REFERENCE TITLE: health care insurance; amendments.

State of Arizona
Senate
Fifty-fifth Legislature
First Regular Session
2021

SB 1075

Introduced by
Senator Livingston

AN ACT

REPEALING SECTIONS 20-110 AND 20-111, ARIZONA REVISED STATUTES; AMENDING SECTIONS 20-118, 20-464 AND 20-821, ARIZONA REVISED STATUTES; REPEALING SECTION 20-827, ARIZONA REVISED STATUTES; AMENDING SECTIONS 20-832, 20-1061, 20-1074, 20-2301 AND 20-2311, ARIZONA REVISED STATUTES; REPEALING SECTIONS 20-2318 AND 20-2320, ARIZONA REVISED STATUTES; AMENDING SECTIONS 20-2502, 20-2531 AND 20-2532, ARIZONA REVISED STATUTES; RELATING TO HEALTH CARE INSURANCE.

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

Section 1. Repeal

Sections 20-110 and 20-111, Arizona Revised Statutes, are repealed.

Sec. 2. Section 20-118, Arizona Revised Statutes, is amended to read:

20-118. Prohibition; definitions

A. A person subject to this title shall not restrict or prohibit, by means of a policy or contract, whether written or otherwise, a licensed health care professional's good faith communication with the health care professional's patient concerning the patient's health care or medical needs, treatment options, health care risks or benefits.

B. A person subject to this title shall not terminate a contract with or refuse to renew a contract with a health care professional solely because the health care professional in good faith does any of the following:

1. Advocates in private or in public on behalf of a patient.

2. Assists a patient in seeking reconsideration of a decision made by the person to deny coverage for a health care service.

3. Reports a violation of law to an appropriate authority.

C. For the purposes of this section:

1. "Contract" means a written contract under which a licensed health care professional agrees to provide specified health care services to covered persons. Contract does not include a contract of salaried employment.

2. "Health care professional" has the same meaning prescribed in section 20-3151.

3. "PERSON" INCLUDES A SERVICE CORPORATION SUBJECT TO CHAPTER 4, ARTICLE 3 OF THIS TITLE AND A HEALTH CARE SERVICES ORGANIZATION SUBJECT TO CHAPTER 4, ARTICLE 9 OF THIS TITLE.

Sec. 3. Section 20-464, Arizona Revised Statutes, is amended to read:

20-464. Prohibiting payment for services to persons other than the assignee

A. If an insured assigns to a covered health care provider performing services covered by the contract payment for benefits under a disability insurance contract, a group disability insurance contract or a blanket disability INSURANCE contract, the contract does not prohibit assignments and the assignment is delivered to the insurer, payment may be made only to the health care provider to whom payment has been assigned.

B. NOTWITHSTANDING CHAPTER 4, ARTICLE 3 OF THIS TITLE, THIS SECTION APPLIES TO A HOSPITAL AND MEDICAL SERVICE CORPORATION.

Sec. 4. Section 20-821, Arizona Revised Statutes, is amended to read:

20-821. Scope of article; rules; authority of director

A. Hospital service corporations, medical service corporations, dental service corporations, optometric service corporations and hospital,

medical, dental and optometric service corporations incorporated in this state are governed by this article and are exempt from all other provisions of this title, except as expressly provided by this article and any rule adopted by the director pursuant to section 20-143 relating to contracts of such service corporations. No insurance law enacted after January 1, 1955 applies to such corporations unless the law specifically refers to corporations.

B. Chapter 2, ~~article~~ ARTICLES 8 AND 12 of this title, sections 20-223, 20-234, 20-261, 20-261.01, 20-261.02, 20-261.03, 20-261.04, 20-1133, 20-1377, 20-1408, 20-1692, 20-1692.01, 20-1692.02 and 20-1692.03 and chapters 15, 17 and 20 of this title and any rules adopted to implement these provisions apply to all corporations governed by this article.

C. Chapter 21 of this title applies to a hospital service corporation, a medical service corporation or a hospital and medical service corporation.

Sec. 5. Repeal

Section 20-827, Arizona Revised Statutes, is repealed.

Sec. 6. Section 20-832, Arizona Revised Statutes, is amended to read:

20-832. Limitation on salaries

A corporation shall not:

1. Pay to any officer~~, agent or employee~~ of the corporation any salary, compensation or emolument amounting in any year to more than ~~five thousand dollars~~ $5,000, unless the board of directors of the corporation~~,~~ first authorizes the salary, compensation or emolument.

