Senate Engrossed House Bill

FILED
KEN BENNETT
SECRETARY OF STATE

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

CHAPTER 215

HOUSE BILL 2550

AN ACT

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

(TEXT OF BILL BEGINS ON NEXT PAGE)

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

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

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

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

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

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

1. MOHAVE, COCONINO, APACHE AND NAVAJO COUNTIES.
2. YAVAPAI COUNTY.
3. LA PAZ AND YUMA COUNTIES.
4. MARICOPA COUNTY.
5. PINAL AND GILA COUNTIES.
6. PIMA AND SANTA CRUZ COUNTIES.
7. GRAHAM, GREENLEE AND COCHISE COUNTIES.

D. FOR THE PURPOSES OF THIS SECTION:

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

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

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

Sec. 2. Section 20-2537, Arizona Revised Statutes, is amended to read:

20-2537. External independent review; expedited external independent review

A. If the utilization review agent denies the member's request for a covered service or claim for a covered service at both the informal

reconsideration level and the formal appeal level, or at the expedited medical review level, the member may initiate an external independent review.

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

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

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

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

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

E. Except as provided in subsection K of this section, for cases involving an issue of medical necessity under the coverage document, within twenty-one days after the date of receiving a case for independent review from the director, the independent review organization shall evaluate and analyze the case and, based on all information required under subsection C, paragraph 2 of this section, render a decision that is consistent with the utilization review plan on whether or not the service or claim for the service is medically necessary and send the decision to the director. Within five business days after receiving a notice of decision from the independent review organization, the director shall mail a notice of the decision to the utilization review agent, the health care insurer, the member and the

member's treating provider. The decision by the independent review organization is a final administrative decision pursuant to title 41, chapter 6, article 10 and is subject to judicial review pursuant to title 12, chapter 7, article 6. The health care insurer shall provide any service or pay any claim determined to be covered and medically necessary by the independent review organization for the case under review regardless of whether judicial review is sought.

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

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

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

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

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

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

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

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

1. Within five business days after the member receives written notice by the utilization review agent of the adverse decision made pursuant to section 20-2534, if the member decides to initiate an external independent review, the member shall mail to the utilization review agent a written request for an expedited external independent review, including any material

justification or documentation to support the member's request for the covered service or claim for a covered service.

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

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

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

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

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

5. For cases involving an issue of coverage, within two business days after receipt of all of the information prescribed in subsection C of this section from the utilization review agent, the director shall determine if

the service or claim is or is not covered and if the adverse decision made pursuant to section 20-2534 conforms to the utilization review agent's utilization review plan and this article and shall mail a notice of determination to the utilization review agent, the health care insurer, the member and the member's treating provider.

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

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

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

Sec. 3. Rule making; exemption

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

Sec. 4. Conditional repeal; notice

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

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

APPROVED BY THE GOVERNOR JUNE 19, 2013.

FILED IN THE OFFICE OF THE SECRETARY OF STATE JUNE 19, 2013.

Passed the House March 6, 2013

by the following vote: 44 Ayes,

14 Nays, 2 Not Voting

Speaker of the House

Chief Clerk of the House

Passed the Senate May 16, 2013

by the following vote: 26 Ayes,

2 Nays, 2 Not Voting

President of the Senate

Secretary of the Senate

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF GOVERNOR

This Bill received by the Governor this

_____ day of _____, 20_____

at _____ o'clock _____M.

_____
Secretary to the Governor

Approved this _____ day of

_____

at _____ o'clock _____M.

_____
Governor of Arizona

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF SECRETARY OF STATE

This Bill received by the Secretary of State

this _____ day of _____, 20_____

at _____ o'clock _____M.

_____
Secretary of State

H.B. 2550

HOUSE CONCURS IN SENATE AMENDMENTS AND FINAL PASSAGE

June 13, 2013,

by the following vote: 40 Ayes,

19 Nays, 1 Not Voting

Speaker of the House

Cheryl Laube

Chief Clerk of the House

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF GOVERNOR

This Bill was received by the Governor this

13 day of June, 2013,

at 4:45 o'clock P M.

Mikenaila Howard

Secretary to the Governor

Approved this 19th day of

June, 2013,

at 11:22 o'clock A. M.

Janice K. Brewer

Governor of Arizona

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF SECRETARY OF STATE

This Bill was received by the Secretary of State

this 19th day of June, 2013,

at 2:05 o'clock P M.

Ken Bennett

Secretary of State

H.B. 2550