RULES AND REGULATIONS

FOR THE

CERTIFICATION OF HEALTH PLANS

(R23-17.13-CHP)

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

Department of Health

September 1997

As amended:
December 1999
March 2001
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INTRODUCTION

It has been determined that it is in the best interest of the public that those individuals and health care entities involved with the delivery of plan coverage in Rhode Island meet the standards of Chapter 23-17.13, Chapter 27-41, and Chapter 23-17.18 to ensure accessibility and quality for state residents. It is not intended to prohibit a health care entity or contractor from forming limited networks of providers.

These regulations are established pursuant to the authority conferred under Chapter 23-17.13, Chapter 27-41, and 23-17.18 of the General Laws of Rhode Island for the purpose of adopting minimum standards and procedures for the implementation of the Health Care Accessibility and Quality Assurance Act of 1997, the Health Maintenance Act of 1983, and the Health Plan Modification Act. It is a vital state function to establish these standards for the conduct of health plans by a health care entity in Rhode Island.

Pursuant to the provision of section 42-35-2(c) of the General Laws of Rhode Island, as amended, in the development of the regulations, consideration was given to the following: (a) alternative approaches to the regulations; (b) overlap or duplication with other state regulations; (c) significant economic impact resulting from the regulations. The proposed regulations have undergone substantial revisions which include alternative approaches. Compliance with the proposed regulations will result in some modest increased costs for health plans. Overlap with *the Rules and Regulations for Utilization Review of Health Care Services (R23-17.12)* was identified and mechanisms are included herein to coordinate the overlapping regulatory activity in order to prevent the duplication of such activity. Consequently these rules and regulations are adopted in the best interest of the public health, safety and welfare.

These rules and regulations shall supercede all previous *Rules and Regulations for the Certification of Health Plans* promulgated by the Department of Health and filed with the Rhode Island Secretary of State.

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Section 1.0 ***Definitions***

Wherever used in these rules and regulations, the following terms shall be construed as follows:

1.1 ***"Act"*** refers to Chapter 23-17.13 of the General Laws of Rhode Island, as amended, entitled "Health Care Accessibility and Quality Assurance Act."

1.2 ***"Adverse decision"*** means any decision by a review agent not to certify a health care service provided, however, that a decision by a review agent to certify a health care service in an alternative setting, a modified extension of stay, or an alternative treatment shall not constitute an adverse determination if the review agent and provider are in agreement regarding the decision. Adverse determinations shall include decisions not to certify formulary and nonformulary medication.

1.3 ***"Complaint"*** means a contact made by an enrollee or provider to the health plan whereby they are not satisfied with the following as they relate to the certified health plan, a health plan employee or the health care entity who operates the health plan:

a) a utilization review decision;

b) the quality of health care;

c) any activity related to the management of the delivery of health care services.

1.4 ***"Contractor"*** means a person/entity that:

a) establishes, operates or maintains a network of participating providers; and/or

b) contracts with an insurance company, a hospital or medical or dental service plan, an employer, whether underwritten or self-insured, an employee organization, or any other entity providing coverage for health care services to administer a plan; and/or

c) conducts or arranges for utilization review activities pursuant to section 23-17.12 of the Rhode Island General Laws, as amended.

1.5 ***"Covered benefit"*** means an enrollee's entitlement to payment for or provision of health services as defined in an agreement with a health plan. Covered benefit shall have the same meaning as covered service.

1.6 ***"Delegation"*** means a formal process by which a health plan gives an organization/agent the authority to perform certain functions the health plan would otherwise perform. The Plan shall maintain oversight and accountability for all delegated activity through a formal agreement describing delegated functions(s) and the oversight program.

1.7 ***"Director"*** means the Director of the Department of Health.

1.8 ***"Direct service ratio"*** means the ratio of the amount of premium dollars expended by the plan for covered services which are provided to enrollees divided by the total premium dollars received for the plan's fiscal year.

1.9 ***"Emergent health care services"*** shall have the same meaning as the meaning contained in the rules and regulations promulgated pursuant to Chapter 42-12.3, as may be amended from time to time, and shall include the sudden onset of medical, mental or substance abuse or other health condition manifesting itself by acute symptoms of severity (e.g. severe pain) where the absence of immediate medical attention could reasonably be expected, by a prudent lay person, to result in placing the patient's health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any body organ or part.

1.10 ***"Enrollee"*** means any individual who is entitled to receive covered benefits under a health plan.

1.11 ***"Health care entity"*** means a licensed insurance company, or hospital, or dental or medical service plan or health maintenance organization, or a contractor as described in section 1.4 herein, that operates a health plan.

1.12 ***"Health care services"*** means and includes an admission, diagnostic procedure, therapeutic procedure, treatment, extension of stay, the ordering and/or filling of formulary medications, and such other services, activities or supplies which are covered by the patient's benefit plan.

1.13 ***HMO Act"*** refers to Chapter 27-41 of the General Laws of Rhode Island, as amended, entitled, "Health Maintenance Organization Act."

1.14 ***"Health maintenance organization"*** hereinafter referred to as an HMO means a single public or private organization seeking or maintaining certification as a health plan, that:

a) provides or otherwise makes available to enrolled participants health care services, including at least the following basic health care services: usual physician services, hospitalization, laboratory, x-ray, emergency and preventive services, and out-of-area coverage;

b) is compensated, except for co-payments, for the provision of the basic health care services listed in section 1.14(a) above to enrolled participants on a predetermined periodic rate basis; and

c) provides physicians' services primarily:

(i) directly through physicians who are either employees or partners of such organization; or

(ii) through arrangements with individual physicians or one or more groups of physicians (organized on a group practice or individual basis).

1.15 ***"Health plan"*** means a plan operated by a health care entity as described in section 1.11 herein, that provides for the delivery of health care services to individuals enrolled in such a plan through:

a) agreements with providers who have been selected by the health plan to furnish health care services; and/or

b) financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan.

1.16 ***"Health organization"*** shall mean the same as ***"health care entity"*** for the purposes of the Rules and Regulations herein.

1.17 ***"Material modification"*** means any substantial systemic change to the certification information on file at the Department which is deemed material by the Department pursuant to section 2.5 herein.

1.18 ***"Operating a health plan in Rhode Island"*** means the establishment of a provider network in Rhode Island for the purposes of the delivery of health care services to health plan enrollees.

1.19 ***"Person"*** shall mean any individual, trust, or estate, partnership, corporation (including associations, joint stock companies), state or political subdivision or instrumentality of the state.

1.20 ***"Participating provider"*** means a physician, hospital, pharmacy, laboratory, dentist, mental health/substance abuse provider, other Rhode Island State licensed or other Rhode Island State recognized provider of health care services or supplies, and whose services are recognized pursuant to 213(d)(1) of the Internal Revenue Code that has entered into an agreement with a health care entity, as described in Section 1.4 and 1.11 herein, to provide such services or supplies to an enrollee of a health plan.