2. Make any agreement with any officer~~, agent or employee~~ whereby the corporation agrees that for any services rendered or to be rendered the officer~~, agent or employee~~ will receive a salary, compensation or emolument for a period of more than three years from the date of the agreement.

3. Pay any bonus, commission or dividend to any director of the corporation.

Sec. 7. Section 20-1061, Arizona Revised Statutes, is amended to read:

20-1061. Prohibited practices; definition

A. Chapter 2, article 6 of this title relating to unfair trade practices and frauds applies to health care services organizations, except to the extent the director determines that the nature of health care services organizations renders particular provisions inappropriate.

~~B. A person subject to this article shall not:~~

~~1. Restrict or prohibit, by means of a policy or contract, whether written or otherwise, a licensed health care professional's good faith communication with the health care professional's patient concerning the patient's health care or medical needs, treatment options, health care risks or benefits.~~

~~2. Terminate a contract with or refuse to renew a contract with a health care professional solely because the professional in good faith does any of the following:~~

~~(a) Advocates in private or in public on behalf of a patient.~~

~~(b) Assists a patient in seeking reconsideration of a decision made by the person to deny coverage for a health care service.~~

~~(c) Reports a violation of law to an appropriate authority.~~

~~C.~~ B. A contract between the health care services organization and a health care professional shall not contain a financial incentive plan that includes a specific payment made to or withheld from the health care professional as an inducement to deny, reduce, limit or delay medically necessary care that is covered by the evidence of coverage with an enrollee or group of enrollees for a specific disease or condition. This section does not prohibit per diem or per case payments, diagnostic related grouping payments~~,~~ or financial incentive plans, including capitation payments or shared risk arrangements, that are not connected to specific medical decisions relating to an enrollee or a group of enrollees for a specific disease or condition. Each health care services organization shall file with its annual report a written statement with the director that certifies that the health care services organization is in compliance with this subsection.

~~D.~~ C. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization.

~~E.~~ D. For the purposes of this section, "health care professional" has the same meaning prescribed in section 20-3151.

Sec. 8. Section 20-1074, Arizona Revised Statutes, is amended to read:

20-1074. Contract termination; duty to report; provision for continued services during insolvency; definitions

A. ~~Each month~~ A health care services organization shall submit QUARTERLY to the director a list of all ~~written~~ provider contracts that have been terminated during the prior ~~month~~ THREE MONTHS. The list shall be in writing and shall include the name and address of each provider whose contract has been terminated but shall not include the reasons for termination.

B. A health care services organization shall include in its contracts with providers a statement that requires the provider to provide services to enrollees at the same rates and subject to the same terms and conditions established in the contract for the duration of the period after the health care services organization is declared insolvent, until the earliest of the following:

1. A determination by the court that the organization cannot provide adequate assurance it will be able to pay contract providers' claims for covered services that were rendered after the health care services organization is declared insolvent.

2. A determination by the court that the insolvent organization is unable to pay contract providers' claims for covered services that were rendered after the health care services organization is declared insolvent.

3. A determination by the court that continuation of the contract would constitute undue hardship to the provider.

4. A determination by the court that the health care services organization has satisfied its obligations to all enrollees under its health care plans.

C. Unless preempted under federal law or unless federal law imposes greater requirements than this section, this section applies to a provider sponsored health care services organization.

D. For the purposes of this section:

1. "Court" has the same meaning prescribed in section 20-611.

2. "Delinquency proceeding" has the same meaning prescribed in section 20-611.

Sec. 9. Section 20-2301, Arizona Revised Statutes, is amended to read:

20-2301. Definitions; late enrollee coverage

A. In this chapter, unless the context otherwise requires:

1. "Accountable health plan" means an entity that offers, issues or otherwise provides a health benefits plan and THAT is approved by the director as an accountable health plan pursuant to section 20-2303.

2. "Affiliation period" means a period of two months, or three months for late enrollees, that under the terms of the health benefits plan offered by a health care services organization must expire before the health benefits plan becomes effective and in which the health care services organization is not required to provide health care services or benefits and cannot charge the participant or beneficiary a premium for any coverage during the period.

3. "Base premium rate" means, for each rating period, the lowest premium rate that could have been charged under a rating system by the accountable health plan to small employers for health benefits plans involving the same or similar coverage, family size and composition, and geographic area.

~~4. "Basic health benefit plan" means a plan that is developed by a committee established by the legislature and that is adopted by the director.~~

~~5.~~ 4. "Bona fide association" means, for a health benefits plan issued by an accountable health plan, an association that meets the requirements of section 20-2324.

