits,” i.e., those benefits that are excepted from the requirements of the Affordable Care Act.

- (2) “Health benefit plan” includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.
- (3) “Health benefit plan” does not include:
 - (a) Coverage only for accident, or disability income insurance, or any combination thereof;
 - (b) Coverage issued as a supplement to liability insurance;
 - (c) Liability insurance, including general liability insurance and automobile liability insurance;
 - (d) Workers’ compensation or similar insurance;
 - (e) Automobile medical payment insurance;

- (f) Credit-only insurance;
 - (g) Coverage for on-site medical clinics; and
 - (h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.
- (4) “Health benefit plan” does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
- (a) Limited scope dental or vision benefits;
 - (b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
 - (c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.
- (5) “Health benefit plan” does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
- (a) Coverage only for a specified disease or illness; or
 - (b) Hospital indemnity or other fixed indemnity insurance.
- (6) “Health benefit plan” does not include the following if offered as a separate policy, certificate or contract of insurance:
- (a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
 - (b) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
 - (c) Similar supplemental coverage provided to coverage under a group health plan.

Q. “Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

Drafting Note: States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not “corporate persons.”

R. “Health care provider” or “provider” means a health care professional or a facility.

S. “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

T. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

Drafting Note: The Affordable Care Act uses the term “health insurance issuer” instead of “health carrier.” The definition of “health carrier” is consistent with the term “health insurance issuer.”

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

- U. “Managed care plan” means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.
- V. “Network” means the group of participating providers providing services to a managed care plan.
- W. “Participating provider” means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.
- X. “Person” means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.
- Y. “Prospective review” means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a health carrier’s requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

Drafting Note: The DOL final rule, which was unchanged by the interim final rules on internal claims and appeals and external review processes published in the *Federal Register*, July 23, 2010, uses the term “pre-service claim” instead of “prospective review.” The DOL final rule defines a “pre-service claim” as “any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.” The definition of “prospective review,” as defined in Subsection Y, has been amended to be consistent with the intent of the definition of “pre-service claim” because both require prior approval of the benefit prior to its provision. The DOL final rule does not state what process the claimant must complete to obtain the approval, but, given the definition of “adverse benefit determination” in the DOL final rule, it is reasonable to conclude that performing utilization review would be an acceptable means to determine whether the provision of a health care service will be approved.

- Z. (1) “Rescission” means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect.
- (2) “Rescission” does not include a cancellation or discontinuance of coverage under a health benefit plan if:
 - (a) The cancellation or discontinuance of coverage has only a prospective effect; or
 - (b) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Drafting Note: The definition of “rescission” is derived from the interim final regulations on rescissions published in the *Federal Register* June 28, 2010.

- AA. (1) “Retrospective review” means any review of a request for a benefit that is not a prospective review request.
- (2) “Retrospective review” does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

Drafting Note: The DOL final rule uses the term “post-service claim” instead of “retrospective review.” The DOL final rule defines a “post-service claim” as “any claim for a benefit under a group health plan that is not a pre-service claim,” as that term is defined under the DOL final rule. To reflect this broad definition of “post-service claim,” the definition of “retrospective review,” in Subsection AA, has been revised to be consistent with the definition of “post-service claim.”

- BB. “Second opinion” means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the medical necessity and appropriateness of the initial proposed health care service.

- CC. “Stabilized” means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, with respect to a pregnant woman, the woman has delivered, including the placenta.

Drafting Note: The definition of “stabilized” is derived from the interim final regulations on rescissions published in the *Federal Register* June 28, 2010.

- DD. (1) “Urgent care request” means a request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination:
- (a) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or
 - (b) In the opinion of an attending health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.
- (2) (a) Except as provided in Subparagraph (b) of this paragraph, in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
- (b) Any request that an attending health care professional with knowledge of the covered person's medical condition determines is an urgent care request within the meaning of Paragraph (1) shall be treated as an urgent care request.
- EE. “Utilization review” means a set of formal techniques designed to monitor the use of, or evaluate the medical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.
- FF. “Utilization review organization” means an entity that conducts utilization review, other than a health carrier performing utilization review for its own health benefit plans.

Section 4. Applicability and Scope

This Act shall apply to a health carrier offering a health benefit plan that provides or performs utilization review services. The requirements of this Act also shall apply to any designee of the health carrier or utilization review organization that performs utilization review functions on the carrier's behalf. This Act also shall apply to a health carrier or its designee utilization review organization that provides or performs prospective review or retrospective review benefit determinations.

