Bill as Introduced

HB 640-FN – AS INTRODUCED

1999 SESSION

99-0783
01/09

HOUSE BILL ***640-FN***

AN ACT relative to grievance procedures of managed care organizations.

SPONSORS: Rep. Hunt, Ches 10

COMMITTEE: Commerce

ANALYSIS

This bill establishes a procedure for an external review process to be used by covered persons after the internal review process of a managed care plan has been exhausted.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

99-0783
01/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord One Thousand Nine Hundred and Ninety-Nine

AN ACT relative to grievance procedures of managed care organizations.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Paragraphs; Definitions Added. Amend RSA 420-J:3 by inserting after paragraph XVI the following new paragraphs:

XVI-a. "External review" means a process by which a covered person may request that an adverse determination be reviewed by an external review organization.

XVI-b. "External review agent" or "review agent" means a clinical peer employed or under contract with an external review organization.

XVI-c. "External review organization" means an organization which employs or contracts with clinical peers to act as external review agents.

2 New Section; Independent External Review. Amend RSA 420-J by inserting after section 5 the following new section:

420-J:5-a External Review Process.

I.(a) There is hereby established an independent external review process for the purposes of a managed care plan's covered person or the covered person's legal representative appealing an adverse determination. A plan's covered person shall have the right to request an independent external review and the plan shall institute the process when:

(1) A covered person has exhausted the internal appeals process of the contracted plan for a covered benefit and the outcome resulted in an adverse determination;

(2) A health carrier has upheld an adverse determination upon a second level review of a grievance pursuant to RSA 420-J:5, V, or has failed to render a decision with respect to a timely request for a second level review of an adverse determination;

(3) The covered person's cost for the amount in controversy is, or is anticipated to be, equal to or in excess of $1,500;

(4) The covered person submits a request, in writing, for such review to the plan within 30 days from the date of receipt of the final internal appeals determination by the managed care plan; and

(5) The covered person submits an external review filing fee of $50 to the plan with the written request. The commissioner may waive the fee in cases of extreme financial hardship. In the event that the external review organization renders a finding that the managed care plan's adverse determination was not warranted, the managed care plan shall reimburse the covered individual the full external review filing fee.

(b) The covered person shall have recourse to an expedited external review for emergency or life threatening situations which would seriously jeopardize the life or health of the covered person, provided that the provisions of subparagraphs I(a)(1), (2), (3) and (5) are met and when:

(1) The individual files a request for expedited review no later than one business day after the managed care plan issues its final determination pursuant to its internal review process;

(2) The adverse determination under review relates to an ongoing inpatient hospital stay; and

(3) The attending provider certifies that taking the time to complete the standard external review process would pose a serious threat to the covered person's health.

II. Managed care plans shall:

(a) Notify the covered person in the evidence of coverage and in writing at the time of the final appeals decision to deny coverage of the opportunity to request the independent external review under the terms of this chapter.

(b) Maintain contracts with at least 2 external review organizations that are certified by the commissioner. A managed care plan shall not contract with an external review organization if the organization performed utilization review functions on behalf of the managed care plan for the specific case under consideration or if the external review organization or its review agents have a significant financial relationship with the managed care plan which would seriously impair the rendering of a fair and impartial decision. A contract under which an academic medical center provides health services to a managed care plan's covered individuals shall not be considered to impair the organization's or agent's ability to render a fair and impartial decision.

(c) Within 3 business days of the carrier's receipt of notification by the covered person, the plan shall select a certified independent external review organization.

(d) Within 14 business days, the plan shall submit to the external review organization all information that was submitted to the plan by the covered person or the covered person's health care provider in support of the covered person's request for coverage under the plan's internal appeals procedures and all other evidence relied upon by the carrier in making its determination.

(e) When an expedited external review is warranted, forward the required documentation to the independent external review organization within one business day of receipt of the request for an expedited external review.

(f) Be responsible for the reasonable fees and costs of the independent external review organization, such that fees and costs of an external review shall not exceed $1,500.

III. The commissioner shall:

(a) Review and verify the criteria for the certification of an external review organization that contracts with managed care plans for the conduct of said external review as in paragraph IV.

Such independent external review shall be conducted solely by such external review organization certified by the commissioner and the commissioner shall notify the certified entities of the $1,500 fees and cost limitation for conducting an external review.

(b) Make determinations regarding a covered person's financial inability to render a filing fee for the review under this chapter. Such determination shall take into consideration the covered person's annual income in the previous year, absent any federal or state subsidized income.

(c) Upon request of the independent external review organization, the covered person, the covered person's health care provider or the managed care plan, the commissioner may grant up to an additional 7 days for the independent external review organization to submit a determination.

(d) Collect data regarding the nature of the service or treatment undergoing external review, the outcome determination, the review organization, and the plan and submit an annual report no later than November 1 of each year to the governor, the speaker of the house and the president of the senate.

IV.(a) An independent external review conducted by an organization at the request of a managed care plan shall meet, at a minimum, the following standards for purposes of being certified by the commissioner. Any such organization that performs an independent external review may apply to the commissioner and be certified upon demonstrating that it complies, at a minimum, with the standards established in this section.

(1) Any independent external review organization which meets the criteria under this paragraph, shall conduct its review pursuant to a written plan.

(2) Expert reviewers assigned by the independent external review organization shall be physicians or other appropriate health care professionals who meet the following requirements:

(A) Be an expert in the treatment of the covered person's medical condition and knowledgeable about the recommended service or treatment through actual clinical experience;

(B) Hold a non-restricted license in a state of the United States, and for physicians, a current certification by a recognized American medical specialty board in the areas appropriate to the subject of review;

(C) Have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restriction, taken or pending by any hospital, health carrier, government or regulatory body.

(3) Neither the expert reviewer, nor the independent external review organization, shall have any material, professional, familial, or financial conflict of interest with any of the following:

(A) The health carrier.

(B) Any officer, director, or management employee of the carrier.

(C) The physician, the physician's medical group, or the independent practice association (IPA) proposing the service or treatment.

(D) The institution at which the service or treatment would be provided.

(E) The development or manufacture of the principal drug, device, procedure, or other therapy proposed for the covered person whose treatment is under review.

(4) The term "conflict of interest" shall not be interpreted to include a contract under which an academic medical center, or other similar medical center, provides health services to health carrier covered persons except: academic medical centers that would provide the service for which coverage is in dispute; affiliations which are limited to staff privileges at a health facility; or an expert reviewer's participation as a contracting health carrier provider where the expert is affiliated with an academic medical center, or other similar medical research center, that is acting as an independent external review organization under this section.

(5) The following organizations are not eligible for certification as independent external review organizations:

(A) Professional or trade associations of health care providers.

(B) Subsidiaries or affiliates of such provider associations.

(C) Health carrier or health plan associations.

(D) Subsidiaries or affiliates of health plan or health carrier associations.

(6) Any independent external review organization shall have a documented process to review and evaluate the effectiveness of its utilization review program.

(7) Any external review organization shall base retrospective review determinations solely on the medical information available to the attending physician or ordering provider at the time the medical care was provided.

(8) Any external review organization shall not compensate an individual rendering utilization review determinations based upon the number of adverse determinations made.

(9) Any external review organization shall have a documented process for compliance with all applicable medical record confidentiality statutes and regulations.

(b) The independent external review organization shall submit the determination to the commissioner, the plan, and the covered person within 30 business days of the receipt of the request for review. Provided however, that when such documentation represents a material change upon which the independent review agent based its adverse determination or upon which the managed care plan based its denial, the managed care plan shall have 3 business days to consider such documentation and amend or confirm such adverse determination.

(c) When rendering a determination, any such independent external review organization shall adopt and any such organization agents shall rely upon utilization review criteria for the specific case pursuant to the clinical standards of the plan, as well as examine the attending health care provider's recommendation and the applicable generally accepted practice guidelines developed by national or professional medical societies, boards and associations.

(d) The determination shall be in written form and state the reasons the requested service or treatment should or should not be covered under the terms and conditions set forth in the evidence of coverage. Determinations shall be based on the applicable coverage documents, including any defined terms that are provided for thereunder, such as "medically necessary," and shall not expand the contractually agreed upon coverage. The determinations shall specifically cite the relevant provisions in the evidence of coverage, the covered person's specific medical condition, and the relevant documents provided, to support the determination.

(e) Notwithstanding any provision of this section to the contrary, independent external review organizations shall provide for an expedited external review process for emergency or life threatening situations which would seriously jeopardize the life or health of a covered person. A covered person shall have the right to an expedited external review if (1) the individual files a request for expedited review no later than one business day after the managed care plan issues its final determination pursuant to its internal review process, (2) the adverse determination under review relates to an ongoing inpatient hospital stay, and (3) the attending provider certifies that taking the time to complete the standard external review process would pose a serious threat to the covered person's health. The managed care plan shall forward the required documentation to the independent external review organization within one business day of receipt of the request for an expedited external review. The review agent shall issue a determination within 3 businesses days of receipt of the request for an expedited external review. All statutory standards, other than time standards, applicable to external reviews shall apply to expedited external reviews.

(f) An independent external review organization acting in good faith shall have immunity from any civil or criminal liability or professional discipline as a result of acts or omissions with respect to any external independent review, unless the acts or omissions constitute willful and wanton misconduct.

V.(a) The determination of the review agent shall be binding on all parties. A determination of the external review agent in favor of the managed care plan shall create a rebuttable presumption in any subsequent action at law that the coverage determination made pursuant to the health carrier's review processes was appropriate.

(b) Decisions relating to the following health care services or treatments shall not be reviewed under this section:

(1) Health care services provided to beneficiaries of managed care plans wherein benefit or service provisions are prescribed by federal law.

(2) Health care services provided to inmates by the department of corrections.

(c) The procedure set forth in this section shall not apply to claims or allegation of health provider malpractice, professional negligence, or other professional fault against participating providers.

3 Repeal. RSA 420-J:5, VIII and IX, relative to an external review process, are hereby repealed.

4 Effective Date. This act shall take effect January 1, 2000.

LBAO
99-0783
2/11/99

HB 640-FN - FISCAL NOTE

AN ACT relative to grievance procedures of managed care organizations.

FISCAL IMPACT:

The Insurance Department stated this bill may increase state revenue by $1,800 in FY 2000, by $3,900 in FY 2001, by $4,000 in FY 2002 and by $4,200 in FY 2003. State expenditures may increase by $6,200 in FY 2000, by $13,000 in FY 2001, by $13,500 in FY 2002 and by $14,000 in FY 2003. County and local expenditures may increase by an indeterminable amount in FY 2000 and each year thereafter. There will be no fiscal impact on county and local revenue.

METHODOLOGY:

The Department assumed additional responsibilities can be absorbed within the existing budget. The Department indicated there are certain costs that health plans might incur in complying with an external review program. In addition, when a plan decision is overturned, the plan is then responsible for the cost of additional care. Research estimates these costs for plans in California to be three cents per member, per month, or approximately .03% of premium. When plan premiums increase, this increases state revenue due to the impact on premium tax. Premium increases also affect state, county and local expenditures due to the impact on the cost of health insurance coverage on employees. The total premium collected by HMO's for its fully insured products was estimated to be approximately $600 million. Premiums paid by the state were estimated to be approximately $40 million. Inflation is assumed at 4%. The increase in county and local government expenditures cannot be determined.

Amendments

Commerce
May 7, 1999
1999-1120h
01/09

Amendment to HB 640-FN

Amend the bill by replacing all after the enacting clause with the following:

1 New Paragraph; Definitions Added. Amend RSA 420-J:3 by inserting after paragraph III the following new paragraph:

III-a. "Authorized representative" means a person to whom a covered person has given consent to represent the covered person in an external review. Authorized representative may include the covered person's treating provider.

2 New Paragraphs; Definitions Added. Amend RSA 420-J:3 by inserting after paragraph XVI the following new paragraphs:

XVI-a. "External review" means a process by which a covered person may request that an adverse determination be reviewed by an external review organization.

XVI-b. "External review agent" or "review agent" means a clinical peer employed or under contract with an external review organization.

XVI-c. "External review organization" means an organization which employs or contracts with clinical peers to act as external review agents.

3 New Section; External Review. Amend RSA 420-J by inserting after section 5 the following new section:

420-J:5-a External Review Process.

I.(a) There is hereby established an external review process for the purposes of a managed care plan's covered person or the covered person's authorized representative appealing an adverse determination. A plan's covered person shall have the right to an external review when:

(1) A covered person has exhausted the internal appeals process of the contracted plan for a covered benefit and the outcome resulted in an adverse determination;

(2) A health carrier has upheld an adverse determination upon a second level review of a grievance or has failed to render a decision pursuant to RSA 420-J:5, V;

(3) The covered person's cost for the amount in controversy is, or is anticipated to be, equal to or in excess of $500; and

(4) The covered person submits a request, in writing, for such review to the plan within 90 days from the date of receipt of the final internal appeals determination by the managed care plan.

(b) The covered person shall have recourse to an expedited external review for emergency or life threatening situations which would seriously jeopardize the life or health of the covered person, provided that the provisions of subparagraphs I(a)(1) and (2) are met and when:

(1) The individual files a request for expedited external review no later than 72 hours after the managed care plan has issued its final adverse determination or has failed to render a decision pursuant to RSA 420-J:5, V; and

(2) The attending provider certifies that taking the time to complete the standard external review process would seriously jeopardize the life or health of the covered person.

II. Managed care plans shall:

(a) Maintain contracts with at least 2 external review organizations that are certified by the commissioner. A managed care plan shall not contract with an external review organization if the organization performed utilization review functions on behalf of the managed care plan for the specific case under consideration. A managed care plan shall not contract with an external review organization if the external review organization or its review agents have a conflict of interest, as described in subparagraph III(a)(3), with the managed care plan.

(b) Within 3 business days of the carrier's receipt of notification by the covered person of a request for external review, the plan shall select a certified external review organization.

(c) Within 10 business days of the carrier's receipt of notification by the covered person, the plan shall submit to the external review organization all information that was submitted to the plan by the covered person or the covered person's health care provider in support of the covered person's request for coverage under the plan's internal appeals procedures and all other evidence relied upon by the carrier in making its determination.

(d) When an expedited external review is warranted pursuant to subparagraph I(b) of this section, forward information described in subparagraph II(c) to the external review organization within one business day of receipt of the request for an expedited external review.

(e) Be responsible for the reasonable fees and costs of the external review organization, such that fees and costs of an external review shall not exceed $1,500.

III.(a) An external review conducted by an organization at the request of a managed care plan shall meet, at a minimum, the following standards for purposes of being certified by the commissioner. Any such organization that performs an external review may apply to the commissioner and be certified upon demonstrating that it complies, at a minimum, with the standards established in this paragraph.

(1) Any external review organization which meets the criteria under this paragraph, shall conduct its review pursuant to a written plan.

(2) Expert reviewers assigned by the external review organization shall be physicians or other appropriate health care professionals who meet the following requirements:

(A) Be an expert in the treatment of the covered person's medical condition and knowledgeable about the recommended service or treatment through actual clinical experience;

(B) Hold a non-restricted license in a state of the United States, and for physicians, a current certification by a specialty board recognized by the American Board of Medical Specialties in the areas appropriate to the subject of review;

(C) Have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restriction, taken or pending by any hospital, health carrier, government or regulatory body; and

(D) Have agreed to disclose any potential conflict of interest.

(3) Neither the expert reviewer, nor the external review organization, shall have any material, professional, familial, or financial conflict of interest with any of the following:

(A) The health carrier.