~~6.~~ 5. "COBRA continuation provision" means:

(a) Section 4980B, except subsection (f)(1) as it relates to pediatric vaccines, of the internal revenue code of 1986.

(b) Title I, subtitle B, part 6, except section 609, of the employee retirement income security act of 1974 (P.L. 93-406; 88 Stat. 829; 29 United States Code sections 1001 through 1461).

(c) Title XXII of the public health service act.

(d) ~~Any~~ SECTION 20-2330 OR A similar provision of the law of this state or any other state.

~~7.~~ 6. "Creditable coverage" means coverage solely for an individual, other than limited benefits coverage, under any of the following:

(a) An employee welfare benefit plan that provides medical care to employees or the employees' dependents directly or through insurance or reimbursement or otherwise pursuant to the employee retirement income security act of 1974.

(b) A church plan as defined in the employee retirement income security act of 1974.

(c) A health benefits plan issued by an accountable health plan as defined in this section.

(d) Part A or part B of title XVIII of the social security act.

(e) Title XIX of the social security act, other than coverage consisting solely of benefits under section 1928.

(f) Title 10, chapter 55 of the United States Code.

(g) A medical care program of the Indian health service or of a tribal organization.

(h) A health benefits risk pool operated by any state of the United States.

(i) A health plan offered pursuant to title 5, chapter 89 of the United States Code.

(j) A public health plan as defined by federal law.

(k) A health benefit plan pursuant to section 5(e) of the peace corps act (P.L. 87-293; 75 Stat. 612; 22 United States Code sections 2501 through 2523).

(l) A policy or contract, including short-term limited duration insurance, issued on an individual basis by an insurer, a health care services organization, a hospital service corporation, a medical service corporation or a hospital, medical, dental and optometric service corporation ~~or made available to persons defined as eligible under section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e)~~.

(m) A policy or contract issued by a health care insurer or an accountable health plan to a member of a bona fide association.

~~8.~~ 7. "Demographic characteristics" means objective factors an insurer considers in determining premium rates. Demographic characteristics do not include health status-related factors, industry or duration of coverage since issue.

~~9.~~ 8. "Different policy forms" means variations between policy forms offered by a health care insurer, including policy forms that have different cost sharing arrangements or different riders.

~~10.~~ 9. "Genetic information" means information about genes, gene products and inherited characteristics that may derive from the individual or a family member, including information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analyses of genes or chromosomes.

~~11.~~ 10. "Health benefits plan" means a hospital and medical service corporation policy or certificate, a health care services organization contract, a group disability policy, a certificate of insurance of a group disability policy that is not issued in this state, a multiple employer welfare arrangement or any other arrangement under which health services or health benefits are provided to two or more individuals. Health benefits plan does not include the following:

(a) Accident only, dental only, vision only, disability income only or long-term care only insurance, fixed or hospital indemnity coverage, limited benefit coverage, specified disease coverage, credit coverage or Taft-Hartley trusts.

(b) Coverage that is issued as a supplement to liability insurance.

(c) Medicare supplemental insurance.

(d) Workers' compensation insurance.

(e) Automobile medical payment insurance.

~~12.~~ 11. "Health status-related factor" means any factor in relation to the health of the individual or a dependent of the individual enrolled or to be enrolled in an accountable health plan, including:

(a) Health status.

(b) Medical condition, including physical and mental illness.

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

(g) Evidence of insurability, including conditions arising out of acts of domestic violence as defined in section 20-448.

(h) The existence of a physical or mental disability.

~~13.~~ 12. "Higher level of coverage" means a health benefits plan offered by an accountable health plan for which the actuarial value of the benefits under the coverage is at least fifteen ~~per cent~~ PERCENT more than the actuarial value of the health benefits plan offered by the accountable health plan as a lower level of coverage in this state but not more than one hundred twenty ~~per cent~~ PERCENT of a policy form weighted average.

~~14.~~ 13. "Index rate" means, as to a rating period, the arithmetic average of the applicable base premium rate and the highest premium rate that could have been charged under a rating system by the accountable health plan to small employers for a health benefits plan involving the same or similar coverage, family size and composition, and geographic area.

~~15.~~ 14. "Late enrollee" means an employee or dependent who requests enrollment in a health benefits plan after the initial enrollment period that is provided under the terms of the health benefits plan if the initial enrollment period is at least thirty-one days. An employee or dependent shall not be considered a late enrollee if:

(a) The person:

(i) At the time of the initial enrollment period was covered under a public or private health insurance policy or any other health benefits plan.