Drafting Note: The DOL final rule expands the scope and application of this model to include initial benefit determinations based on whether a covered person is eligible to participate in the health carrier's health benefit plan, as well as any other determination that results in a denial, reduction or termination of, or a failure to provide payment, in whole or in part, for a benefit. To be consistent with the DOL final rule, this section was revised to include these types of determinations as well as utilization review determinations that involve medical necessity. The definition of “adverse determination” in Section 3A has been revised to reflect the DOL final rule's definition of “adverse benefit determination.” That term has also been revised to reflect the inclusion of rescission of coverage determinations, as provided in the interim final rules on internal claims and appeals and external review processes published in the *Federal Register*, July 23, 2010. Any denial, reduction, termination of or failure to provide or make payment, in whole or in part, based on a determination of the covered person's eligibility to participate in the health carrier's health benefit plan and any other determination that results in a denial, reduction or termination of, or a failure to provide payment, in whole or in part, for a benefit will be an adverse determination under this Act and, consequently, eligible for an appeal under the NAIC Health Carrier Grievance Procedure Model Act. Rescission of coverage determinations are also eligible for an appeal under the NAIC Health Carrier Grievance Procedure Model Act.

Drafting Note: The provisions of this Act are consistent with the provisions in the interim final regulations on internal claims and appeals and external review processes, as published in the *Federal Register* July 23, 2010 and, as those regulations were amended by the interim final regulations published in the *Federal Register* June 24, 2011. However, states should be aware that the Affordable Care Act's preemption standards permit States to impose more stringent, consumer protection requirements.

Drafting Note: States that regulate utilization review organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the appropriate commissioner instead of, or in addition to, the insurance commissioner

Drafting Note: States may wish to consider accreditation by a nationally recognized private accrediting entity, with established and maintained standards, as evidence of meeting some or all of this Act's requirements. Under such an approach, the accrediting entity will make available to the state its current standards to demonstrate that the entity's standards meet or exceed the state's requirements. The private accrediting entity shall file or provide the state with documentation that a health carrier has been accredited by the entity. A health carrier accredited by the private accrediting entity would then be deemed to have met the requirements of the relevant sections of this Act where comparable standards exist. States should periodically review a health carrier's private accreditation and eligibility for deemed compliance.

Drafting Note: States that have defined and regulated limited benefit plans should compare their regulatory structure with the requirements of this Act and may want to exempt limited benefit plans from certain requirements that duplicate the existing structure or that are not appropriate for limited benefit plans because their services are less comprehensive. States that have not defined or regulated limited benefit plans may want to adopt a definition similar to the one above and decide which of the requirements of this Act are feasible and appropriate for these plans. Exemptions from the requirements of this Act should only be granted where the limited benefit plan does not perform the activity to which the requirement applies or where the technology necessary to comply does not exist for limited benefit plans. Exemptions should not be granted merely because compliance with the requirement would be expensive or inconvenient for the limited benefit plan.

States also may wish to consider whether Medicare supplement, long-term care of disability income insurance, coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical payment insurance is appropriate for inclusion in this Act.

Section 5. Corporate oversight of Utilization Review Program

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

Section 6. Contracting

Whenever a health carrier contracts to have a utilization review organization or other entity perform the utilization review functions required by this Act or applicable regulations, the commissioner shall hold the health carrier responsible for monitoring the activities of the utilization review organization or entity with which the health carrier contracts and for ensuring that the requirements of this Act and applicable regulations are met.

Section 7. Scope and Content of Utilization Review Program

- A. (1) A health carrier that requires a request for benefits under the covered person's health benefit plan to be subjected to utilization review shall implement a written utilization review program that describes all review activities and procedures, both delegated and non-delegated for:
 - (a) The filing of benefit requests;
 - (b) The notification of utilization review and benefit determinations; and
 - (c) The review of adverse determinations in accordance with [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act].
- (2) The program document shall describe the following:
 - (a) Procedures to evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services;
 - (b) Data sources and clinical review criteria used in decision-making;
 - (c) Mechanisms to ensure consistent application of clinical review criteria and compatible decisions;
 - (d) Data collection processes and analytical methods used in assessing utilization of health care services;
 - (e) Provisions for assuring confidentiality of clinical and proprietary information;
 - (f) The organizational structure (e.g. utilization review committee, quality assurance or other committee) that periodically assesses utilization review activities and reports to the health carrier's governing body; and

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

Section 8. Operational Requirements

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

Drafting Note: Each state should identify the agencies authorized to request a health carrier's clinical review criteria.