(B) Any officer, director, or management employee of the carrier.

(C) The physician, the physician's medical group, or the independent practice association (IPA) proposing the service or treatment.

(D) The institution at which the service or treatment would be provided.

(E) The development or manufacture of the principal drug, device, procedure, or other therapy proposed for the covered person whose treatment is under review.

(F) The covered person or authorized representative.

(4) The commissioner may determine, in specific cases, that an affiliation with a hospital, an institution, an academic medical center, or a health carrier provider network does not in and of itself constitute a conflict of interest.

(5) The following organizations are not eligible for certification as external review organizations:

(A) Professional or trade associations of health care providers.

(B) Subsidiaries or affiliates of such provider associations.

(C) Health carrier or health plan associations.

(D) Subsidiaries or affiliates of health plan or health carrier associations.

(6) Any external review organization shall have a documented process to review and evaluate the effectiveness of its external review program.

(7) The external review organization shall consider anew all previously determined facts, allow the introduction of new relevant information and make a decision that is not bound by decisions or conclusions made by the health carrier during internal review.

(8) Any external review organization shall not compensate an individual rendering review determinations based upon the number of adverse determinations upheld or denied.

(9) Any external review organization shall have a documented process for compliance with all applicable medical record confidentiality statutes and regulations.

(10) Any external review organization shall base its determination on the plan's applicable coverage documents, including any terms that are defined thereunder, and shall not expand the contractually agreed upon coverage.

(b) The external review organization shall submit the determination to the commissioner, the plan, and the covered person within 30 business days of the receipt of the request for review. For an expedited external review, the review agent shall issue a determination within 3 business days of receipt of the request. All statutory standards, other than time standards, applicable to external reviews shall apply to expedited external reviews. Reversal of the internal review decision made by the health plan shall be without prejudice to the health plan when the external review organization certifies that it has received new documentation which:

(1) Represents a material change in the submitted information upon which the external review agent based its adverse determination or upon which the managed care plan based its denial; and

(2) Has been made available to the health plan in a manner which failed to provide the plan with sufficient time, not less than 3 business days, to consider such documentation, and amend or confirm the adverse determination.

(c) When rendering a determination, any such external review organization shall consider and rely upon utilization review criteria for the specific case pursuant to the clinical standards of the plan. The external review organization shall examine the attending health care provider's recommendation, and shall consider the applicable generally accepted practice guidelines developed by the federal government or through national or professional medical societies, boards and associations.

(d) The determination shall be in written form and shall state the reasons the requested service or treatment should or should not be covered under the terms and conditions set forth in the evidence of coverage. The determinations shall specifically cite the relevant provisions in the evidence of coverage, the covered person's specific medical condition, and the relevant documents provided, to support the determination.

(e) An external review organization acting in good faith shall have immunity from any civil or criminal liability or professional discipline as a result of acts or omissions with respect to any external review, unless the acts or omissions constitute willful and wanton misconduct.

IV. The commissioner:

(a) Shall review and verify compliance criteria for the certification of an external review organization that contracts with managed care plans for the conduct of the external review as provided in paragraph III.

(b) Shall notify the certified entities of the $1,500 fees and cost limitation for conducting an external review.

(c) May grant up to an additional 5 business days for the external review organization to submit a determination, upon request of the external review organization, the covered person, the covered person's health care provider, or the managed care plan.

(d) Shall collect data regarding the nature of the service or treatment undergoing external review, the outcome determination, the external review organization, and the plan. The commissioner shall submit an annual report no later than November 1 of each year to the governor, the speaker of the house and the president of the senate.

V.(a) The determination of the review agent shall be binding on all parties.

(b) Decisions relating to the following health care services or treatments shall not be reviewed under this section:

(1) Health care services provided to beneficiaries of managed care plans regulated by the federal government through medicaid, the state children's health insurance program (Title XXI of the Social Security Act), medicare or services provided under these programs but through a contracted health carrier.

(2) Health care services provided to inmates by the department of corrections.

(c) The procedure set forth in this section shall not apply to claims or allegation of health provider malpractice, professional negligence, or other professional fault against participating providers.

3 External Review; Notification to Covered Persons, Amend 420-J:5, II(a)-(d) to read as follows:

(a) A description of the grievance procedure for adverse determinations, ***including a description and availability of the external review process*** and other matters which shall be set forth in or attached to the policy, certificate, membership booklet, or other evidence of coverage provided to covered persons.

(b) A statement of a covered person's right to contact the commissioner's office for assistance at any time. The statement shall include the toll-free telephone number and address of the commissioner.

(c) Upon written denial of a requested medical service or claim by the health carrier, a statement of the covered person's right to access the internal grievance process.

(d) [~~Staff assistance in filing a grievance~~] ***Upon exhausting the second level grievance review process, a statement of the covered person's right to access to the external review process, including what the covered person must do to initiate the external review process and the availability of expedited external review under certain circumstances generally described.***

4 Availability of External Review. Amend RSA 420-J:5, V(a)(3) to read as follows:

(3) The review panel shall issue a written decision to the covered person within 5 business days of completing the review meeting. Upon concurrence of the covered person, a copy of the decision shall be forwarded to the insurance department. The decision shall include the titles of

the members of the review panel; a statement of the review panel's understanding of the nature of the grievance, including issues raised by the covered person, and all pertinent facts; the rationale for the review panel's decision; reference to evidence or documentation considered by the review panel in making the decision; if an adverse decision is made, the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; [~~and~~] a statement of the covered person's right to file an external appeal as provided in RSA 420-J:5, VIII***; and a description of the availability of external review, how to initiate an external review and the written procedures governing an external review, including the required time frame for review and notice of decision.***

5 Availability of External Review. Amend RSA 420-J:5, V(b)(3) to read as follows:

(3) The review panel shall issue a written decision to the covered person within 5 business days of completing the review meeting. The decision shall include the titles of the members of the review panel; a statement of the review panel's understanding of the nature of the grievance and all pertinent facts; the rationale for the review panel's decision; reference to evidence or documentation considered by the review panel in making the decision; if an adverse decision is made, the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; [~~and~~] a statement of the covered person's right to file an external appeal as provided in RSA 420-J:5, VIII***; and a description of the availability of an expedited external review, how to initiate an expedited external review and the written procedures governing an external review, including the required time frame for review and notice of decision.***

6 Repeal. RSA 420-J:5, VIII and IX, relative to an external review process, are hereby repealed.

7 Effective Date. This act shall take effect January 1, 2000.

Speakers

SIGN UP SHEET

To Register Opinion If Not Speaking

Bill # HB 640 Date March 23, 1999

Committee Commerce

**** Please Print All Information ****

Name	Address	Phone	Representing	(check one) Pro	Con
Geraldine Rudenfeldt			AARP	Monitor	
	Concord, NH	229-0397	NH HMO Association	✓	
Bonnie B. Packard			TWAS Health Plan	✓	
Jeanne Farley			AARP	Monitor	
Denise Pelech	NHAHU	4831606		✓	

Hearing Minutes

HOUSE COMMITTEE ON COMMERCE

PUBLIC HEARING ON HB 640-FN

BILL TITLE: relative to grievance procedures of managed care organizations.

DATE: March 23, 1999

LOB ROOM: 302 **Time Public Hearing Called to Order:** 10:25 a.m.

Time Adjourned: 11:40 a.m.

(please circle if present)

Committee Members: Reps. Hunt, Herman, Tsiros, Belanger, Francoeur, McGough, Pappas, Avery, Kenney, Langley, Dalianis, DiFruscia, Marshall, M. Clark, Crosby, Russell, T. Reardon, Vachon, Garrish, Taylor, Curran and Keye.

Bill Sponsors: Rep. Hunt, Ches 10

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Rep. Hunt – Need to have some assurance that grievances are addressed in a timely manner. Hope this is a reasonable approach. Want to have flexibility to use the resources available throughout the country. This can be integrated with the consumer advocate bill.

Rep. Herman – Why did you come up with the amount of $1,500?

Rep. Hunt – It is an amount used in other states and used to indicate not to be used for trivial matters.

***Alex Feldvebel** (New Hampshire Insurance Department) oppose as written. Number of issues on how this should be done. (Passed out recommendations of department and discussed same.) Department in favor of an IRO.

Rep. Herman – Why should I be able to grieve if I do not have the coverage; that is, pregnancy coverage.

Alex Feldvebel – Most areas are not so clear-cut. Frivolous appeals are not a problem.

Rep. Garrish – What is the experience in other states in reference to coverage determinations.

Alex Feldvebel – Most states limit it to medical necessity.

Rep. McGough – If you allow new evidence in, should you not also allow the carrier to change their determination?

Alex Feldvebel – Carriers should be able to do that until the final determination.

Rep. McGough – Would the state contract with the IRO and bill the carrier?

Alex Feldvebel – Yes, that is how it is done in other states.

***Janet Monahan** (New Hampshire Medical Society) support. External grievance.

Rep. Herman – How practical is it to have New Hampshire licensed practitioners.

Janet Monahan – That is practical and currently required in some areas.

Liz Murphy (Harvard Pilgrim) support. Believe that lack of coverage based on medical necessity is the exception and not the norm in New Hampshire. External review will increase consumer confidence. External review is a better means of resolving disputes.

Erik Taylor (Healthsource) support. This bill will increase client confidence. Currently at Healthsource this review is at the discretion of the Medical Director. Congress is currently working on a bill. NCQA is working on a process.

Dr. Deborah Warner (Practitioner) support. Recommends that a covered person or the covered person's provider be allowed to request a review. Would like to see an internal review on an expedited basis; that is, an emergency room situation. Should remove page 2, line 8 – 9. Other than this, this is a good bill. Has good standards for the reviewers.

***Betsey Andrews Parker** (Coalition for a Healthy New Hampshire) support.

***Yvonne Nanasi** (Blue Cross Blue Shield of New Hampshire) support. This bill is for consumers, not providers. This bill is for adverse determinations. The plan picks up the cost of the external review.

Rep. Garrish – What do you see that might be cost drivers in the external review process?

Ms. Nanasi – A new bureaucracy, cost decisions. Will revisit and prepare a list.

Suzanne Amidon (New Hampshire Hospital Association) support. External grievance process. Any financial relationship with a managed care plan would be under consideration regarding to ongoing inpatient stay. Feels that his was written properly by sponsor. An opportunity to build on this with a reporting process that can identify areas with problems.

Don Dickey (Department of Health and Human Services) oppose as written. Department has come up with a report that has twenty-seven recommendations for changes, "Guidelines for change Report." Supportive of independent review and department of insurance do the contracting. Regarding to $1,500 – volume of claims low and cost low relative to claims. On expedited review, question on inpatient and on twenty-four hours. Is that the best way to go? Need a reporting and tabulating mechanism. Have the health plans do some sort of yearly review.

Paula Rogers (HIAA) support. Issues to watch:
- Who is going to initiate? The plan member.
- Who is going to select the IRO, want some flexibility?
- What role is the Medical Society going to have?
- Are we looking at medical necessity or coverage issues?

- Is review going to be a "paper review?" Cost drivers would be for testimony transcripts, etc.
- IROs subject to medical licensure. Would be concerned about limiting to New Hampshire license.

Bill is well drafted, but want to be vigilant.

Respectfully submitted,

Sheila T. Francoeur
Clerk

HOUSE COMMITTEE ON COMMERCE

PUBLIC HEARING ON HB 640-FN

BILL TITLE: relative to grievance procedures of managed care organizations.

DATE: 3-23-99

LOB ROOM: 302 **Time Public Hearing Called to Order:** 10:25

Time Adjourned: 11:40

(please circle if present)

Committee Members: Reps. Hunt, Herman, Tsiros, Belanger, Francoeur, McGough, Pappas, Avery, Kenny, Langley, Dalianis, DiFruscia, Marshall, M. Clark, Crosby, Russell, T. Reardon, Vachon, Garrish, Taylor, Curran and Keye

Bill Sponsors: Rep. Hunt, Ches 10

TESTIMONY

* Use asterisk if written testimony and/or amendments are submitted.

Rep Hunt - Need to have some assurance that grievances are addressed in a timely manner. Hope this is a reasonable approach. Want to have flexibility to use the resources available throughout the country. This can be integrated with the consumer advocate bill.

Rep Herman - Why did you come up with the amount of $1500

Rep Hunt - It is an amount used in other states and used to indicate not to be used for trivial matters.

*Alex Feldvebel - NH Insurance Dept - oppose as written. Number of issues on how this should be done. (Passed out recommendations of Dept and discussed same). Dept in favor of an IRO

Rep Harman - why should I be able to grieve if I do not have the coverage - i.e. pregnacy coverage.

Atty F - Most areas are not so clear cut. Frivolous appeals are not a problem.

Rep Garrish - What is the experience in other states in ref. to coverage determinations

Atty F - Most states limit it to medical necessity.

Rep McGough - If you allow new evidence in should you not also allow the carrier to change their determination.

Atty F - Carriers should be able to do that until the final determination.

Rep McGough - Would the state contract with the IRO & Bill the carrier

Atty F - Yes, that is how it is done in other states.

* Janet Monahon - NH Medical Society - Support External grievance

Rep Herman - How practical is it to have NH licensed practioners

Janet Monahon - That is practical & currently required in some areas

Liz Murphy - Harvard Pilgrim - support Believe that lack of coverage based on medical necessity is the exception and not the norm in NH. External review will increase

consumer confidence. External review is a better means of resolving disputes

Erika Taylor - HealthSource - support - This bill will increase client confidence. Currently at HealthSource this review is at the discretion of the Medical Director Congress is currently working on a bill. NCQA is working on a process

Dr. Deborah Warner - practitioner - support. Recommends that a covered person or the covered person's provider be allowed to request a review. Would like to see an internal review on an expedited basis - i.e. an emergency room situation. Should remove - p. 2 line 8-9 Other than this - this is a good bill. Has good standards for the reviewers.

* Betsey Andrews Parker - Coalition for a Healthy NH - support

* Yvonne Nanasi - BC/BS NH - support - This bill is for consumers - not providers. This bill is for adverse determinations. The plan pays for the cost of the external review.

Rep Garrish - What do you see that might be cost drivers in the external review process

Ms. Nanasi - A new bureaucracy - cost decisions

Will revisit and prepare a list.

Suzanne Amidon - NH Hosp Assn - Support internal/grievance process. Any financial relationship with a managed care plan would be under consideration
Re: to ongoing inpatient stay - feels that this was written properly by sponsor
An opportunity to build on this with a reporting process that can identify areas with problems

Dan Hickey - Dept of Health & Human Services
oppose as written.
Dept has come up with a report that has 27 recommendation for changes: 'Guidelines for change Report." Suggestion of independent review and dept of insurance to be contracting. RE: to #1500 - Volume of claims low and cost low relative to claims. On expedited review - question on inpatient - and on 24 hrs. Is that the best way to go?
Need a reporting and tabulating mechanism - How the Health plans do some sort of yearly review.

Paula Rogers - HIHA - support
Issues to watch:
. Who is going to initiate? - the plan member
. Who is going to select the IRO - want some flexibility
. ~~Who~~ What role is the Medical Society going to have.

- Are we looking at Medical Necessity or coverage issues
- Is review going to be a paper review
  Cost drivers would be for testimony transcripts etc
- IRO subject to medical licensure. Would be concerned about limiting to NH licensee.