(ii) Lost coverage under a public or private health insurance policy or any other health benefits plan due to the employee's termination of employment or eligibility, the reduction in the number of hours of employment, the termination of the other plan's coverage, the death of the spouse, legal separation or divorce or the termination of employer contributions toward the coverage.

(iii) Requests enrollment within thirty-one days after the termination of creditable coverage that is provided under a public or private health insurance or other health benefits plan.

(iv) Requests enrollment within thirty-one days after the date of marriage.

(b) The person is employed by an employer that offers multiple health benefits plans and the person elects a different plan during an open enrollment period.

(c) A court orders that coverage be provided for a spouse or minor child under a covered employee's health benefits plan and the person requests enrollment within thirty-one days after the court order is issued.

(d) The person becomes a dependent of a covered person through marriage, birth, adoption or placement for adoption and requests enrollment no later than thirty-one days after becoming a dependent.

~~16.~~ 15. "Lower level of coverage" means a health benefits plan offered by an accountable health plan for which the actuarial value of the benefits under the health benefits plan is at least eighty-five ~~per cent~~ PERCENT but not more than one hundred ~~per cent~~ PERCENT of the policy form weighted average.

~~17.~~ 16. "Network plan" means a health benefits plan provided by an accountable health plan under which the financing and delivery of health benefits are provided, in whole or in part, through a defined set of providers under contract with the accountable health plan in accordance with the determination made by the director pursuant to section 20-1053 regarding the geographic or service area in which an accountable health plan may operate.

~~18.~~ 17. "Policy form weighted average" means the average actuarial value of the benefits provided by all health benefits plans issued by either the accountable health plan or, if the data are available, by all

accountable health plans in the group market in this state during the previous calendar year, weighted by the enrollment for all coverage forms.

~~19.~~ 18. "Preexisting condition" means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within not more than six months before the date of the enrollment of the individual under a health benefits plan issued by an accountable health plan. A genetic condition is not a preexisting condition in the absence of a diagnosis of the condition related to the genetic information and shall not result in a preexisting condition limitation or preexisting condition exclusion.

~~20.~~ 19. "Preexisting condition limitation" or "preexisting condition exclusion" means a limitation or exclusion of benefits for a preexisting condition under a health benefits plan offered by an accountable health plan.

~~21.~~ 20. "Small employer" means an employer who employs at least two but not more than fifty eligible employees on a typical business day during any one calendar year. ~~As used in~~ FOR THE PURPOSES OF this paragraph, "employee" ~~shall include~~ INCLUDES the employees of the employer and the individual proprietor or self-employed person if the employer is an individual proprietor or self-employed person.

~~22.~~ 21. "Taft-Hartley trust" means a jointly-managed trust, as allowed by 29 United States Code sections 141 through 187, that contains a plan of benefits for employees and that is negotiated in a collective bargaining agreement governing the wages, hours and working conditions of the employees, as allowed by 29 United States Code section 157.

~~23.~~ 22. "Waiting period" means the period that must pass before a potential participant or beneficiary in a health benefits plan offered by an accountable health plan is eligible to be covered for benefits as determined by the individual's employer.

B. Coverage for a late enrollee begins on the date the person becomes a dependent if a request for enrollment is received within thirty-one days after the person becomes a dependent.

Sec. 10. Section 20-2311, Arizona Revised Statutes, is amended to read:

20-2311. Premium rates and rating practices

A. The premium rate that an accountable health plan charges during a rating period for a health benefits plan issued to a small employer shall not vary by more than sixty ~~per cent~~ PERCENT from the index rate for health benefits plans involving the same or similar coverage, family size and composition, and geographic area.

B. In establishing premium rates for health benefits plans offered to small employers:

1. An accountable health plan making adjustments with respect to demographic characteristics shall apply those adjustments consistently across all small employers.

2. An accountable health plan may not use a geographic area that is smaller than a county or smaller than an area that includes all areas in which the first three digits of the zip code are identical, whichever is smaller.

C. The percentage increase in the premium rate that is charged to a small employer for a new rating period may not exceed the sum of the following:

1. The percentage change in the base premium rate.

2. Fifteen percentage points.

3. Any adjustment due to a change in coverage, family size or composition, geographic area or demographic characteristics.

D. At the time an accountable health plan offers a health benefits plan to a small employer, the accountable health plan shall fully disclose to the employer all of the following:

1. Rating practices for small employer health benefits plans, including rating practices for different populations and benefit designs.