- B. Qualified health care professionals shall administer the utilization review program and oversee utilization review decisions. A clinical peer shall evaluate the clinical appropriateness of adverse determinations.
- C. (1) A health carrier shall issue utilization review and benefit determinations in a timely manner pursuant to the requirements of Sections 9 and 10 of this Act.
- (2) (a) Whenever a health carrier fails to adhere to the requirements of section 9 or section 10 of this Act with respect to making utilization review and benefit determinations of a benefit request or claim, the covered person shall be deemed to have exhausted the provisions of this Act and may take action under subparagraph (b) of this paragraph.
- (b) (i) A covered person may file a request for external review in accordance with the procedures outlined in [insert reference in state law equivalent to the Uniform Health Carrier External Review Model Act].
- (ii) In addition to item (i), a covered person is entitled to pursue any available remedies under State or federal law on the basis that the health carrier failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.
- (3) (a) Notwithstanding paragraph (2), the provisions of section 9 or section 10 of this Act shall not be deemed exhausted based on a *de minimus* violation that does not cause, and is not likely to cause, prejudice or harm to the covered person as long as the health carrier demonstrates that the violation was for good cause or due to matters beyond the control of the health carrier and that the violation occurred in the context of an ongoing, good faith exchange of information between the health carrier and the covered person or, if applicable, the covered person's authorized representative.
- (b) The exception provided in subparagraph (a) of this paragraph does not apply if the violation is part of a pattern or practice of violations by the health carrier.
- (c) (i) A covered person may request a written explanation of the violation from the health carrier.
- (ii) The health carrier shall:
- (I) Provide the written explanation within ten (10) days of receiving the request; and
- (II) Include in the written explanation a specific description of its bases, if any, for asserting that the violation does not deem the provisions of this Act to be exhausted.

- (d) (i) If an independent reviewer or a court of competent jurisdiction rejects the benefit request or claim for immediate review on the basis that the health carrier met the requirements of the exception provided in subparagraph (a) of this paragraph, the covered person has the right to resubmit and, as appropriate, pursue a review of the benefit request or claim under this Act or file a grievance pursuant to [insert reference in state law equivalent to the Health Carrier Grievance Procedure Model Act].
 - (ii) In this case, within a reasonable time, after the independent reviewer or the court rejects the benefit request or claim for immediate review, but not exceeding ten (10) days, the health carrier shall provide to the covered person or, if applicable, the covered person's authorized representative notice of the opportunity to resubmit and, as appropriate, pursue a review of the benefit request or claim under this Act or file a grievance pursuant to [insert reference in state law equivalent to the Health Carrier Grievance Procedure Model Act].
 - (iii) For purposes of calculating the time period for re-filing the benefit request or claim under this subparagraph, the time period shall begin to run upon the covered person's or, if applicable, the covered person's authorized representative's receipt of the notice of opportunity to resubmit.
- D. A health carrier shall have a process to ensure that utilization reviewers apply clinical review criteria in conducting utilization review consistently.
- E. A health carrier shall routinely assess the effectiveness and efficiency of its utilization review program.
- F. A health carrier's data systems shall be sufficient to support utilization review program activities and to generate management reports to enable the health carrier to monitor and manage health care services effectively.
- G. If a health carrier delegates any utilization review activities to a utilization review organization, the health carrier shall maintain adequate oversight, which shall include:
 - (1) A written description of the utilization review organization's activities and responsibilities, including reporting requirements;
 - (2) Evidence of formal approval of the utilization review organization program by the health carrier; and
 - (3) A process by which the health carrier evaluates the performance of the utilization review organization.
- H. The health carrier shall coordinate the utilization review program with other medical management activity conducted by the carrier, such as quality assurance, credentialing, provider contracting, data reporting, grievance procedures, processes for assessing member satisfaction and risk management.
- I. A health carrier shall provide covered persons and participating providers with access to its review staff by a toll-free number or collect call telephone line.
- J. When conducting utilization review, the health carrier shall collect only the information necessary, including pertinent clinical information, to make the utilization review or benefit determination
- K. (1) In conducting utilization review, the health carrier shall ensure that the review is conducted in a manner to ensure the independence and impartiality of the individuals involved in making the utilization review or benefit determination.

- (2) In ensuring the independence and impartiality of individuals involved in making the utilization review or benefit determination, the health carrier shall not make decisions regarding hiring, compensation, termination, promotion or other similar matters based upon the likelihood that the individual will support the denial of benefits.