Bill is well drafted, but want to be vigilant

Sub Committee - Herman
Francoeur
Mc Gough
Crosby
Taylor

HB 640-FN – AS INTRODUCED

1999 SESSION

99-0783
01/09

HOUSE BILL ***640-FN***

AN ACT relative to grievance procedures of managed care organizations.

SPONSORS: Rep. Hunt, Ches 10

COMMITTEE: Commerce

ANALYSIS

This bill establishes a procedure for an external review process to be used by covered persons after the internal review process of a managed care plan has been exhausted.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

HB 640-FN – AS INTRODUCED

99-0783
01/09

STATE OF NEW HAMPSHIRE

In the Year of Our Lord One Thousand Nine Hundred and Ninety-Nine

AN ACT relative to grievance procedures of managed care organizations.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Paragraphs; Definitions Added. Amend RSA 420-J:3 by inserting after paragraph XVI the following new paragraphs:

XVI-a. "External review" means a process by which a covered person may request that an adverse determination be reviewed by an external review organization.

XVI-b. "External review agent" or "review agent" means a clinical peer employed or under contract with an external review organization.

XVI-c. "External review organization" means an organization which employs or contracts with clinical peers to act as external review agents.

2 New Section; Independent External Review. Amend RSA 420-J by inserting after section 5 the following new section:

420-J:5-a External Review Process.

I.(a) There is hereby established an independent external review process for the purposes of a managed care plan's covered person or the covered person's ~~legal~~ representative appealing an adverse determination. A plan's covered person shall have the right to ~~request~~ an independent external review ~~and the plan shall institute the process~~ when:

(1) A covered person has exhausted the internal appeals process of the contracted plan for a covered benefit and the outcome resulted in an adverse determination;

(2) A health carrier has upheld an adverse determination upon a second level review of a grievance ~~pursuant to RSA 420-J:5-V~~, or has failed to render a decision ~~with respect to a timely request for a second-level review of an adverse determination~~;

(3) The covered person's cost for the amount in controversy is, or is anticipated to be, equal to or in excess of $1,500;

(4) The covered person submits a request, in writing, for such review to the plan within 30 days from the date of receipt of the final internal appeals determination by the managed care plan; and

(5) The covered person submits an external review filing fee of $50 to the plan with the written request. The commissioner may waive the fee in cases of extreme financial hardship. In the event that the external review organization renders a finding that the managed care plan's adverse determination was not warranted, the managed care plan shall reimburse the covered individual the full external review filing fee.

(b) The covered person shall have recourse to an expedited external review for emergency or life threatening situations which would seriously jeopardize the life or health of the covered person, provided that the provisions of subparagraphs I(a)(1), (2), [redacted] are met and when:

(1) The individual files a request for expedited review no later than ~~one business day~~ 72 hours after the managed care plan issues its final determination pursuant to its internal review process;

(2) The adverse determination under review relates to an ongoing inpatient hospital stay; and

(3) The attending provider certifies that taking the time to complete the standard external review process would ~~pose a serious threat to the covered person's health~~ seriously jeopardize the life or health of the covered person.

II. Managed care plans shall:

(a) Notify the covered person in the evidence of coverage, and in writing at the time of the final appeals decision to deny coverage of the opportunity to request the independent external review under the terms of this chapter.

(b) Maintain contracts with at least 2 external review organizations that are certified by the commissioner. A managed care plan shall not contract with an external review organization if the organization performed utilization review functions on behalf of the managed care plan for the specific case under consideration, or if the external review organization or its review agents have a significant financial relationship with the managed care plan, ~~which would seriously impair the rendering of a fair and impartial decision.~~ A contract under which an academic medical center provides health services to a managed care plan's covered individuals shall not be considered to impair the organization's or agent's ability to render a fair and impartial decision.

(c) Within 3 business days of the carrier's receipt of notification by the covered person, the plan shall select a certified independent external review organization.

(d) Within ~~10 business~~ days, the plan shall submit to the external review organization all information that was submitted to the plan by the covered person or the covered person's health care provider in support of the covered person's request for coverage under the plan's internal appeals procedures and all other evidence relied upon by the carrier in making its determination.

(e) When an expedited external review is warranted, forward the ~~required documentation~~ information described in c above to the independent external review organization within one business day of receipt of the request for an expedited external review.

(f) Be responsible for the reasonable fees and costs of the independent external review organization, such that fees and costs of an external review shall not exceed $1,500.

III. The commissioner ~~shall~~ [redacted] shall conduct

(a) Review and verify the criteria for the certification of an external review organization that contracts with managed care plans for the conduct of said external review as in paragraph IV.

Such independent external review shall be conducted solely by such external review organization certified by the commissioner and the commissioner shall notify the certified entities of the $1,500 fees and cost limitation for conducting an external review.

(b) Make determinations regarding a covered person's financial inability to render a filing fee for the review under this chapter. Such determination shall take into consideration the covered person's annual income in the previous year, absent any federal or state subsidized income.

(c) Upon request of the independent external review organization, the covered person, the covered person's health care provider or the managed care plan, the commissioner may grant up to an additional 5 days for the independent external review organization to submit a determination.

(d) Collect data regarding the nature of the service or treatment undergoing external review, the outcome determination, the review organization, and the plan, and submit an annual report no later than November 1 of each year to the governor, the speaker of the house and the president of the senate.

III. (a) An independent external review conducted by an organization at the request of a managed care plan shall meet, at a minimum, the following standards for purposes of being certified by the commissioner. Any such organization that performs an independent external review may apply to the commissioner and be certified upon demonstrating that it complies, at a minimum, with the standards established in this section.

(1) Any independent external review organization which meets the criteria under this paragraph, shall conduct its review pursuant to a written plan.

(2) Expert reviewers assigned by the independent external review organization shall be physicians or other appropriate health care professionals who meet the following requirements:

(A) Be an expert in the treatment of the covered person's medical condition and knowledgeable about the recommended service or treatment through actual clinical experience;

(B) Hold a non-restricted license in a state of the United States, and for physicians, a current certification by a recognized American medical specialty board in the areas appropriate to the subject of review;

(C) Have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restriction, taken or pending by any hospital, health carrier, government or regulatory body.

(3) Neither the expert reviewer, nor the independent external review organization, shall have any material, professional, familial, or financial conflict of interest with any of the following:

(A) The health carrier.

(B) Any officer, director, or management employee of the carrier.

(C) The physician, the physician's medical group, or the independent practice association (IPA) proposing the service or treatment.

F) The covered person or authorized Rep.

(D) The institution at which the service or treatment would be provided.

(E) The development or manufacture of the principal drug, device, procedure, or other therapy proposed for the covered person whose treatment is under review.

(4) The term "conflict of interest" shall not be interpreted to include a contract under which an academic medical center, or other similar medical center, provides health services to health carrier covered persons except academic medical centers that would provide the service for which coverage is in dispute; affiliations which are limited to staff privileges at a health facility; or an expert reviewer's participation as a contracting health carrier provider where the expert is affiliated with an academic medical center, or other similar medical research center, that is acting as an independent external review organization under this section.

(5) The following organizations are not eligible for certification as independent external review organizations:

(A) Professional or trade associations of health care providers.

(B) Subsidiaries or affiliates of such provider associations.

(C) Health carrier or health plan associations.

(D) Subsidiaries or affiliates of health plan or health carrier associations.

(6) Any independent external review organization shall have a documented process to review and evaluate the effectiveness of its ~~utilization~~ external review program.

(7) Any external review organization shall base retrospective review determinations solely on the medical information available to the attending physician or ordering provider at the time the medical care was provided.

(8) Any external review organization shall not compensate an individual rendering ~~utilization~~ review determinations based upon the number of adverse determinations ~~made~~.

(9) Any external review organization shall have a documented process for compliance with all applicable medical record confidentiality statutes and regulations.

(b) The independent external review organization shall submit the determination to the commissioner, the plan, and the covered person within 30 business days of the receipt of the request for review. Provided however, that when such documentation represents a material change upon which the independent review agent based its adverse determination or upon which the managed care plan based its denial, the managed care plan shall have 3 business days to consider such documentation and amend or confirm such adverse determination.

(c) When rendering a determination, any ~~such~~ independent external review organization ~~shall adopt and any such organization agents shall rely upon~~ utilization review criteria for the specific case pursuant to the clinical standards of the plan, ~~as well as~~ examine the attending health care provider's recommendation and the applicable generally accepted practice guidelines developed by national or professional medical societies, boards and associations.

(d) The determination shall be in written form and state the reasons the requested service or treatment should or should not be covered under the terms and conditions set forth in the evidence of coverage. ~~Determinations shall be based on the applicable coverage documents, including any defined terms that are provided for thereunder, such as "medically necessary," and shall not expand the contractually agreed upon coverage~~. The determinations shall specifically cite the relevant provisions in the evidence of coverage, the covered person's specific medical condition, and the relevant documents provided, to support the determination.

(e) ~~Notwithstanding any provision of this section to the contrary, independent external review organizations shall provide for an expedited external review process for emergency or life threatening situations which would seriously jeopardize the life or health of a covered person. A covered person shall have the right to an expedited external review if (1) the individual files a request for expedited review no later than one business day after the managed care plan issues its final determination pursuant to its internal review process, (2) the adverse determination under review relates to an ongoing inpatient hospital stay, and (3) the attending provider certifies that taking the time to complete the standard external review process would pose a serious threat to the covered person's health. The managed care plan shall forward the required documentation to the independent external review organization within one business day of receipt of the request for an expedited external review. The review agent shall issue a determination within 3 businesses days of receipt of the request for an expedited external review. All statutory standards, other than time standards, applicable to external reviews shall apply to expedited external reviews.~~

(f) An independent external review organization acting in good faith shall have immunity from any civil or criminal liability or professional discipline as a result of acts or omissions with respect to any external independent review, unless the acts or omissions constitute willful and wanton misconduct.

~~(g)~~ (a) The determination of the review agent shall be binding on all parties. A determination of the external review agent ~~in favor of the managed care plan~~ shall create a rebuttable presumption in any subsequent action at law that the coverage determination made pursuant to the health carrier's review processes was appropriate.

(b) Decisions relating to the following health care services or treatments shall not be reviewed under this section:

(1) ~~Health care services provided to beneficiaries of managed care plans wherein benefit or service provisions are prescribed by federal law.~~

(2) Health care services provided to inmates by the department of corrections.

(c) The procedure set forth in this section shall not apply to claims or allegation of health provider malpractice, professional negligence, or other professional fault against participating providers.

~~(h)~~ Repeal. RSA 420-J:5, VIII and IX, relative to an external review process, are hereby repealed.

~~(i)~~ Effective Date. This act shall take effect January 1, 2000.

LBAO
99-0783
2/11/99

HB 640-FN - FISCAL NOTE

AN ACT relative to grievance procedures of managed care organizations.

FISCAL IMPACT:

The Insurance Department stated this bill may increase state revenue by $1,800 in FY 2000, by $3,900 in FY 2001, by $4,000 in FY 2002 and by $4,200 in FY 2003. State expenditures may increase by $6,200 in FY 2000, by $13,000 in FY 2001, by $13,500 in FY 2002 and by $14,000 in FY 2003. County and local expenditures may increase by an indeterminable amount in FY 2000 and each year thereafter. There will be no fiscal impact on county and local revenue.

METHODOLOGY:

The Department assumed additional responsibilities can be absorbed within the existing budget. The Department indicated there are certain costs that health plans might incur in complying with an external review program. In addition, when a plan decision is overturned, the plan is then responsible for the cost of additional care. Research estimates these costs for plans in California to be three cents per member, per month, or approximately .03% of premium. When plan premiums increase, this increases state revenue due to the impact on premium tax. Premium increases also affect state, county and local expenditures due to the impact on the cost of health insurance coverage on employees. The total premium collected by HMO's for its fully insured products was estimated to be approximately $600 million. Premiums paid by the state were estimated to be approximately $40 million. Inflation is assumed at 4%. The increase in county and local government expenditures cannot be determined.

Sub-Committee Actions

HOUSE COMMITTEE ON COMMERCE

SUBCOMMITTEE WORK SESSION ON HB 640-FN

BILL TITLE: relative to grievance procedures of managed care organizations.

DATE: May 11, 1999

Subcommittee Members: Reps. Herman, Francoeur, McGough, ~~Crosby~~ Kaye and Taylor

Comments and Recommendations:

Amendments:

Sponsor: Rep. Commerce OLS Document #: 1999-1120h

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep. Taylor

Seconded by Rep. McGough

Vote: 5-0

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep. McGough

Seconded by Rep. Keye

Vote: 4-0

Respectfully submitted,

Rep. Keith R. Herman
Subcommittee Chairman/Clerk

Sub-Committee Minutes

HOUSE COMMITTEE ON COMMERCE

SUBCOMMITTEE WORK SESSION ON HB 640-FN

BILL TITLE: relative to grievance procedures of managed care organizations.

DATE: April 6, 1999

Subcommittee Members: Reps. Herman, Francoeur, McGough, Crosby and ~~Taylor~~ Cornish Keye

Comments and Recommendations: Discussed bill Line by Line to make necessary changes. sub-committee adjourned to meet 4/7/99

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Respectfully submitted,

Rep. Keith R. Herman
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON COMMERCE

SUBCOMMITTEE WORK SESSION ON HB 640-FN

BILL TITLE: relative to grievance procedures of managed care organizations.

DATE: April 7, 1999

Subcommittee Members: Reps. Herman, Francoeur, McGough, Crosby and Taylor

Keye

Comments and Recommendations: Further reviewed bill line by line and agreed to meet 4/13/99

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Respectfully submitted,

Rep. Keith R. Herman
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON COMMERCE

SUBCOMMITTEE WORK SESSION ON HB 640-FN

BILL TITLE: relative to grievance procedures of managed care organizations.

DATE: April 13, 1999

Subcommittee Members: Reps. Herman, Francoeur, McGough, Crosby and Taylor

Comments and Recommendations: Talked about Expedited Review

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Respectfully submitted,

Rep. Keith R. Herman
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON COMMERCE

SUBCOMMITTEE WORK SESSION ON HB 640-FN

BILL TITLE: relative to grievance procedures of managed care organizations.

DATE: April 20, 1999

Subcommittee Members: Reps. Herman, Francoeur, McGough, Crosby and Taylor

Comments and Recommendations:

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Respectfully submitted,

Rep. Keith R. Herman
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON COMMERCE

SUBCOMMITTEE WORK SESSION ON HB 640-FN

BILL TITLE: relative to grievance procedures of managed care organizations.

DATE: April 21, 1999 The committee went through the bill final/ provisions and will have a revised draft made for final vote

Subcommittee Members: Reps. Herman, Francoeur, McGough, Crosby and Taylor

Comments and Recommendations:

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Respectfully submitted,

Rep. Keith R. Herman
Subcommittee Chairman/Clerk

HOUSE COMMITTEE ON COMMERCE

SUBCOMMITTEE WORK SESSION ON HB 640-FN

BILL TITLE: relative to grievance procedures of managed care organizations.

DATE: May 5, 1999

Subcommittee Members: Reps. Herman, Francoeur, McGough, Keyle, Crosby and Taylor

Comments and Recommendations: reviewed Final draft and discussed Technical corrections from Blue Cross. sub-committee sent draft to legislative services for Final vote.

Amendments:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Sponsor: Rep. OLS Document #:

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep.

Seconded by Rep.

