

REFERENCE TITLE: health insurance; policies; rating areas

State of Arizona
House of Representatives
Fifty-first Legislature
First Regular Session
2013

HB 2550

Introduced by
Representative Carter

AN ACT

AMENDING TITLE 20, CHAPTER 2, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-238; AMENDING TITLE 20, CHAPTER 13, ARTICLE 1, ARIZONA REVISED STATUTES, BY ADDING SECTION 20-2333; AMENDING SECTION 20-2537, ARIZONA REVISED STATUTES; RELATING TO HEALTH INSURANCE; PROVIDING FOR CONDITIONAL REPEAL.

(TEXT OF BILL BEGINS ON NEXT PAGE)

1 Be it enacted by the Legislature of the State of Arizona:

2 Section 1. Title 20, chapter 2, article 1, Arizona Revised Statutes,
3 is amended by adding section 20-238, to read:

4 20-238. Health insurance; state regulation; rating areas;
5 definitions

6 A. THE DIRECTOR, THROUGH THE ADOPTION OF RULES OR OTHER REGULATORY AND
7 ADMINISTRATIVE ACTIONS WITHIN THE DIRECTOR'S AUTHORITY, SHALL ENSURE THAT
8 THIS STATE RETAINS ITS FULL AUTHORITY TO REGULATE POLICIES, CERTIFICATES,
9 EVIDENCES OF COVERAGE AND CONTRACTS THAT ARE ISSUED OR DELIVERED BY HEALTH
10 INSURERS CONSIDERING THE ENACTMENT OF THE ACT.

11 B. NOTWITHSTANDING ANY OTHER PROVISION OF THIS TITLE, A HEALTH INSURER
12 SUBJECT TO THE ACT SHALL NOT ISSUE A CONTRACT, POLICY, CERTIFICATE OR
13 EVIDENCE OF COVERAGE OR OTHERWISE TRANSACT INSURANCE IF THE COVERAGE AND
14 BENEFITS PROVIDED IN THE CONTRACT, POLICY, CERTIFICATE OR EVIDENCE OF
15 COVERAGE ARE INCONSISTENT WITH THE APPLICABLE PROVISIONS OF THE ACT.

16 C. EXCEPT FOR COVERAGE UNDER INDIVIDUAL AND SMALL GROUP POLICIES,
17 CERTIFICATES, EVIDENCES OF COVERAGE AND CONTRACTS THAT ARE GRANDFATHERED AS
18 PRESCRIBED BY 42 UNITED STATES CODE SECTION 18011, THE FOLLOWING RATING AREAS
19 ARE ESTABLISHED AND SHALL BE USED BY ALL HEALTH INSURERS ISSUING INDIVIDUAL
20 AND SMALL GROUP POLICIES, CERTIFICATES, EVIDENCES OF COVERAGE OR CONTRACTS IN
21 THIS STATE:

- 22 1. MOHAVE, COCONINO, APACHE AND NAVAJO COUNTIES.
- 23 2. YAVAPAI COUNTY.
- 24 3. LA PAZ AND YUMA COUNTIES.
- 25 4. MARICOPA COUNTY.
- 26 5. PINAL AND GILA COUNTIES.
- 27 6. PIMA AND SANTA CRUZ COUNTIES.
- 28 7. GRAHAM, GREENLEE AND COCHISE COUNTIES.

29 D. FOR THE PURPOSES OF THIS SECTION:

30 1. "ACT" MEANS THE PATIENT PROTECTION AND AFFORDABLE CARE ACT
31 (P.L. 111-148) AS AMENDED BY THE HEALTH CARE AND EDUCATION RECONCILIATION ACT
32 (P.L. 111-152) OR ANY RULES ADOPTED PURSUANT TO THOSE ACTS.

33 2. "HEALTH INSURER" MEANS A DISABILITY INSURER, GROUP DISABILITY
34 INSURER, BLANKET DISABILITY INSURER, HEALTH CARE SERVICES ORGANIZATION,
35 HOSPITAL SERVICE CORPORATION, MEDICAL SERVICE CORPORATION, DENTAL SERVICE
36 CORPORATION, PREPAID DENTAL PLAN ORGANIZATION OR HOSPITAL, MEDICAL, DENTAL
37 AND OPTOMETRIC SERVICE CORPORATION.

38 3. "RATING AREA" MEANS AN AREA WITHIN WHICH A HEALTH INSURER SHALL NOT
39 VARY RATES BASED ON GEOGRAPHY.

40 Sec. 2. Title 20, chapter 13, article 1, Arizona Revised Statutes, is
41 amended by adding section 20-2333, to read:

42 20-2333. Accountable health plans; premium rates; exemption

43 FOR HEALTH BENEFITS PLANS ISSUED ON OR AFTER JANUARY 1, 2014, IF AN
44 ACCOUNTABLE HEALTH PLAN IS SUBJECT TO AND IN COMPLIANCE WITH SECTION 2701 OF
45 THE PUBLIC HEALTH SERVICE ACT AND ANY RULES ADOPTED PURSUANT TO THAT SECTION,
46 THE ACCOUNTABLE HEALTH PLAN IS DEEMED TO COMPLY WITH THE PROVISIONS OF

1 SECTION 20-2311 THAT ARE CONSISTENT WITH SECTION 2701 OF THE PUBLIC HEALTH
2 SERVICE ACT AND THE RULES ADOPTED PURSUANT TO THAT SECTION.