1.21 ***"Physician"*** means a person registered or licensed to practice allopathic or osteopathic medicine in this state under Rhode Island General Laws.

1.22 ***"Premium"*** means the amount of money paid to and/or utilized by a health plan for providing coverage for health care services for the health plan's enrollees.

1.23 ***"Primary care "*** means the basic or general health care furnished by a provider who is responsible for the overall and ongoing coordination of a patient's health care. In most instances, primary care is focused on the point at which a patient first seeks assistance from the health care system for non-emergency services.

1.24 ***"Professional provider"*** means an individual clinician who provides health care services. Professional provider shall have the same meaning as non-institutional provider.

1.25 ***"Prospective enrollee"*** means any individual who is eligible for enrollment or reenrollment in a health plan.

1.26 ***"Provider"*** means a physician, hospital, pharmacy, laboratory, dentist, mental health/substance abuse provider, other Rhode Island state licensed or other Rhode Island state recognized provider of health care services or supplies, and whose services are recognized pursuant to 213 (d)(1) of the Internal Revenue Code.

1.27 ***"Provider incentive plan"*** means any compensation arrangement between a health care entity or health plan and a provider or provider group that may directly or indirectly have the effect of reducing or limiting services provided with respect to an individual enrolled in a health plan.

1.28 ***"Provider network"*** means those providers who have a written agreement with the health plan to deliver medical and health care services to health plan enrollees.

1.29 ***"Qualified health plan"*** means a plan that the Director of the Department of Health certified, upon application by the program, as meeting the requirements of the Act.

1.30 ***"Qualified utilization review program"*** means a utilization review program that meets the requirements of Chapter 23-17.12 of the Rhode Island General Laws, as amended.

1.31 ***"Second opinion"*** means an additional clinical consultation concerning a medical/health condition.

1.32 ***"Subscriber"*** means an individual who accepts the terms of an agreement with a health care entity, as defined in section 1.11 herein, to receive covered benefits under a specified health plan for him/herself and any dependents and in whose name a payment is made for such covered benefits. The term beneficiary shall have the same meaning as subscriber.

1.33 ***"Urgent health care services"*** shall have the same meaning as that meaning contained in the rules and regulations promulgated pursuant to Chapter 12.3 of Title 42 as may be amended from time to time and shall include those resources necessary to treat a symptomatic medical, mental health or substance abuse or other health care condition requiring treatment within a twenty-four (24) hour period of the onset of such a condition in order that the patient's health status not decline as a consequence. This does not include those conditions considered to be emergent health care services as defined herein.

1.34 ***"Utilization review"*** means the prospective, concurrent or retrospective assessment of the necessity and appropriateness of the allocation of health care services of a provider, given or proposed to be given to a patient, or group of patients. Utilization review does not mean the elective requests for the clarification of coverage; or claims review that does not include the assessment of the medical necessity and appropriateness; or a provider's internal quality assurance program except if it is associated with a health care financing mechanism.

Section 2.0 *Health Plan Application for Certification*

2.1 Each health care entity operating a health plan in Rhode Island under this Act must submit a completed application form as prescribed by the Director which is accompanied by supporting documents as required.

2.2 The cost of the application process, certification, recertification, material modifications, health plan reviews, and other activities directly related to obtaining and maintaining plan certification such as compliance with the rules and regulations herein shall be borne by the entities operating the certified health plan.

2.2.1 The cost shall be one hundred and fifty percent (150%) of the total salaries paid to the certifying personnel of the Department for the certification activities described in section 2.2 herein. Such cost shall be in addition to any fines, taxes and fees otherwise payable to the Department as a result of the enforcement of the regulations herein.

2.2.2 Certified health plans shall have the opportunity to review documents to substantiate their costs as described in section 2.2 herein.

2.2.3 Payments for the cost of the application process, certification, recertification, material modification and health plan reviews shall be made payable to the General Treasurer, state of Rhode Island according to Section 23-17.13-3 (A) (3) of the Act.

2.2.3 (a) Payments for the cost of the application process, certification, recertification, material modification, and health plan reviews shall be billed on the fifth of each month and payment by the review agency is due by the close of the same month.

2.2.3 (b) Failure to make payment by the required due date will result in a fine determined by the Director. Failure to respond to the Department and remit fine within a ninety (90) day period will be subject to Section 9.0 herein.

2.3 The Department shall act upon the health plan's completed application within ninety (90) days of receipt of a complete application for certification, recertification or material modification.

2.4 Upon receipt of a completed application for certification, recertification or material modification, the Department shall notify and afford the public an opportunity to comment on the application in accordance with the following:

a) The Department shall post a notice for public comment within thirty (30) days of receipt of a completed application.

b) The notification shall be in the form of a public notice in a newspaper of statewide distribution.

c) The public shall have ten (10) days from the date of publication of public notice to submit their written comments to the Department.

d) The Department shall take a final action on an application after the public comment period.

2.5 The certified health plan shall notify the Department prior to the implementation of any substantial systemic change in the information on file with the Department. If the Department determines a change is material, the certified health plan shall submit an application for a material modification.

2.5.1 This application shall contain sufficient information to enable the Department to determine compliance with the rules and regulations herein.

2.5.2 No implementation of any material modification shall be effected without the prior approval of the Department.

2.5.3 If the Department does not disapprove of the modification within ninety (90) days of the receipt of all necessary information, it shall be deemed approved.

2.5.4 Every Plan shall give prompt notice of its intent to surrender/withdraw its Rhode Island Health Plan Certification as defined herein.

(a) Notice shall be made to the Department, enrollees and providers at least ninety (90) calendar days prior to such action unless otherwise authorized by the Department.

2.6 If any health plan responsibility, in part or whole, as defined in these rules and regulations is delegated to another organization/agent, the health plan shall maintain oversight and accountability for all delegated activity through a formal agreement describing delegated function(s) and the oversight program.

(a) Health plans may not delegate the responsibility of oversight assuring that the delegated function(s) is performed appropriately.

(b) It is the responsibility of the Plan to re-assume the activity delegated should it be determined necessary by the Department to assure compliance with the regulations herein.

(c) Deficiencies cited by the Department for activities of the delegate shall accrue to the Plan regardless of the contractual responsibility for carrying out the activity.

(d) The Department shall have direct access to information held by the delegate to determine compliance of the Plan to the requirements herein.

2.7 The Department shall review a certified health plan any time there exists evidence that a health plan may be in violation of the rules and regulations herein.

2.8 Each health care entity shall submit an application for recertification of each of its certified health plans every two years.

2.9 To conduct reviews for purposes of certification, recertification, material modification or other activities related to health plan certification, a duly authorized representative of the Department shall have the right to enter a facility (if any) and/or to examine any premises and services where health care services of a health plan are provided. Such examination shall furthermore include examination of medical and related records such as medical audit records, utilization review records, quality assurance studies and the like.