Vote:

Respectfully submitted,

Rep. Keith R. Herman
Subcommittee Chairman/Clerk

Testimony

NEW HAMPSHIRE MEDICAL SOCIETY

For the betterment of public health since 1791

7 North State Street
Concord, New Hampshire 03301
(603) 224-1909
Toll Free (800) 564-1909
FAX (603) 226-2432
E-mail: nhmsppj@aol.com
EXECUTIVE VICE PRESIDENT
Palmer P. Jones

HB 640, relative to grievance procedures of managed care organizations.

March 23, 1999

The NH Medical Society believes that access to binding independent, external review for managed care denials is a matter of fundamental fairness. To be a truly fair grievance review process:

- Patients or their authorized representative should be able to initiate an appeal;
- Access to the process should not be restricted by burdensome thresholds or cost sharing requirements;
- Reviewing physicians must be truly independent; of the same specialty as the treating physician, with equal or a higher level of expertise; and hold a current NH medical license;
- Reviews must be timely -- taking into account the patient's medical condition;
- Review decisions must be available for public scrutiny, while protecting patient confidentiality; and
- Retaliation by health plans against physicians who serve as patient advocates must be prohibited.

There appears to be growing support for some type of independent grievance process from patients, providers and health plans. Whatever plan is ultimately adopted, the key to external grievance success remains in the definition of "medical necessity." No matter how sound and effective an internal or external grievance process is, if the "medical necessity" standard being applied to both is arbitrarily dictated by the health plan, the patient will never be guaranteed a fair and objective evaluation. Those of you who were here last year for the "medical necessity" debate will remember that many health plans include language in their policies that basically states that "medical necessity" is whatever the medical director determines it to be. As such, the Medical Society would urge this committee to consider "medical necessity" as part of the external grievance debate.

The American Medical Association defines "medical necessity" as follows:

> *Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (1) in accordance with generally*

accepted standards of medical practice; (2) clinically appropriate in terms of type, frequency, extent, site, and duration; and (3) not primarily for the convenience of the patient, physician, or other health care provider.

Additionally, the Medical Society would like you to consider adding language to an external grievance bill to include some type of oversight by the Board of Medicine. As Chairman Hunt stated at the hearing on HB 637, if a health plan medical director shows a pattern of poor decision making as evidenced by repeated external grievance reviews, that person should be reported to the Board of Medicine. The Board of Medicine can then determine whether the medical director's decisions have been appropriate for the symptoms and diagnosis given and whether or not the decisions reflect the appropriate standards of medical practice. As we stated at the hearing on HB 637 -- medical directors who are making appropriate decisions will not be affected by Board of Medicine oversight.

In collecting research on external grievance I came upon an article from the *Wall Street Journal*, which had the following quote from an HMO executive: "We see people as numbers, not patients ... We're a mass-production medical assembly line, and there is no room for the human equation in our bottom line." That is an unfortunate comment and sadly it is accurate. Medical Society member physicians treat individual patients with individual needs. They are people, not numbers. That is why we are here today in support of external grievance as a means to recognize the individual needs of patients and to try to bring a little fairness to the managed care process.

Articles....
Medicare external review
Medicaid external review
Wall Street Journal , 6-18-97
Coopers & Lybrand cost study
"Medical decision" - Arizona case

AMERICAN MEDICAL NEWS 9-7-98

AMERICAN MEDICAL ASSOCIATION VOLUME 41 NUMBER 33

Court mandates stronger appeals rights for Medicare HMO patients

AT A GLANCE

STRONGER SAFEGUARDS | Court ruling will force HHS to strengthen its appeals process for Medicare patients in managed care plans.

Geri Aston
AMNEWS STAFF

Washington ALTHOUGH EFFORTS TO establish a federal law ensuring patients' rights to appeal HMO decisions have stalled in Congress, a federal court has issued a ruling shoring up those rights for the 6.5 million Medicare beneficiaries in managed care plans.

Last month, the 9th U.S. Circuit Court of Appeals upheld a lower court ruling that determined that HMOs are "federal actors" in the context of Medicare. That decision gives beneficiaries the right to due process, a constitutional protection under the Fifth Amendment.

"The government cannot avoid the due process requirements of the Constitution merely by delegating its duty to determine Medicare coverage to private entities," the three-judge panel stated.

They agreed with the lower court's conclusion that the government's Medicare HMO appeals rules and its failure to monitor health plan service denials to beneficiaries fail to meet the due process standard.

> **"The biggest problem was beneficiaries didn't get a notice."**
>
> **Sally Hart, an attorney at the Center for Medicare Advocacy**

Change in appeals process required

THE RULING IS THE LATEST CHAPTER in a class-action suit brought against the Dept. of Health and Human Services in 1993 by five Tucson, Ariz., women. The suit began when Medicare beneficiary Gregoria Grijalva fought her health plan for medical services that she and her physician believed were necessary.

Grijalva eventually received the care she sought, but the U.S. District Court in Arizona pursued the case to guard against similar problems in the future.

The appeals court's ruling means that the government must implement changes in Medicare appeals rules laid out in last year's district court or-

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Court mandates stronger appeals rights for Medicare HMO patients

Continued from page 1

der unless HHS takes the case to the Supreme Court or convinces the district court to change its initial decision. Both options would be uphill battles for the agency, experts said.

The government has not yet decided what path it will take, a Health Care Financing Administration spokesman said.

The decision corrects some glaring problems in the Medicare HMO appeals process, beneficiary advocacy groups said. The court order requires that plans notify seniors in plain language that coverage for a requested treatment has been denied, explain patients' appeals rights and describe how beneficiaries may present evidence to argue their cases against the HMO decision.

"The biggest problem was that beneficiaries didn't get a notice, and the second problem was that if they did get it, it didn't have much information," said Sally Hart, an attorney at the Center for Medicare Advocacy who represented the plaintiffs.

The appeals court shot down HHS's criticism of the district court's assumption that plans' inadequate appeals processes result in fewer challenges. "The secretary fails to recognize the real problem: inadequate notice renders the existence of an appeals process meaningless," the judges stated.

HHS: Stronger process now in place

HHS ARGUED IT HAD STRENGTHened many of the government's appeals rules on its own. In April 1997, the agency issued rules creating an expedited appeals process that mandated HMOs mak[illegible]erage decisions within 72 hours [illegible]request — the same period ordered by the district court. This stepped-up process is used in cases in which the beneficiary's life, health or ability to regain maximum function could be jeopardized by delaying a treatment decision.

Earlier this year, the government issued proposed Medicare+Choice regulations that further tighten appeals rules. For example, the proposal requires that in routine cases, health plans make coverage decisions within 14 days of a request by a patient or physician. HMOs previously had 60 days to make a determination.

In light of its efforts, HHS asked the appeals court to modify the court's order, but the judges declined.

Beneficiary advocates acknowledged the government's progress but noted that HHS's rules still are weaker than the court's requirements.

"It is true that HCFA has been making improvements — the Medicare+Choice regulations show that — but they're not as far as the court order," said Mary Ellen Bliss, of the American Assn. of Retired Persons' federal affairs health team.

One example of the differences is the length of time allowed for routine coverage decisions. The court order requires HMOs to issue a ruling in five days, as opposed to 14 days under Medicare+Choice.

Another difference pertains to continuation of care while an appeal is pending. The court mandates that when acute services have been denied, thus triggering an expedited appeal process, treatment must continue until the health plan issues a final decision. The acute care definition includes certain types of nursing facility care, home health care and therapy.

The Medicare+Choice regulations appear to apply this standard only to inpatient hospital care. HHS argued that requiring plans to pay for all acute care pending an appeal would "create an incentive for beneficiaries to request reconsideration without regard to the merits of an appeal."

Continuation of care is one of the most important protections, Bliss said. "In some cases, restarting therapy won't put you back where you were when it stopped," she said.

HMO compliance with rules required

THE APPEALS COURT RULING IS also significant in that it requires the government to monitor HMOs' compliance with the appeals rules and prohibits HHS from renewing or entering into subsequent contracts with violators.

The judges dismissed the agency's argument that the government should use this harshest of penalties at its discretion.

Beneficiary advocates applauded the courts' tough stance.

"You need so[illegible]ing to make the plans sit up a[illegible]e notice," the AARP's Bliss said.

Officials at the American Assn. of Health Plans predicted that the ruling's impact on HMOs will not be "that significant."

"For the most part, the [Medicare+Choice] regulations go a long way to getting there already," said Louis Saccoccio, the group's general counsel.

The decision to treat HMOs as government agents, or "state actors" in legal terms, also will have little impact, he said.

"The government has rules you have to comply with whether you're a state actor or not," he said.

In Congress, lawmakers are debating several bills that would establish consumer protections, including internal and external appeals processes for enrollees in private health plans disputing a coverage denial.

The Republican measure passed in July in the House, but the issue has languished in the Senate, where partisan bickering has prevented agreement on how to call competing GOP and Democratic bills for a vote. ◆

APPEALING HMO DECISIONS

Court-ordered Medicare HMO appeals rules:

- HMOs must provide written notice when a coverage determination results in treatments being denied, reduced or ended.
- Denial notices must be given no more than five working days after a written or oral request.
- Denial notices must be on a clear, readable form in at least 12-point type. They must include an explanation in lay language of the coverage rule on which the HMO based the decision, a description of the regular and expedited appeal processes, and a description of how enrollees can use additional evidence to support their cases.
- HMOs must provide an expedited appeals process in urgent cases.
- Plans must render expedited appeals decisions within three working days.
- A written statement by a doctor can trigger an expedited appeal, but lay testimony may also suffice in some circumstances.
- Services must continue until a final decision has been issued in appeals cases involving acute care.
- The Dept. of Health and Human Services must monitor HMO compliance and is prohibited from renewing or entering into Medicare contracts with HMOs that have violated the appeals rules.

FOR IMMEDIATE RELEASE
Friday, Sept. 25, 1998

Contact: HCFA Press Office
(202) 690-6145

NEW PATIENT PROTECTIONS ANNOUNCED FOR MEDICAID MANAGED CARE
New regulation implements BBA provisions

As announced last week by President Clinton, the Department of Health and Human Services has finalized a regulation establishing strong, new patient protections for Medicaid beneficiaries enrolled in managed care plans. The new proposed rule is on display today at the *Federal Register*. The *Notice of Proposed Rulemaking* opens a 60-day comment period for interested parties to respond to the proposed regulation.

The new Medicaid regulation fulfills a promise made earlier this year by President Clinton to extend a Patients' Bill of Rights to all Americans enrolled in public health care programs. The rule would implement provisions of the bipartisan Balanced Budget Act of 1997 (BBA).

"Managed care provides the promise of better coordinated health care at a more reasonable cost," said HHS Secretary Donna E. Shalala. "But all Americans – whether they are in Medicare, Medicaid, or private health plans -- deserve the basic protections that a Patients' Bill of Rights provides. It's not too late for Congress to enact real legislation to protect all Americans."

Under the new rule, managed care plans serving Medicaid beneficiaries would provide consumers with comprehensive, easy-to-understand information about the operation of those plans, including the names of all participating providers and their locations. States that mandate managed care would also offer most beneficiaries a choice of at least two qualified health plans.

The new proposed rule would also require managed care plans to cover the cost of emergency health care services wherever and whenever the need for such services arises. Plans would be prohibited from requiring prior approval for such services or requiring that consumers go only to approved facilities. Emergency services would be based on a "prudent layperson" standard, that is, when a beneficiary reasonably assumes that he or she is in an emergency situation.

In addition to consumer protections, the proposed regulation would also implement other important changes to Medicaid, the jointly administered federal-state health insurance program for low-income families and disabled individuals, which were included in the BBA. For example, the regulation would allow states to mandate that most Medicaid beneficiaries enroll in managed care plans simply by submitting a state plan amendment. Previously, states had to obtain a waiver of

Medicaid rules in order to require beneficiaries to enroll in managed care plans. Currently, an estimated 15 million Medicaid beneficiaries are enrolled in managed care plans. An estimated 568 private plans participate in Medicaid.

Under the BBA, the states' option to guarantee up to six months of Medicaid eligibility to beneficiaries has been expanded. This would insure continued enrollment to families who otherwise move in and out of eligibility due to work status or income changes.

Other patients' protections included in the proposed regulation are:

Access to Specialists. Beneficiaries with chronic or severe medical conditions would be guaranteed direct access to medical specialists within a health plan's provider network. Women would be permitted to go to women's health care specialists for routine and preventive care.

Patient-Provider Communication. Managed care plans would be prohibited from establishing restrictions (e.g., gag rules) that interfere with patient-provider communications.

Network Adequacy. Managed care plans would be required to assure that they have the capacity to serve the expected enrollment in their service area.

Marketing Activities. States would be required to approve the marketing materials used by managed care plans to attract and enroll Medicaid beneficiaries. Plans would be prohibited from using door-to-door, telephonic, and other forms of "cold call" marketing.

Grievance Systems. All managed care plans would establish grievance systems that allow beneficiaries to appeal plan decisions to deny, limit, or terminate coverage of services as well as actions related to payment and quality. Plans would be required to resolve grievances in a timely manner, including expedited review when necessary, and involve personnel who were not involved in previous levels of review or decision-making.

Finally, the new regulation would also establish new quality performance standards for states regarding health plans. These quality standards have been developed in consultation with representatives of plans and states, and are consistent with quality improvement efforts of purchasers in the private sector. By basing the department's efforts on private-sector strategies and standards, HHS will be able to promote quality improvement for our Medicare and Medicaid beneficiaries without imposing new types of burdens on health plans participating in these programs.

"Through this new regulation we are ensuring that Medicaid beneficiaries receive the same high quality managed health care that is available to others, no matter their economic situation," said Nancy-Ann DeParle, administrator of the Health Care Financing Administration (HCFA), which administers Medicaid.

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Note: HHS press releases are available on the World Wide Web at: http://www.hhs.gov.

What's Happened to the Healing Process?

WALL STREET JOURNAL 6-18-97

By Robert M. Goldberg

A stick ripped through nine-year-old Steven Olsen's cheek and lodged at the base of his brain. But Steven was not rushed to the nearest hospital. Instead—following the instructions of his parents' health plan—they called a toll-free number for permission to go to a hospital of the insurer's choice. Ten hours later, surgeons removed the stick and mended the gash. Days later Steven was still feeling ill. Was his injury the cause? asked his parents. Shouldn't we get an MRI? No, said the managed-care gatekeeper, it's the flu: Give Steven some Advil and wait.

Two more days, and Steven's head was throbbing. His parents took him to the hospital. Twice they asked doctors if the injury had anything to do with the pain and whether he should get a brain scan. Twice they were told he had some form of meningitis. Steven was sent home after a day, still in pain.

Steven's condition kept getting worse. Finally, weeks later, he got a brain scan. It showed an abscess in his brain, caused by the stick, which was inducing seizures—hence the pain. Because he had been left untreated, Steven went blind and developed cerebral palsy. His intellectual development is now stunted. His parents found out that their health plan knew all along about the possibility of a brain abscess, even as it was forbidding Steven to get an $800 scan or see a neurologist.

Delivering 'Inputs'

Steven Olsen is a victim of the slow death of the doctor-patient relationship, at the hands of both corporate and government bureaucracies. Of course doctors still see patients, make diagnoses, write prescriptions and perform surgery. But increasingly they are losing authority over their patients' care. Instead, they are expected to deliver medical "inputs" according to organizational directives. Those who resist are treated as uncooperative employees. Is it any wonder that Texas recently passed legislation allowing patients to sue health-maintenance organizations for malpractice? Or that an increasing number of doctors are joining labor unions?