2. The extent to which premium rates for the small employer are established or adjusted based on the actual or expected variation in claims costs or health condition of the employees of the small employer and their dependents.

3. The accountable health plan's right to change premium rates, the extent to which premiums can be modified and the factors that affect changes in premium rates.

E. Each accountable health plan shall file annually with the director a written statement by a member of the American academy of actuaries or another individual acceptable to the director certifying that based on an examination by the individual, including a review of the appropriate records and of the actuarial assumptions of the accountable health plan and methods used by the accountable health plan in establishing base premium rates, index rates and premium rates for small employer health benefits plans:

1. The accountable health plan is in compliance with the applicable provisions of this article.

2. The rating methods are actuarially sound.

F. Each accountable health plan shall retain a copy of the statement required by subsection E for examination at its principal place of business.

G. Each accountable health plan shall annually file with the director for informational purposes the accountable health plan's base premium rates and index rates. On request, the director shall make the base premium rates or the index rates available to the public for inspection.

H. THIS SECTION DOES NOT APPLY IF A SMALL EMPLOYER OBTAINS A HEALTH BENEFITS PLAN THAT IS SUBJECT TO AND COMPLIES WITH 42 UNITED STATES CODE SECTION 300gg.

Sec. 11. Repeal

Sections 20-2318 and 20-2320, Arizona Revised Statutes, are repealed.

Sec. 12. Section 20-2502, Arizona Revised Statutes, is amended to read:

20-2502. Utilization review activities; exemptions

A. A utilization review agent shall not conduct utilization review in this state unless the utilization review agent meets or is exempt from ~~the provisions of~~ this article.

B. A person is exempt from ~~the provisions of this article~~ SECTIONS 20-2504, 20-2505, 20-2506, 20-2507 AND 20-2508 AND SECTION 20-2509, SUBSECTION A if the person:

1. Is accredited by the utilization review accreditation commission, the national committee for quality assurance or any other nationally recognized accreditation process recognized by the director.

2. Conducts internal utilization review for hospitals, home health agencies, clinics, private offices or other health facilities or entities if the review does not result in the approval or denial of payment for hospital or medical services.

3. Conducts utilization review activities exclusively for work related injuries and illnesses covered under the workers' compensation laws in title 23.

4. Conducts utilization review activities exclusively for a self-funded or self-insured employee benefit plan if the regulation of that plan is preempted by section 514(b) of the employee retirement income security act of 1974~~,~~ (29 United States Code section 1144(b)).

C. A utilization review agent shall conduct utilization review in accordance with the agent's utilization review plan that is on file with the department pursuant to section 20-2505 and in accordance with section 20-2532.

Sec. 13. Section 20-2531, Arizona Revised Statutes, is amended to read:

20-2531. Applicability; requirements; exception

A. Notwithstanding article 1 of this chapter and subject to subsection B of this section, this article applies to all utilization review decisions made by utilization review agents and health care insurers operating in this state.

B. Each utilization review agent and each health care insurer operating in this state whose utilization review system includes the power to affect the direct or indirect denial of requested medical or health care services or claims for medical or health care services shall adopt written utilization review standards and criteria and processes for the review, reconsideration and appeal of denials that do all of the following:

1. Meet the requirements of this article.

2. Are consistent with chapter 1 of this title.

3. Comply with section 20-2505, paragraphs 2 through 6.

C. This article does not apply to utilization review:

1. Performed under contract with the federal government for utilization review of patients eligible for all services under title XVIII of the social security act.

2. Performed by a self-insured or self-funded employee benefit plan or a multiemployer employee benefit plan created in accordance with and pursuant to 29 United States Code section 186(c) if the regulation of that plan is preempted by section 514(b) of the employee retirement income security act of 1974 (29 United States Code section 1144(b)), but this article does apply to a health care insurer that provides coverage for services as part of an employee benefit plan.

3. Of work related injuries and illnesses covered under the workers' compensation laws in title 23.

4. Performed under the terms of a policy that pays benefits based on the health status of the insured and does not reimburse the cost of or provide covered services.

5. Performed under the terms of a long-term care insurance policy as defined in section 20-1691.

6. Performed under the terms of a medicare supplement policy as defined by the department.

D. This article does not create any new private right or cause of action for or on behalf of any member. This article provides only an administrative process for a member to pursue an external independent review of a denial for a covered service or claim for a covered service.

E. Utilization review activities involving retrospective claims review ~~shall be~~ ARE limited to the provisions of this article only as clearly and specifically provided in the provisions of this article.