Section 9. Procedures for Standard Utilization Review and Benefit Determinations

- A. A health carrier shall maintain written procedures pursuant to this section for making standard utilization review and benefit determinations on requests submitted to the health carrier by covered persons or their authorized representatives for benefits and for notifying covered persons and their authorized representatives of its determinations with respect to these requests within the specified time frames required under this section.
- B. (1) (a) (i) Subject to Subparagraph (b) of this paragraph, for prospective review determinations, a health carrier shall make the determination and notify the covered person or, if applicable, the covered person's authorized representative of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than fifteen (15) days after the date the health carrier receives the request.
- (ii) Whenever the determination is an adverse determination, the health carrier shall make the notification of the adverse determination in accordance with Subsection F.
- (b) The time period for making a determination and notifying the covered person or, if applicable, the covered person's authorized representative of the determination pursuant to Subparagraph (a) of this paragraph may be extended one time by the health carrier for up to fifteen (15) days, provided the health carrier:
- (i) Determines that an extension is necessary due to matters beyond the health carrier's control; and
- (ii) Notifies the covered person or, if applicable, the covered person's authorized representative, prior to the expiration of the initial fifteen-day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.
- (c) If the extension under Subparagraph (b) of this paragraph is necessary due to the failure of the covered person or the covered person's authorized representative to submit information necessary to reach a determination on the request, the notice of extension shall:
- (i) Specifically describe the required information necessary to complete the request; and
- (ii) Give the covered person or, if applicable, the covered person's authorized representative at least forty-five (45) days from the date of receipt of the notice to provide the specified information.
- (2) (a) Whenever the health carrier receives a prospective review request from a covered person or the covered person's authorized representative that fails to meet the health carrier's filing procedures, the health carrier shall notify the covered person or, if applicable, the covered person's authorized representative of this failure and provide in the notice information on the proper procedures to be followed for filing a request.
- (b) (i) The notice required under Subparagraph (a) of this paragraph shall be provided, as soon as possible, but in no event later than five (5) days following the date of the failure.

- (ii) The health carrier may provide the notice orally or, if requested by the covered person or the covered person's authorized representative, in writing.
 - (c) The provisions of this paragraph shall apply only in the case of a failure that:
 - (i) Is a communication by a covered person or the covered person's authorized representative that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and
 - (ii) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which certification is being requested.
- C.
 - (1) For concurrent review determinations, if a health carrier has certified an ongoing course of treatment to be provided over a period of time or number of treatments:
 - (a) Any reduction or termination by the health carrier during the course of treatment before the end of the period or number treatments, other than by health benefit plan amendment or termination of the health benefit plan, shall constitute an adverse determination; and
 - (b) The health carrier shall notify the covered person of the adverse determination in accordance with Subsection F at a time sufficiently in advance of the reduction or termination to allow the covered person or, if applicable, the covered person's authorized representative to file a grievance to request a review of the adverse determination pursuant to [insert reference in state law equivalent to the Health Carrier Grievance Procedure Model Act] and obtain a determination with respect to that review of the adverse determination before the benefit is reduced or terminated.
 - (2) The health care service or treatment that is the subject of the adverse determination shall be continued without liability to the covered person with respect to the internal review request made pursuant to [insert reference in state law equivalent to the Health Carrier Grievance Procedure Model Act].

Drafting Note: Paragraph (2) requires health carriers to continue the health care service or treatment that is the subject of the adverse determination without liability to the covered person until the covered person has been notified of the determination made with respect to the appeal of the adverse determination involving a concurrent review request. The DOL final rule does not include such a requirement. However, based on the preemption standards of ERISA and the DOL final rule, states may impose more stringent requirements. Therefore, the NAIC has chosen to retain the provisions of Paragraph (2).

- D.
 - (1)
 - (a) For retrospective review determinations, a health carrier shall make the determination within a reasonable period of time, but in no event later than thirty (30) days after the date of receiving the benefit request.
 - (b) If the determination is an adverse determination, the health carrier shall provide notice of the adverse determination to the covered person or, if applicable, the covered person's authorized representative in accordance with Subsection F.
 - (2)
 - (a) The time period for making a determination and notifying the covered person or, if applicable, the covered person's authorized representative of the determination pursuant to Paragraph (1) may be extended one time by the health carrier for up to fifteen (15) days, provided the health carrier:
 - (i) Determines that an extension is necessary due to matters beyond the health carrier's control; and
 - (ii) Notifies the covered person or, if applicable, the covered person's authorized representative, prior to the expiration of the initial thirty-day time period, of the circumstances requiring the extension of time and the date by which the health carrier expects to make a determination.