2.10 Every health plan shall be given prompt notice by the Department of all deficiencies cited upon examination. A plan to correct all deficiencies shall be submitted to the Department by the health plan within a twenty (20) calendar day period. If said plan is not acceptable to the Department, the Department may take action according to Section 9.0 herein.

Section 3.0 ***Requirements for the Certification of Health Plans***

3.1 On or after January 1, 1998, an individual and/or health care entity operating a health plan in Rhode Island under this Act, shall not enroll members into its plan unless the Department has certified that health plan and it shall meet the requirements herein.

3.1.1 However, if an application for certification has been filed, health plans may enroll members pending the Department's final determination on such application.

3.1.2 An HMO shall not operate in Rhode Island until the Department has granted a certificate and determined by application that the HMO has met the requirements defined in the rules and regulations, except for section 4.0 set forth herein.

3.2 The Department shall certify health plans complying with the minimum standards defined in the rules and regulations herein.

3.2.1 Health plans shall provide prospective and current enrollees and the Department with the information as to the terms and conditions of the plan consistent with the rules and regulations promulgated under 42-12.3 and those requirements in section 4.0 herein.

3.2.2 Health plans shall adhere to the credentialing and contracting criteria defined in sections 5.0 herein for providers delivering care within the state of Rhode Island.

3.2.3 Health plans shall provide health care services in a manner to assure the availability, accessibility, continuity, quality and adequate personnel and facilities which shall consist of those requirements in section 6.0 herein.

3.2.3(a) An HMO shall provide sufficient information to enable the Department to determine the ability of the applicant to assure that the health care services will be provided in a manner to enhancing availability, accessibility and continuity of health care services as described in the requirements herein.

3.3 The health plan shall adhere to any and all applicable state or federal laws.

3.4 An HMO must have the professional services under the direction of a medical director who is licensed in Rhode Island in accordance with Chapter 5-37 of the General Laws of Rhode Island, as amended, and who shall be responsible for the following:

(a) to arrange for the provision of health care services to enrollees;

(b) the coordination, supervision, and functioning of professional services;

(c) achievement and maintenance of the quality management of professional practices through peer review mechanisms.

3.5 A health plan will meet certification requirements by providing information required in sections 4.0 and 6.0 herein pursuant to any state or federal agency in conformance with any other applicable state or federal law, or in conformity with standards adopted by an accrediting organization which the Department determines that the information is substantially similar to that required in sections 4.0 and 6.0 and is presented in a format the Department determines will provide meaningful comparison between health plans.

3.5.1 The Department shall require all health plans meeting one or more certification requirements under this section to report data and other information to the Department as the Department deems necessary to enforce the requirements of the Act.

Section 4.0 ***Disclosure Of Information***

4.1 Health plans shall disclose to prospective and current enrollees, through the subscriber or prospective subscriber, the information defined in section 4.3 (a)-(t) in a standardized manner approved by the Department.

4.1.1 Upon receipt of initial certification as a health plan as defined herein, the health plan shall meet the disclosure requirements of section 4.0 within 90 days of initial certification.

4.1.2 The health plan shall submit to the Department for prior approval, its mechanism for the direct distribution of the information defined in section 4.3 (a-q) to current and prospective subscribers.

a) This mechanism shall include a provision for posting and maintaining a current and correct version of the information defined in section 4.3 (a-q) in the standardized format, approved by the Department, on the health plan's website and notification to the Department of the Internet address for public access to the information.

4.1.3 The information defined in Section 4.3 (r)-(t) shall be disclosed to prospective and current enrollees upon request.

4.1.4 The information defined in Section 4.3 (a)-(t) shall be provided to the Department, at intervals determined by the Department.

4.1.5 The Department shall provide the health plan with a twenty (20) day comment period after changing the reporting requirements.

a) The health plan shall have a period of ninety (90) days after the comment period to comply with this section given new or changed requirements.

4.2 To ensure that prospective and current enrollees have the opportunity to make informed decisions regarding their health care, the health plans shall utilize the definitions contained in Appendix A herein, for the purposes of the disclosures required in section 4.0 herein.

4.3 The information to be disclosed regarding coverage provisions and benefits shall include, but not be limited to, the following:

a) restrictions or limitations on health care services including exclusions as follows:

i) by category of service;

ii) if applicable, by specific service, technology, procedure, medication, provider, treatment modality, diagnosis and condition; and

iii) treatment modality, diagnosis and condition shall be listed by name;

b) experimental treatment modalities which are subject to change with the advent of new technology may be listed by the broad category "Experimental Treatment";

c) a description of health plan limitations, including information on enrollee financial responsibilities for payment including the following:

i) coinsurance;

ii) copayments;

iii) deductibles;

iv) annual limits;

v) maximum lifetime benefits;

vi) enrollee's financial responsibility for out-of-plan services; and

vii) other non-covered, out-of-pocket health care expenses;

d) a summary of the enrollee's responsibilities regarding the coordination of benefits;

e) the plan's telephone number and address where enrollees may call or write for more information on benefits, coverage provisions, restrictions, exclusions and complaints regarding the health plan's operation;

f) a written statement of the enrollee's right to seek a second opinion, and related reimbursement, if applicable;

g) the enrollee's appeal rights and any time limitations to file an appeal, as defined in Chapter 23-17.12 of the Rhode Island General Laws as amended and the *Rules and Regulations for Utilization Review;*

i) the telephone number and address of the health plan's office(s) which is (are) responsible for the management of utilization review appeals and complaints;

h) a summary of the utilization review criteria, requirements and procedures which may lead to a denial of coverage for the service or a denial of the service including:

i) preauthorization review;

ii) concurrent review;

iii) post-service review; and

iv) post-payment review;

i) a summary of the criteria used to authorize treatment and procedures to obtain authorization;

j) a summary statement of the plan's confidentiality policy including measures taken by the plan to ensure confidentiality of the individual's health care record which is consistent with the requirements in section 6.5 herein. This statement shall include the measures taken by the plan to ensure confidentiality of individual health care records which meet the requirements of all state and federal confidentiality laws;

k) a written statement of the enrollee's right to be free from discrimination by the health plan;

l) a summary statement of the enrollee's right to refuse treatment without jeopardizing future treatment;

m) the health plan's policy to direct enrollees to particular participating providers which

shall include limitations, if any, on the reimbursement should the enrollee refuse the referral and obtain health care services or treatment from a non-participating provider;

n) the existence of financial arrangements for capitation or other risk sharing arrangements which exist with providers shall be disclosed through the use of one of the following:

i) "The health plan utilizes capitation, with its participating providers, or contains other similar risk sharing arrangements.";

ii) "The health plan may include a capitated reimbursement arrangement or other similar risk sharing arrangement, and other financial arrangements with a provider."; and

iii) "The health plan is not capitated and it does not contain other risk sharing arrangements.";

