LEGISLATIVE BILL 1162

Approved by the Governor April 14, 1998

Introduced by Landis, 46; Wesely, 26

AN ACT relating to insurance; to amend sections 44-5401, 44-5402, 44-5409 to 44-5414, 84-1601, and 84-1604, Reissue Revised Statutes of Nebraska, and sections 44-6801, 44-6802, 44-6820, 44-6823, and 81-1307, Revised Statutes Supplement, 1997; to adopt the Health Care Professional Credentialing Verification Act, the Managed Care Plan Network Adequacy Act, the Quality Assessment and Improvement Act, and the Health Carrier Grievance Procedure Act; to rename the Utilization Review Certification Act and the Managed Care Patient Protection Act; to require health care coverage for certain drugs and surgical and nonsurgical treatments; to provide powers and duties; to eliminate provisions relating to utilization review and managed care plans; to provide for coverage under the Nebraska State Insurance Program for temporary state employees; to harmonize provisions; to provide operative dates; to provide severability; to repeal the original sections; and to outright repeal sections 44-5403 to 44-5408 and 44-5415, Reissue Revised Statutes of Nebraska, and sections 44-6803 to 44-6819, 44-6821, 44-6822, and 44-6824, Revised Statutes Supplement, 1997.

Be it enacted by the people of the State of Nebraska,

Section 1. Section 44-5401, Reissue Revised Statutes of Nebraska, is amended to read:

~~44-5401.~~ Sections ~~44-5401 to 44-5415~~ 1 to 16 of this act shall be known and may be cited as the Utilization Review ~~Certification~~ Act.

Sec. 2. Section 44-5402, Reissue Revised Statutes of Nebraska, is amended to read:

~~44-5402.~~ The purpose of the Utilization Review ~~Certification~~ Act is to establish requirements and standards of operation for certification of medical utilization review agents. It is proper for the state to oversee utilization review agents as a part of the state's regulation and supervision of the business of insurance and to encourage effective, efficient, and consistent utilization review.

Sec. 3. For purposes of the Utilization Review Act:

(1) Adverse determination means a determination by a health carrier or its designee utilization review agent that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested health care service is therefor denied, reduced, or terminated;

(2) Ambulatory review means utilization review of health care services performed or provided in an outpatient setting;

(3) Case management means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions;

(4) Certification means a determination by a health carrier or its designee utilization review agent that an admission, availability of care, continued stay, or other health care service 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;

(5) Clinical review criteria means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by the health carrier to determine the necessity and appropriateness of health care services;

(6) Closed plan means a managed care plan that requires covered persons to use participating providers under the terms of the managed care plan;

(7) Concurrent review means utilization review conducted during a patient's hospital stay or course of treatment;

(8) Covered person means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

(9) Department means the Department of Insurance;

(10) Director means the Director of Insurance;

(11) 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;

(12) Emergency medical condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such person or others in serious jeopardy, (b) serious impairment to such person's bodily functions, (c) serious impairment of any bodily organ or part of such person, or (d) serious disfigurement of such person;

(13) Emergency services means health care services necessary to screen and stabilize a covered person in connection with an emergency medical condition;

(14) 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. Facility does not include physicians' offices;

(15) Health benefit plan means a policy, contract, certificate, or agreement entered into, offered, or issued by any person to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. Health benefit plan does not include workers' compensation insurance coverage;

(16) Health care professional means a physician or other health care practitioner licensed, certified, or registered to perform specified health services consistent with state law;

(17) Health care provider or provider means a health care professional or a facility;

(18) Health care services or health services means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease;

(19) Health carrier means an entity that contracts, offers to contract, or enters into an agreement 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 prepaid limited health service organization, a prepaid dental service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services. Health carrier does not include a workers' compensation insurer, risk management pool, or self-insured employer who contracts for services to be provided through a managed care plan certified pursuant to section 48-120.02;

(20) Managed care plan means a health benefit plan, including closed plans and open plans, that either requires a covered person to use or creates financial incentives by providing a more favorable deductible, coinsurance, or copayment level for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier;

(21) Network means the group of participating providers providing services to a managed care plan;

(22) Open plan means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan;

(23) 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;

(24) 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;

(25) Prospective review means utilization review conducted prior to an admission or a course of treatment;

(26) Retrospective review means utilization review of medical necessity that is conducted after health services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment;

(27) 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 service to assess the clinical necessity

and appropriateness of the initial proposed health service;

(28) Significant beneficial interest means the ownership of any financial interest that is greater than the lesser of (a) five percent of the whole or (b) five thousand dollars;

(29) Stabilize means when, with respect to transfer to another facility, the examining physician at a hospital emergency department where an individual has sought treatment for an emergency medical condition has determined, within reasonable medical probability:

(a) With respect to an emergency medical condition, that no material deterioration of the condition is likely to result from or occur during a transfer of the individual from the facility; and

(b) The receiving facility has available space and qualified personnel for the treatment of the individual and has agreed to accept transfer of the individual and provide appropriate medical treatment;

(30) Utilization review means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. Utilization review does not include elective requests for clarification of coverage; and

(31) Utilization review agent means any person, company, health carrier, organization, or other entity performing utilization review. The following shall not be considered utilization review agents:

(a) An agency of the federal government;

(b) An agent acting on behalf of the federal government or a federally qualified peer review organization or the State of Nebraska but only to the extent that the agent is providing services to the federal government or the State of Nebraska;

(c) An agency of the State of Nebraska;

(d) Internal quality assurance programs conducted by hospitals, home health agencies, preferred provider organizations, health maintenance organizations, other managed care entities, clinics, or private offices for purposes other than for allowing, denying, or making a recommendation on allowing or denying a covered person's claim for payment;

(e) Nebraska licensed pharmacists, pharmacies, or organizations thereof while engaged in the practice of pharmacy, including the dispensing of drugs, participating in drug utilization reviews, and monitoring of patient drug therapy;

(f) Any person performing utilization review of workers' compensation benefits but only to the extent that the person is providing utilization review of workers' compensation benefits;

(g) Any individual or group employed or used by a utilization review agent certified under the Utilization Review Act when performing utilization review for or on behalf of such agent, including nurses and physicians; and

(h) An employee benefit plan or any person on behalf of an employee benefit plan to the extent that the activities of such plan or person are exempt from state regulation of the business of insurance pursuant to the federal Employee Retirement Income Security Act of 1974, as amended.

Sec. 4. Section 44-5409, Reissue Revised Statutes of Nebraska, is amended to read:

**44-5409.** On or after July 1, 1993, a utilization review agent may not conduct utilization review upon ~~an enrollee~~ a covered person in this state unless the agent is granted a certificate by the director. Certificates granted under the Utilization Review ~~Certification~~ Act shall be valid for two years from the date of issuance.

Sec. 5. Section 44-5410, Reissue Revised Statutes of Nebraska, is amended to read:

**44-5410.** (1) An applicant for a certificate as a utilization review agent shall submit an application to the ~~Department of Insurance~~ department upon a form which may be obtained from the department. The application shall be signed and verified by the applicant.

Along with the application, the applicant shall pay the application fee of three hundred dollars.

(2) As a part of the application, the applicant shall submit the following:

(a) Documentation that the applicant has received approval or accreditation by the ~~Utilization Review Accreditation Commission, Inc.~~ American Accreditation HealthCare Commission/URAC, or a similar organization which has standards for utilization review agents that are substantially similar to the standards of the ~~Utilization Review Accreditation Commission, Inc.~~ American Accreditation HealthCare Commission/URAC, and which has been

approved by the director;

(b) A statement of the street and mailing address of the entity, telephone number of the entity, and a list of the principal officers of the entity responsible for its operation, management, and control; and

(c) Such other reasonable information or documentation as the department requires for enforcement of the Utilization Review ~~Certification~~ Act.

Sec. 6. Section 44-5411, Reissue Revised Statutes of Nebraska, is amended to read:

**44-5411.** The director shall grant or deny a certificate within forty-five days of receipt of a completed application under section ~~44-5410~~ 5 of this act. The director shall deny a certificate if the applicant does not meet the requirements of the Utilization Review ~~Certification~~ Act. If a certificate is denied, the director shall notify the applicant by certified mail and shall specify the reasons for denial in the notice. The applicant shall have ten days from the date of receipt of the notice to request a hearing before the director pursuant to the Administrative Procedure Act, or he or she may reapply and respond to the reasons for the denial.

Sec. 7. Section 44-5412, Reissue Revised Statutes of Nebraska, is amended to read:

**44-5412.** (1) Utilization review agents operating in this state shall comply with the following provisions:

(a) A utilization review agent, employees of a utilization review agent, or persons acting on behalf of a utilization review agent may not refer a patient who has undergone utilization review by that utilization review agent, employee, or person to:

(i) A health care facility or other provider in which the utilization review agent owns a significant beneficial interest; or

(ii) The utilization review agent's own health care practice;

(b) A utilization review agent, employees of a utilization review agent, or persons acting on behalf of a utilization review agent shall not accept or agree to accept any sum from any person for bringing or referring a patient to a health care provider;

(c) A utilization review agent shall not compensate employees or persons acting on behalf of the utilization review agent based directly on the number of ~~denials of claims~~ adverse determinations;

(d) A utilization review agent shall allow a minimum of twenty-four hours following an emergency admission, service, or procedure for ~~an enrollee~~ a covered person or his or her representative to notify the utilization review agent and request certification or continuing treatment for the condition;

(e) ~~An enrollee~~ A covered person or an attending physician on behalf of ~~an enrollee~~ a covered person may request an appeal of a decision not to approve or certify for clinical reasons. For such appeal, ~~an enrollee~~ a covered person or attending physician on behalf of ~~an enrollee~~ a covered person shall, upon request, have timely access to the clinical basis for the decision, including any criteria, standards, or clinical indicators used as a basis for such recommendation or decision;

(f) During a final appeal of a decision not to certify or approve for clinical reasons, a utilization review agent shall assure that a physician is reasonably available to review the case, except that if the health care services were provided or authorized by a provider other than a physician, such appeal may be reviewed by a nonphysician provider whose scope of practice includes the treatment or services. Hospitals, health care providers, or representatives of the ~~enrollee~~ covered person may assist in an appeal; and

(g) A utilization review agent shall comply with the standards adopted by the organization that has granted the agent approval or accreditation and upon which the certificate was granted by the director, whether or not action is taken by such organization to enforce the standards.