An HMO executive, quoted last September in the Business Record of Des Moines, Iowa, summed up the industry's approach chillingly: "We see people as numbers, not patients. It's easier to make a decision. Just like Ford, we're a mass-production medical assembly line, and there is no room for the human equation in our bottom line. Profits are king." That comparison insults Ford, a company that has become focused on customer satisfaction. Indeed, any company in any industry would go bankrupt if it had the take-it-or-leave attitude of most managed-care organizations, with their gatekeepers and indifferent "benefits managers" who often stumble over the pronunciation of medical procedures.

Health plans are not directly accountable to either doctors or patients. For them the key to profits is to get doctors to do what they are told and keep patients in the dark. Even doctors who aren't employees of an HMO are often pressured to behave as if they were. Despite their claims to the contrary, HMOs frequently threaten to "lay off" doctors—kicking them out of a plan—if they fail to hold down costs or hit their quota of patients.

An HMO executive summed up the industry's approach: 'We see people as numbers, not patients . . . We're a mass-production medical assembly line, and there is no room for the human equation in our bottom line.'

Physicians have accepted limits on their income, with resignation if not acceptance. They are willing to learn ways to improve the quality of care. But they are frustrated, because the quality of their relationships with their patients has deteriorated under managed care. Doctors work the same number of hours—fewer, in some case—under HMO contracts. But the loss of control over resources, restrictions on referrals and the pressure to hurry through a larger number of patients per hour engender cynicism and resentment.

A survey of 200 primary-care physicians in the New York area by New York Doctors MSO, a physician practice management group, found that 45% believe that managed care has had a "negative impact" on the quality of physician-patient relationships. (Eleven percent said the relationship has improved under managed care.) Nearly half the doctors surveyed said they had recently considered leaving the profession.

Many managed-care organizations maintain that limiting doctor autonomy eliminates wide differences in the amount and quality of care. They say that their systems will integrate care, providing better treatment at lower cost than a lonely doctor in a traditional practice can. Several managed care plans, including HealthPartners in Minnesota, have lived up to these claims. But they have taken great pains to preserve physicians' autonomy and to encourage patients to become more involved in their treatment. Most plans, however, make it harder for doctors and patients to create such partnerships.

Make no mistake: A strong doctor-patient relationship is critical to successful treatment. Studies have shown that more than half of all Americans fail to understand or follow through on a doctor's advice, often ending up sicker than they were before seeking treatment. Likewise, half of all parents leave their pediatrician's office confused about his directions. Studies of doctor-patient relationships in the treatment of diabetes, mental illness and heart disease show that more time, information and patient involvement in treatment decisions contribute to better health. And surveys show that patients consistently rank good information second only to clinical skill as the most important thing a doctor has to offer.

On average, doctors spend eight minutes talking to each patient, less than half as much as a decade ago. As managed care drives up the number of patients a doctor must see, the time he can devote to each continues to dwindle. Doctors who feel they have lost the freedom to practice medicine are less likely to take a personal interest in their patients. They show up, do their job, get paid, gripe about the boss and try not to get emotionally involved.

Managed-care organization should take seriously the movement toward litigation and regulation. The 1974 Employee Retirement Income Security Act, which governs employer-provided health plans, provided managed care organizations virtual immunity from liability. But this barrier is crumbling under public pressure. Other states are likely to follow Texas's lead, spurred by a Virginia federal court ruling that held that Erisa does not pre-empt state claims alleging medical malpractice by physicians and vicarious liability by HMOs. In this case, a couple sued when they found out that the HMO paid their child's pediatrician bonuses for avoiding excessive treatments and testing. The court allowed the claims to go forward because they involve the quality of medical care provided by physicians.

The ability to sue HMOs for malpractice, however, will not improve the doctor-patient relationship, and thus will not insure that people will get better care. First, lawsuits occur after the fact. It will likely still be more cost effective to let people (or their estates) sue than it will to give doctors and patients more control over medical decisions. Second, plans are forcing doctors to pay for their patients' care out of their own pockets if they exceed a certain average rate per patient. Oxford Health Plan, for instance, allows specialists to manage the care of patients without any direct intervention. But Oxford requires such doctors to stay under budget, as defined by Oxford. If someone gets sicker or dies because a doctor tried to stay under budget, the legal liability could well fall on the physician.

Lumbering and Statist

There is no defensible economic or clinical reason that health care has to take these forms. Enhancing the doctor-patient relationship could generate better care at lower cost. But our lumbering and statist medical system is leaving less and less room for a doctor-patient partnership. Steven Olsen was left brain damaged and blind not because he didn't have "access" to integrated health care systems or the best medical technology in the world, but because among the too many doctors just following orders, there wasn't one he could trust to do the right thing.

Mr. Goldberg is a senior research fellow at the Center for Neuroscience, Medical Progress and Society, George Washington University.

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September/October 1998

Three Legal Decisions Bolster Doctor-Patient Relationship

RICHARD C. W. HALL, M.D.

Discussion of court cases figured prominently during the APA's Managed Care Committee meeting this spring in Toronto, prompting the Committee to ask one of its members, Dr. Hall, to summarize his research on important cases for Psychiatric Practice & Managed Care. Dr. Hall is Courtesy Clinical Professor of Psychiatry at the University of Florida in Gainesville.

Court cases in Arizona, California, and Florida have resulted in rulings that have assisted physicians in providing better care to their patients by maintaining the doctor-patient relationship, which is so often disrupted in managed care systems. The cases described here suggest that physicians should not be forced to make decisions against their patients' best interest, that physicians are responsible for their behavior, and that they need to stand up for their patients.

MCO Medical Director Held Responsible for "Medical Decision"

Murphy v. Board of Medical Examiners

In an important suit, *Murphy v. Board of Medical Examiners* (1), the court decided that John F. Murphy, Medical Director for Blue Cross/Blue Shield of Arizona, made a "medical decision" when he overruled a patient's physicians and denied precertification for treatment.

On December 29, 1992, Dr. Murphy refused to pre-certify a patient's laparoscopic cholecystectomy (gallbladder surgery). Dr. Murphy opined that the surgery was "not medically necessary." His decision contradicted the advice of the patient's surgeon and her referring physician, Dr. Johnson. The surgery was performed despite Blue Cross's refusal to pre-certify.

Dr. Johnson registered a complaint with the Board of Medical Examiners, and in February of 1993 the Board sent Dr. Murphy a copy of Dr. Johnson's complaint and requested a response. Dr. Murphy returned the letter, questioning whether the Board of Medical Examiners could review his action because he was "not involved in patient care and not involved in the practice of medicine." He provided the requested information "as a courtesy" and to avoid "a claim of unprofessional conduct." In October 1993, the Board ordered an investigation and subpoenaed Blue Cross documents concerning 20 cases in which Dr. Murphy denied pre-certification. Blue Cross objected to the subpoena and said that the Board lacked jurisdiction because Dr. Murphy worked for an insurance company and that he was not practicing medicine.



The Court ruled that although Dr. Murphy was not engaged in the traditional practice of medicine, to the extent that he renders medical decisions his conduct is reviewable by the Board of Medical Examiners. The Court found that Dr. Murphy substituted his medical judgment for that of the patient's physicians and determined that the surgery was "not medically necessary." The Court ruled that such decisions were not insurance decisions but, rather, medical decisions because they required Dr. Murphy to determine whether the procedure was "appropriate for the symptoms and diagnosis of the condition," whether it was to be "provided for the diagnosis, care or treatment," and whether it was "in accordance with standards of good medical practice in Arizona."

Patient Care Supersedes Profits

The Self Case

In April 1998, a San Diego jury awarded Thomas Self, M.D., a pediatrician, $1.7 million after finding that he was fired in a malicious fashion and that he had been defamed. As reported in the *Orlando Sentinel* (2), Dr. Self sued the medical group for which he worked after he had been discharged. He contended that he was fired because he spent too much time with patients, ordered too many tests that did not generate profit, and refused to perform unnecessary surgeries. The jury agreed with Dr. Self.

The Sentinel noted that this was the first verdict of its kind in the country, setting an important precedent when Dr. Self successfully argued that the medical company's emphasis on the bottom line precluded doctors from providing good medical care. Many observers have suggested that this case sends a signal of the public's growing unease about the disproportionate balance between corporate profits and the medicine that is delivered to patients.

The basis of the Self suit was a 1993 California statute that prohibited medical groups and MCOs from retaliating against physicians for giving patients appropriate care. About half the states in the country have enacted similar laws.

Medical Necessity Defined in Medicaid Case

Tallahassee Memorial v. Cook

(continued on page 8)

Coalition for a Healthy New Hampshire Testimony
HB 640-relative to grievance procedures of managed care organizations
March 23, 1999

Good morning. My name is Betsey Andrews Parker and I am here representing the Coalition for a Healthy New Hampshire. The Coalition for a Healthy NH is composed of more than 20 statewide health care provider and consumer organizations whose members include among others, NH Citizens Alliance, NH Medical Society, NH AIDS Foundation, the Home Care Association of NH, NH Nurses Association, NH Nurse Practitioner's Association, and The Council on Chronic Illness and Disability.

The coalition supports the effort to legislate a required external review process for all managed care organizations. As provider and advocate organizations, we understand the need for such a process. Almost daily, we receive phone calls or meet with clients who are trying to navigate the confusing world of managed care. Many have a diminished health capacity and have experienced the physical, emotional, or financial burden of a fruitless internal review. These are the people who would most benefit from an external review process. The Coalition's goal here today is to identify the essential components that, by our view, should be included in any proposal.

- First and foremost, the bill we pass must require an external review entity to be free of conflict, and the process, by design, to be fair to all parties.

- The successful proposal must permit either the health plan member or his/her representative or health care provider to initiate the independent review process. Due to illness, health plan members may not be able to advocate for themselves; the new law, therefore, must permit others to advocate in their place. Health care providers, because of their level of expertise, may be the preferred representatives.

- The successful proposal must require the opportunity for a hearing. A record of the hearings should be available for monitoring purposes. The Coalition can not support any proposal that limits the external review process to a paper appeal.

- The successful proposal must require disclosure to health plan members of their right to access the external review process, along with a clear and simple explanation of the manner in which the process is initiated. Further, if a filing fee is required to initiate the process is proposed, that fee should be minimal so as not to inhibit or discourage health plan members from initiating the process. The plan must also permit a waiver of filing fees and costs in the event of financial hardship to the health plan member. Any fees paid by the health plan member should be reimbursed by the health plan if the review finds in favor of the health plan member.

- The threshold for the health plan member's cost for the amount in controversy must be low enough that a lay person can determine if he/she would qualify without having to consult a financial analyst or guess if the amount would or would not exceed the threshold.

- The successful proposal must impose clear and reasonable timelines for the external review process, including but not limited to:
    - Initiation of the process;
    - Provision of requested documentation;
    - Schedule of hearing(s); and
    - Filing of the decision.

- The successful proposal should contain provisions requiring an expedited process for serious and life-threatening circumstances.

- The successful proposal must set an effective date no later than January 1, 2000. The Coalition would not support efforts to delay passage of legislation due to activity on the federal or private accreditation levels.

We support the efforts of this Committee to craft an external review process that meets these fundamental criteria. Members of the Coalition for a Healthy New Hampshire are happy to work with the Committee and offer our collective expertise.

If you have any questions for the coalition, please contact
Betsey Andrews Parker at 225-2097 ext. 21

BlueCross BlueShield of New Hampshire
An Independent Licensee of the Blue Cross and Blue Shield Association

Matthew Thornton Health Plan
A subsidiary of Blue Cross and Blue Shield of New Hampshire

House Commerce Committee
March 23, 1999
HB 640: External Review Process

Submitted by: Yvonne Nanasi, BCBSNH Director of Government Relations

Blue Cross and Blue Shield of New Hampshire believes that an appropriate external review process, such as that embodied in HB 640, builds consumer trust in managed care and results in a higher quality health care system. Furthermore, a common process for all plans provides less confusion for consumers.

At least twenty one states have passed legislation that provides for some type of independent external review process. These states are Arizona, California, Connecticut, Delaware, Florida, Hawaii, Maryland, Michigan, Minnesota, Missouri, New Hampshire, New Jersey, New York, New Mexico, North Carolina, Ohio, Pennsylvania, Rhode Island, Tennessee, Texas, and Vermont.

State independent external appeals mechanisms take various forms, some have worked better than others. BCBSNH examined several of these states' processes to determine what would be most suitable for New Hampshire. HB 640 combines the approaches of various states to formulate a process that:

- is easy to understand,
- efficient to administer,
- involves appropriate medical professionals,
- will not substantially increase premiums, and most importantly,
- provides resolution in a timely manner.

The process, in HB 640, whereby a consumer accesses external review is reflective of the process in most states that have recently enacted such legislation. The common components among most states are that the consumer must have exhausted the plan's internal appeals process and it resulted in an adverse determination. It provides for the consumer to be represented and submit information to the external review entity.

Some states, such as Hawaii, did not build into their external review legislation specific time frames and process details. Subsequently, the implementation has become bogged down in an administrative rulemaking process and required further legislation. HB 640 avoids those problems by specifying time frames for both standard as well as expedited reviews. In easily understood language, HB 640, details the responsibilities of the health plan, the Department of Insurance and the consumer.

In almost all states, external review is performed by independent experts who must be free of financial conflicts of interest. Some states external review process places more administrative burden on the state's regulatory agency to conduct the external review process, imposing added costs and staffing requirements for the regulator. HB 640 avoids imposing extensive administrative costs on the regulatory agency while maintaining a review by independent experts.

While enacting an external review process to address consumer concerns is a far better alternative for resolution of disputes than encouraging costly litigation, it does not solve the real challenge facing consumers, health care providers and health plans. BCBSNH believes that much more needs to be done in the area of outcomes research and medical technology assessment. These will provide decision makers with the kind of information that they can rely upon to make the best decisions possible in these areas at the earliest possible stage, so that our knowledge about what is proven and effective is able to keep pace with the constant advances in medical practice.

4/23/99

Overview of HB 640: External Review Process

Type of Products	- All managed care plans except Inmates and plans where the benefits are proscribed by federal law.
Cost of Appeal	- Covered person pays external review filing fee of $50. Which is refundable if determination is against the plan or can be waived by the Commissioner due to financial hardship. - Carrier assumes cost of independent external review organization and cost is capped at $1500 per case.
Who Can Appeal	- Covered person or their legal representative - also, can submit information to reviewing body.
Type of Appeal	- Exhausted internal process - Adverse Medical Necessity Decision of contracted benefits - covered person's liability for disputed service is for over $1500
Initiating External Appeal	- In writing to DOI and carrier w/in 30 days of carrier's final internal process determination. - for expedited within 1 business day after internal process determination.
Reviewing Entity	- plan chooses an acknowledged review organization that is certified by DOI. - cost of external review not to exceed $1500.
Expedited External Appeal	- emergency or life threatening that would seriously jeopardize life or health of the person certified by the attending provider during an inpatient hospital stay.
Review Decision time-frame	- 30 days from receipt of request for review (commissioner option to grant 7 added days). - 3 business day expedited external process available in life-threatening cases. - if new information is presented, plan may reinitiate internal process and put a hold on external process
External Decision Appeal	- Binding on both parties, - A decision of the independent review organization in favor of the plan shall create a rebuttable presumption in any subsequent action at law.