o) the criteria for accessing emergency health care services which shall include:

i) the payment criteria for examinations to determine if emergency services are necessary;

ii) the payment criteria for the emergency care itself; and

iii) the payment criteria for the services following emergency treatment or stabilization, if necessary;

p) the terms under which the health plan may be renewed or canceled including:

i) any reservation by the plan to increase premiums if renewed;

q) a comprehensive list of the health plan's participating providers by name as defined in section 6.2 herein;

r) a schedule of revenues and expenses, including direct service ratios on a form prescribed by the Department, that shall include, but not be limited to, the following costs of health care services:

i) physician services;

ii) all other health care professional services;

iii) hospital services, including both inpatient and outpatient services;

iv) pharmacy services, excluding pharmaceutical product dispensed in a physician's office;

v) health education;

vi) inpatient and outpatient substance abuse and mental health services; and

vii) emergency department services;

s) the health plan's complaint, adverse decision, and prior authorization statistics on a form prescribed by the Director and including the following ratios:

i) the ratio of the number of complaints received to the total number of covered persons, reported by category, listed in section 4.3(r) (i)-(vii) herein;

ii) the ratio of the number of adverse decisions issued to the number of services requested by providers reported by category; listed in section 4.3 (r) (i)-(vii) herein;

iii) the ratio of the number of prior authorizations denied to the number prior authorizations requested, reported by category, listed in section 4.3 (r) (i)-(vii) herein; and

iv) the ratio of the number of successful enrollee appeals to the total number of appeals filed.

t) Health plans must provide to the Director, at intervals determined by the Director, enrollee satisfaction measures.

i) The Director is authorized to specify reasonable requirements for such measures consistent with industry standards to assure an acceptable degree of statistical validity and comparability of satisfaction measures over time and among plans.

ii) The Director shall publish periodic reports for the public providing information on health plan enrollee satisfaction.

Section 5.0 ***Provider Contracting and Credentialing***

5.1 A health plan shall not refuse to contract with or compensate for covered benefits an otherwise eligible provider or non-participating provider solely because that provider has in good faith communicated with one or more of his/her patients regarding the provisions, terms, or requirements of the health plan, as they relate to the needs of that provider's patient.

5.2 An HMO shall maintain contracts with participating providers that include a statement that no enrollee shall be liable to any provider for charges for covered health services, except as described in section 27-41-26 of the General Laws of Rhode Island, as amended.

5.3 Plans shall not be allowed to include clauses in the physician or other provider contracts that allow for the plan to terminate the contract "without cause"; provided however, "cause" shall include the lack of need due to economic considerations.

5.4 Any health plan that operates a provider incentive plan shall not enter into any compensation agreement with any provider of covered services or pharmaceutical manufacturer pursuant to which specific payment is made directly or indirectly to the provider as an inducement or incentive to reduce or limit services, to reduce the length of stay or the use of alternative treatment settings or the use of a particular medication with respect to an individual patient, provided however, that capitation agreements and similar risk sharing arrangements are not prohibited.

5.5 If the plan places a provider or a provider group at financial risk for services not provided by the provider or provider group, the plan must require that such provider or group has met all the appropriate standards of the Rhode Island Department of Business Regulation.

5.6 A health plan shall publicly notify professional providers within the health plan's geographic service area of the opportunity to apply for credentials when the plan contemplates adding providers.

5.6.1 Such notification may be specific to geographic area and professional provider specialty.

5.6.2 The notification shall be in the form of a public notice in a newspaper of statewide distribution or its equivalent which is acceptable to the Department.

5.6.3 The notification shall be made at least thirty (30) days prior to the close of the health plan's application process.

5.6.4 Any professional provider not selected by the health plan may be placed on a waiting list and this list shall be made available upon request.

5.7 A professional provider credentialing process shall begin upon the acceptance of an application from a professional provider and shall include, but not be limited to, the following:

5.7.1 Each application shall be reviewed by the plan's credentialing body.

5.7.2 All health plans shall maintain written credentialing criteria to be utilized in adding professional providers to the plan's network;

a) criteria shall be based on input from the professional providers credentialed in the plan;

b) criteria shall be made available to applicants; and

c) criteria shall include, but not be limited to, a review of the following:

i) a current valid license, registration or certificate required in order for the professional provider to operate in Rhode Island or any other state, as applicable;

ii) the history relative to any revocation, suspension, probationary status or other disciplinary action regarding a license, registration or certificate in Rhode Island or any other state, as applicable;

iii) clinical privileges in good standing at a hospital, as applicable;

iv) a valid Drug Enforcement Agency and Controlled Substance certificate/registration for professional providers that prescribe controlled substances;

v) education and training consistent with the provision of services by the professional provider;

vi) evidence of current board certification if a professional provider states that he/she is board certified;

vii) evidence of malpractice/professional liability insurance; and

viii) history of professional liability claims for those that resulted in settlements and/or judgements paid to the claimant.

5.7.3 If economic profiling is utilized as part of a professional providers credentialing, the health plan shall consider the following factors, if available;

a) specialty utilization;

b) practice patterns;

c) information comparing the professional provider to his/her peers in the same specialty;

d) case mix;

e) severity of illness;

f) age of patients; and

g) other features of a professional provider's practice that may account for higher than or lower than expected costs.

5.7.4 Economic profiles and the criteria utilized shall be made available upon request to those so profiled.

5.8 A plan shall not exclude a professional provider of covered benefits from participation in its provider network based solely on the following:

a) the professional provider's degree or type of license as applicable under state law; or

b) the professional provider of covered services lack of affiliation with, or admitting privileges at a hospital, if such lack of affiliation is due solely to the professional providers' type of license.

Nothing in these regulations is intended to prohibit a health care entity or contractor from forming a limited network of providers.

5.9 The health plan shall not discriminate against providers solely because the provider treats a substantial number of patients who require expensive or uncompensated medical/health care.

5.10 The health plans shall take action concerning a professional providers' application within one hundred and eighty (180) days of receipt of the application.

5.11 If the health plan denies a professional providers' application, the provider shall receive written notification of all the reasons for the denial within sixty (60) days of receipt of a completed and verified application.

5.12 The health plan shall provide due process for credentialed professional providers for all adverse decisions resulting in a change of contractual privileges of a credentialed professional provider. The details of the health plan's due process shall be included in the plan's professional provider contracts.

5.12.1 The health plan's due process shall include the following:

a) a health plan is deemed to have met the adequate notice and hearing requirement with respect to a professional provider if the following conditions are met:

i) the professional provider shall be notified in writing of the proposed actions or immediate action pursuant to section 5.12.1(a)(v) herein;

ii) the professional provider shall be notified in writing of the reasons for the proposed actions;

iii) the professional provider shall be given the opportunity to appeal the proposed actions;

iv) the appeal, if requested, shall be completed prior to the implementation of the proposed actions;

v) the health plan shall maintain an internal appeals process for the professional provider which has reasonable time limits for the resolution of such internal appeals.

b) the health plan's due process may be waived, in writing, by the professional provider.

i) health plans shall not require professional providers to waive their rights to appeal under this section as a condition of their contract.

c) when a health plan has reason to suspect that there is immediate danger to a patient, it shall notify the Director of Health immediately and shall take the appropriate action to protect its enrollees.