(2) Subdivisions (1)(a) and (b) of this section shall not apply to a utilization review agent, employees of the utilization review agent, or other persons acting on behalf of such utilization review agent who refer a patient to:

(a) The health care provider or facility that participates in a health maintenance organization in which the patient is enrolled; or

(b) A preferred provider network of participating ~~health care~~ providers or facilities to which the patient would otherwise be referred as part of the patient's insurance contract or policy.

Sec. 8. Section 44-5413, Reissue Revised Statutes of Nebraska, is amended to read:

**44-5413.** A utilization review agent shall notify the director within five working days of any change of the agent's approval or accreditation status or of any material change in the information contained in

the agent's application or renewal or that the agent no longer meets the requirements of the Utilization Review ~~Certification~~ Act.

Sec. 9. Section 44-5414, Reissue Revised Statutes of Nebraska, is amended to read:

~~44-5414.~~ Certificates granted under the Utilization Review ~~Certification~~ Act may be renewed prior to their expiration date upon the filing of the following with the ~~Department of Insurance~~ department (1) a renewal fee of one hundred dollars, (2) a statement detailing any changes in the information or documentation filed with the initial application, and (3) such other reasonable information as the department requires for enforcement of the act.

Sec. 10. 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 the Utilization Review Act and applicable rules and regulations are met. The health carrier shall also ensure that appropriate personnel have operational responsibility for the conduct of the health carrier's utilization review program.

Sec. 11. 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.

Sec. 12. (1) 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.

(2) A health carrier shall include a summary of its utilization review procedures in enrollment materials intended for prospective covered persons.

(3) A health carrier shall print on its membership cards a toll-free telephone number to call for utilization review decisions.

Sec. 13. If the director finds that any utilization review agent doing business in this state is engaging in any violation of the Utilization Review Act and that a proceeding in respect thereto would be in the public interest, he or she shall issue and serve upon such utilization review agent a statement of the charges in that respect and a notice of hearing thereon, which notice shall set a hearing date not less than ten days after the date of the notice.

Sec. 14. If, after the hearing, the director finds a utilization review agent has violated the Utilization Review Act, the director shall reduce his or her findings to writing and shall issue and cause to be served upon the utilization review agent charged with the violation a copy of the findings and an order requiring the utilization review agent to cease and desist from engaging in the violation and the director may order any one or more of the following:

(1) Payment of a monetary penalty of not more than one thousand dollars for each violation, not to exceed an aggregate penalty of thirty thousand dollars, unless the violation was committed flagrantly and in conscious disregard of the Utilization Review Act, in which case the penalty shall not be more than fifteen thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the utilization review agent's license to do business in this state if the utilization review agent knew or reasonably should have known it was in violation of the act.

Sec. 15. Any utilization review agent who violates a cease and desist order of the director under section 14 of this act may after notice and hearing and upon order of the director be subject to:

(1) A monetary penalty of not more than thirty thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the utilization review agent's license to do business in this state.

Sec. 16. The director may adopt and promulgate rules and regulations to carry out the Utilization Review Act.

Sec. 17. Section 44-6801, Revised Statutes Supplement, 1997, is amended to read:

~~44-6801.~~ Sections ~~44-6801 to 44-6824~~ 17 to 25 of this act shall be known and may be cited as the Managed Care ~~Patient Protection~~ Emergency Services Act.

Sec. 18. Section 44-6802, Revised Statutes Supplement, 1997, is amended to read:

~~44-6802.~~ The ~~purposes~~ purpose of the Managed Care ~~Patient Protection~~ Emergency Services Act ~~are to (1) establish standards and requirements for written agreements between health carriers offering managed care plans and participating providers regarding the standards, terms, and provisions under which the participating provider will provide services to covered persons and (2)~~ is to establish standards for health carriers that offer managed care plans to provide for access by covered persons to and delivery of emergency ~~medical~~ services.

Sec. 19. For purposes of the Managed Care Emergency Services Act:

(1) Closed plan means a managed care plan that requires covered persons to use participating providers under the terms of the managed care plan;

(2) Covered benefits means those health care services to which a covered person is entitled under the terms of a health benefit plan;

(3) Covered person means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

(4) Director means the Director of Insurance;

(5) Emergency medical condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, (b) serious impairment to such person's bodily functions, (c) serious impairment of any bodily organ or part of such person, or (d) serious disfigurement of such person;

(6) Emergency services means health care services necessary to screen and stabilize a covered person in connection with an emergency medical condition;

(7) 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. Facilities does not include physicians' offices;

(8) Health benefit plan means a policy, contract, certificate, or agreement entered into, offered, or issued by any person to provide, deliver, arrange for, pay for, or reimburse the costs of health care services. Health benefit plan does not include workers' compensation insurance coverage;

(9) Health care professional means a physician or other health care practitioner licensed, certified, or registered to perform specified health care services consistent with state law;

(10) Health care provider means a health care professional or a facility;

(11) Health care services means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease;

(12) Health carrier means an entity that contracts, offers to contract, or enters into an agreement 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 prepaid limited health service organization, a prepaid dental service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services. Health carrier does not include a workers' compensation insurer, risk management pool, or self-insured employer who contracts for services to be provided through a managed care plan certified pursuant to section 48-120.02;

(13) Managed care plan means a health benefit plan, including closed plans and open plans, that either requires a covered person to use or creates financial incentives by providing a more favorable deductible, coinsurance, or copayment level for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier;

(14) Network means the group of participating providers providing services to a managed care plan;

(15) Open plan means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan;

(16) 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;

(17) Person means an individual, a corporation, a partnership, an association, a joint venture, joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing; and

(18) Stabilize means when, with respect to transfer to another facility, the examining physician at a hospital emergency department where an individual has sought treatment for an emergency medical condition has determined, within reasonable medical probability:

(a) With respect to an emergency medical condition, that no material deterioration of the condition is likely to result from or occur during a transfer of the individual from the facility; and

(b) The receiving facility has available space and qualified personnel for the treatment of the individual and has agreed to accept transfer of the individual and provide appropriate medical treatment.

Sec. 20. Section 44-6820, Revised Statutes Supplement, 1997, is amended to read:

**44-6820.** The Managed Care ~~Patient Protection~~ Emergency Services Act applies to all health carriers that offer managed care plans.

Sec. 21. Section 44-6823, Revised Statutes Supplement, 1997, is amended to read:

**44-6823.** (1) A health carrier which provides a covered benefit for emergency services is, subject to the terms and conditions of the health benefit plan, responsible for charges for medically necessary emergency services provided to a covered person, including services furnished outside the network and services deemed approved under subsection (2) of this section.

(2) If a treating physician or other emergency department personnel who have provided emergency services to a covered person ~~covered by a health carrier~~ determine that additional medically necessary services are promptly needed by the covered person and they have requested health carrier approval for such services, the health carrier is deemed to have approved the request if the treating physician or other emergency department personnel involved:

(a) Has made a reasonable effort to contact the individual at the health carrier authorized to approve such requests and the health carrier has not provided access to that individual; or

(b) Has requested authorization from the individual at the health carrier authorized to approve such requests and the individual has not denied authorization within thirty minutes after the time the request was made, unless the ~~plan~~ health carrier can document that it had made a good faith effort but was unable to reach the emergency physician within thirty minutes after receiving a request for authorization.

A request which is deemed approved under this subsection shall be treated as approval for any medically necessary covered benefits that are required to treat the medical condition identified by the treating physician or other emergency department personnel.

(3) A health carrier may impose a reasonable copayment for emergency services to deter inappropriate use of services of hospital emergency departments if the copayment is the same without regard to whether the health care ~~professional or facility~~ provider has a contractual or other arrangement with the health carrier.

Sec. 22. If the director finds that any health carrier doing business in this state is engaging in any violation of the Managed Care Emergency Services Act and that a proceeding in respect thereto would be in the public interest, the director shall issue and serve upon such health carrier a statement of the charges in that respect and a notice of hearing thereon, which notice shall set a hearing date not less than ten days after the date of the notice.

Sec. 23. If, after the hearing, the director finds a health carrier has violated the Managed Care Emergency Services Act, the director shall reduce his or her findings to writing and shall issue and cause to be served upon the health carrier charged with the violation a copy of the findings and an order requiring the health carrier to cease and desist from engaging in the violation and the director may order any one or more of the following:

(1) Payment of a monetary penalty of not more than one thousand dollars for each violation, not to exceed an aggregate penalty of thirty thousand dollars, unless the violation was committed flagrantly and in conscious disregard of the Managed Care Emergency Services Act, in which case the penalty shall not be more than fifteen thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the health carrier's certificate of

authority if the health carrier knew or reasonably should have known it was in violation of the act.

Sec. 24. Any health carrier who violates a cease and desist order of the director under section 23 of this act may after notice and hearing and upon order of the director be subject to:

(1) A monetary penalty of not more than thirty thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the health carrier's certificate of authority.

Sec. 25. The director may adopt and promulgate rules and regulations to carry out the Managed Care Emergency Services Act.

Sec. 26. Sections 26 to 38 of this act shall be known and may be cited as the Health Care Professional Credentialing Verification Act.

Sec. 27. The Health Care Professional Credentialing Verification Act requires a health carrier to establish a comprehensive health care professional credentialing verification program to ensure that its participating health care professionals meet specific minimum standards of professional qualification. The standards set out in the act address the initial credentialing verification and subsequent recredentialing process.