Regional Office
15 Constitution Drive
Bedford, New Hampshire
03110-6002
FAX: (603)471-4301
(603)471-4300
(800)330-3394

TUFTS Health Plan

March 23, 1999

Representative John Hunt, Chair
House Committee on Commerce
New Hampshire State House, Room 302
Concord, NH 03301

RE: HB 640 - An Act Relative to Grievance Procedures of Managed Care Organizations

Dear Representative Hunt:

On behalf of the Tufts Health Plan, I would like to thank you and your committee for the opportunity to provide written testimony on HB 640 - An Act Relative to Grievance Procedures of Managed Care Organizations.

Tufts Health Plan supports the concept of an external appeals mechanism. A well designed external appeals program can provide health care consumers with an added level of confidence in their managed care organization. We believe that such an independent review should:

- be easy for consumers to use
- produce high quality, fair, and binding decisions based on medical experts' review of medical evidence
- be free of conflicts of interest;
- provide for the quick and efficient disposition of appeals.

In addition to the criteria just mentioned, an effective review program should avoid duplicative or conflicting review systems, base final decisions on the terms and conditions of an individual's health benefits, and only be conducted after completion of plans' internal appeal processes. Tufts Health Plan commends Representative Hunt and his recognition of the need to incorporate these patient protections into legislation while providing plans the ability to resolve disputes through existing internal appeal mechanisms before the external option may be exercised.

Recently, The National Committee for Quality Assurance (NCQA) which serves as the national accrediting body for HMO's announced that it is in the process of implementing external review procedures as a condition of accreditation beginning in 2000. Tufts Health Plan has received full NCQA accreditation, the highest level of accreditation provided and will be working on an external review process to comply with these requirements. We would recommend allowing this NCQA process to be implemented and in place for some time before further legislating a managed care external grievance appeals processes.

RE: HB 640 - An Act Relative to Grievance Procedures of Managed Care Organizations

Furthermore, Tufts Health Plan is a member of The American Association of Health Plans (AAHP). The organization is the national trade association representing health maintenance organizations (HMOs), preferred provider organizations (PPOs) and other similar health plans that provide coverage for over 140 million Americans. AAHP is also supportive of an effective appeals system as a means to achieve fast, fair and efficient dispute resolution, specifically for medical necessity decisions.

Tufts Health Plan is committed to working with state lawmakers and policy makers to create an appropriate external appeals mechanism. Thank you for the opportunity to submit testimony on this very important issue. If you have any questions please feel free to give me a call at 1-800-330-3394.

Sincerely,



Lisa Swenson, Vice President and General Manager
Tufts Health Plan

Estimated Costs of Selected Consumer Protection Proposals

A Cost Analysis of the President's Advisory Commission's Consumer Bill of Rights and Responsibilities and the Patient Access to Responsible Care Act

April 1998

By Coopers & Lybrand L.L.P.

Sandra Hunt, M.P.A.

John Saari, M.A.A.A.

Kelly Traw, J.D.

Mark Ficker, C.P.A.

Prepared for the Henry J. Kaiser Family Foundation

Third Party Appeals

Both the CBRR and PARCA have provisions that seek to provide health plan members with processes for challenging health plan decisions. These provisions establish criteria for internal review by the health plan of service requests and for external review of utilization management decisions when a member has exhausted a plan's internal review mechanisms. An external review allows for a decision-maker outside of a health plan to review health plan coverage determinations in the case of a dispute between a member and a plan. The purpose of this provision is to assure health plan members that there is a fair and impartial decision-making process in place for determining the medical necessity of covered services. Currently, 14 states require health plans to provide enrollees with an external grievance process, with some states limiting that process to certain types of patients. In both CBRR and PARCA the external review process is to be provided by a health care provider who possesses the appropriate skills to evaluate the decision and has not been involved in the case.

The use of an external review process is rapidly becoming a standard of practice. A number of large health plans, including Group Health Plan, Kaiser Permanente, and the Blue Cross and Blue Shield plans in New York have recently announced implementation of external review processes. In addition, those plans holding contracts with Medicare or Medicaid are required to have processes in place that meet these requirements, representing 65% of the plans in the 41 largest MSAs. Plans holding contracts with the Office of Personnel Management for federal employees are also subject to external review requirements. As of March, 1998 fourteen states have legislation in place that requires implementation of an external review process, with legislation pending in nearly every other state.

The cost of implementing an external review process depends on both the actual administrative cost of the process and the cost of medical services that would be covered by health plans resulting from an overturned decisions. Thus, the cost depends in part on the percentage of decisions that are overturned and the associated medical services costs. A secondary effect may be a change in health plan utilization review practices that results in higher utilization rates if health plans decide the cost of the external review process exceeds the value of constraining utilization through their existing practices.

Evidence to date on the cost of requiring external review suggests that relatively few cases reach the external review stage. Texas passed a law in September, 1997 that established an external review mechanism, with health plans held responsible for the administrative costs of the system. To date, very few (14) cases have reached the external review process, compared to an

expectation of approximately 4,400. Of these 14 cases, the external review board overturned 6 of the decisions made by HMOs.

The responses to this provision from our interviews were mixed. One interviewee suggested this would change the way health plans perform utilization review and utilization management functions and could increase claims costs by 3%. Others felt that this would create an additional administrative cost and would create a very small increase in claims costs. The key factor in determining if claims costs would increase substantially would be whether a plan has good internal appeals processes established and whether the utilization review standards are consistent with medical necessity. Those plans with solid internal appeals processes will likely see fewer decisions reach the external review stage and ultimately overturned.

One component of the Lewin Group's study on behalf of the President's Commission on Consumer Protection and Quality in Health Care was the costs of an external review process. Their analysis was largely related to the administrative costs of implementing an external review process, and did not address any associated health care costs of overturned decisions or changes in practice patterns that may result from concern about overturned decisions. Their analysis showed that implementation of an external appeals process would increase rates for health coverage between $0.003 and $0.07 per person per month. Lewin's study focused on existing appeals processes in effect in Florida and for Medicare. These figures relate specifically to the administrative costs of an external review process. We assume that the costs of the external review process would be charged back to health plans.

It is likely that the costs of an external review process would be different if health plan members are required to pay all or a portion of the costs of an appeal. Under these circumstances we would expect the number of appeals filed to decrease and the cost of overturned decisions to increase. Overall, requiring health plan members to contribute to the cost of external appeals would be expected to yield a net decrease in the cost of this provision.

Assuming that at least a small portion of appeals that reach the external review stage would be overturned and would result in additional health care expenditures, we have estimated the appeals per thousand and the costs in the following tables.

Table 8 – CBRR & PARCA – External Appeals per 1,000 Estimates

	Low Estimate	High Estimate
Number of Appeals per 1,000[21]	0.093	0.56

[21] We used Florida's experience of 0.000093 per person (The Lewin Group "Consumer Bill of Rights and Responsibilities Cost Benefits: Information Disclosure and External Appeals", November 15, 1997) as our low estimate for appeals experience and a 500% increase for our high estimate. We applied the experience to the data for the 41 largest MSAs.

Table 9 – CBRR & PARCA – External Appeals Cost Estimates				
	Best Estimate		Range	
	Cost Per Person Per Month	Percent of Premium	Cost Per Person Per Month	Percent of Premium
Administration Cost[22]	$0.03	0.02%	$0.01 - $0.06	0.01% - 0.05%
Claims Cost[23]	$0.07	0.06%	$0.01 - $0.10	0.01% - 0.08%
Total Cost	$0.10	0.08%	$0.02 – $0.16	0.02% - 0.13%

[22] We assumed that all external appeals would be performed by physicians and that the average appeal would take 4 hours of time. We estimated an average cost per hour of $250-$300.

[23] We assumed that health plans have a sufficient internal appeals processes so as to allow for only 15% of appeals to be overturned by the external appeals process. We also assumed that the cases overturned would be serious in nature and estimated the average claims cost for an overturned appeal to be between $5,000-$15,000.

New Hampshire Insurance Department March 23, 1999

HB 640 FN Regarding an independent external review process for persons covered under managed care plans

Changes to HB 640 FN proposed by the Insurance Department:

1. *Issues subject to external review:* Not just medical necessity issues but also coverage determinations should be subject to external review.

2. *Who receives the appeals and selects the external reviewer:* The Insurance Department and not the health carrier should receive the appeals and select and contract with the external reviewer.

3. *The amount in controversy requirement:* If the covered person is required to exhaust all levels of the internal appeals process before being eligible for the external appeals process, there should be no amount in controversy requirement. If there is an amount in controversy requirement at all, it should be no more than the average cost of conducting the external review—approximately $350.

4. *The deadline for requesting external review:* The deadline for filing the request for external review should be at least 60 days from receipt of the final internal appeals determination and not 30 days for regular review and one day for expedited review.

5. *The filing fee:* There should be no filing fee, or it should be a nominal amount ($25) which should be waivable by the Commissioner upon a showing of financial hardship and not "extreme financial hardship."

6. *Expedited review:* Eligibility for expedited review should not be limited to only a subset of life threatening situations. All persons in life threatening situations should be eligible for expedited review and not just those for which the amount in controversy exceeds $1500, who are hospital inpatients and who are in a position to file their request for review in less than 24 hours.

7. *Conflict of interest of the independent review organization:* The independent review organization and its subcontractors should not have any financial relationship of any kind with the health carrier.

8. *Option to receive a hearing:* The external review process should not be limited to a paper review. Instead, the covered person should be given the option to present his or her case in person in an informal hearing.

9. *New evidence:* At the external review, the covered person should be allowed to submit new information and should not be limited to the information that the

health carrier relied on in making its original determination.

10. *Health carriers amending their determinations after external review:* Health carriers should not be allowed to amend their original decision after the external review decision is made and thereby artificially lower the rate at which their decisions are overturned.

11. *The binding nature of the determination of the external reviewer:* If the determination of the external reviewer is to have any binding effect in subsequent actions at law, it should create a rebuttable presumption in favor of the covered person when the covered person prevails and not just in favor of the health carrier when the health carrier prevails.

Hilary B. Michaud, Psy.D.

Licensed Psychologist
(603-448-2543

29 School Street
P.O. Box 890

Lebanon, N.H. 03766

May 11, 1999

Representative John B. Hunt
79 Sunridge Rd.
Rindge, NH 03461-3433

Dear Representative Hunt:

I am writing you on behalf of the Legislative Committee of the New Hampshire Psychological Association. At our last meeting, we reviewed the bill you are sponsoring, HB640. We still have some concerns about this bill, but we certainly see it as a good start in creating a process for external review to protect consumers whose health needs are covered by managed care contracts.

Sincerely yours,

Hilary B. Michaud, Psy.D.

May 10, 1999

House Commerce Committee
LOB, Room 302
North State Street
Concord, NH 03301

Dear Chairman Hunt and Members of the Commerce Committee:

We, the undersigned members of the Coalition for a Healthy New Hampshire ("Coalition"), are writing to express our ongoing concern about a number of provisions in the 4/22/99 Working Draft Amendment to HB 640.

We recognize the work that went into this draft of HB 640 and the time spent by committee members. While members of the Coalition were regular participants in the seven work sessions held by the subcommittee on HB 640, consensus was not reached in a number of key areas which include: conflict of interest; the selection process for reviewers; hearing opportunity; notification to members of who may initiate the external review process; financial thresholds; and time limits. Respectfully, we request that further consideration be taken regarding these issues before making a final determination on HB 640.

- **Conflict of Interest and Selection Process for Reviewers** The intent of this legislation is to create a review process that will be perceived by consumers seeking remedy for their grievances. If a process free of conflict is not attained, we will be left with nothing more than the present internal processes. As proposed, HB 640 fails to meet this intent.

  There is a perception among the Coalition, which represents a wide range of consumer groups, that the process outlined in HB 640 is *not* free of conflict. HB 640 mandates that health carriers *contract with, select,* and *pay* the independent review organization ("IRO"). The Commissioner may waive certain conflicts of interest, but there is no mechanism by which the aggrieved individual might object. We would prefer the disclosure of any reviewer conflict of interest be made available to all parties (the aggrieved individual or his/her representative, and the health plan). In addition, any party should have the option to object to the use of the conflicted reviewer. If there is an objection, the plan must find another reviewer.

- **Hearing Opportunity** By limiting a review to paper only, the review process does not allow for an interchange between reviewers and the aggrieved individual. While we acknowledge that permitting patient testimony is a step in the right direction, this process cannot fully represent or fairly convey the interests of the aggrieved individual if it is limited to paper only. The Coalition suggests that, at a minimum, there be an opportunity for an interactive exchange between the aggrieved individual and reviewers.

- **Notification to Members of Who May Initiate the Independent, External Review** Written notification to aggrieved individuals about their right to access an independent, external review should clarify who can initiate the review process if a person is incapable of doing so. The notification should also make clear the right of the covered person to have a pre-determined guardian (i.e. a person appointed as Durable Power of Attorney for Health Care), or the potential for obtaining a guardian through the Probate Court system.

- **Financial Thresholds** HB 640 states that the denial of services valued at $500 or less cannot be grieved. This threshold will preclude people from pursuing an independent, external review for things such as prescription medication. For example, a common problem arises when health plan members cannot tolerate lower priced prescription medication, or react badly to the medications in the health plan's formulary (a list of pre-approved medication that providers may prescribe from). Patients may need to by-pass the lower priced prescription medications in the formulary, or use medications outside of the formulary to successfully treat their medical condition. These prescription medications are medically necessary but, if coverage for them is denied, the denial would not be eligible for an independent, external review. Eliminating the threshold would ensure that all cases would have an equal opportunity for review.

- **Time Limits** Placing tight time limits on when an aggrieved individual may file for an independent, external appeal may force people to file just to be on the safe side. Imposing a tight time limit would work against its intended purpose to prevent frivolous cases from going to independent, external appeal. Allowing a member up to one year to file his/her request for an independent, external review gives the member time to fully think through his/her reasoning for initiating the appeals process and whether it would be beneficial.

We appreciate your consideration of the above recommendations. If you have questions for any of the Coalition members, we would be happy to assist you.

Sincerely,

New Hampshire Citizens Alliance
New Hampshire Minority Health Coalition
New Hampshire Nurses' Association
New Hampshire Nurse Practitioner Association
New Hampshire Psychological Association
Bi-State Primary Care Association
New Hampshire AIDS Foundation
New Hampshire Women's Lobby
National Association of Social Workers
New Hampshire Mental Health Coalition
New Hampshire Association for Marriage and Family Therapy
Council for Children & Adolescents with Chronic Health Conditions

Cc: Governor Shaheen
Karen Hicks, Department of Health and Human Services
Thomas Bunnell, Office of the Governor
Senate Insurance and Public Institutions Committee

All changes to HB 640 as introduced are indicated by bolding and italics or strikethrough.

Underlined sections have been added to text that has been already reviewed to further clarify text *in three places only*: 420-J:5-a, I(b)(1), I(b)(3), and II(a), pages 2 and 3.

1 New Paragraphs; Definitions Added. Amend RSA 420-J:3 by inserting after paragraph XVI the following new paragraphs:

III-a. "Authorized representative" means a person to whom a covered person has given consent to represent the covered person in an external review. Authorized representative may include the covered person's treating provider.

XVI-a. "External review" means a process by which a covered person may request that an adverse determination be reviewed by an external review organization.

XVI-b. "External review agent" or "review agent" means a clinical peer employed or under contract with an external review organization.

XVI-c. "External review organization" means an organization which employs or contracts with clinical peers to act as external review agents.

2 New Section; Independent External Review. Amend RSA 420-J by inserting after section 5 the following new section:

420-J:5-a External Review Process.