5.13 A health plan may make changes to a physician's contract. These changes shall include, but not be limited to, effects upon utilization review and management activities or payment or coverage policies. Any such proposed contractual changes must include the following:

a) an explanation of the contractual changes, including the impact of the proposed changes, in non-technical terms.

b) notice must be sent to the physician in writing by mail.

5.14 The physician shall have an opportunity to amend or terminate the contract as a result of the proposed changes within sixty (60) calendar days of receipt of the notice of the changes.

5.14.1 Any decision to terminate a contract by a physician shall be effective fifteen (15) calendar days from the mailing of the notice of termination.

a) Notice of termination by the physician must be made in writing by mail to the health plan.

5.14.2 Termination of a physician's contract shall not affect the method of payment or reduce the amount of reimbursement to the physician by the health plan for any patient in active treatment for an acute medical condition at the time the patient's physician terminates the contract with the health plan until the active treatment is concluded or, if earlier, one (1) year after the termination.

a) During the active treatment period, the physician shall be subject to all the reimbursement provisions which limit the patient's liability.

Section 6.0 ***Management of Health Care Services***

6.1 The health plan shall have written policies/procedures in place which ensures the availability and

accessibility of covered health care services to its enrollees.

6.1.1. Enrollees of a plan shall have reasonable access to providers, as defined in sections 6.1.2 - 6.1.7, so that all covered services shall be provided;

a) this requirement cannot be waived and shall be met in all geographic areas where the health plan has enrollees.

6.1.2 Emergency health care services, if a covered benefit, shall be made available immediately by the health plan.

6.1.3 Urgent health care services, if a covered benefit, shall be available within twenty-four (24) hours of request for such services.

6.1.4 An HMO shall have preventive health care services available within time frames set by the HMO and shall be set according to accepted standards:

a) policies related to the provision of preventive health care services shall be specific to age and gender.

6.1.5 The health plan shall establish standards for reasonable access to routine health care services covered by the plan.

6.1.6 The health plan shall enable an enrollee to obtain timely information on the mechanisms for accessing health care services.

6.1.7 The health plan shall establish standards, acceptable to the Director, for accessing after-hours care.

6.2 The health plan shall provide a list of all the names of the participating providers to its enrollees. Said list shall be sufficient in scope given the covered benefits provided to enrollees by the health plan.

6.2.1 This comprehensive list of participating providers shall include the following:

a) provider's full name;

b) office location; and

c) primary care and other specialties.

6.2.2 There shall be a mechanism in place to routinely issue the list along with periodic updates to include:

a) a mechanism, on at least an annual basis, to furnish current enrollees, through the subscriber, an up-to-date provider list.

b) upon request, new enrollees and any individual shall receive the most current published

participating provider list;

c) a phone number to confirm the current status of any participating provider.

6.3 The health plan shall establish a mechanism to provide for the continuity of care to its enrollees.

6.3.1 In the event of contractual changes with the health plan's participating providers, the health plan shall have a process in place to allow enrollees to transfer their care to an alternate participating provider in the same or similar specialty to the previous provider.

6.3.2 In the event of contractual changes with the health plan's participating providers, the health plan shall provide for the transition of care in accordance with section 5.14.2 and 5.14.2 a) herein.

6.3.3 The health plan shall have a mechanism in place for coverage of necessary health care services twenty-four (24) hours a day, seven (7) days a week which meets the standards for availability and access defined herein.

6.4 The health plan shall maintain an ongoing quality management program to review processes and measure outcomes for those services rendered by participating providers.

6.4.1 The health plan shall monitor the quality of patient outcomes.

6.4.2 The health plan shall establish a mechanism to collect data which enable the plan to track the quality of clinical care received by enrollees.

6.4.3 The health plan shall establish a process for routine reporting of results of quality management program activities to the health plan's administration, providers, and the Department.

6.4.4 The health plan shall establish processes to review medical/health records for the purposes of evaluating the quality of clinical care of their enrollees which complies with state and federal confidentiality laws.

6.4.5 The health plan shall maintain a process for investigating and appropriately addressing quality of care complaints which conforms with the requirements of section 6.9 herein.

6.4.6 The health plan shall maintain written procedures to initiate remedial action for correction of deficiencies regarding individual providers, organizational performance, or whenever inappropriate or substandard services have been provided or needed services failed to be provided.

6.4.7 An HMO shall have a quality management program accredited by an organization acceptable to the Department within two (2) years of initial licensure.

6.5 A health plan shall maintain a written confidentiality policy that complies with all state and federal confidentiality laws and shall include:

a) a mechanism to ensure the confidentiality of health care record information that is in the possession of and/or control of the health plan, its employees, its agents, and parties with whom a contractual agreement exists;

b) all those external to the health care entity who have access to individually identified health care information and the purposes for which they are given such access;

c) a mechanism to determine what individually identified health care information may be provided to those persons identified by the health plan according to 6.5 (b) herein; and

d) a mechanism to determine how enrollees access their health care information, and how enrollees petition to correct erroneous information.

6.6 A health plan shall maintain a written emergency health care policy which shall include, but not be limited to, the following:

a) the health plans process for responding to the request of the treating provider for authorization of post-stabilization treatment;

b) the criteria for accessing emergency health care services; and

c) the health plans policies for the payment of examinations to determine if emergency health care services are necessary.

6.7 All health plans shall establish a formal mechanism, under which providers, including local providers participating in the plan, provide input into the following written policies of the health plan:

a) technology;

b) medications;

c) procedures;

d) utilization review criteria;

e) quality criteria;

f) credentialing criteria; and

g) medical/health care management procedures.

6.8 All health plans shall establish a mechanism and maintain a written policy whereby local individual

subscribers to the plan provide periodic input into the plan's procedures and processes regarding the delivery of health care services.

6.9 The health plan shall maintain a mechanism and a written policy for the processing of enrollee complaints as defined in section 1.3 herein which shall include:

a) identifying, evaluating, resolving and following up on potential and actual problems in a timely manner;

b) all recommendations to address identified problems;

c) compliance with Chapter 23-17.12 of the General Laws of Rhode Island, as amended, and the *Rules and Regulations for the Utilization Review of Health Care Services*;

d) Health plans must have a mechanism to process complaints that shall include, but not be limited to, the following:

i) the responsibilities of the medical director in the review of each quality of care complaint;

ii) the establishment of a quality assurance committee and its responsibility in the review of each quality of care complaint;

iii) a process to inform the complainant of the review findings within sixty (60) business days of receipt of the necessary information, except for those decisions as defined in Chapter 23-17.12 of the General Laws of Rhode Island, as amended, and the *Rules and Regulation for the Utilization Review of Health Care Services;* and

iv) a process to inform complainants of their right to notify the Department if they are not satisfied with the outcome of the health plan's internal complaint/appeal processes.