3 Sec. 3. Section 20-2537, Arizona Revised Statutes, is amended to read:
4 20-2537. External independent review; expedited external
5 independent review

6 A. If the utilization review agent denies the member's request for a
7 covered service or claim for a covered service at both the informal
8 reconsideration level and the formal appeal level, or at the expedited
9 medical review level, the member may initiate an external independent review.

10 B. Except as provided in subsection K of this section, within ~~thirty~~
11 **ONE HUNDRED TWENTY** days after the member receives written notice by the
12 utilization review agent of the adverse decision made pursuant to section
13 20-2534 or 20-2536, if the member decides to initiate an external independent
14 review, the member shall mail to the utilization review agent a written
15 request for an external independent review, including any material
16 justification or documentation to support the member's request for the
17 covered service or claim for a covered service.

18 C. Except as provided in subsection K of this section, within five
19 business days after the utilization review agent receives a request for an
20 external independent review from the member pursuant to subsection B of this
21 section or the director pursuant to subsection G of this section, or if the
22 utilization review agent initiates an external independent review pursuant to
23 section 20-2536, subsection F, the utilization review agent shall:

24 1. Mail a written acknowledgment to the director, the member, the
25 member's treating provider and the health care insurer.

26 2. Forward to the director the request for review, the terms of
27 agreement in the member's policy, evidence of coverage or a similar document
28 and all medical records and supporting documentation used to render the
29 decision pertaining to the member's case, a summary description of the
30 applicable issues including a statement of the utilization review agent's
31 decision, the criteria used and the clinical reasons for that decision, the
32 relevant portions of the utilization review agent's utilization review plan
33 and the name and credentials of the licensed health care provider who
34 reviewed the case as required by section 20-2533, subsection G.

35 D. Except as provided in subsection K of this section, within five
36 days after the director receives all of the information prescribed in
37 subsection C, paragraph 2 of this section and if the case involves an issue
38 of medical necessity under the coverage document, the director shall choose
39 an independent review organization procured pursuant to section 20-2538 and
40 forward to the organization all of the information required by subsection C,
41 paragraph 2 of this section.

42 E. Except as provided in subsection K of this section, for cases
43 involving an issue of medical necessity under the coverage document, within
44 twenty-one days after the date of receiving a case for independent review
45 from the director, the independent review organization shall evaluate and
46 analyze the case and, based on all information required under subsection C,

1 paragraph 2 of this section, render a decision that is consistent with the
2 utilization review plan on whether or not the service or claim for the
3 service is medically necessary and send the decision to the director. Within
4 five business days after receiving a notice of decision from the independent
5 review organization, the director shall mail a notice of the decision to the
6 utilization review agent, the health care insurer, the member and the
7 member's treating provider. The decision by the independent review
8 organization is a final administrative decision pursuant to title 41, chapter
9 6, article 10 and is subject to judicial review pursuant to title 12, chapter
10 7, article 6. The health care insurer shall provide any service or pay any
11 claim determined to be covered and medically necessary by the independent
12 review organization for the case under review regardless of whether judicial
13 review is sought.

14 F. Except as provided in subsection K of this section, for cases
15 involving an issue of coverage, within fifteen business days after receipt of
16 all of the information prescribed in subsection C, paragraph 2 of this
17 section from the utilization review agent, the director shall determine if
18 the service or claim is or is not covered and if the adverse decision made
19 pursuant to section 20-2536 conforms to the utilization review agent's
20 utilization review plan and this article and shall mail a notice of
21 determination to the utilization review agent, the health care insurer, the
22 member and the member's treating provider.

23 G. If the director finds that the case involves a medical issue or is
24 unable to determine issues of coverage, the director shall submit the
25 member's case to the external independent review organization in accordance
26 with subsections E and K of this section.

27 H. After a decision is made pursuant to subsection E, F, G or K of
28 this section, the reconsideration, appeal and administrative processes are
29 completed and the department's role is ended, except:

30 1. To transmit, when necessary, a record of the proceedings to
31 superior court or to the office of administrative hearings.

32 2. To issue a final administrative decision pursuant to section
33 41-1092.08.

34 I. Except as provided in subsection K of this section, on written
35 request by the independent review organization, the member or the utilization
36 review agent, the director may extend the twenty-one day time period
37 prescribed in subsection E of this section for up to an additional thirty
38 days if the requesting party demonstrates good cause for an extension.

39 J. A decision made by the director or an independent review
40 organization pursuant to this section is admissible in proceedings involving
41 a health care insurer or utilization review agent.

