DIGEST

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Cromer HB No. 645

Abstract: Deletes the existing medical necessity appeals process and external review process and replaces it with a utilization appeals process, grievance appeals process, internal review process, and external review procedures.

Present law generally establishes minimum standards required for entities that determine what medical services or procedures will be covered under a health benefit plan based on medical necessity. Designates such entities as medical necessity organizations (MNROs) and independent review organizations (IROs).

Proposed law revises these standards and additionally provides for grievances and review of adverse determinations not limited to those solely based on medical necessity, as follows:

(1) Present law requires the licensing of MNROs and requires IROs to be certified by the department.

Proposed law requires the licensing of any entity that conducts an utilization review (URO) unless it is a health insurance issuer, which must then be approved by the commissioner of insurance to conduct utilization review. Requires the approval by the commissioner of IROs. Additionally provides standards and criteria for an IRO.

(2) Present law requires a licensing fee of $1,500 and an annual report filing fee of $500 for MNROs other than health insurance issuers.

Proposed law instead requires an application fee of $1,500 licensing fee and an annual report filing fee of $500 for utilization review organizations (URO) other than health insurance issuers. Also provides for an application fee of $500 for a two-year approval of an IRO with an annual filing fee of $500.

(3) Proposed law deletes the existing medical necessity appeals process and external review process provided for in present law and replaces it with a utilization appeals process, grievance appeals process, and external review process. Establishes utilization and benefit determination procedures, standards, and criteria for the structure and operation of utilization review and benefit determination processes designed to facilitate ongoing assessment and management of health services. Also provides standards for the establishment and maintenance of procedures by health insurance issuers to assure that covered persons have the opportunity for an independent review of an adverse

determination or final adverse determination. Provides uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination. Clarifies that proposed law relative to external reviews shall apply only to adverse determinations and final adverse determinations that involve medical necessity, appropriateness, health care setting, level of care, effectiveness, experimental or investigational treatment, or a rescission.

(4) Present law, relative to internal reviews, establishes minimum standards for informal consideration and first level and second level appeals required for entities that determine what medical services or procedures will be covered under a health benefit plan based on medical necessity. Provides for informal reconsideration and a two-level internal appeals process all for review of adverse determinations based on a lack of medical necessity.

Proposed law requires that health insurance issuers shall implement effective processes for appeal of coverage determinations and claims pursuant to provisions of applicable federal law, the Public Health Services Act, as amended by the Patient Protection and Affordable Care Act (PPACA), and regulations promulgated pursuant to that law by the U. S. Department of Labor and the U. S. Department of Health and Human Services. Such federal law requires only one level of appeal in the internal grievance process, under new time frames consistent with federal law for making benefit determinations, which is now considered a utilization review. Expands such utilization review to include rescission, denial, or reduction in payment and eligibility issues. Provides for timely notification to health care providers and covered persons of health insurance issuers' determinations. Additionally establishes new procedures for a first level review of grievances involving an adverse determination, a standard review of grievances not involving an adverse determination, and a voluntary internal second level of review of grievances at the discretion of the covered person, which may include an adverse determination or a grievance not involving an adverse determination.

Proposed law further specifies that such appeal processes shall, at a minimum, have in effect an internal claims appeal process, provide notice to covered persons of available internal and external appeals processes and the availability of the office of consumer advocacy of the state's Department of Insurance to assist such persons with the appeals process, and allow covered persons to review all documents relevant to the claim for benefits, to submit comments and documents relating to the claim, and to receive continued coverage pending the outcome of the appeals process.

(5) Present law provides for an expedited internal appeal for emergency services.

Proposed law, pursuant to applicable federal law and regulations, adds an expedited internal appeal for urgent care requests.

(6) Present law requires that a request for internal review be filed by the covered person within 60 days of receipt of an adverse determination.

Proposed law, pursuant to applicable federal law and regulations, allows for at least 180 days to file a request for internal review after the receipt of notice of an adverse benefit determination. Also allows four months to file a request for an external appeal of a final adverse benefit determination.

(7) Present law provides for an expedited external appeal for emergency services or investigational or experimental services.

Proposed law additionally provides for an expedited external appeal for urgent care requests.

(8) Present law restricts requests for an internal or external review of experimental or investigational appeals to a minimum claim of $500 before being eligible for external review.

Proposed law provides that a covered person may make a request, regardless of the claim amount, for any type of external review.