Sec. 28. For purposes of the Health Care Professional Credentialing Verification Act:

(1) Closed plan means a managed care plan that requires a covered person to use participating providers under the terms of the managed care plan;

(2) Covered person means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

(3) Credentialing verification means the process of obtaining and verifying information about a health care professional, and evaluating that health care professional, when that health care professional applies to become a participating provider in a managed care plan offered by a health carrier;

(4) Director means the Director of Insurance;

(5) 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. Facility does not include physicians' offices;

(6) Health benefit plan means a policy, contract, certificate, or agreement entered into, offered, or issued by any person to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. Health benefit plan does not include workers' compensation insurance coverage;

(7) Health care professional means a physician or other health care practitioner licensed, certified, or registered to perform specified health services consistent with state law;

(8) Health care provider or provider means a health care professional or a facility;

(9) Health care services or health services means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease;

(10) Health carrier means an entity that contracts, offers to contract, or enters into an agreement 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 prepaid limited health service organization, a prepaid dental service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services. Health carrier does not include a workers' compensation insurer, risk management pool, or self-insured employer who contracts for services to be provided through a managed care plan certified pursuant to section 48-120.02;

(11) Managed care plan means a health benefit plan, including closed plans and open plans, that either requires a covered person to use or creates financial incentives by providing a more favorable deductible, coinsurance, or copayment level for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier;

(12) Open plan means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan;

(13) 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;

(14) 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;

(15) Primary verification means verification by the health carrier of a health care professional's credentials based upon evidence obtained from the issuing source of the credential; and

(16) Secondary verification means verification by the health carrier of a health care professional's credentials based upon evidence obtained by means other than direct contact with the issuing source of the credential, such as copies of certificates provided by the applying health care professional.

Sec. 29. The Health Care Professional Credentialing Verification Act applies to health carriers that offer closed plans or combination plans having a closed component.

Sec. 30. The director may recognize accreditation by one or more nationally recognized private accrediting entities, with established and maintained standards, as evidence of meeting some or all of the requirements of the Health Care Professional Credentialing Verification Act. A recognized accrediting entity shall make available to the director its current standards to demonstrate that the entity's standards meet or exceed this state's requirements. The health carrier may provide the director with documentation that a managed care plan has been accredited by the entity.

Sec. 31. (1) A health carrier shall:

(a) Establish written policies and procedures for credentialing verification of all health care professionals with whom the health carrier contracts and apply these standards consistently;

(b) Verify the credentials of a health care professional before entering into a contract with that health care professional. The medical director of the health carrier or other designated health care professional shall have responsibility for, and shall participate in, credentialing verification;

(c) Establish a credentialing verification committee consisting of licensed physicians and other health care professionals to review credentialing verification information and supporting documents and make decisions regarding credentialing verification;

(d) Make available for review by the applying health care professional upon written request all application and credentialing verification policies and procedures;

(e) Retain all records and documents relating to a health care professional's credentialing verification process for at least five years; and

(f) Keep confidential all information obtained in the credentialing verification process except as otherwise provided by law.

(2) Nothing in the Health Care Professional Credentialing Verification Act shall be construed to require a health carrier to select a provider as a participating provider solely because the provider meets the health carrier's credentialing verification standards or to prevent a health carrier from utilizing separate or additional criteria in selecting the health care professionals with whom it contracts.

(3) The policies and procedures for credentialing verification shall be available for review by the director, and, in the case of a health maintenance organization, shall also be available for review by the chief medical officer, if one is appointed pursuant to section 81-3201, and if not, then the Director of Regulation and Licensure.

Sec. 32. A health carrier shall:

(1) Obtain primary verification of at least the following information about the applicant:

(a) Current license, certificate, or registration to practice a health care profession in this state and history of licensure, certification, or registration;

(b) Current level of professional liability coverage, if applicable;

(c) Status of hospital privileges, if applicable;

(d) Specialty board certification status, if applicable;

(e) Current federal Drug Enforcement Agency registration certificate, if applicable;

(f) Graduation from a health care professional school; and

(g) Completion of postgraduate training, if applicable;

(2) Obtain, subject to either primary or secondary verification at the health carrier's discretion:

(a) The health care professional's licensure, certification, or registration history in this and all other states;

(b) The health care professional's malpractice history; and

(c) The health care professional's practice history;

(3) At least every three years obtain primary verification of a participating health care professional's:

(a) Current license, certificate, or registration to practice a health care profession in this state;

(b) Current level of professional liability coverage, if applicable;

(c) Status of hospital privileges, if applicable;

(d) Current federal Drug Enforcement Agency registration certificate, if applicable; and

(e) Specialty board certification status, if applicable; and

(4) Require all participating providers to notify the health carrier of changes in the status of any of the items listed in this section at any time and identify for participating providers the individual to whom they should report changes in the status of an item listed in this section.

Sec. 33. (1) A health carrier shall provide a health care professional the opportunity to review and correct information submitted in support of that health care professional's credentialing verification application as set forth below.

(2)(a) Each health care professional who is subject to the credentialing verification process shall have the right to review all information, including the source of that information, obtained by the health carrier to satisfy the requirements of the Health Care Professional Credentialing Verification Act during the health carrier's credentialing process.

(b) A health carrier shall notify a health care professional of any information obtained during the health carrier's credentialing verification process that does not meet the health carrier's credentialing verification standards or that varies substantially from the information provided to the health carrier by the health care professional, except that the health carrier shall not be required to reveal the source of information if the information is not obtained to meet the requirements of the act or if disclosure is prohibited by law.

(c) A health care professional shall have the right to correct any erroneous information. A health carrier shall have a formal process by which a health care professional may submit supplemental or corrected information to the health carrier's credentialing verification committee and request a reconsideration of the health care professional's credentialing verification application if the health care professional feels that the health carrier's credentialing verification committee has received information that is incorrect or misleading. Supplemental information shall be subject to confirmation by the health carrier.

Sec. 34. Whenever a health carrier contracts to have another entity perform the credentialing functions required by the Health Care Professional Credentialing Verification Act or applicable rules and regulations, the director shall hold the health carrier responsible for monitoring the activities of the entity with which it contracts and for ensuring that the requirements of the act and applicable rules and regulations are met.

Sec. 35. If the director finds that any health carrier doing business in this state is engaging in any violation of the Health Care Professional Credentialing Verification Act and that a proceeding in respect thereto would be in the public interest, the director shall issue and serve upon such health carrier a statement of the charges in that respect and a notice of hearing thereon, which notice shall set a hearing date not less than ten days after the date of the notice.

Sec. 36. If, after the hearing, the director finds a health carrier has violated the Health Care Professional Credentialing Verification Act, the director shall reduce his or her findings to writing and shall issue and cause to be served upon the health carrier charged with the violation a copy of the findings and an order requiring the health carrier to cease and desist from engaging in the violation and the director may order any one or more of the following:

(1) Payment of a monetary penalty of not more than one thousand dollars for each violation, not to exceed an aggregate penalty of thirty thousand dollars, unless the violation was committed flagrantly and in conscious disregard of the Health Care Professional Credentialing Verification Act, in which case the penalty shall not be more than fifteen thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the health carrier's certificate of authority if the health carrier knew or reasonably should have known it was in violation of the act.

Sec. 37. Any health carrier who violates a cease and desist order of the director under section 36 of this act may after notice and hearing and upon order of the director be subject to:

(1) A monetary penalty of not more than thirty thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the health carrier's certificate of authority.

Sec. 38. The director may adopt and promulgate rules and regulations to carry out the Health Care Professional Credentialing Verification Act.

Sec. 39. Sections 39 to 50 of this act shall be known and may be cited as the Managed Care Plan Network Adequacy Act.

Sec. 40. The purpose and intent of the Managed Care Plan Network Adequacy Act are to establish standards for the creation and maintenance of networks by health carriers and to assure the adequacy, accessibility, and quality of health care services offered under a managed care plan by establishing requirements for written agreements between health carriers offering managed care plans and participating providers regarding the standards, terms, and provisions under which the participating provider will provide services to covered persons.

Sec. 41. For purposes of the Managed Care Plan Network Adequacy Act:

(1) Closed plan means a managed care plan that requires a covered person to use participating providers under the terms of the managed care plan;

(2) Covered benefits or benefits means those health care services to which a covered person is entitled under the terms of a health benefit plan;

(3) Covered person means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

(4) Director means the Director of Insurance;

(5) Emergency medical condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, (b) serious impairment to such person's bodily functions, (c) serious impairment of any bodily organ or part of such person, or (d) serious disfigurement of such person;

(6) Emergency services means health care services necessary to screen and stabilize a covered person in connection with an emergency medical condition;

(7) 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. Facility does not include physicians' offices;

(8) Health benefit plan means a policy, contract, certificate, or agreement entered into, offered, or issued by any person to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. Health benefit plan does not include workers' compensation insurance coverage;

(9) Health care professional means a physician or other health care practitioner licensed, certified, or registered to perform specified health services consistent with state law;

(10) Health care provider or provider means a health care professional or a facility;

(11) Health care services or health services means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease;

(12) Health carrier means an entity that contracts, offers to contract, or enters into an agreement 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 prepaid limited health service organization, a prepaid dental service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services. Health carrier does not include a workers' compensation insurer, risk management pool, or self-insured employer who contracts for services to be provided through a managed care plan certified pursuant to section 48-120.02;

(13) Intermediary means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network;

(14) Managed care plan means a health benefit plan, including closed plans and open plans, that either requires a covered person to use or creates financial incentives by providing a more favorable deductible, coinsurance, or copayment level for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier;

(15) Network means the group of participating providers providing services to a managed care plan;

(16) Open plan means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan;

(17) 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;

(18) 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;

(19) Primary care professional means a participating health care professional designated by the health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of health care services rendered to the covered person; and

(20) Stabilize means when, with respect to transfer to another facility, the examining physician at a hospital emergency department where an individual has sought treatment for an emergency medical condition has determined, within reasonable medical probability:

(a) With respect to an emergency medical condition, that no material deterioration of the condition is likely to result from or occur during a transfer of the individual from the facility; and

(b) The receiving facility has available space and qualified personnel for the treatment of the individual and has agreed to accept transfer of the individual and provide appropriate medical treatment.