- (b) If the extension under Subparagraph (a) of this paragraph is necessary due to the failure of the covered person or, if applicable, the covered person's authorized representative to submit information necessary to reach a determination on the request, the notice of extension shall:
 - (i) Specifically describe the required information necessary to complete the request; and
 - (ii) Give the covered person or, if applicable, the covered person's authorized representative at least forty-five (45) days from the date of receipt of the notice to provide the specified information.
- E. (1) For purposes of calculating the time periods within which a determination is required to be made under Subsections B and D, the time period within which the determination is required to be made shall begin on the date the request is received by the health carrier in accordance with the health carrier's procedures established pursuant to Section 7 of this Act for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.
- (2) (a) If the time period for making the determination under Subsection B or D is extended due to the covered person's or, if applicable, the covered person's authorized representative's failure to submit the information necessary to make the determination, the time period for making the determination shall be tolled from the date on which the health carrier sends the notification of the extension to the covered person or, if applicable, the covered person's authorized representative until the earlier of:
 - (i) The date on which the covered person or, if applicable, the covered person's authorized representative responds to the request for additional information; or
 - (ii) The date on which the specified information was to have been submitted.
- (b) If the covered person or the covered person's authorized representative fails to submit the information before the end of the period of the extension, as specified in Subsection B or D, the health carrier may deny the certification of the requested benefit.

Drafting Note: The DOL final rule does not specifically state what actions a group health plan may take if the claimant or the claimant's authorized representative fails to submit the information requested before the end of the period of the extension. However, the provisions of Subsection E(2)(b), which would permit the health carrier to deny certification of the requested benefit if the covered person or the covered person's authorized representative does not submit the requested information within the specified time frame, are consistent with provisions of the DOL final rule. Therefore, the NAIC has chosen to retain the provisions of Subsection E(2)(b).

- F. (1) A notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:
 - (a) Information sufficient to identify the benefit request or claim involved, including the date of service, if applicable, the health care provider and the claim amount, if applicable;
 - (b) A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. For purposes of this subparagraph, a health carrier: (i) shall provide to the covered person or, if applicable, the covered person's authorized representative, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse determination; and (ii) shall not consider a request for the diagnosis code and treatment information, in itself, to be a request to file a grievance for review of an adverse determination pursuant to [insert reference in state law equivalent to the Health Carrier Grievance Procedure Model Act], or a request for external review;

- (c) The specific reasons or reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier’s standard, if any, that was used in denying the benefit request or claim;
- (d) Reference to the specific plan provisions on which the determination is based;
- (e) A description of any additional material or information necessary for the covered person to perfect the benefit request, including an explanation of why the material or information is necessary to perfect the request;
- (f) A description of the health carrier’s grievance procedures established pursuant to [insert reference in state law equivalent to the Health Carrier Grievance Procedure Model Act], including any time limits applicable to those procedures;
- (g) If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;
- (h) If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person’s medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;
- (i) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as provided in Subparagraph (g) of this paragraph; or
- (j) The written statement of the scientific or clinical rationale for the adverse determination, as provided in Subparagraph (h) of this paragraph; and
- (k) A statement explaining the availability of and the right of the covered person, as appropriate, to contact the commissioner’s office or ombudsman’s office at any time for assistance or, upon completion of the health carrier’s grievance procedure process as provided under [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act], to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the commissioner’s office or ombudsman’s office.

Drafting Note: States may need to revise subparagraph (k) above to reflect whatever office or offices established in their state pursuant to section 2793 of PHSa to provide assistance to individuals with internal claims and appeals and external review processes.

- (2) (a) A health carrier shall provide the notice required under this section in a culturally and linguistically appropriate manner in accordance with federal regulations.
- (b) To be considered to meet the requirements of subparagraph (a) of this paragraph, the health carrier shall:
 - (i) Provide oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests and claims and appeals in any applicable non-English language;
 - (ii) Provide, upon request, a notice in any applicable non-English language; and

- (iii) Include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the carrier.
- (c) For purposes of this paragraph, with respect to any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten (10) percent or more of the population residing in the county is literate only in the same non-English language, as determined in published federal guidance.
- (3) If the adverse determination is a rescission, the health carrier shall provide in the advance notice of the rescission determination required to be provided under [insert reference to provision in State law or regulation related to the advance notice requirement of a proposed rescission], in addition to any applicable disclosures required under paragraph (1):
 - (a) Clear identification of the alleged fraudulent act, practice or omission or the intentional misrepresentation of material fact;
 - (b) An explanation as to why the act, practice or omission was fraudulent or was an intentional misrepresentation of a material fact;
 - (c) Notice that the covered person or the covered person's authorized representative, prior to the date the advance notice of the proposed rescission ends, may immediately file a grievance to request a review of the adverse determination to rescind coverage pursuant to [insert reference to State law equivalent to the Health Carrier Grievance Procedure Model Act];
 - (d) A description of the health carrier's grievance procedures established pursuant to [insert reference in State law to the Health Carrier Grievance Procedure Model Act], including any time limits applicable to those procedures; and
 - (e) The date when the advance notice ends and the date back to which the coverage will be retroactively rescinded.
- (4) A health carrier may provide the notice required under this section in writing or electronically.