I.(a) There is hereby established an independent external review process for the purposes of a managed care plan's covered person or the covered person's [~~legal~~] ***authorized*** representative appealing an adverse determination. A plan's covered person shall have the right to [~~request~~] an independent external review [~~and the plan shall institute the process~~] when:

(1) A covered person has exhausted the internal appeals process of the contracted plan for a covered benefit and the outcome resulted in an adverse determination;

(2) A health carrier has upheld an adverse determination upon a second level review of a grievance [~~pursuant to RSA 420-J:5, V,~~] or has failed to render a decision [~~with respect to a timely request for a second level review of an adverse determination~~] ***pursuant to RSA 420-J:5, V***;

(3) The covered person's cost for the amount in controversy is, or is anticipated to be, equal to or in excess of [~~$1,500~~] ***$500***;

(4) The covered person submits a request, in writing, for such review to the plan within [~~30~~] ***90*** days from the date of receipt of the final internal appeals determination by the managed care plan; and

[~~(5) The covered person submits an external review filing fee of $50 to the plan with the written request. The commissioner may waive the fee in cases of extreme financial hardship. In the event that the external review organization renders a finding that the managed care plan's adverse determination was not warranted, the managed care plan shall reimburse the covered individual the full external review filing fee.~~]

(b) The covered person shall have recourse to an expedited external review for emergency or life threatening situations which would seriously jeopardize the life or health of the covered person, provided that the provisions of subparagraphs I(a)(1) ***and*** (2)[~~, (3) and (5)~~] are met and when:

(1) The individual files a request for expedited review no later than [~~one business day~~] ***72 hours*** after the managed care plan issues its final determination [~~pursuant to its internal review process~~] ***in connection with a second level review***; ***and***

(2) [~~The adverse determination under review relates to an ongoing inpatient hospital stay; and~~]

[~~(3)~~] The attending provider certifies that taking the time to complete the ***review required under subparagraph I(a)*** [~~standard external review process~~] would [~~pose a serious threat to the covered person's health~~] ***seriously jeopardize the life or health of the covered person.***

II. Managed care plans shall:

[~~(a) Notify the covered person in the evidence of coverage and in writing at the time of the final appeals decision to deny coverage of the opportunity to request the independent external review under the terms of this chapter.~~]

[~~(b)~~] ***(a)*** Maintain contracts with at least 2 external review organizations that are certified by the commissioner. A managed care plan shall not contract with an external review organization if the organization performed utilization review ~~process~~

~~independent review~~ functions on behalf of the managed care plan for the specific case under consideration. ***A managed care plan shall not contract with an external review organization*** [~~or~~] if the external review organization or its review agents have a Conflict of Interest as defined in Section ~~14~~ significant financial relationship ~~with the managed care plan, [which would seriously impair the rendering of a fair and impartial decision. A contract under which an academic medical center provides health services to a managed care plan's covered individuals shall not be considered to impair the organization's or agent's ability to render a fair and impartial decision.~~]. ***The commissioner may certify an academic medical center which provides healthcare services to members of managed care plans as an independent review organization provided that the academic medical center has a written policy which requires it to review conflicts of interest before agreeing to undertake any matter for external review.***

[~~(c)~~] ***(b)*** Within 3 business days of the carrier's receipt of notification by the covered person, the plan shall select a certified independent external review organization.

[~~(d)~~] ***(c)*** Within [~~14~~] ***10*** business days ***of the carrier's receipt of notification by the covered person***, the plan shall submit to the external review organization all information that was submitted to the plan by the covered person or the covered person's health care provider in support of the covered person's request for coverage under the plan's internal appeals procedures and all other evidence relied upon by the carrier in making its determination.

[~~(e)~~] ***(d)*** When an expedited external review is warranted, forward the [~~required documentation~~] ***information described in (c)*** to the independent external review organization within one business day of receipt of the request for an expedited external review.

[~~(f)~~] ***(e)*** Be responsible for the reasonable fees and costs of the independent external review organization, such that fees and costs of an external review shall not exceed $1,500.

III. The commissioner shall:

(a) Review and verify the criteria for the certification of an external review organization that contracts with managed care plans for the conduct of said external review as in paragraph IV. Such independent external review shall be conducted solely

by such external review organization certified by the commissioner and the commissioner shall notify the certified entities of the $1,500 fees and cost limitation for conducting an external review.

(b) Make determinations regarding a covered person's financial inability to render a filing fee for the review under this chapter. Such determination shall take into consideration the covered person's annual income in the previous year, absent any federal or state subsidized income.

(c) Upon request of the independent external review organization, the covered person, the covered person's health care provider or the managed care plan, the commissioner may grant up to an additional 7 days for the independent external review organization to submit a determination.

(d) Collect data regarding the nature of the service or treatment undergoing external review, the outcome determination, the review organization, and the plan and submit an annual report no later than November 1 of each year to the governor, the speaker of the house and the president of the senate.

IV.(a) An independent external review conducted by an organization at the request of a managed care plan shall meet, at a minimum, the following standards for purposes of being certified by the commissioner. Any such organization that performs an independent external review may apply to the commissioner and be certified upon demonstrating that it complies, at a minimum, with the standards established in this section.

(1) Any independent external review organization which meets the criteria under this paragraph, shall conduct its review pursuant to a written plan.

(2) Expert reviewers assigned by the independent external review organization shall be physicians or other appropriate health care professionals who meet the following requirements:

(A) Be an expert in the treatment of the covered person's medical condition and knowledgeable about the recommended service or treatment through actual clinical experience;

(B) Hold a non-restricted license in a state of the United States, and for physicians, a current certification by a recognized American medical specialty board

in the areas appropriate to the subject of review;

(C) Have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restriction, taken or pending by any hospital, health carrier, government or regulatory body.

(3) Neither the expert reviewer, nor the independent external review organization, shall have any material, professional, familial, or financial conflict of interest with any of the following:

(A) The health carrier.

(B) Any officer, director, or management employee of the carrier.

(C) The physician, the physician's medical group, or the independent practice association (IPA) proposing the service or treatment.

(D) The institution at which the service or treatment would be provided.

(E) The development or manufacture of the principal drug, device, procedure, or other therapy proposed for the covered person whose treatment is under review.

(4) The term "conflict of interest" shall not be interpreted to include a contract under which an academic medical center, or other similar medical center, provides health services to health carrier covered persons except: academic medical centers that would provide the service for which coverage is in dispute; affiliations which are limited to staff privileges at a health facility; or an expert reviewer's participation as a contracting health carrier provider where the expert is affiliated with an academic medical center, or other similar medical research center, that is acting as an independent external review organization under this section.

(5) The following organizations are not eligible for certification as independent external review organizations:

(A) Professional or trade associations of health care providers.

(B) Subsidiaries or affiliates of such provider associations.

(C) Health carrier or health plan associations.

(D) Subsidiaries or affiliates of health plan or health carrier associations.

(6) Any independent external review organization shall have a documented process to review and evaluate the effectiveness of its utilization review program.

(7) Any external review organization shall base retrospective review determinations solely on the medical information available to the attending physician or ordering provider at the time the medical care was provided.

(8) Any external review organization shall not compensate an individual rendering utilization review determinations based upon the number of adverse determinations made.

(9) Any external review organization shall have a documented process for compliance with all applicable medical record confidentiality statutes and regulations.

(b) The independent external review organization shall submit the determination to the commissioner, the plan, and the covered person within 30 business days of the receipt of the request for review. Provided however, that when such documentation represents a material change upon which the independent review agent based its adverse determination or upon which the managed care plan based its denial, the managed care plan shall have 3 business days to consider such documentation and amend or confirm such adverse determination.

(c) When rendering a determination, any such independent external review organization shall adopt and any such organization agents shall rely upon utilization review criteria for the specific case pursuant to the clinical standards of the plan, as well as examine the attending health care provider's recommendation and the applicable generally accepted practice guidelines developed by national or professional medical societies, boards and associations.

(d) The determination shall be in written form and state the reasons the requested service or treatment should or should not be covered under the terms and conditions set forth in the evidence of coverage. Determinations shall be based on the applicable coverage documents, including any defined terms that are provided for thereunder, such as "medically necessary," and shall not expand the contractually agreed upon coverage. The determinations shall specifically cite the relevant provisions in the evidence of coverage, the covered person's specific medical condition, and the relevant

documents provided, to support the determination.

(e) Notwithstanding any provision of this section to the contrary, independent external review organizations shall provide for an expedited external review process for emergency or life threatening situations which would seriously jeopardize the life or health of a covered person. A covered person shall have the right to an expedited external review if (1) the individual files a request for expedited review no later than one business day after the managed care plan issues its final determination pursuant to its internal review process, (2) the adverse determination under review relates to an ongoing inpatient hospital stay, and (3) the attending provider certifies that taking the time to complete the standard external review process would pose a serious threat to the covered person's health. The managed care plan shall forward the required documentation to the independent external review organization within one business day of receipt of the request for an expedited external review. The review agent shall issue a determination within 3 businesses days of receipt of the request for an expedited external review. All statutory standards, other than time standards, applicable to external reviews shall apply to expedited external reviews.

(f) An independent external review organization acting in good faith shall have immunity from any civil or criminal liability or professional discipline as a result of acts or omissions with respect to any external independent review, unless the acts or omissions constitute willful and wanton misconduct.

V.(a) The determination of the review agent shall be binding on all parties. A determination of the external review agent in favor of the managed care plan shall create a rebuttable presumption in any subsequent action at law that the coverage determination made pursuant to the health carrier's review processes was appropriate.

(b) Decisions relating to the following health care services or treatments shall not be reviewed under this section:

(1) Health care services provided to beneficiaries of managed care plans wherein benefit or service provisions are prescribed by federal law.

(2) Health care services provided to inmates by the department of corrections.

(c) The procedure set forth in this section shall not apply to claims or

allegation of health provider malpractice, professional negligence, or other professional fault against participating providers.

NEW SECTION

3 External Review; Notification to Covered Persons. Amend RSA 420-J:5, II and V as follows:

II. A health carrier shall provide to consumers:

(a) A description of the grievance procedure for adverse determinations ***including a description of the independent external review process*** and other matters which shall be set forth in or attached to the policy, certificate, membership booklet, or other evidence of coverage provided to covered persons.

(b) A statement of a covered person's right to contact the commissioner's office for assistance at any time. The statement shall include the toll-free telephone number and address of the commissioner.

(c) Upon written denial of a requested medical service or claim by the health carrier, a statement of the covered person's right to access the internal grievance process.

(d) Upon exhausting the second level grievance review process, a statement of the covered person's right to access to the external grievance process, including what the covered person must do to initiate the external grievance process and the availability of and requirements for expedited external review.

[~~(d)~~] *(e)* Staff assistance in filing a grievance.

[~~(e)~~] *(f)* If requested by the consumer or health care provider acting on behalf of the consumer, a written explanation of any adverse determination, with the name and credentials of the health carrier medical director or designee, including board status and the state or states where the person is currently licensed, and the relevant clinical rationale used to make the adverse determination. Nothing in this section shall be construed to require a health carrier to provide proprietary information protected by third party contracts.

V. A health carrier shall provide second level grievance review procedures as follows:

(a) A second level grievance review panel shall be established to give those covered persons who are dissatisfied with the first level grievance review decision the option to

request a second level review.

(1) With respect to a second level review of a grievance concerning an adverse determination, a health carrier shall appoint a second level grievance review panel for each grievance.

(2) A majority of the panel shall be comprised of persons who were not previously involved in the grievance. A health carrier shall provide at least one clinical peer who has appropriate expertise to review a grievance involving an adverse determination.

(3) The review panel shall issue a written decision to the covered person within 5 business days of completing the review meeting. Upon concurrence of the covered person, a copy of the decision shall be forwarded to the insurance department. The decision shall include the titles of the members of the review panel; a statement of the review panel's understanding of the nature of the grievance, including issues raised by the covered person, and all pertinent facts; the rationale for the review panel's decision; reference to evidence or documentation considered by the review panel in making the decision; if an adverse decision is made, the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; and a statement of the covered person's right to file an external appeal as provided in RSA 420-J:5, VIII, ***and a description of the external review process, how to initiate external review and the written procedures governing an external review, including the required timeframe for review and notice of decision.***

(b) Whenever a covered person requests the opportunity to appear in person before authorized representatives of the health carrier, a health carrier's procedures for conducting a second level grievance review shall include the following:

(1) The review panel shall schedule and hold a review meeting within 45 business days of receiving a request from a covered person for a second level review. The covered person shall be notified in writing at least 15 business days in advance of the review date.

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

(3) The review panel shall issue a written decision to the covered person within 5 business days of completing the review meeting. The decision shall include the titles of the members of the review panel; a statement of the review panel's understanding of the

nature of the grievance and all pertinent facts; the rationale for the review panel's decision; reference to evidence or documentation considered by the review panel in making the decision; if an adverse decision is made, the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; and a statement of the covered person's right to file an external appeal as provided in RSA 420-J:5, VIII, ***and a description of the external review process, how to initiate external review and the written procedures governing an external review, including the required timeframe for review and notice of decision.***

4 Repeal. RSA 420-J:5, VIII and IX, relative to an external review process, are hereby repealed.

5 Effective Date. This act shall take effect January 1, 2000.

Replace all after the enacting clause with the following: w/ changes of 5/5/99

1 New Paragraphs; Definitions Added. Amend RSA 420-J:3 by inserting the following new paragraphs:

III-a. "Authorized representative" means a person to whom a covered person has given consent to represent the covered person in an external review. Authorized representative may include the covered person's treating provider.

XVI-a. "External review" means a process by which a covered person may request that an adverse determination be reviewed by an external review organization.

XVI-b. "External review agent" or "review agent" means a clinical peer employed or under contract with an external review organization.

XVI-c. "External review organization" means an organization which employs or contracts with clinical peers to act as external review agents.

2 New Section; External Review. Amend RSA 420-J by inserting after section 5 the following new section:

420-J:5-a External Review Process.

I.(a) There is hereby established an external review process for the purposes of a managed care plan's covered person or the covered person's authorized representative appealing an adverse determination. A plan's covered person shall have the right to an external review when:

(1) A covered person has exhausted the internal appeals process of the contracted plan for a covered benefit and the outcome resulted in an adverse determination;

(2) A health carrier has upheld an adverse determination upon a second level review of a grievance or has failed to render a decision pursuant to RSA 420-J:5, V;

(3) The covered person's cost for the amount in controversy is, or is anticipated to be, equal to or in excess of $500;

(4) The covered person submits a request, in writing, for such review to the plan within 90 days from the date of receipt of the final internal appeals determination by the managed care plan; and

(b) The covered person shall have recourse to an expedited external review for emergency or life threatening situations which would seriously jeopardize the life or health of the covered person, provided that the provisions of subparagraphs I(a)(1) and (2) are met and when:

(1) The individual files a request for expedited external review no later than 72 hours after the managed care plan has issued its final adverse determination or has failed to render a decision pursuant to RSA 420-J:5, V; and

(2) The attending provider certifies that taking the time to complete the standard external review process would seriously jeopardize the life or health of the covered person.

II. Managed care plans shall:

(a) Maintain contracts with at least 2 external review organizations that are certified by the commissioner. A managed care plan shall not contract with an external review organization if the organization performed utilization review functions on behalf of the managed care plan for the specific case under consideration. A managed care plan shall not contract with an external review organization if the external review organization or its review agents have a conflict of interest, as described in III(a)(3), with the managed care plan.