Section 7.0 ***Facility Requirements***

7.1 Any HMO operating a facility for the delivery of inpatient or outpatient health care services to its enrollees shall comply with all federal and state laws which shall include, but not be limited to, Chapters 5-19, 21-31, 23-1.3, 23-16.2, and 23-17 of the General Laws of Rhode Island, as amended.

7.2 The HMO shall establish a mechanism to coordinate their facility operations with section 6.0 of the regulations herein.

Section 8.0 ***Reporting Requirements***

8.1 Certified health plans shall provide reports and information required on forms prescribed by the Department to determine if the certified health plans are in compliance with the provisions of Chapter 23-17.13 of the Rhode Island General Laws, as amended and the rules and regulations herein.

8.1.1 The Department shall provide the health plan with a twenty (20) day comment period after issuing or changing the reporting requirements.

a) The health plan shall have a period of ninety (90) days after the comment period to comply with this section given new or changed reporting requirements.

8.1.2 Quarterly reports shall be submitted to the Department sixty (60) days after the end of each quarter of the calendar year.

8.1.3 Annual reports shall be submitted to the Department ninety (90) days after the end of each calendar year.

8.1.4 Failure to report in accordance with the timeframes set forth in Sections 8.1.2 and 8.1.3 herein, will result in a fine determined by the Director.

Section 9.0 ***Health Plan Penalties and Enforcement***

9.1 If the Director of Health shall for any reason have cause to believe that any violation of the Act and the rules and regulations herein has occurred or is threatened, the Director of Health may give notice to the particular health organization and to their representatives, or other persons who appear to be involved in the suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violation. Proceedings under this subsection shall be governed by Chapter 35 of Title 42 of the General Laws of the state of Rhode Island.

9.2 The Director of Health may issue an order directing a particular health organization or a representative of the health organization to cease and desist from engaging in any act or practice in violation of the provisions of the Act and the rules and regulations herein;

9.2.1 Within thirty (30) days after service of the order to cease and desist, the respondent may request a hearing on the question of whether acts or practices in violation of the Act and the rules and regulations herein have occurred. Those hearings shall be conducted pursuant to sections 42-35-9 through 42-35-13, and judicial review shall be available as provided by sections 42-35-15 and 42-35-16 of the Rhode Island General Laws, as amended.

9.3 In the case of any violation of the provisions of the Act and the rules and regulations herein, if the Director of Health elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to section 9.2 herein, the Director of Health may institute a proceeding to obtain injunctive relief, or seeking other appropriate relief, in the Superior Court for the County of Providence.

9.4 The Director of the Department of Health may, in lieu of the suspension or revocation of a certification,

levy an administrative penalty in an amount not less than five hundred dollars ($500) nor more than fifty thousand dollars ($50,000), if reasonable notice in writing is given of the intent to levy the penalty and the particular health organization has a reasonable time in which to remedy the defect in its operations which gave rise to the penalty citation. The Director of Health may augment this penalty by an amount equal to the sum that the Director calculates to be the damages suffered by enrollees or other members of the public.

9.5 Any person who knowingly and willfully violates the Act and the rules and regulations herein shall be guilty of a misdemeanor and may be punished by a fine not to exceed five hundred dollars ($500) or by imprisonment for a period not exceeding one (1) year, or both.

Section 10.0 ***HMO Violations***

10.1 If the Director shall have for any reason to believe that any violation of the standards herein has occurred or is threatened, the Director may give notice to the HMO and to the representatives, or other person(s) who appear to be involved in such suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation.

10.1.1 In the event it appears that nay violation has occurred or is threatened, and there is failure to arrive at an adequate and effective means of correcting or preventing such violations, the matter shall be referred by the Director to the Director of the Rhode Island Department of Business Regulation pursuant to section 27-41-17(2) of the Act.

10.2 Pursuant to section 27-41-20, the Director of Health or his/her designated representative, shall be in attendance at hearings regarding denial of an application for a license, or grounds for the suspension or revocation of a license, and shall participate in the proceedings. The recommendation and findings of the Director of Health with respect to matters relating to the quality of health care services provided by the HMO in connection with any decision regarding denial, suspension or revocation of a license, shall be conclusive and binding upon the Director of Business Regulation.

Section 11.0 ***Variance Procedures***

11.1 The Department may grant a variance upon its own motion or upon request of the health care entity from the provisions defined in section 4.0 herein in a specific case if it finds that a literal enforcement of such provision will result in unnecessary hardship to the health care entity and that such a variance will not be contrary to the public interest, public health and/or health and safety of enrollees.

11.2 A request for a variance shall be filed by a health care entity in writing, setting forth in detail the basis upon which the request is made.

11.2.1 Upon filing of each request for variance with the Department, and within a reasonable time thereafter, the Department shall notify the health care entity of its approval or in the case of a denial, a hearing date, time and place may be scheduled if the health care entity appeals the denial. All hearings and reviews shall be in accordance with the provisions of section 12.0

herein.

Section 12.0 ***Rules Governing Practices and Procedures***

12.1 All hearings and reviews required under the provisions of Chapter 23-17 of the General Laws of Rhode Island, as amended, shall be held in accordance with the provisions of the *Rules and Regulations of the Rhode Island Department of Health Regarding Practices and Procedures Before the Department of Health and Access to Public Records of the Department of Health (R42-35-PP).*

Section 13.0 ***Severability***

13.1 If any provision of these rules and regulations or the application thereof to any person or circumstances shall be held invalid, such invalidity shall not affect the provisions of application of theses rules and regulations which can be given effect without the invalid provision or application, and to this end the provisions of these rules and regulations herein are declared to be severable.

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APPENDIX "A"

STANDARDIZED DEFINITIONS

To help ensure a patient's ability to make informed decisions regarding their health care, the director shall promulgate regulation(s) to provide for standardized definitions of the following, provided, however, that no definition shall be construed to require a health care entity to add any benefit, to increase the scope of any benefit, or to increase any benefit under contract. Enrollees should refer to their official plan document issued by their health plan for information regarding the specific terms and provisions of their health care coverage.

1. **Adverse Decision:** The cost of a covered service ordered by your provider is not paid by your health plan because the health plan decided that the service was not medically necessary. The health plan's decision not to pay for this health care service is called an adverse decision.

   Example: Your doctor orders an x-ray, which is a covered service, but your health plan does not pay for the x-ray because it decided the x-ray was not medically necessary.

2. **Allowable Charge:** This is the most money your health plan pays your provider for a specific health care service.