Drafting Note: Section 2719 of the PHSA of the Patient Protection and Affordable Care Act, and the interim final regulations implementing that section, as published in the *Federal Register* July 23, 2010, establish the NAIC's Uniform Health Carrier External Review Model Act as the minimum standard for state external review processes. Because the Uniform Health Carrier External Review Model Act references the procedures and timeframes in this Act and the NAIC's Health Carrier Grievance Procedure Model Act, states are strongly encouraged to adopt both this Act and the NAIC's Health Carrier Grievance Procedure Model Act. The Health Carrier Grievance Procedure Model Act sets out a process, including timeframes, for covered persons to file a grievance requesting a review of an adverse determination made by a health carrier under this Act.

Section 10. Procedures for Expedited Utilization Review and Benefit Determinations

- A.
 - (1) A health carrier shall establish written procedures in accordance with this section for receiving benefit requests from covered persons or their authorized representatives and for making and notifying covered persons or their authorized representatives of expedited utilization review and benefit determinations with respect to urgent care requests and concurrent review urgent care requests.
 - (2)
 - (a) As part of the procedures required under Paragraph (1), a health carrier shall provide that, in the case of a failure by a covered person or the covered person's authorized representative to follow the health carrier's procedures for filing an urgent care request, the covered person or the covered person's authorized representative shall be notified of the failure and the proper procedures to be following for filing the request.

- (b) The notice required under Subparagraph (a) of this paragraph:
 - (i) Shall be provided to the covered person or the covered person's authorized representative, as appropriate, as soon as possible, but not later than twenty-four (24) hours after receipt of the request; and
 - (ii) May be oral, unless the covered person or the covered person's authorized representative requests the notice in writing.
 - (c) The provisions of this paragraph apply only in the case of a failure that:
 - (i) Is a communication by a covered person or, if applicable, the covered person's authorized representative that is received by a person or organizational unit of the health carrier responsible for handling benefit matters; and
 - (ii) Is a communication that refers to a specific covered person, a specific medical condition or symptom, and a specific health care service, treatment or provider for which approval is being requested.
- B.
- (1) (a) For an urgent care request, unless the covered person or the covered person's authorized representative has failed to provide sufficient information for the health carrier to determine whether, or to what extent, the benefits requested are covered benefits or payable under the health carrier's health benefit plan, the health carrier shall notify the covered person or, if applicable, the covered person's authorized representative of the health carrier's determination with respect to the request, whether or not the determination is an adverse determination, as soon as possible, taking into account the medical condition of the covered person, but in no event later than seventy-two (72) hours after the receipt of the request by the health carrier.
 - (b) If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with Subsection E.
 - (2) (a) If the covered person or, if applicable, the covered person's authorized representative has failed to provide sufficient information for the health carrier to make a determination, the health carrier shall notify the covered person or, if applicable, the covered person's authorized representative either orally or, if requested by the covered person or the covered person's authorized representative, in writing of this failure and state what specific information is needed as soon as possible, but in no event later than twenty-four (24) hours after receipt of the request.
 - (b) The health carrier shall provide the covered person or, if applicable, the covered person's authorized representative a reasonable period of time to submit the necessary information, taking into account the circumstances, but in no event less than forty-eight (48) hours after notifying the covered person or the covered person's authorized representative of the failure to submit sufficient information, as provided in Subparagraph (a) of this paragraph.
 - (c) The health carrier shall notify the covered person or, if applicable, the covered person's authorized representative of its determination with respect to the urgent care request as soon as possible, but in no event more than forty-eight (48) hours after the earlier of:
 - (i) The health carrier's receipt of the requested specified information; or
 - (ii) The end of the period provided for the covered person or, if applicable, the covered person's authorized representative to submit the requested specified information.

- (d) If the covered person or the covered person's authorized representative fails to submit the information before the end of the period of the extension, as specified in Subparagraph (b) of this paragraph, the health carrier may deny the certification of the requested benefit.

Drafting Note: The DOL final rule does not specifically state what actions a group health plan may take if the claimant or the claimant's authorized representative fails to submit the information requested by the plan before the end of the period of the extension. However, the provisions of Subsection B(2)(d), which would permit a health carrier to deny certification of the requested benefit if the covered person or the covered person's authorized representative does not submit the requested information within the specified time frame, are consistent with the provisions of the DOL final rule. Therefore, the NAIC has chosen to retain the provisions of Subsection B(2)(d).