(9) Present law provides that unless the covered person has an emergency medical condition or the MNRO agrees to waive the requirements for the first level appeal, the second level appeal, or both, then the MNRO shall not be required to grant a request for an external review until the second level appeal process has been exhausted.

Proposed law, pursuant to applicable federal law and regulations, states that if exhaustion of internal appeals is required prior to external review, exhaustion shall be unnecessary if: (a) the health insurance issuer waives the exhaustion requirement; (b) the issuer is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process except those failures that are based on de minimus violations that do not cause, and are not likely to cause, prejudice, or harm to the covered person; or (c) the covered person simultaneously requests an expedited internal appeal and an expedited external review when the covered person has a medical condition when any delay in appealing the adverse determination may pose an imminent threat to the covered person's health, including but not limited to severe pain, potential loss of life, limb, or major bodily function, or the immediate deterioration of the health of the covered person.

(10) Present law is silent on the issue of which person or entity shall be responsible for the cost of an external review.

Proposed law provides that the cost of an IRO for conducting an external review shall be paid by the health insurance issuer against which a request for such review is filed. Further specifies that no fee or other charge may be levied upon a covered person for any costs of an external review.

(11) Present law requires that a request for an external review be filed by the covered person

within 60 days of receipt of the second level appeal adverse determination.

Proposed law, pursuant to applicable federal law and regulations, allows four months to file a request for external review after the receipt of notice of an adverse benefit determination or final internal adverse benefit determination.

(12) Present law requires an MNRO to provide covered persons with a notice explaining their rights to an external review.

Proposed law requires that health insurance issuers include a description of the external review procedures in their materials provided to covered persons, including a statement that informs such persons' of their rights to an external review.

(13) Present law requires a health insurance issuer to provide for an independent review process to examine its coverage decisions based on medical necessity and requires the MNRO to forward documents and any information used in making the second level appeal adverse determination to its designated IRO.

Proposed law requires that an IRO be assigned to an external review by the commissioner on a random basis. Provides for the impartiality of the IRO and clinical peers conducting the external review. Further provides with respect to the information submitted to the IRO.

(14) Present law requires that an IRO hold a nonrestricted license in a state of the U.S. and, in the case of a physician, hold a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review. Does not require an IRO to be accredited by a nationally recognized private accrediting organization.

Proposed law requires that the process for assigning the IRO provide for the maintenance of a list by the commissioner of approved IROs (only those that are accredited by a nationally recognized private accrediting organization) qualified to conduct the external review, based on the nature of the health care service that is the subject of the review. Further requires that any clinical peer assigned to an external review by an IRO hold an unrestricted license in a state of the United States. Provides for the avoidance of conflicts of interest by an IRO or a clinical peer assigned by an IRO to conduct an external review.

(15) Present law requires an IRO to review all information and documents received and any other information submitted in writing by a covered person or the covered person's health care provider.

Proposed law provides that a covered person must be allowed to submit information to the IRO which the IRO must consider, if timely submitted, when conducting the external review, and the covered person must be notified of the right to submit additional information to the IRO. Additionally requires that the IRO allow the covered person at

least five business days to submit any additional information and any additional information submitted by the covered person must be forwarded to the health insurance issuer within one business day of receipt by the IRO.

(16) Present law provides that a covered person's health care provider may request an expedited external review at the time that he receives an adverse determination involving an emergency medical condition. Within 72 hours after receiving appropriate medical information, requires the IRO to make a decision to uphold or reverse the adverse determination and notify the covered person, the MNRO, and the covered person's health care provider of the decision.

Proposed law requires that the process provide for an expedited external review in certain circumstances and, in such cases, provide notice of the decision as expeditiously as possible, but not later than 72 hours after receipt of the request for external review. Provides that if notice of the IRO's decision is not in writing, the IRO must provide written confirmation of its decision within 48 hours after the date of the notice of the decision.

(17) Proposed law provides that no IRO, clinical peer working on its behalf, or its employee, agent, or contractor shall be liable in damages to any person for opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under proposed law during or upon completion of an external review, unless the opinion was rendered or act or omission was performed in bad faith or involved negligence or gross negligence.

(18) Present law provides that an MNRO shall maintain written records in the aggregate and by health insurance issuer and health benefit plan on all requests for external review for which an external review was conducted during a calendar year, referred to as the "register".