42 K. If the utilization review agent denies the member's request for a
43 covered service or claim for a covered service at the expedited medical
44 review level presented and resolved pursuant to section 20-2534, subsections
45 A and E, the member may initiate an expedited external independent review in
46 accordance with the following:

1 1. Within five business days after the member receives written notice
2 by the utilization review agent of the adverse decision made pursuant to
3 section 20-2534, if the member decides to initiate an external independent
4 review, the member shall mail to the utilization review agent a written
5 request for an expedited external independent review, including any material
6 justification or documentation to support the member's request for the
7 covered service or claim for a covered service.

8 2. Within one business day after the utilization review agent receives
9 a request for an **EXPEDITED** external independent review from the member
10 pursuant to this subsection or if the utilization review agent initiates an
11 **EXPEDITED** external independent review pursuant to section 20-2534, subsection
12 D, the utilization review agent shall:

13 (a) Mail a written acknowledgment to the director, the member, the
14 member's treating provider and the health care insurer.

15 (b) Forward to the director the request for an expedited independent
16 external review, the terms of agreement in the member's policy, evidence of
17 coverage or a similar document and all medical records and supporting
18 documentation used to render the decision pertaining to the member's case, a
19 summary description of the applicable issues including a statement of the
20 utilization review agent's decision, the criteria used and the clinical
21 reasons for that decision, the relevant portions of the utilization review
22 agent's utilization review plan and the name and credentials of the licensed
23 health care provider who reviewed the case as required by section 20-2534,
24 subsection B.

25 3. Within two business days after the director receives all of the
26 information prescribed in this subsection and if the case involves an issue
27 of medical necessity, the director shall choose an independent review
28 organization procured pursuant to section 20-2538 and forward to the
29 organization all of the information required by this subsection.

30 4. For cases involving an issue of medical necessity, within ~~five~~
31 ~~business days~~ **SEVENTY-TWO HOURS** from the date of receiving a case for
32 expedited external independent review from the director, the independent
33 review organization shall evaluate and analyze the case and, based on all
34 information required under subsection C, paragraph 2 of this section, render
35 a decision that is consistent with the utilization review plan on whether or
36 not the service or claim for the service is medically necessary and send the
37 decision to the director. Within one business day after receiving a notice
38 of decision from the independent review organization, the director shall mail
39 a notice of the decision to the utilization review agent, the health care
40 insurer, the member and the member's treating provider. The decision by the
41 independent review organization is a final administrative decision pursuant
42 to title 41, chapter 6, article 10 and, except as provided in section
43 41-1092.08, subsection H, is subject to judicial review pursuant to title 12,
44 chapter 7, article 6. The health care insurer shall provide any service or
45 pay any claim determined to be covered and medically necessary by the

1 independent review organization for the case under review regardless of
2 whether judicial review is sought.

3 5. For cases involving an issue of coverage, within two business days
4 after receipt of all of the information prescribed in subsection C of this
5 section from the utilization review agent, the director shall determine if
6 the service or claim is or is not covered and if the adverse decision made
7 pursuant to section 20-2534 conforms to the utilization review agent's
8 utilization review plan and this article and shall mail a notice of
9 determination to the utilization review agent, the health care insurer, the
10 member and the member's treating provider.

11 L. Notwithstanding title 41, chapter 6, article 10 and section 12-908,
12 if a party to a decision issued under this section seeks further
13 administrative review, the department shall not be a party to the action
14 unless the department files a motion to intervene in the action.

15 M. The independent review organization, the director or the office of
16 administrative hearings may not order the health care insurer to provide a
17 service or to pay a claim for a benefit or service that is excluded from
18 coverage by the contract.

19 N. The health care insurer shall provide any service or pay any claim
20 determined in a final administrative decision to be covered and medically
21 necessary for the case under review regardless of whether judicial review is
22 sought. Any proceedings before the office of administrative ~~proceedings~~
23 ~~HEARINGS~~ that involve an expedited external independent review and that are
24 subject to subsection K of this section shall be promptly instituted and
25 completed.

26 Sec. 4. Rule making; exemption

27 The director of the department of insurance is exempt from the rule
28 making requirements of title 41, chapter 6, Arizona Revised Statutes, for
29 three years after the effective date of this act for the purposes of adopting
30 rules pursuant to section 20-238, Arizona Revised Statutes, as added by this
31 act, except that the department shall provide public notice and an
32 opportunity for public comment on proposed rules at least thirty days before
33 a rule is adopted or amended.

34 Sec. 5. Conditional repeal; notice

35 A. Sections 20-238 and 20-2333, Arizona Revised Statutes, as added by
36 this act, and section 20-2537, Arizona Revised Statutes, as amended by this
37 act, are repealed as of the date title 1 of the patient protection and
38 affordable care act (P.L. 111-148), as amended by the health care and
39 education reconciliation act (P.L. 111-152) is declared unconstitutional by
40 the United State supreme court or is repealed by the United States Congress.
41 Any rules adopted pursuant to section 20-238, Arizona Revised Statutes, as
42 added by this act, become ineffective and unenforceable on that date.

43 B. The director of the department of insurance shall notify in writing
44 the director of the Arizona legislative council of this date.