- (e) If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with Subsection E.
- C.
- (1) For concurrent review urgent care requests involving a request by the covered person or the covered person's authorized representative to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, the health carrier shall make a determination with respect to the request and notify the covered person or, if applicable, the covered person's authorized representative of the determination, whether it is an adverse determination or not, as soon as possible, taking into account the covered person's medical condition, but in no event more than twenty-four (24) hours after the health carrier's receipt of the request.
 - (2) If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with Subsection E.
- D.
- For purposes of calculating the time periods within which a determination is required to be made under Subsection B or C, the time period within which the determination is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established pursuant to Section 7 of this Act for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.
- E.
- (1) A notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:
 - (a) Information sufficient to identify the benefit request or claim involved, including the date of service, if applicable, the health care provider and the claim amount, if applicable;
 - (b) A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. For purposes of this subparagraph, a health carrier: (i) shall provide to the covered person or, if applicable, the covered person's authorized representative, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse determination; and (ii) shall not consider a request for the diagnosis code and treatment information, in itself, to be a request to file a grievance for review of an adverse determination pursuant to [insert reference in state law equivalent to the Health Carrier Grievance Procedure Model Act], or a request for external review;
 - (c) The specific reasons or reasons for the adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in denying the benefit request or claim;
 - (d) Reference to the specific plan provisions on which the determination is based;
 - (e) A description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;

- (f) A description of the health carrier’s internal review procedures established pursuant to [insert reference in state law equivalent to the Health Carrier Grievance Procedure Model Act], including any time limits applicable to those procedures;
- (g) A description of the health carrier’s expedited review procedures established pursuant to [insert reference in state law equivalent to Section 10 of the Health Carrier Grievance Procedure Model Act].
- (h) If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;
- (i) If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person’s medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;
- (j) If applicable, instructions for requesting:
 - (i) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination in accordance with Subparagraph (h) of this paragraph; or
 - (ii) The written statement of the scientific or clinical rationale for the adverse determination in accordance with Subparagraph (i) of this paragraph; and
- (k) A statement explaining the availability of and the right of the covered person, as appropriate, to contact the commissioner’s office or ombudsman’s office at any time for assistance or, upon completion of the health carrier’s grievance procedure process as provided under [insert reference to state law equivalent to the Health Carrier Grievance Procedure Model Act], to file a civil suit in a court of competent jurisdiction. The statement shall include contact information for the commissioner’s office or ombudsman’s office.

Drafting Note: States may need to revise subparagraph (k) above to reflect whatever office or offices established in their state pursuant to section 2793 of PHSa to provide assistance to individuals with internal claims and appeals and external review processes.

- (2) (a) A health carrier shall provide the notice required under this section in a culturally and linguistically appropriate manner in accordance with federal regulations.
- (b) To be considered to meet the requirements of subparagraph (a) of this paragraph, the health carrier shall:
 - (i) Provide oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests and claims and appeals in any applicable non-English language;
 - (ii) Provide, upon request, a notice in any applicable non-English language; and
 - (iii) Include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the carrier.

- (c) For purposes of this paragraph, with respect to any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten (10) percent or more of the population residing in the county is literate only in the same non-English language, as determined in published federal guidance.
- (3) If the adverse determination is a rescission, the health carrier shall provide, in addition to any applicable disclosures required under paragraph (1):
- (a) Clear identification of the alleged fraudulent act, practice or omission or the intentional misrepresentation of material fact;
 - (b) An explanation as to why the act, practice or omission was fraudulent or was an intentional misrepresentation of a material fact;
 - (c) The date the health carrier made the decision to rescind the coverage; and
 - (d) The date when the advance notice of the health carrier's decision to rescind the coverage ends.
- (4) (a) A health carrier may provide the notice required under this section orally, in writing or electronically.
- (b) If notice of the adverse determination is provided orally, the health carrier shall provide written or electronic notice of the adverse determination within three (3) days following the oral notification.

Drafting Note: Section 2719 of the PHS Act of the Patient Protection and Affordable Care Act, and the interim final regulations implementing that section, as published in the *Federal Register* July 23, 2010, establish the NAIC's Uniform Health Carrier External Review Model Act as the minimum standard for state external review processes. Because the Uniform Health Carrier External Review Model Act references the procedures and timeframes in this Act and the NAIC's Health Carrier Grievance Procedure Model Act, states are strongly encouraged to adopt both this Act and the NAIC's Health Carrier Grievance Procedure Model Act. The Health Carrier Grievance Procedure Model Act sets out a process, including timeframes, for covered persons to file a grievance requesting a review of an adverse determination made by a health carrier under this Act.