   Example: Your health plan pays a doctor no more than $40 for an office visit.
   Example: Your health plan pays a hospital no more than $200 for an emergency room visit.

3. **Annual Limits:** Your health plan sets a maximum limit on the total number of health care services or on the total amount of money it pays for health care services each year. This limit is called an annual limit.

   Example: Your health plan includes dental services. Each year your health plan pays up to $900 in dental services. You pay for all dental services over the $900 annual limit.
   Example: Your health plan includes mental health counseling. The health plan pays for up to 20 visits each year. You pay for all mental health services after your 20th visit.

4. **Appeal:** When your health plan decides not to pay for a covered service, you may ask your health plan to review the decision. This review is called an appeal.

   Example: Your health plan tells you it will not pay for your emergency room visit. You ask your health plan to look at the information again to see if they will change their decision and pay for the emergency room visit. You may want to give your health plan more information for this appeal.

5. **Capitation:** Capitation is one way that a health plan pays participating providers. It is a form of risk sharing. The health plan pays a participating provider a set amount of money per year for all of the covered services that the he or she gives to an enrollee.

Example: Your health plan pays your doctor $240 each year no matter how many times you visit the doctor.
Example: Your health plan pays the hospital $480 each year for hospital care whether or not you go to the hospital for services.

6. **Co-Insurance:** Each time you receive certain health care services, you pay a **percent** of the allowable charge. Your payment is known as co-insurance.

   Example: Your health plan will pay up to $40 for an office visit. $40 is the allowable charge. You pay 20% of the allowable charge or $8, and your health plan pays the rest. The $8 is your co-insurance.
   Example: Your health plan's allowable charge for a day of hospital care is $600. You pay 25% of the allowable charge or $150, and your health plan pays the rest.
   The $150 is your co-insurance.

7. **Concurrent Review:** You are currently being treated by your health care provider for a medical or health problem. A concurrent review is when your health plan reviews the covered services ordered by your provider **while you are currently being treated for the medical or health problem.** The health plan decides if the services are medically necessary as a part of its decision to continue to pay for services.

   Example: You are in the hospital and your doctor wants to keep you in the hospital. Your health plan reviews your medical condition to decide if it will pay for more hospital days.
   Example: Your provider is continuing your physical therapy treatment. Your health plan reviews your provider's orders to decide if it will pay for more physical therapy visits.

8. **Co-payment:** Each time you receive certain health care services, you pay **a set amount** of money. Your payment is known as a co-payment.

   Example: You must pay $5 to your doctor for each office visit and your health plan pays the rest. The $5 is your co-payment.
   Example: You must pay $2 for each prescription and your health plan pays the rest.
   The $2 is your co-payment.

9. **Covered Services:** Your health plan agrees to provide or pay for specific health care services as part of your health care coverage. These health care services are called covered services. (Also known as covered benefits).

   Example: You are pregnant and your participating provider orders an ultrasound. Your health plan pays for the ultrasound because it is a covered service.
   Example: You have a back problem and go to a massage therapist. Massage therapy is not a covered service. Your health plan does not pay for this service.

10. **Credentialing:** This is when a health plan reviews the qualifications of a provider so the provider can be a participating provider in the health plan.

Example: Your health plan reviews the education, training, licensing and experience of a provider who wants to become a participating provider in the health plan.

11. **Deductible:** The amount of money that you must pay for covered services before your health plan begins to pay for the services.

    Example: Your health plan includes a $200 deductible. Each year, you must pay the first $200 for health services before your health plan begins to pay for any services.
    Example: Each time you are admitted to the hospital, you pay the first $1,000.

12. **Emergency Service:** A service given to treat a person with a serious medical or health problem. That person needs to be seen by a provider **right away** to prevent permanent damage or death. A medical problem includes physical, mental, and dental conditions.

    Example: Your child has a severe asthma attack and it is becoming more and more difficult for him/her to breathe.
    Example: Your child threatens to kill him/herself and is extremely upset.
    Example: Your teenager has taken drugs and has passed out.

13. **Enrollee:** An enrollee is anyone who is covered by your health plan. This may include you, your spouse, or your children.

14. **Formulary:** This is a list of medicines that your health plan pays for or provides when ordered by a provider in your health plan.

    Example: Your doctor orders a medicine which is on the approved list of medications for your health plan. Your health plan pays for the medication except for any co-pay or co-insurance that you have to pay.
    Example: Your provider orders a medicine which is **not** on the approved list of medications for your health plan. Your health plan does not pay for the medication. You must pay all of the cost for the medication.

15. **Grace Period:** Payment for your health plan coverage is due on a date set by the health plan. Your health plan coverage continues for a set number of days after this date -- this is known as a grace period. If the bill is paid during the grace period, your health plan coverage continues. If the bill is not paid during the grace period, your coverage is canceled and you pay for all health care services received during the grace period.

    Example: Payment for your health plan coverage is due on November 1, and payment is made on November 15, which is within the 30-day grace period. Your health plan coverage continues.
    Example: Payment for your health plan coverage is due on November 1, and payment is not made during the grace period which ends on November 30. You no longer have health plan coverage and your health plan will not pay for any health care services you received after November 1.

16. **Indemnity Insurance: This** is one way that a health insurance company pays for health care. After you receive services you pay your provider in full. Then you ask your health plan to pay you back. Your health plan may refund some or all of the money you paid.

    Example: You go to your doctor for an office visit and pay the bill. After the visit, you send the paid bill to your health plan and ask that your health plan pay you back. Your health plan may refund some or all of the money you paid.

17. **Inpatient Services: Health** care services which you receive when you stay one night or more in a hospital, nursing home, or rehabilitation center are called inpatient services.

    Example: You have major surgery and you stay in the hospital for two days. This is two days of inpatient services.

18. **Maximum Lifetime Benefit**: The total amount of health care that your plan pays for a certain service while enrolled in that plan during your lifetime.

    Example: Your health plan will pay for no more than a total of 100 outpatient physical therapy visits in your lifetime. After this maximum lifetime benefit has been reached, you pay the entire cost of all future days outpatient physical therapy visits as long as you are a member of that plan.

19. **Maximum Lifetime Cap:** This is the total amount of money that your health plan pays for all of the care that you receive while in that health plan.

    Example: Your health plan pays no more than one million dollars for your health care. After the maximum lifetime cap has been reached, you pay the entire cost of your future health care.

20. **Medical Necessity:** Your provider thinks you need certain health care services to treat your health care problem. Your health plan may review these services before, during or after you receive these services. Your health plan then decides if it thinks the services are needed based on its own medical or health care standards. If your health plan does not agree that you need the services, it will not pay for the service. Your provider and your health plan have made different "medical necessity" decisions.

    Example: You fell and hurt your ankle. Your doctor orders an X-ray. Your health plan agrees that this is medically necessary and pays for the X-ray.