F. THE PROCESSES AVAILABLE UNDER THIS ARTICLE DO NOT APPLY TO A DENIAL OF A FORMULARY EXCEPTION REQUEST THAT WAS APPEALED PURSUANT TO 45 CODE OF FEDERAL REGULATIONS SECTION 156.122(c). A PROVIDER OR ENROLLEE MAY APPEAL A DENIAL OF A FORMULARY EXCEPTION FOR A PLAN COVERED BY 45 CODE OF FEDERAL REGULATIONS SECTION 156.122(c) THROUGH THE PROCESS PRESCRIBED IN THE FEDERAL RULE.

Sec. 14. Section 20-2532, Arizona Revised Statutes, is amended to read:

20-2532. Utilization review standards and criteria; requirements

A. Each utilization review agent shall:

1. Adopt a written utilization review plan with standards and criteria that apply to all utilization review decisions and that are objective, clinically valid and compatible with established principles of health care.

2. Establish the utilization review plan with input from physician advisors who represent major medical specialties and who are certified or

board eligible under the standards of the appropriate American medical specialty board.

3. Include in the adopted utilization review plan a process for prompt initial reconsideration of an adverse decision and a process for appeals that meet the requirements of this article. This paragraph does not apply to utilization review activities limited to retrospective claims review.

B. Deviations from the written standards and criteria in the utilization review plan are ~~permitted~~ ALLOWED if the utilization review agent determines that the member and other members with similar symptoms and diagnoses would materially benefit from new treatments available because of medical or technological advances made since the adoption of the utilization review plan and made in accordance with accepted medical standards. This subsection does not apply to utilization review activities limited to retrospective claims review. Nothing in this subsection creates a private right or cause of action against a health care insurer or utilization review agent for failure to deviate from the utilization review plan.

C. A health care insurer who ~~utilizes~~ USES the services of an outside utilization review agent shall adopt a utilization review plan pursuant to subsections A and B of this section. The utilization review plan adopted and filed by the health care insurer who ~~utilizes~~ USES the services of an outside utilization review agent is deemed adopted by that utilization review agent.

D. A health care insurer who ~~utilizes~~ USES the services of an outside utilization review agent is responsible for the utilization review agent's acts that are within the scope of the written and filed utilization review plan, including the administration of all patient claims processed by the utilization review agent on behalf of the health care insurer.

E. ~~Notwithstanding section 20-2502, subsection B,~~ Each utilization review agent shall file a notice with the director that provides a specific description and the published date of the source of the written standards and criteria of the utilization review plan and that certifies that the utilization review plan in use complies with the requirements of this section, is available for review and inspection at a designated location in this state or at an office accessible to authorized representatives of the director in another state and is the complete utilization review plan with all standards and criteria on which utilization review decisions are based. A copy of any portion of the utilization review plan on which any adverse decisions have been based shall be made before the effective date of any modification and the utilization review agent shall retain a copy at the designated location for review and inspection for a period of five years after the date of the modification. If at any time a complete change in the written standards

and criteria occurs, the utilization review agent shall file a new certification notice with the director.

F. On or before March 1 of each year after the year in which the utilization review agent filed the notice prescribed in subsection E of this section, the utilization review agent or the agent's successor shall submit a signed and notarized annual report to the director that includes the designated location for review and inspection by the director or the director's authorized representative and that certifies that:

1. The utilization review plan and all modifications remain in compliance with the requirements of this section.

2. The utilization review agent will conduct all utilization reviews in accordance with the plan.

3. All adverse decisions made in the prior year were based on the plan in effect on the date of those decisions.

G. On written request, the utilization review agent shall provide copies to any member or the member's treating provider of:

1. Those portions of the utilization review agent's utilization review plan that are relevant to the request for a covered service or claim for a covered service.

2. The protocols or guidelines that were used if the standards and criteria adopted are based on protocols or guidelines developed by an American medical specialty board.

H. Any person who requests records pursuant to subsection G of this section shall direct the request to the utilization review agent and not to the department.

I. If the utilization review plan is copyrighted by a person other than the utilization review agent, the health care insurer shall make a good faith effort to obtain permission from that person to make copies of the relevant material. If the health care insurer is unable to secure copyright permission, the utilization review agent shall provide a detailed summary of the relevant portions of the utilization review plan.

J. Health care insurers having utilization review activities limited to retrospective claims review shall be required to adopt only those procedures and sources of review that are traditionally associated with and necessary for retrospective claims review.