Section 11. Emergency Services

- A. When conducting utilization review or making a benefit determination for emergency services, a health carrier that provides benefits for services in an emergency department of a hospital shall follow the provisions of this section.
 - B. A health carrier shall cover emergency services to screen and stabilize a covered person in the following manner:
 - (1) Without the need for prior authorization of such services if a prudent layperson would have reasonably believed that an emergency medical condition existed even if the emergency services are provided on an out-of-network basis;
 - (2) Shall cover emergency services whether the health care provider furnishing the services is a participating provider with respect to such services;
 - (3) If the emergency services are provided out-of-network, without imposing any administrative requirement or limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from network providers;
 - (4) If the emergency services are provided out-of-network, by complying with the cost-sharing requirements of subsection C(2); and
- (5) Without regard to any other term or condition of coverage, other than:
- (a) The exclusion of or coordination of benefits;

- (b) An affiliation or waiting period as permitted under section 2704 of the Public Health Service Act (PHSA); or
 - (c) Applicable cost-sharing, as provided in subsection C(1) or subsection C(2).
- C. (1) For in-network emergency services, coverage of emergency services shall be subject to applicable copayments, coinsurance and deductibles.
- (2) (a) For out-of-network emergency services, any cost-sharing requirement expressed as a copayment amount or coinsurance rate imposed with respect to a covered person cannot exceed the cost-sharing requirement imposed with respect to a covered person if the services were provided in-network.
 - (b) Notwithstanding subparagraph (a) of this paragraph, a covered person may be required to pay, in addition to the in-network cost-sharing, the excess of the amount the out-of-network provider charges over the amount the health carrier is required to pay under this subparagraph.

Drafting Note: The provisions of subparagraph (b) above would permit an out-of-network provider to balance bill the covered person for the excess of the amount the provider charged over the amount the health carrier paid, as provided in the interim final regulations on emergency services published in the *Federal Register* June 28, 2010. States should be aware that some states do not permit this practice under certain circumstances and may continue to prohibit such a practice based on the Affordable Care Act’s preemption standards, which permit states to impose more stringent requirements to protect consumers.

- (c) A health carrier complies with the requirements of this paragraph if it provides payment of emergency services provided by an out-of-network provider in an amount not less than the greatest of the following:
 - (i) The amount negotiated with in-network providers for emergency services, excluding any in-network copayment or coinsurance imposed with respect to the covered person;
 - (ii) The amount of the emergency service calculated using the same method the plan uses to determine payments for out-of-network services, but using the in-network cost-sharing provisions instead of the out-of-network cost-sharing provisions; or
 - (iii) The amount that would be paid under Medicare for the emergency services, excluding any in-network copayment or coinsurance requirements.
 - (d) (i) For capitated or other health benefit plans that do not have a negotiated per-service amount for in-network providers, subparagraph (c)(i) of this paragraph does not apply.
 - (ii) If a health benefit plan has more than one negotiated amount for in-network providers for a particular emergency service, the amount in subparagraph (c)(i) of this paragraph is the median of these negotiated amounts.
- (3) (a) Any cost-sharing requirement other than a copayment or coinsurance requirement, such as a deductible or out-of-pocket maximum, may be imposed with respect to emergency services provided out-of-network if the cost-sharing requirement generally applies to out-of-network benefits.
- (b) A deductible may be imposed with respect to out-of-network emergency services only as part of a deductible that generally applies to out-of-network benefits.
 - (c) If an out-of-pocket maximum generally applies to out-of-network benefits, that out-of-network maximum must apply to out-of-network emergency services.
- D. For immediately required post-evaluation or post-stabilization services, a health carrier shall provide access to designated representative twenty-four (24) hours a day, seven (7) days a week, to facilitate review.

Section 12. Confidentiality Requirements

A health carrier shall annually certify in writing to the commissioner that the utilization review program of the health carrier or its designee complies with all applicable state and federal law establishing confidentiality and reporting requirements.

Drafting Note: The NAIC's Health Information Privacy Model Act establishes more detailed standards.

Section 13. Disclosure Requirements

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

Section 14. Regulations

The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rule making and review of regulations].

Section 15. Penalties

A violation of this Act shall [insert appropriate administrative penalty from state law].

Section 16. Separability

If any provisions of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 17. Effective Date

This Act shall be effective [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1996 Proc. 2nd Quarter 10, 30, 732, 770, 802-809 (adopted).
2002 Proc. 4th Quarter 281, 333-347 (amended and reprinted, adopted by task force).
2003 Proc. 1st Quarter 174-175 (adopted by parent committee).
2003 Proc. 2nd Quarter 12, 16 (adopted by Plenary).
2010 Proc. 3rd Quarter, Vol. I, 115, 119, 130, 242, 606, 740-953 (amended).
2012 Proc. 1st Quarter, Vol. I, 98-99, 113-116, 276, 285-344 (amended).