    Example: You take your child to a hospital emergency room for a sore throat. Your health plan decides that it was not medically necessary to go to the hospital emergency room for treatment. Your health plan does not pay for the emergency room services

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21. **Non-Covered Service:** A health care service that is not provided or paid for by your health plan is known as a non-covered service. Your health plan does not pay for non-covered services. (Also known as excluded service.)

    Example: During an eye examination, your optometrist conducts a test on your eyes. This test is not a

covered service of your plan. Your plan does not pay for this test. You must pay for the test yourself.

22. **Official Plan Document:** This is a formal booklet given to you by your health plan that describes your health care coverage in detail.

    Example: Health plans may call this booklet your "subscriber certificate, member certificate employee benefit manual, member handbook, employee handbook, evidence of coverage or certificate of coverage".

23. **Out-of-Network Provider:** A provider who is not a participating provider in your health plan is known as an out-of-network provider.

    Example: You go to a doctor for a flu shot and that physician is not a participating provider in your health plan. As a result, you may have to pay for all or most of the cost for these services.
    Example: You go to a pharmacy to fill a prescription and that pharmacy is not a participating provider in your health plan. You may have to pay for all or most of the cost for this prescription.

24. **Out-of-Pocket Expenses:** Out-of-Pocket expenses are payments you make for health care services. This may include co-payments, co-insurance, deductibles, and payments for non-covered services.

    Example: You have broken your leg and need crutches. The crutches are a covered service but require a $25 co-payment. The $25 co-payment is an out-of-pocket expense.

25. **Out-Patient Services: Health** care services provided at a hospital or other health care facility which do not require an overnight stay are known as out-patient services.

    Example: You go to a hospital for a minor surgery but you do not stay overnight.

26. **Participating Provider:** A provider is a person or an organization who can deliver health care services. A participating provider is a provider who has an agreement with your health plan to deliver health care services to people in that plan.

    Example: You want to have a prescription filled at the pharmacy near your home. That pharmacy is a participating provider in your health plan. Your prescription can be filled at the pharmacy, and your health plan pays for all or part of the prescription.
    Example: You need to have a blood test done. The laboratory that you go to is **not** a participating provider. Your health plan does not pay for the laboratory test.

27. **Point-of-Service:** This is when your health plan allows you to go to a provider who does not participate in your health plan. Usually, you pay more of the bill than if you went to a participating provider.

    Example: You are treated by a doctor who is not in your health plan. You pay more for that service than if you were treated by a doctor who is a participating provider.

28. **Post-Payment Review:** A post payment review is when your health plan reviews the cost of a covered

service **after payment has been made** for the service.

Example: You went to the emergency room, and your health plan has paid the emergency room for the visit. Your health plan reviews the visit to see if it was correct in paying for the emergency room service. If your health plan decides it was not correct in paying the emergency room fee, you will be responsible for paying this fee.

Example: You went to the emergency room, and you paid the emergency room for the visit. Your health plan reviews the visit to see if it will pay you back for what you paid for the emergency room service.

29. **Post-Service Review:** A post-service review is when your health plan reviews a covered service **after you receive** the service but before payment is made to your provider for the service.

Example: You went to the emergency room for services, but payment for the service has not been made. Your health plan reviews your visit to decide if it will pay for the emergency room services.

30. **Pre-Existing Condition:** A medical or health condition which was diagnosed or treated by a provider before you joined your current health plan.

Example: You had been treated for a heart condition before you enrolled in the health plan.

31. **Premium:** A premium is the amount of money paid for health plan coverage.

Example: The cost of your health plan coverage is $200 a month. This $200 which must be paid every month for your health plan coverage to continue, is called your premium.

32. **Prior-Authorization Review:** A prior-authorization review is when your health plan requires that it review certain covered services **before you receive** them to decide if the services are medically necessary and if the health plan will pay for the services.

Example: You or your provider are required to call your health plan before you go to the emergency room. If you don't call the health plan first, your health plan may not pay for the emergency room visit.

33. **Provider:** A provider is a person or an organization who delivers health care services.

Example: A doctor, hospital, laboratory and dentist are examples of a provider.
Example: When you fill a prescription, the pharmacy is a provider of health care services.

34. **Provider Network:** A provider network is all of the providers who have an agreement with the health plan to deliver medical or health care services to plan members. Once in the provider network, the providers are known as participating providers.

Example: Your health plan may contract with one or more providers to deliver health care services to

enrollees in your health plan.

35. Rider: This is a separate part of your health care coverage that adds specific benefits to your general health plan coverage. There will be an additional cost for a rider paid. Riders are agreed to before you enroll in a health plan.

Example: Your health plan agrees to provide prescription coverage for an additional $10.00 per month. This $10.00 is added to your monthly premium if you choose to obtain this prescription rider.
Example: Your health plan agrees to provide routine dental coverage for an additional $15.00 per month. Your employer has selected this rider on your behalf. This $15.00 is added to your monthly premium and is paid for by your employer.

36. Risk Sharing: A participating provider has an agreement with your health plan to provide all covered services. The health plan and the participating provider agree on how much the provider will get paid for these services. **If** the cost of the services is **more than** what was agreed to, then the health plan and the participating provider agree to share in the extra cost. **If** the cost of the services is **less than** what was agreed to, then the health plan and the participating provider agree to share in the money saved.

Example: Your health plan pays your provider $300 a year to take care of you. The cost of your health care is $400 for the year. Your provider and health plan share the added costs of your health care.
Example: Your health plan pays your provider $300 each year to take care of you. The cost of your health care is $200 for the year. Your doctor and health plan share the money saved.

37. Second Opinion: When you go to a second provider for a recommendation on the first provider's diagnostic or treatment plan.

Example: Your doctor recommends surgery for your health problem. You go to a second doctor and ask whether you need the surgery the first doctor recommended.

38. Subscriber: A subscriber is the person with whom the health plan has an agreement. The health plan agrees to provide health care services to the subscriber and all other members of his/her family covered in the agreement.

Example: Your employer provides health care coverage for you, your spouse and your children. You are the subscriber because the policy is in your name.

39. Urgent Care: A serious but not life threatening medical or health problem which needs to be treated by a provider within 24 hours to prevent the problem from getting worse is known as urgent care.

Example: You are vomiting and have a high fever. You are treated by your provider that same day. This visit is an urgent care visit.

40. Utilization Review: A utilization review is when your health plan reviews the covered services ordered by your provider to decide if the services are medically necessary.

Example: You were in the hospital for two days. Your health plan reviews your care, your medical condition, and the services you received during those two days to decide if your two-day hospital stay was medically necessary.
Example: You are in the hospital and your health plan reviews your care and medical condition while you are still in the hospital to determine if more days in the hospital are medically necessary.
Example: You are planning to go into the hospital and you let your health plan know. Your health plan reviews the request for the service and your medical condition, and determines if your planned hospital stay is medically necessary.