Sec. 42. The Managed Care Plan Network Adequacy Act applies to all health carriers that offer managed care plans.

Sec. 43. (1) A health carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of providers to assure that all health care services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four hours per day, seven days per week. Sufficiency shall be determined in accordance with the requirements of this section and may be established by reference to any reasonable criteria used by the health carrier, including, but not limited to: Provider-covered person ratios by specialty; primary care provider-covered person ratios; geographic accessibility; waiting times for appointments with participating providers; hours of operation; and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care.

(a) In any case in which the health carrier has an insufficient number or type of participating provider to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit and the health carrier shall reimburse the nonparticipating provider at the health carrier's usual and customary rate or at an agreed upon rate.

(b) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of covered persons. In determining whether a health carrier has complied with this provision, the director shall give due consideration to the relative availability of health care providers in the service area under consideration.

(2) A health carrier shall maintain an access plan meeting the requirements of the Managed Care Plan Network Adequacy Act for each of the managed care plans that the health carrier offers in this state. The health carrier may request the director to deem sections of the access plan as proprietary or competitive information that shall not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information would cause the health carrier's competitors to obtain valuable business information. The health carrier shall make the

access plans, absent proprietary information, available on its business premises and shall provide them to the director or any interested party upon request. The health carrier shall prepare an access plan prior to offering a new managed care plan and shall update an existing access plan whenever it makes any material change to an existing managed care plan. The access plan shall describe or contain at least the following:

(a) The health carrier's network;

(b) The health carrier's procedures for making referrals within and outside its network;

(c) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in managed care plans;

(d) The health carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(e) The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with health care services;

(f) The health carrier's method of informing covered persons of the managed care plan's services and features, including, but not limited to, the managed care plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care;

(g) The health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(h) The health carrier's process for enabling covered persons to change primary care professionals;

(i) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination or the health carrier's insolvency or other cessation of operations and transferred to other providers in a timely manner; and

(j) Any other information required by the director to determine compliance with the provisions of the act.

Sec. 44. (1) A health carrier offering a managed care plan shall satisfy all the requirements contained in this section.

(2)(a) A health carrier shall establish a mechanism by which the participating provider will be notified on an ongoing basis of the specific covered health services for which the provider will be responsible, including any limitations or conditions on health care services.

(b) Every contract between a health carrier that offers closed plans or combination plans having a closed component and a participating provider shall set forth in writing a hold harmless provision specifying protection for covered persons. This requirement shall be met by including a provision substantially similar to the following:

"Provider agrees that in no event, including, but not limited to, nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a covered person or a person, other than the health carrier or intermediary, acting on behalf of the covered person for health care services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles, or copayments, as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider, except for a health care professional who is employed full time on the staff of a health carrier and has agreed to provide health care services exclusively to that health carrier's covered persons and no others, and a covered person from agreeing to continue health care services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific health care service or health care services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy."

(c) Every contract between a health carrier that offers closed plans or combination plans having a closed component and a participating provider shall set forth that in the event of a health carrier or intermediary insolvency or other cessation of operations, covered benefits to covered

persons will continue through the period for which a premium has been paid to the health carrier on behalf of the covered person or until the covered person's discharge from an inpatient facility, whichever time is greater. Covered benefits to covered persons confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary.

(d) The contract provisions that satisfy the requirements of subdivisions (2)(b) and (c) of this section shall be construed in favor of the covered person, shall survive the termination of the contract regardless of the reason for termination, including the insolvency of the health carrier, and shall supersede any oral or written contrary agreement between a provider and a covered person or the representative of a covered person if the contrary agreement is inconsistent with the hold harmless and continuation of covered benefits provisions required by such subdivisions.

(e) In no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the health carrier.

(f) A health carrier shall make its selection standards for participating providers available for review by the director.

(g) At the time the participating providers execute contracts with the health carrier, a health carrier shall notify participating providers of the providers' responsibilities with respect to the health carrier's applicable administrative policies and programs, including, but not limited to, payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements, and any applicable federal or state programs.

(h) A health carrier shall not offer an inducement under the managed care plan to a provider to provide less than medically necessary health care services to a covered person.

(i) A health carrier shall not prohibit a participating provider from discussing treatment options with covered persons irrespective of the health carrier's position on the treatment options or from advocating on behalf of covered persons within the utilization review or grievance processes established by the health carrier or a person contracting with the health carrier.

(j) A health carrier shall require a provider to make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

(k) A health carrier and participating provider shall provide at least sixty days' written notice to each other before terminating the contract without cause. The health carrier shall make a good faith effort to provide written notice of a termination within fifteen working days of receipt or issuance of a notice of termination to all covered persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. Where a contract termination involves a primary care professional, all covered persons who are patients of that primary care professional shall also be notified.

(l) The rights and responsibilities under a contract between a health carrier and a participating provider shall not be assigned or delegated by the provider without the prior written consent of the health carrier.

(m) A health carrier is responsible for ensuring that a participating provider furnishes covered benefits to all covered persons without regard to the covered person's enrollment in the managed care plan as a private purchaser of the managed care plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render health care services due to limitations arising from lack of training, experience, skill, or licensing restrictions.

(n) A health carrier shall notify the participating providers of their obligations, if any, to collect applicable coinsurance, copayments, or deductibles from covered persons pursuant to the evidence of coverage, or of the providers' obligations, if any, to notify covered persons of their personal financial obligations for noncovered health care services.

(o) A health carrier shall not penalize a provider because the provider, in good faith, reports to state or federal authorities any act or practice by the health carrier that jeopardizes patient health or welfare.

(p) A health carrier shall establish a mechanism by which the participating providers may determine in a timely manner whether or not a

person is covered by the health carrier.

(q) A health carrier shall establish procedures for resolution of administrative, payment, or other disputes between providers and the health carrier.

(r) A contract between a health carrier and a provider shall not contain definitions or other provisions that conflict with the definitions or provisions contained in the managed care plan or the Managed Care Plan Network Adequacy Act.

(3) Subdivisions (2)(a) through (q) and (j) through (r) of this section become operative on July 1, 1999.

Sec. 45. (1) A contract between a health carrier and an intermediary shall satisfy all the requirements contained in this section.

(2)(a) Intermediaries and participating providers with whom they contract shall comply with all the applicable requirements of section 44 of this act.

(b) A health carrier's statutory responsibility to monitor the offering of covered benefits to covered persons shall not be delegated or assigned to the intermediary.

(c) A health carrier shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering covered benefits to the health carrier's covered persons.

(d) A health carrier shall maintain copies of all intermediary health care subcontracts at its principal place of business in the state, or ensure that it has access to all intermediary subcontracts, including the right to make copies to facilitate regulatory review, upon twenty days' prior written notice from the health carrier. A health carrier may meet the requirements of this subdivision by maintaining a copy of the intermediary health care subcontract forms used by its intermediaries, and if the health carrier does so, the health carrier shall also maintain a copy of any portion of an intermediary health care subcontract which substantially differs from the intermediary health care subcontract form in subject areas other than reimbursement.

(e) If applicable, an intermediary shall transmit utilization documentation and claims paid documentation to the health carrier. The health carrier shall monitor the timeliness and appropriateness of payments made to providers and health care services received by covered persons.

(f) If applicable, an intermediary shall maintain the books, records, financial information, and documentation of health care services provided to covered persons at its principal place of business in the state and preserve them for five years in a manner that facilitates regulatory review.

(g) An intermediary shall allow the director and a health maintenance organization shall allow the director and the Director of Regulation and Licensure access to the intermediary's books, records, financial information, and any documentation of health care services provided to covered persons, as necessary to determine compliance with the Managed Care Plan Network Adequacy Act.

(h) A health carrier shall have the right, in the event of the intermediary's insolvency, to require the assignment to the health carrier of the provisions of a provider's contract addressing the provider's obligation to furnish covered services.

Sec. 46. (1) A health carrier that offers closed plans or combination plans having a closed component shall file with the director sample contract forms proposed for use with its participating providers and intermediaries.

(2) A health carrier that offers closed plans or combination plans having a closed component shall submit material changes to a contract that would affect a provision required by the Managed Care Plan Network Adequacy Act or applicable rules and regulations to the director for approval. Changes in provider payment rates, coinsurance, copayments, or deductibles, or other plan benefit modifications are not considered material changes for the purpose of this subsection.

(3) If the director takes no action within thirty days after submission of a material change to a contract by a health carrier, the change is deemed approved.

(4) The health carrier shall maintain provider and intermediary contracts at its principal place of business in the state, or the health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon twenty days' prior written notice from the director.

Sec. 47. If the director finds that any health carrier doing business in this state is engaging in any violation of the Managed Care

Network Adequacy Act and that a proceeding in respect thereto would be in the public interest, the director shall issue and serve upon such health carrier a statement of the charges in that respect and a notice of hearing thereon, which notice shall set a hearing date not less than ten days after the date of the notice.

Sec. 48. If, after the hearing, the director finds a health carrier has violated the Managed Care Network Adequacy Act, the director shall reduce his or her findings to writing and shall issue and cause to be served upon the health carrier charged with the violation a copy of the findings and an order requiring the health carrier to cease and desist from engaging in the violation and the director may order any one or more of the following:

(1) Payment of a monetary penalty of not more than one thousand dollars for each violation, not to exceed an aggregate penalty of thirty thousand dollars, unless the violation was committed flagrantly and in conscious disregard of the Managed Care Network Adequacy Act, in which case the penalty shall not be more than fifteen thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the health carrier's certificate of authority if the health carrier knew or reasonably should have known it was in violation of the act.

Sec. 49. Any health carrier who violates a cease and desist order of the director under section 48 of this act may after notice and hearing and upon order of the director be subject to:

(1) A monetary penalty of not more than thirty thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the health carrier's certificate of authority.