Proposed law requires an IRO to maintain written records in the aggregate, by state, and by health insurance issuer on all requests for external review for which it conducted an external review during a calendar year and, upon request, to submit a report to the commissioner. Also requires submission of an annual report to the commissioner.

(19) Proposed law requires health insurance issuers to provide a description of the external review process in or attached to the summary plan descriptions, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to covered persons.

(20) Proposed law makes all external review decisions binding on the health insurance issuer and the covered person except to the extent that either has other remedies available under applicable federal or state law.

(21) Proposed law provides that if at any time any of its provisions is in conflict with federal

law or applicable regulations, such a provision shall be preempted only to the extent necessary to avoid direct conflict with such federal law or regulations. Further provides that the commissioner shall, pursuant to rule or regulation promulgated and adopted in accordance with the Administrative Procedure Act, subsequently administer and enforce proposed law in a manner that conforms to such federal law or regulations.

(22) Present law provides for penalties to be imposed by the commissioner for violations of present law, including fines and suspension or revocation of licensure.

Proposed law provides for penalties to be imposed by the commissioner for violations of proposed law, including fines or suspension or revocation of licensure or approval, as well as granting him cease and desist authority and the authority to bring a cause of action in the 19th Judicial District Court.

Effective January 1, 2015.

(Adds R.S. 22:821(B)(36) and (37) and 2391- 2453; Repeals R.S. 22:821(B)(28) and 1121-1144)

Summary of Amendments Adopted by House

Committee Amendments Proposed by House Committee on Insurance to the original bill.

1. Defined "immediately" for purposes of proposed law as expeditiously as the medical situation of the covered person requires but in no event longer than one day for expedited reviews or one business day for standard reviews.

2. Clarified that proposed law relative to external reviews shall apply only to adverse determinations and final adverse determinations that involve medical necessity, appropriateness, health care setting, level of care, effectiveness, or a recission and not to those involving contractual disputes between a health insurance issuer and an insured.

3. Provided more specific language for situations in which a covered person may request an expedited external review, limiting it to those situations in which the treating physician certifies in writing that any delay in appealing the adverse determination may pose an imminent threat to the covered person's health, including but not limited to severe pain, potential loss of life, limb, or major bodily function, or the immediate deterioration of the health of the covered person.

4. Specified minimum requirements which health insurance issuers' appeals processes must meet, including providing notice to covered persons of available internal and external appeals processes and the availability of the office of consumer advocacy of the state's Department of Insurance to assist such persons with the appeals process.

5. Clarified that an URO or a health insurance issuer acting as an URO may transmit

protected health information to an IRO without breaching confidentiality laws.

6. Removed the requirement for notice by health insurance issuers to the commissioner of insurance in certain appeals situations when no subsequent action is required of the commissioner.

7. Provided that any appeal of eligibility for an external review heard by the commissioner shall be limited to applicable provisions of proposed law, including the standards by which a health insurance issuer determines eligibility, but not including the terms of the covered person's benefit plan.

8. Clarified that if a covered person submits information to an IRO for consideration during an external review, the IRO is only required to consider such information that is timely filed.

9. Deleted language which gave a covered person or his health care providers a cause of action for benefits or damages against an URO, health insurance issuer, health benefit plan, or IRO for any action involving a decision made pursuant to proposed law if the determination or opinion was rendered in bad faith or involved negligence, gross negligence, or intentional misrepresentation of factual information about the covered person's medical condition.

10. Added language relative to preemption of any provision of proposed law and the enforcement authority of the commissioner.

11. Changed the effective date from January 1, 2014, to January 1, 2015.

House Floor Amendments to the engrossed bill.

1. Clarified that proposed law relative to external reviews shall additionally apply to adverse determinations and final adverse determinations that involve experimental or investigational treatment.

2. Further clarified the minimum requirements which health insurance issuers' appeals processes must meet.

3. Further clarified criteria for determining whether an expedited review is warranted, including reviews for investigational or experimental treatments.

3. Clarified that requests made by an issuer for an external review are to be made through the department's website.

4. Clarified that notification of selection of an IRO shall also be sent to the health insurance issuer in addition to the covered person.

5. Clarified that certain processes apply to both standard external reviews and expedited external reviews, including the choice of reviewing health care professionals and time frames for provisions of documents to an IRO.

6. Clarified that no fee or other charge may be levied upon a covered person for any costs of an external review.