Sec. 50. The director may adopt and promulgates rules and regulations to carry out the Managed Care Plan Network Adequacy Act.

Sec. 51. Sections 51 to 65 of this act shall be known and may be cited as the Quality Assessment and Improvement Act.

Sec. 52. The Quality Assessment and Improvement Act establishes criteria for the quality assessment activities of all health carriers that offer managed care plans and for the quality improvement activities of health carriers issuing closed plans or combination plans having a closed component. The purpose of the criteria is to enable health carriers to evaluate, maintain, and improve the quality of health care services provided to covered persons.

Sec. 53. For purposes of the Quality Assessment and Improvement Act:

(1) Closed plan means a managed care plan that requires a covered person to use participating providers under the terms of the managed care plan;

(2) Consumer means someone in the general public who may or may not be a covered person or a purchaser of health care, including employers;

(3) Covered person means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

(4) Department means the Department of Insurance;

(5) Director means the Director of Insurance;

(6) 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. Facility does not include physicians' offices;

(7) Health benefit plan means a policy, contract, certificate, or agreement entered into, offered, or issued by any person to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. Health benefit plan does not include workers' compensation insurance coverage;

(8) Health care professional means a physician or other health care practitioner licensed, certified, or registered to perform specified health services consistent with state law;

(9) Health care provider or provider means a health care professional or a facility;

(10) Health care services or health services means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease;

(11) Health carrier means an entity that contracts, offers to contract, or enters into an agreement 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 prepaid limited health service organization, a prepaid dental service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services. Health carrier does not include a workers' compensation insurer, risk management pool, or self-insured employer who contracts for services to be provided through a managed care plan certified pursuant to section 48-120.02;

(12) Managed care plan means a health benefit plan, including closed plans and open plans, that either requires a covered person to use or creates financial incentives by providing a more favorable deductible, coinsurance, or copayment level for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier;

(13) Open plan means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan;

(14) 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;

(15) 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;

(16) Quality assessment means the measurement and evaluation of the quality and outcomes of medical care provided to individuals, groups, or populations; and

(17) Quality improvement means the effort to improve the processes and outcomes related to the provision of care within the health benefit plan.

Sec. 54. The Quality Assessment and Improvement Act applies to all health carriers that offer closed plans or combination plans having a closed component on and after the operative date of this section. The act, except sections 57 to 59 of this act, applies to all health carriers that offer open plans on and after July 1, 1999.

Sec. 55. The director may recognize accreditation by one or more nationally recognized private accrediting entities, with established and maintained standards, as evidence of meeting some or all of the requirements of the Quality Assessment and Improvement Act. A recognized accrediting entity shall make available to the director its current standards to demonstrate that the entity's standards meet or exceed this state's requirements. The health carrier may provide the director with documentation that a managed care plan has been accredited by the entity.

Sec. 56. A health carrier that provides managed care plans shall develop and maintain the infrastructure and disclosure systems necessary to measure the quality of health care services provided to covered persons on a regular basis and appropriate to the types of managed care plans offered by the health carrier. A health carrier shall:

(1) Establish a system designed to assess the quality of health care provided to covered persons and appropriate to the types of managed care plans offered by the health carrier. The system shall include systematic collection, analysis, and reporting of relevant data in accordance with statutory and regulatory requirements;

(2) Communicate findings in a timely manner to applicable regulatory agencies, providers, and consumers as provided in section 59 of this act;

(3) Report to the appropriate licensing authority any persistent pattern of problematic care provided by a provider that is sufficient to cause the health carrier to terminate or suspend contractual arrangements with the provider. A health carrier acting in good faith shall be granted immunity from any cause of action under state law in making the report; and

(4) Develop a written description of the quality assessment program available for review by the director, which shall include a signed certification by a corporate officer of the health carrier that the filing meets the requirements of the Quality Assessment and Improvement Act. The written description of the quality assessment program of a health maintenance organization shall also be available for review by the Director of Regulation and Licensure.

Sec. 57. A health carrier that issues a closed plan or a combination plan having a closed component shall, in addition to complying with the requirements of section 56 of this act, develop and maintain the internal structures and activities necessary to improve quality as required by this section. A health carrier subject to the requirements of this section shall:

(1) Establish an internal system capable of identifying opportunities to improve care. This system shall be structured to identify practices that result in improved health care outcomes, identify problematic utilization patterns, identify those providers that may be responsible for either exemplary or problematic patterns, and foster an environment of continuous quality improvement;

(2) Use the findings generated by the system to work, on a continuing basis, with participating providers and other staff within the closed plan or closed component to improve the health care services delivered to covered persons;

(3) Develop and maintain an organizational program for designing, measuring, assessing, and improving the processes and outcomes of health care as identified in the health carrier's quality improvement program filed with the director and consistent with the provisions of the Quality Assessment and Improvement Act. This program shall be under the direction of the chief medical officer or clinical director of the health carrier. The organizational program shall include:

(a) A written statement of the objectives, lines of authority and accountability, evaluation tools, including data collection responsibilities, performance improvement activities, and an annual effectiveness review of the quality improvement program;

(b) A written quality improvement plan that describes how the health carrier intends to:

(i) Analyze both processes and outcomes of care, including focused review of individual cases as appropriate, to discern the causes of variation;

(ii) Identify the targeted diagnoses and treatments to be reviewed by the quality improvement program each year. In determining which diagnoses and treatments to target for review, the health carrier shall consider practices and diagnoses that affect a substantial number of the managed care plan's covered persons or that could place covered persons at serious risk. This section shall not be construed to require a health carrier to review every disease, illness, and condition that may affect a covered person under a managed care plan offered by the health carrier;

(iii) Use a range of appropriate methods to analyze quality, including:

(A) Collection and analysis of information on over-utilization and under-utilization of health care services;

(B) Evaluation of courses of treatment and outcomes of health care services, including health status measures, consistent with reference data bases such as current medical research, knowledge, standards, and practice guidelines; and

(C) Collection and analysis of information specific to a covered person or persons or provider or providers, gathered from multiple sources such as utilization management, claims processing, and documentation of both the satisfaction and grievances of covered persons;

(iv) Compare program findings with past performance, as appropriate, and with internal goals and external standards, when available, adopted by the health carrier;

(v) Measure the performance of participating providers and conduct peer review activities, such as:

(A) Identifying practices that do not meet the health carrier's standards;

(B) Taking appropriate action to correct deficiencies;

(C) Monitoring participating providers to determine whether they have implemented corrective action; and

(D) Taking appropriate action when the participating provider has not implemented corrective action;

(vi) Utilize treatment protocols and practice parameters developed with appropriate clinical input and using the evaluations described in subdivisions (3)(b)(i) and (ii) of this section, or utilize acquired treatment protocols developed with appropriate clinical input; and provide participating providers with sufficient information about the protocols to enable participating providers to meet the standards established by these protocols;

(vii) Evaluate access to care for covered persons according to standards established by the insurance laws of this state. The quality improvement plan shall describe the health carrier's strategy for integrating public health goals with health services offered to covered persons under the managed care plans of the health carrier, including a description of the health carrier's good faith efforts to initiate or maintain communication with public health agencies;

(viii) Implement improvement strategies related to program findings; and

(ix) Evaluate periodically, but not less than annually, the effectiveness of the strategies implemented in subdivision (3)(b)(viii) of this section; and

(4) Assure that participating providers have the opportunity to participate in developing, implementing, and evaluating the quality improvement system.

Sec. 58. The chief medical officer or clinical director of the health carrier shall have primary responsibility for the quality assessment and quality improvement activities carried out by, or on behalf of, the health carrier and for ensuring that all requirements of the Quality Assessment and Improvement Act are met. The chief medical officer or clinical director shall approve the written quality assessment and quality improvement programs, as applicable, implemented in compliance with the act, and shall periodically review and revise the program document and act to assure ongoing appropriateness. Not less than semiannually, the chief medical officer or clinical director shall review reports of quality assessment and quality improvement activities. The director shall hold the health carrier responsible for the actions of the chief medical officer or clinical director carried out on behalf of the health carrier and shall hold the health carrier responsible for ensuring that all requirements of the act are met.

Sec. 59. (1) A health carrier shall document and communicate information, as provided in this section, about its quality assessment program and its quality improvement program, if it has one, and shall include a description of its quality assessment and quality improvement programs and a statement of patient rights and responsibilities with respect to those programs in the certificate of coverage or handbook provided to newly enrolled covered persons.

(2)(a) A health carrier shall certify to the director annually that its quality assessment program and its quality improvement program, if it has one, along with the materials provided to providers and consumers in accordance with subsection (1) of this section, meet the requirements of the Quality Assessment and Improvement Act.

(b) A health carrier shall make available for review by the public upon request, subject to a reasonable fee, the materials certified pursuant to subdivision (2)(a) of this section, except for the materials subject to the confidentiality requirements of section 60 of this act and materials that are proprietary to the health benefit plan. A health carrier shall retain all certified materials for at least three years from the date the material has been used or until the material has been examined as part of a market conduct examination, whichever is longer.

Sec. 60. (1) Data or information pertaining to the diagnosis, treatment, or health of a covered person obtained from the person or from a provider by a health carrier is confidential and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of the Quality Assessment and Improvement Act and as allowed by state law; or upon the express consent of the covered person; or pursuant to statute or court order for the production of evidence or the discovery thereof; or in the event of a claim or litigation between the covered person and the health carrier in which the data or information is pertinent, regardless of whether the information is in the form of paper, is preserved on microfilm, or is stored in computer retrievable form. If any data or information pertaining to the diagnosis, treatment, or health of any covered person or applicant is disclosed pursuant to the provisions of this subsection, the health carrier making this required disclosure shall not be liable for the disclosure or any subsequent use or misuse of the data. A health carrier shall be entitled to claim any statutory privileges against disclosure that the provider who furnished the information to the health carrier is entitled to claim.

(2) A person who, in good faith and without malice, takes an action or makes a decision or recommendation as a member, agent, or employee of a health carrier's quality committee in furtherance of and consistent with the quality assessment or quality improvement activities of the health carrier, or who furnishes any records, information, or assistance to a quality committee in furtherance of and consistent with the quality assessment or quality improvement activities of the health carrier, shall not be subject to liability for civil damages or any legal action in consequence of his or her action, nor shall the health carrier that established the quality committee or the officers, directors, employees, or agents of the health carrier be liable for the activities of the person. This section shall not be construed to relieve any person of liability arising from treatment of a patient.

(3)(a) The information considered by a quality committee and the records of its actions and proceedings shall be confidential and not subject to subpoena or order to produce except in proceedings before the appropriate

state licensing agency, or in an appeal, if permitted, from the quality committee's findings or recommendations. No member of a quality committee, or officer, director, or other member of a health carrier or its staff engaged in assisting the quality committee, or engaged in the health carrier's quality assessment or quality improvement activities, or any person assisting or furnishing information to the quality committee may be subpoenaed to testify in any judicial or quasi-judicial proceeding if the subpoena is based solely on these activities.

(b) Information considered by a quality committee and the records of its actions and proceedings that are used pursuant to subdivision (3)(a) of this section by a state licensing or certifying agency or in an appeal shall be kept confidential and shall be subject to the same provisions concerning discovery and use in legal actions as are the original information and records in the possession and control of a quality committee.

(4) To fulfill its obligations under this section, the health carrier shall have access to treatment records and other information pertaining to the diagnosis, treatment, or health status of any covered person.

Sec. 61. Whenever a health carrier contracts to have another entity perform the quality assessment or quality improvement functions required by the Quality Assessment and Improvement Act or applicable rules and regulations, the director shall hold the health carrier responsible for monitoring the activities of the entity with which it contracts and for ensuring that the requirements of the act and applicable rules and regulations are met.

Sec. 62. If the director finds that any health carrier doing business in this state is engaging in any violation of the Quality Assessment and Improvement Act and that a proceeding in respect thereto would be in the public interest, the director shall issue and serve upon such health carrier a statement of the charges in that respect and a notice of hearing thereon, which notice shall set a hearing date not less than ten days from the date of the notice.

Sec. 63. If, after the hearing, the director finds a health carrier has violated the Quality Assessment and Improvement Act, the director shall reduce his or her findings to writing and shall issue and cause to be served upon the health carrier charged with the violation a copy of the findings and an order requiring the health carrier to cease and desist from engaging in the violation and the director may order any one or more of the following:

(1) Payment of a monetary penalty of not more than one thousand dollars for each violation, not to exceed an aggregate penalty of thirty thousand dollars, unless the violation was committed flagrantly and in conscious disregard of the Quality Assessment and Improvement Act, in which case the penalty shall not be more than fifteen thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the health carrier's certificate of authority if the health carrier knew or reasonably should have known it was in violation of the act.

Sec. 64. Any health carrier who violates a cease and desist order of the director under section 63 of this act may after notice and hearing and upon order of the director be subject to:

(1) A monetary penalty of not more than thirty thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the health carrier's certificate of authority.

Sec. 65. The director may adopt and promulgate rules and regulations to carry out the Quality Assessment and Improvement Act.

Sec. 66. Sections 66 to 80 of this act shall be known and may be cited as the Health Carrier Grievance Procedure Act.

Sec. 67. The purpose of the Health Carrier Grievance Procedure Act is to provide standards for the establishment and maintenance of procedures by health carriers to assure that covered persons have the opportunity for the appropriate resolution of their grievances as defined in the act.

Sec. 68. For purposes of the Health Carrier Grievance Procedure Act:

(1) Adverse determination means a determination by a health carrier or its designee utilization review agent that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested health care service is

therefor denied, reduced, or terminated;

(2) Ambulatory review means utilization review of health care services performed or provided in an outpatient setting;

(3) Case management means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions;

(4) Certification means a determination by a health carrier or its designee utilization review agent that an admission, availability of care, continued stay, or other health care service 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;

(5) 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;

(6) Clinical review criteria means the written screening procedures, decision abstracts, clinical protocols, and practice guidelines used by the health carrier to determine the necessity and appropriateness of health care services;

(7) Closed plan means a managed care plan that requires a covered person to use participating providers under the terms of the managed care plan;

(8) Concurrent review means utilization review conducted during a patient's hospital stay or course of treatment;

(9) Covered person means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

(10) Director means the Director of Insurance;

(11) 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;

(12) Emergency medical condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, (b) serious impairment to such person's bodily functions, (c) serious impairment of any bodily organ or part of such person, or (d) serious disfigurement of such person;

(13) Emergency services means health care services necessary to screen and stabilize a covered person in connection with an emergency medical condition;

(14) 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. Facility does not include physicians' offices;

(15) Grievance means a written complaint submitted in accordance with the health carrier's formal grievance procedure by or on behalf of a covered person regarding any aspect of the managed care plan, relative to the covered person, such as:

(a) Availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

(b) Claims payment, handling, or reimbursement for health care services; or

(c) Matters pertaining to the contractual relationship between a covered person and a health carrier;

(16) Health benefit plan means a policy, contract, certificate, or agreement entered into, offered, or issued by any person to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. Health benefit plan does not include workers' compensation insurance coverage;

(17) Health care professional means a physician or other health care practitioner licensed, certified, or registered to perform specified health services consistent with state law;

(18) Health care provider or provider means a health care professional or a facility;

(19) Health care services or health services means services for the diagnosis, prevention, treatment, cure, or relief of a health condition,

illness, injury, or disease;

(20) Health carrier means an entity that contracts, offers to contract, or enters into an agreement 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 prepaid limited health service organization, a prepaid dental service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services. Health carrier does not include a workers' compensation insurer, risk management pool, or self-insured employer who contracts for services to be provided through a managed care plan certified pursuant to section 48-120.02;

(21) Managed care plan means a health benefit plan, including closed plans and open plans, that either requires a covered person to use or creates financial incentives by providing a more favorable deductible, coinsurance, or copayment level for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier;

(22) Network means the group of participating providers providing services to a managed care plan;

(23) Open plan means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan;

(24) 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;

(25) 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;

(26) Prospective review means utilization review conducted prior to an admission or a course of treatment;

(27) Retrospective review means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment;

(28) 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 service to assess the clinical necessity and appropriateness of the initial proposed health service;

(29) Stabilize means when, with respect to transfer to another facility, the examining physician at a hospital emergency department where an individual has sought treatment for an emergency medical condition has determined, within reasonable medical probability:

(a) With respect to an emergency medical condition, that no material deterioration of the condition is likely to result from or occur during a transfer of the individual from the facility; and

(b) The receiving facility has available space and qualified personnel for the treatment of the individual and has agreed to accept transfer of the individual and provide appropriate medical treatment;

(30) Utilization review means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, providers, or facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. Utilization review does not include elective requests for clarification of coverage; and

(31) Written means transmission of correspondence by mail, facsimile, or electronic medium.

Sec. 69. Except as otherwise specified, the Health Carrier Grievance Procedure Act applies to all health carriers that offer managed care plans.

Sec. 70. The director may recognize accreditation by one or more nationally recognized private accrediting entities, with established and maintained standards, as evidence of meeting some or all of the requirements of the Health Carrier Grievance Procedure Act. A recognized accrediting entity shall make available to the director its current standards to demonstrate that the entity's standards meet or exceed this state's requirements. The health carrier may provide the director with documentation that a managed care plan has been accredited by the entity.

Sec. 71. (1) A health carrier shall maintain in a grievance

register written records to document all grievances received during a calendar year. A request for a first-level review of an adverse determination shall be processed in compliance with section 73 of this act but not considered a grievance for purposes of the grievance register unless such request includes a written grievance. A request for a second-level review of an adverse determination shall be considered a grievance for purposes of the grievance register. For each grievance required to be recorded in the grievance register, the grievance register shall contain, at a minimum, the following information:

(a) A general description of the reason for the grievance;

(b) Date received;

(c) Date of each review or hearing;

(d) Resolution at each level of the grievance;

(e) Date of resolution at each level; and

(f) Name of the covered person for whom the grievance was filed.

(2) The grievance register shall be maintained in a manner that is reasonably clear and accessible to the director. A grievance register maintained by a health maintenance organization shall also be accessible to the Director of Regulation and Licensure.

(3) A health carrier shall retain the grievance register compiled for a calendar year for the longer of three years or until the director has adopted a final report of an examination that contains a review of the grievance register for that calendar year.

Sec. 72. (1) Except as specified in section 76 of this act, a health carrier shall use written procedures for receiving and resolving grievances from covered persons.

(2)(a) A copy of the grievance procedures, including all forms used to process a grievance, shall be made available to the director upon request. A health carrier shall file annually with the director a certificate of compliance stating that the health carrier has established and maintains grievance procedures that fully comply with the provisions of the Health Carrier Grievance Procedure Act.

(b) A description of the grievance procedure shall be set forth in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to covered persons.

(c) The grievance procedure documents shall include a statement of a covered person's right to contact the director's office for assistance at any time. The statement shall include the telephone number and address of the director.

Sec. 73. (1) If a covered person makes a request to a health carrier for a health care service and the request is denied, the health carrier shall provide the covered person with an explanation of the reasons for the denial, a written notice of how to submit a grievance, and the telephone number to call for information and assistance. The health carrier, at the time of a determination not to certify an admission, a continued stay, or other health care service, shall inform the attending or ordering provider of the right to submit a grievance or a request for an expedited review and, upon request, shall explain the procedures established by the health carrier for initiating a review. A grievance involving an adverse determination may be submitted by the covered person, the covered person's representative, or a provider acting on behalf of a covered person, except that a provider may not submit a grievance involving an adverse determination on behalf of a covered person in a situation in which federal or other state law prohibits a provider from taking that action. A health carrier shall ensure that a majority of the persons reviewing a grievance involving an adverse determination have appropriate expertise. A health carrier shall issue a copy of the written decision to a provider who submits a grievance on behalf of a covered person. A health carrier shall conduct a first-level review of a grievance involving an adverse determination in accordance with subsection (3) of this section and section 75 of this act, but such a grievance is not subject to the grievance register reporting requirements of section 71 of this act unless it is a written grievance.

(2)(a) A grievance concerning any matter except an adverse determination may be submitted by a covered person or a covered person's representative. A health carrier shall issue a written decision to the covered person or the covered person's representative within fifteen working days after receiving a grievance. The person or persons reviewing the grievance shall not be the same person or persons who made the initial determination denying a claim or handling the matter that is the subject of the grievance. If the health carrier cannot make a decision within fifteen working days due to circumstances beyond the health carrier's control, the health carrier may take up to an additional fifteen working days to issue a

written decision, if the health carrier provides written notice to the covered person of the extension and the reasons for the delay on or before the fifteenth working day after receiving a grievance.

(b) A covered person does not have the right to attend, or to have a representative in attendance, at the first-level grievance review. A covered person is entitled to submit written material. The health carrier shall provide the covered person the name, address, and telephone number of a person designated to coordinate the grievance review on behalf of the health carrier. The health carrier shall make these rights known to the covered person within three working days after receiving a grievance.

(3) The written decision issued pursuant to the procedures described in subsections (1) and (2) of this section and section 75 of this act shall contain:

(a) The names, titles, and qualifying credentials of the person or persons acting as the reviewer or reviewers participating in the first-level grievance review process;

(b) A statement of the reviewers' understanding of the covered person's grievance;

(c) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position;

(d) A reference to the evidence or documentation used as the basis for the decision;

(e) In cases involving an adverse determination, the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination;

(f) If applicable, a statement indicating:

(i) A description of the process to obtain a second-level grievance review of a decision; and

(ii) The written procedures governing a second-level review, including any required timeframe for review; and

(g) Notice of the covered person's right to contact the director's office. The notice shall contain the telephone number and address of the director's office.

Sec. 74. (1) A health carrier that offers managed care plans shall establish a second-level grievance review process for its managed care plans to give those covered persons who are dissatisfied with the first-level grievance review decision the option to request a second-level review, at which the covered person has the right to appear in person before authorized representatives of the health carrier. A health carrier required by this section to establish a second-level grievance review process shall provide covered persons with adequate notice of that option.

(2)(a) With respect to a second-level review of a grievance, a health carrier shall appoint a second-level grievance review panel. A majority of the panel shall be comprised of persons who were not previously involved in the grievance. The panel shall have the legal authority to bind the health carrier to the panel's decision.

(b) A health carrier shall ensure that a majority of the persons reviewing a grievance involving an adverse determination are health care professionals who have appropriate expertise.

(3) A health carrier's procedures for conducting a second-level panel review shall include the following:

(a) The review panel shall schedule and hold a review meeting within forty-five working days after receiving a request from a covered person for a second-level review. In cases in which the covered person cannot appear in person, a health carrier shall offer the covered person the opportunity to communicate with the review panel by conference call or other available technology;

(b) Upon the request of a covered person, a health carrier shall provide to the covered person all relevant information that is not confidential or privileged;

(c) A covered person has the right to:

(i) Attend the second-level review;

(ii) Present his or her cases to the review panel;

(iii) Submit supporting material both before and at the review meeting;

(iv) Ask questions of any representative of the health carrier; and

(v) Be assisted or represented by a person of his of her choice;

(d) The notice shall advise the covered person of the rights specified in subdivision (3)(c) of this section;

(e) The review shall include (i) documentation of the substance of the grievance and (ii) full investigation of the substance of the grievance,

including all known aspects of clinical care involved; and

(f) The review panel shall issue a written decision to the covered person within five working days after completing the review meeting.

Sec. 75. (1) A health carrier shall establish written procedures for a standard review of an adverse determination. Review procedures shall be available to a covered person and to the provider acting on behalf of a covered person. For purposes of this section, covered person includes the representative of a covered person.

(2) When reasonably necessary or when requested by the provider acting on behalf of a covered person, standard reviews shall be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The clinical peer shall not have been involved in the initial adverse determination.

(3) For standard reviews the health carrier shall notify in writing both the covered person and the attending or ordering provider of the decision within fifteen working days after the request for a review. The written decision shall contain the provisions required in subsection (3) of section 73 of this act.

(4) In any case in which the standard review process does not resolve a difference of opinion between the health carrier and the covered person or the provider acting on behalf of the covered person, the covered person or the provider acting on behalf of the covered person may submit a written grievance, unless the provider is prohibited from filing a grievance by federal or other state law. A health carrier that offers managed care plans shall review it as a second-level grievance.

Sec. 76. (1) A health carrier shall establish written procedures for the expedited review of a grievance involving a situation in which the timeframe of the standard grievance procedures set forth in sections 73 to 75 of this act would seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function. A request for an expedited review may be submitted orally or in writing. A request for an expedited review of an adverse determination may be submitted orally or in writing and shall be subject to the review procedures of this section, if it meets the criteria of this section. However, for purposes of the grievance register requirements of section 71 of this act, a request for an expedited review shall not be included in the grievance register unless the request is submitted in writing. Expedited review procedures shall be available to a covered person and to the provider acting on behalf of a covered person. For purposes of this section, covered person includes the representative of a covered person.

(2) Expedited reviews which result in an adverse determination shall be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The clinical peer or peers shall not have been involved in the initial adverse determination.

(3) A health carrier shall provide expedited review to all requests concerning an admission, availability of care, continued stay, or health care service for a covered person who has received emergency services but has not been discharged from a facility.

(4) An expedited review may be initiated by a covered person or a provider acting on behalf of a covered person.

(5) In an expedited review, all necessary information, including the health carrier's decision, shall be transmitted between the health carrier and the covered person or the provider acting on behalf of a covered person by telephone, facsimile, or the most expeditious method available.

(6) In an expedited review, a health carrier shall make a decision and notify the covered person or the provider acting on behalf of the covered person as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two hours after the review is commenced. If the expedited review is a concurrent review determination, the health care service shall be continued without liability to the covered person until the covered person has been notified of the determination.

(7) A health carrier shall provide written confirmation of its decision concerning an expedited review within two working days after providing notification of that decision, if the initial notification was not in writing. The written decision shall contain the provisions required in subsection (3) of section 73 of this act.

(8) A health carrier shall provide reasonable access, not to exceed one business day after receiving a request for an expedited review, to a clinical peer who can perform the expedited review.

(9) In any case in which the expedited review process does not resolve a difference of opinion between the health carrier and the covered

person or the provider acting on behalf of the covered person, the covered person or the provider acting on behalf of the covered person may submit a written grievance, unless the provider is prohibited from filing a grievance by federal or other state law. A health carrier that offers managed care plans shall review it as a second-level grievance. Except as expressly provided in this section, in conducting the review, the health carrier shall adhere to timeframes that are reasonable under the circumstances.

(10) A health carrier shall not be required to provide an expedited review for retrospective adverse determinations.

Sec. 77. If the director finds that any health carrier doing business in this state is engaging in any violation of the Health Carrier Grievance Procedure Act and that a proceeding in respect thereto would be in the public interest, the director shall issue and serve upon such health carrier a statement of the charges in that respect and a notice of hearing thereon, which notice shall set a hearing date not less than ten days from the date of the notice.

Sec. 78. If, after the hearing, the director finds a health carrier has violated the Health Carrier Grievance Procedure Act, the director shall reduce his or her findings to writing and shall issue and cause to be served upon the health carrier charged with the violation a copy of the findings and an order requiring the health carrier to cease and desist from engaging in the violation and the director may order any one or more of the following:

(1) Payment of a monetary penalty of not more than one thousand dollars for each violation, not to exceed an aggregate penalty of thirty thousand dollars, unless the violation was committed flagrantly and in conscious disregard of the Health Carrier Grievance Procedure Act, in which case the penalty shall not be more than fifteen thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the health carrier's certificate of authority if the health carrier knew or reasonably should have known it was in violation of the act.

Sec. 79. Any health carrier who violates a cease and desist order of the director under section 78 of this act may after notice and hearing and upon order of the director be subject to:

(1) A monetary penalty of not more than thirty thousand dollars for each violation, not to exceed an aggregate penalty of one hundred fifty thousand dollars; and

(2) Suspension or revocation of the health carrier's certificate of authority.

Sec. 80. The director may adopt and promulgated rules and regulations to carry out the Health Carrier Grievance Procedure Act.

Sec. 81. (1) Notwithstanding section 44-3,131, any individual or group sickness and accident insurance policy or subscriber contract delivered, issued for delivery, or renewed in this state and any hospital, medical, or surgical expense-incurred policy, except for policies that provide coverage for a specified disease or other limited-benefit coverage, and any self-funded employee benefit plan to the extent not preempted by federal law, which provides reimbursement for prescription drugs approved by the federal Food and Drug Administration for the treatment of a specific type of cancer shall not exclude coverage of any drug or combination of drugs on the basis that the drug or combination of drugs has not been approved by the federal Food and Drug Administration for the treatment of another specific type of cancer if (a) the drug or combination of drugs is recognized for treatment of the other specific type of cancer in the United States Pharmacopeia-Drug Information and the drug or combination of drugs is approved for sale by the federal Food and Drug Administration or (b) the drug or combination of drugs is recognized for treatment of the other specific type of cancer in medical literature and the drug or combination of drugs is approved for sale by the federal Food and Drug Administration.

(2) Notwithstanding section 44-3,131, any individual or group sickness and accident insurance policy or subscriber contract delivered, issued for delivery, or renewed in this state and any hospital, medical, or surgical expense-incurred policy, except for policies that provide coverage for a specified disease or other limited-benefit coverage, and any self-funded employee benefit plan to the extent not preempted by federal law, which provides reimbursement for prescription drugs approved by the federal Food and Drug Administration for the treatment of human immunodeficiency virus or acquired immunodeficiency syndrome shall not exclude coverage of any drug or combination of drugs on the basis that the drug or combination of drugs has not been approved by the federal Food and Drug Administration for the treatment of human immunodeficiency virus or acquired immunodeficiency

syndrome if (a) the drug or combination of drugs is recognized for treatment of human immunodeficiency virus or acquired immunodeficiency syndrome in the United States Pharmacopeia-Drug Information and the drug or combination of drugs is approved for sale by the federal Food and Drug Administration or (b) the drug or combination of drugs is recognized for treatment of human immunodeficiency virus or acquired immunodeficiency syndrome in medical literature and the drug or combination of drugs is approved for sale by the federal Food and Drug Administration.

(3) Any coverage of a drug or combination of drugs required by this section shall include medically necessary services associated with the administration of the drug if such services are covered by the insurance policy, contract, or plan.

(4) Nothing in this section shall be construed to require coverage for any experimental or investigational drug not approved by the federal Food and Drug Administration.

(5) For purposes of this section, medical literature means two articles from major peer-reviewed professional medical journals that have recognized, based on scientific or medical criteria, the safety and effectiveness of the drug or combination of drugs for treatment of the indication for which it has been prescribed unless two articles from major peer-reviewed professional medical journals have concluded, based on scientific or medical criteria, that the drug or combination of drugs is unsafe or ineffective or that the safety and effectiveness of the drug or combination of drugs cannot be determined for the treatment of the indication for which the drug or combination of drugs has been prescribed. Each article shall meet the uniform requirements for manuscripts submitted to biomedical journals established by the International Committee of Medical Journal Editors or shall have been published in a journal specified by the United States Department of Health and Human Services pursuant to 42 U.S.C. 1395x(t)(2)(B), as amended, as acceptable peer-reviewed medical literature. Peer-reviewed medical literature shall not include publications or supplements that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

(6) Within ninety days after the operative date of this section, the chief medical officer, if one is appointed pursuant to section 81-3201, and if not, then the Director of Regulation and Licensure, shall appoint a panel of five medical experts as follows: Three medical oncologists, upon the recommendation of the Nebraska Oncology Society, and two specialists in the management of patients being treated for human immunodeficiency virus or acquired immunodeficiency syndrome, upon the recommendation of the Nebraska Medical Association. Members of the panel shall serve without compensation, except that they shall be reimbursed for their actual and necessary expenses pursuant to sections 81-1174 to 81-1177. When there is a question regarding acceptable medical literature support of an administration under this section, the panel, upon request of the Director of Insurance, shall review the use in dispute and the medical literature and shall advise the Director of Insurance whether an administration is medically appropriate for purposes of this section. A majority vote of the members of the panel shall be necessary to determine that coverage is medically appropriate. The panel may meet in person or by telephone conference call or other communication means acceptable to the Director of Insurance and the chief medical officer, if one is appointed pursuant to section 81-3201, and if not, then the Director of Regulation and Licensure.

(7) This section shall apply to policies, plans, or contracts for insurance as provided in subsections (1) and (2) of this section which are delivered, issued for delivery, or renewed in this state on or after the operative date of this section.

Sec. 82. (1) Notwithstanding section 44-3,131, no group policy of accident or health insurance, health services plan, or health maintenance organization subscription shall be offered for sale in this state on or after the operative date of this section unless such policy, plan, subscription, or contract which specifically provides coverage for surgical and nonsurgical treatment involving a bone or joint of the skeletal structure includes the option to provide coverage for the same diagnostic or surgical procedure involving any other bone or joint of the face, neck, or head through the use of an endorsement or similar amendment. Such endorsement may limit benefits for services to an amount of not less than two thousand five hundred dollars.

Sec. 83. Section 81-1307, Revised Statutes Supplement, 1997, is amended to read:

81-1307. The Director of Personnel shall be responsible for the administration of the personnel division. Subject to the review powers of the State Personnel Board, the director shall be responsible for development of

recommendations on personnel policy and for development of specific administrative systems and shall have the authority to adopt, promulgate, and enforce rules and regulations pertaining thereto. The director shall be responsible for specific administrative systems including, but not limited to, the following:

(1) Employment Services:

(a) General employment policies and procedures;

(b) Position classification plans;

(c) Job descriptions;

(d) Job specifications;

(e) Salary or pay plans;

(f) Staffing patterns; and

(g) Recruiting of qualified applicants for employment and the maintenance of qualified applicants for employment for all positions in state government;

(2) Personnel Records:

(a) A system of records and statistical reports containing general data on all employees, including current salary levels and such other information as may be required by the operating needs of state departments and agencies and the budget division; and

(b) Standards for the development and maintenance of personnel records to be maintained within operating departments of the state government;

(3) Personnel Management:

(a) Minimum standards for evaluation of employee efficiency and a system of regular evaluation of employee performance;

(b) Administrative guidelines governing such matters as hours of work, promotions, transfers, demotions, probation, terminations, reductions in force, salary actions, and other such matters as may not be otherwise provided for by law;

(c) Administrative policies and general procedural instructions for use by all state agencies relating to such matters as employee benefits, vacation, sick leave, holidays, insurance, sickness and accident benefits, and other employee benefits as the Legislature may from time to time prescribe; and

(d) A system of formally defined relationships between the personnel division and departments and agencies to be covered by the State Personnel System;

(4) Salary and Wage Survey: Measuring, through the use of surveys, the state's comparative level of employee compensation with the labor market;

(5) Staffing Patterns:

(a) Staffing patterns for each department and agency of state government that conform with those authorized by the budget division;

(b) Revisions to staffing patterns of all departments and agencies that have been approved by the budget division;

(c) Merit increases provided for any employee of the state that are the result of positive action by the appropriate supervisor; and

(d) The state's pay plan, as enacted by the Legislature, together with such amendments as may occur, is explained in appropriate handbooks for employees of the state;

(6) Temporary ~~Employee Pool~~ Employees:

(a) The director shall administer ~~a temporary employee applicant pool~~ the Temporary Employee Pool containing applicants from which state agencies can draw when in need of a short-term labor supply; and

(b) State agencies must receive approval from the director before hiring any temporary employee; and

(7) Employee Recognition Program: The director shall administer an employee recognition program for state employees. The program shall serve as the authorized program for honoring state employees for dedicated and quality service to the government of the State of Nebraska.

Sec. 84. The personnel division of the Department of Administrative Services shall provide an annual report to the Clerk of the Legislature. The report shall include the following information based on the prior fiscal year: (1) The number of temporary employees employed by the state; (2) the number of such temporary employees who were eligible for health insurance coverage pursuant to section 84-1601; (3) the number of such temporary employees who elected coverage; and (4) the average length of health insurance coverage for those temporary employees who elected coverage.

Sec. 85. Section 84-1601, Reissue Revised Statutes of Nebraska, is amended to read:

84-1601. (1) There is hereby established a program of group life and health insurance for all permanent employees of this state who work one-half or more of the regularly scheduled hours during each pay period,

excluding employees of the University of Nebraska, the state colleges, and the community colleges. Such program shall be known as the Nebraska State Insurance Program and shall replace any current program of such insurance in effect in any agency and funded in whole or in part by state contributions.

(2) Temporary employees of the state who have a work assignment of at least six months' duration and who work at least twenty hours per week may purchase health insurance through the Nebraska State Insurance Program. The state shall pay the same proportion of the insurance premium for temporary employees as is established through the collective bargaining process for permanent employees. For purposes of this subsection, temporary employees means individuals (a) employed in the Temporary Employee Pool as described in subdivision (6) of section 81-1307 and (b) hired directly by state agencies. In no event shall a temporary employee mean an individual hired through a private employment agency. The provisions of this subsection shall terminate on July 1, 1999.

(3) For purposes of sections 84-1601 to 84-1615, health insurance may be construed to include coverage for disability and dental health care services.

~~(3)~~ (4) Any commissioned employee of the Nebraska State Patrol who on or after July 17, 1986, has reached fifty-one years of age or becomes medically disabled and who will not receive benefits from the federal social security program shall be afforded the opportunity to remain enrolled in the state employees group health insurance program until age sixty-five. Employees electing this option shall be responsible for the entire premium cost, including the state's share, the employee's share, and an administrative fee consistent with that allowed by federal guidelines for continuation of health insurance.

Sec. 86. Section 84-1604, Reissue Revised Statutes of Nebraska, is amended to read:

84-1604. The coverages provided for by sections 84-1601 to 84-1615 shall be afforded to each permanent state employee who works one-half or more of the regularly scheduled hours during each pay period, commencing after thirty days of such employment, and to each temporary employee only as described in subsection (2) of section 84-1601, commencing after thirty days of such employment. ~~Employees~~ Permanent and temporary employees who are employed less than the regularly scheduled hours as defined for a permanent employee shall be entitled to state contributions on a proportionately reduced basis. The life and health insurance coverages provided by sections 84-1601 to 84-1615 shall be totally independent of one another and the loss experience and the rates for the two coverages shall be maintained separate and apart from one another.

Sec. 87. Sections 26 to 38, 43, 45, and 46 of this act become operative on July 1, 1999. The other sections of this act become operative on their effective date.

Sec. 88. If any section in this act or any part of any section is declared invalid or unconstitutional, the declaration shall not affect the validity or constitutionality of the remaining portions.

Sec. 89. Original sections 44-5401, 44-5402, 44-5409 to 44-5414, 84-1601, and 84-1604, Reissue Revised Statutes of Nebraska, and sections 44-6801, 44-6802, 44-6820, 44-6823, and 81-1307, Revised Statutes Supplement, 1997, are repealed.

Sec. 90. The following sections are outright repealed: Sections 44-5403 to 44-5408 and 44-5415, Reissue Revised Statutes of Nebraska, and sections 44-6803 to 44-6819, 44-6821, 44-6822, and 44-6824, Revised Statutes Supplement, 1997.