(b) Within 3 business days of the carrier's receipt of notification by the of a request for external review covered person, the plan shall select a certified external review organization.

(c) Within 10 business days of the carrier's receipt of notification by the covered person, the plan shall submit to the external review organization all information that was submitted to the plan by the covered person or the covered person's health care provider in support of the covered person's request for coverage under the plan's internal appeals procedures and all other evidence relied upon by the carrier in making its determination.

(d) When an expedited external review is warranted, forward information as in I(b) described in II(c) to the external review organization within one business day of receipt of the request for an expedited external review.

(e) Be responsible for the reasonable fees and costs of the external review organization, such that fees and costs of an external review shall not exceed $1,500.

III.(a) An external review conducted by an organization at the request of a managed care plan shall meet, at a minimum, the following standards for purposes of being certified by the commissioner. Any such organization that performs an external review may apply to the commissioner and be certified upon demonstrating that it complies, at a minimum, with the standards established in this section.

(1) Any external review organization which meets the criteria under this paragraph, shall conduct its review pursuant to a written plan.

(2) Expert reviewers assigned by the external review organization shall be physicians or other appropriate health care professionals who meet the following requirements:

(A) Be an expert in the treatment of the covered person's medical condition and knowledgeable about the recommended service or treatment through actual clinical experience;

(B) Hold a non-restricted license in a state of the United States, and for physicians, a current certification by a specialty board recognized by the American Board of Medical Specialties in the areas appropriate to the subject of review;

(C) Have no history of disciplinary action or sanctions, including, but not limited to, loss of staff privileges or participation restriction, taken or pending by any hospital, health carrier, government or regulatory body; and

(D) Have agreed to disclose any potential conflict of interest.

(3) Neither the expert reviewer, nor the external review organization, shall have any material, professional, familial, or financial conflict of interest with any of the following:

(A) The health carrier.

(B) Any officer, director, or management employee of the carrier.

(C) The physician, the physician's medical group, or the independent practice association (IPA) proposing the service or treatment.

(D) The institution at which the service or treatment would be provided.

(E) The development or manufacture of the principal drug, device, procedure, or other therapy proposed for the covered person whose treatment is under

review.

(F) The covered person or authorized representative.

(4) The commissioner may determine, in specific cases, that an affiliation with a hospital, an institution, an academic medical center, or a health carrier provider network does not in and of itself constitute a conflict of interest.

(5) The following organizations are not eligible for certification as external review organizations:

(A) Professional or trade associations of health care providers.

(B) Subsidiaries or affiliates of such provider associations.

(C) Health carrier or health plan associations.

(D) Subsidiaries or affiliates of health plan or health carrier associations.

(6) Any external review organization shall have a documented process to review and evaluate the effectiveness of its external review program.

(7) The external review organization shall consider anew all previously determined facts, allow the introduction of new relevant information and make a decision that is not bound by decisions or conclusions made by the health carrier during internal review.

(8) Any external review organization shall not compensate an individual rendering review determinations based upon the number of adverse determinations upheld or denied.

(9) Any external review organization shall have a documented process for compliance with all applicable medical record confidentiality statutes and regulations.

(10) Any external review organization shall base its determination on the plan's applicable coverage documents, including any terms that are defined thereunder, and shall not expand the contractually agreed upon coverage.

(b) The external review organization shall submit the determination to the commissioner, the plan, and the covered person within 30 business days of the receipt of the request for review. Insert Language from original bill page 5 lines 18-20 Provided however, that reversal of the internal review decision made by the health plan shall be without prejudice to the health plan when the external review organization certifies that it has received new documentation which:

(1) represents a material change in the submitted information upon which the external review agent based its adverse determination or upon which the managed care plan based its denial; and

(2) has been made available to the health plan in a manner which failed to provide the plan with sufficient time, not less than 3 business days, to consider such documentation, and amend or confirm the adverse determination.

(c) When rendering a determination, any such external review organization shall consider and rely upon utilization review criteria for the specific case pursuant to the clinical standards of the plan. The external review organization shall examine the attending health care provider's recommendation, and shall consider the applicable generally accepted practice guidelines developed by the federal government, through Agency for Health Care Policy Research, ~~Medicaid, the state children's health insurance program (Title XXI of the Social Security Act), medicare or services provided under these programs but through a contracted health carrier,~~ or through national or professional medical societies, boards and associations.

(d) The determination shall be in written form and state the reasons the requested service or treatment should or should not be covered under the terms and conditions set forth in the evidence of coverage. The determinations shall specifically cite the relevant provisions in the evidence of coverage, the covered person's specific medical condition, and the relevant documents provided, to support the determination.

(e) An external review organization acting in good faith shall have immunity from any civil or criminal liability or professional discipline as a result of acts or omissions with respect to any external review, unless the acts or omissions constitute willful and wanton misconduct.

IV. The commissioner:

(a) Shall review and verify compliance criteria for the certification of an external review organization that contracts with managed care plans for the conduct of said external review as in paragraph III.

(b) Shall notify the certified entities of the $1,500 fees and cost limitation for conducting an external review.

(c) May grant up to an additional 5 business days for the external review organization to submit a determination, upon request of the external review organization,

the covered person, the covered person's health care provider or the managed care plan.

(d) Shall collect data regarding the nature of the service or treatment undergoing external review, the outcome determination, the external review organization, and the plan. The commissioner shall submit an annual report no later than November 1 of each year to the governor, the speaker of the house and the president of the senate.

V.(a) The determination of the review agent shall be binding on all parties. A determination of the external review agent shall create a rebuttable presumption in any subsequent action at law that the coverage determination made pursuant to the health carrier's review processes was appropriate.

(b) Decisions relating to the following health care services or treatments shall not be reviewed under this section:

(1) Health care services provided to beneficiaries of managed care plans regulated by the federal government through medicaid, the state children's health insurance program (Title XXI of the Social Security Act), medicare or services provided under these programs but through a contracted health carrier.

(2) Health care services provided to inmates by the department of corrections.

(c) The procedure set forth in this section shall not apply to claims or allegation of health provider malpractice, professional negligence, or other professional fault against participating providers.

3 External Review; Notification to Covered Persons, Amend 420-J:5, Grievance Procedures by adding the following language to sections II and V

A health carrier shall provide to consumers:

(a) A description of the grievance procedure for adverse determinations ***including a description and availability of the external review process*** and other matters which shall be set forth in or attached to the policy, certificate, membership booklet, or other evidence of coverage provided to covered persons.

(b) A statement of a covered person's right to contact the commissioner's office for assistance at any time. The statement shall include the toll-free telephone number and address of the commissioner.

(c) Upon written denial of a requested medical service or claim by the health carrier, a statement of the covered person's right to access the internal grievance process.

(d) Upon exhausting the second level grievance review process, a statement of the covered person's right to access to the external review process, including what the covered person must do to initiate the external review process and the availability of expedited external review under certain circumstance generally described.

~~[(d)] (e) Staff assistance in filing a grievance.~~

[~~(e)~~] **(f)** If requested by the consumer or health care provider acting on behalf of the consumer, a written explanation of any adverse determination, with the name and credentials of the health carrier medical director or designee, including board status and the state or states where the person is currently licensed, and the relevant clinical rationale used to make the adverse determination. Nothing in this section shall be construed to require a health carrier to provide proprietary information protected by third party contracts.

V. A health carrier shall provide second level grievance review procedures as follows:

(a) A second level grievance review panel shall be established to give those covered persons who are dissatisfied with the first level grievance review decision the option to request a second level review.

(1) With respect to a second level review of a grievance concerning an adverse determination, a health carrier shall appoint a second level grievance review panel for each grievance.

(2) A majority of the panel shall be comprised of persons who were not previously involved in the grievance. A health carrier shall provide at least one clinical peer who has appropriate expertise to review a grievance involving an adverse determination.

(3) The review panel shall issue a written decision to the covered person within 5 business days of completing the review meeting. Upon concurrence of the covered person, a copy of the decision shall be forwarded to the insurance department. The decision shall include the titles of the members of the review panel; a statement of the review panel's understanding of the nature of the grievance, including issues raised by the covered person, and all pertinent facts; the rationale for the review panel's decision;

reference to evidence or documentation considered by the review panel in making the decision; if an adverse decision is made, the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; and a statement of the covered person's right to file an external appeal as provided in RSA 420-J:5, VIII.; and ***a description of the availability of external review, how to initiate an external review and the written procedures governing an external review, including the required timeframe for review and notice of decision.***

(b) Whenever a covered person requests the opportunity to appear in person before authorized representatives of the health carrier, a health carrier's procedures for conducting a second level grievance review shall include the following:

(1) The review panel shall schedule and hold a review meeting within 45 business days of receiving a request from a covered person for a second level review. The covered person shall be notified in writing at least 15 business days in advance of the review date.

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

(3) The review panel shall issue a written decision to the covered person within 5 business days of completing the review meeting. The decision shall include the titles of the members of the review panel; a statement of the review panel's understanding of the nature of the grievance and all pertinent facts; the rationale for the review panel's decision; reference to evidence or documentation considered by the review panel in making the decision; if an adverse decision is made, the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; and a statement of the covered person's right to file an external appeal as provided in RSA 420-J:5, VIII; and ***a description of the availability of an expedited external review, how to initiate an expedited external review and the written procedures governing an external review, including the required timeframe for review and notice of decision.***

4 Repeal. RSA 420-J:5, VIII and IX, relative to an external review process, are hereby repealed.

5 Effective Date. This act shall take effect January 1, 2000.

5/5/99

HB 640:External Review Process

EXAMPLE CASE STUDY

THE CASE BACKGROUND:

Timmie goes to Dr. Benton, her Primary Care Physician, because of continued pain in her hand. Dr. Benton determines that Timmie has Carpal Tunnel Syndrome (CTS) and recommends that surgery is needed.

Dr. Benton calls Nurse Hathaway at the Managed Care Plan (MCP) which is Timmie's health care insurance plan. Nurse Hathaway reviews the facts and the plan's guidelines for treatment of CTS. The guidelines recommend that steroid injections should, in most cases, be tried prior to surgery. Since steroid injections have not been tried, Nurse Hathaway refers the case to Doctor Green (MCP's medical director). Dr. Green reviews the facts and determines based on Timmie's file that steroid injections may be beneficial and should be tried prior to surgery.

Dr. Green applies the findings to MCP's definition of medical necessity which requires that the service be essential. Because steroid injection may be beneficial, Dr. Green determines that surgery is not yet essential and denies coverage for surgery.

Dr. Green issues a letter to Timmie and Dr. Green that provides a contact phone number, describes his credentials and why the recommendation to cover the surgery under Timmie's insurance was denied.

Patient Timmie is concerned and requests an internal appeal of the decision.

Patient Timmie exhaust the internal appeal procedures. { for this example, we have assumed that the internal appeal procedures resulted in MCP's denial of services being upheld.}.

Patient Timmie is still concerned and files for an external appeal as she has read the notifications on her denial of coverage letter as well as the information in her certificate of coverage. HB 640 requires health care plans to provide notice to subscribers regarding external appeal opportunities.

>>> At this point HB 640 provides the process for an external appeal<<<<<

5/5/99 (HB 640 case study)

HB 640 Process in Example Case Study
External Review Process

<<NOTE:
Commissioner and External Review Agent certification process initiates prior to effective date of HB 640. Health Plan and External Review Agent contracting process initiates prior to the effective date of HB 640. Also, Health plan insertion of notices into certificates of coverage and in denial letter notices regarding options for external review appeals must be provided to subscribers upon the effective date of HB 640. >>

January 1	Timmie receives notice from MCP of the denial for coverage of surgery for CTS. Timmie consults with her PCP and decides to further pursue the surgery option based on the PCP's recommendations for her case. They collect information regarding the early surgery intervention option to submit to the plan for the external review.
March 30	Timmie submits a written request to MCP for an external review of the previous denial of coverage for surgery.
April 2	MCP informs a "certified" external review agent of case for review.
April 9	Plan submits all information received from internal review and from patient and provider to external review agent. External review agent submits information to clinical peer panel for determination. Clinical peers review information based on Plan's guidelines and other pertinent federal and medical professional society guidelines in making determination.
May 2	External Review Agent sends notice of decision to the Department of Insurance, Timmie, Dr. Benton, and Dr. Green (the MCP).
May 30	Health care plan receives and pays bill for external review agent's services on the case (up to $1500 for external review services cost).

New Hampshire Insurance Department March 23, 1999

HB 640 FN Regarding an independent external review process for persons covered under managed care plans

Changes to HB 640 FN proposed by the Insurance Department:

1. *Issues subject to external review:* Not just medical necessity issues but also coverage determinations should be subject to external review.

2. *Who receives the appeals and selects the external reviewer:* The Insurance Department and not the health carrier should receive the appeals and select and contract with the external reviewer.

3. *The amount in controversy requirement:* If the covered person is required to exhaust all levels of the internal appeals process before being eligible for the external appeals process, there should be no amount in controversy requirement. If there is an amount in controversy requirement at all, it should be no more than the average cost of conducting the external review—approximately $350.

4. *The deadline for requesting external review:* The deadline for filing the request for external review should be at least 60 days from receipt of the final internal appeals determination and not 30 days for regular review and one day for expedited review.

5. *The filing fee:* There should be no filing fee, or it should be a nominal amount ($25) which should be waivable by the Commissioner upon a showing of financial hardship and not "extreme financial hardship."

6. *Expedited review:* Eligibility for expedited review should not be limited to only a subset of life threatening situations. All persons in life threatening situations should be eligible for expedited review and not just those for which the amount in controversy exceeds $1500, who are hospital inpatients and who are in a position to file their request for review in less than 24 hours.

7. *Conflict of interest of the independent review organization:* The independent review organization and its subcontractors should not have any financial relationship of any kind with the health carrier.

8. *Option to receive a hearing:* The external review process should not be limited to a paper review. Instead, the covered person should be given the option to present his or her case in person in an informal hearing.

9. *New evidence:* At the external review, the covered person should be allowed to submit new information and should not be limited to the information that the

Nothing should be introduced to after appeals ends

health carrier relied on in making its original determination.

10. *Health carriers amending their determinations after external review:* Health carriers should not be allowed to amend their original decision after the external review decision is made and thereby artificially lower the rate at which their decisions are overturned.

11. *The binding nature of the determination of the external reviewer:* If the determination of the external reviewer is to have any binding effect in subsequent actions at law, it should create a rebuttable presumption in favor of the covered person when the covered person prevails and not just in favor of the health carrier when the health carrier prevails.

Tennessee 100th General Assembly
1997 TN S 3279 same as 1997 TN H 3135
Enacted - Interim
980511
Rochelle

HOUSE BILL 3135

By Rhinehart

SENATE BILL 3279

By Rochelle

AN ACT to amend Tennessee Code Annotated, Title 56, relative to managed health care plans.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 32, Part 2 is amended by adding thereto the following new section to be appropriately designated:

(a) Every health maintenance organization (hereafter referred to as "plan") shall provide an independent review process to examine the plan's coverage decisions for individual enrollees who meet the following criteria:

(1) The enrollee has been denied coverage based on a determination by the plan that the proposed service or treatment does not meet the definition of "medical necessity" (or a similar coverage definition) set forth in the enrollee's evidence of coverage under the plan; the service or treatment is not considered experimental or investigational by the plan; and the proposed service or treatment would be a covered benefit; except for the plan's determination that the service or treatment does not meet the definition of "medical necessity" (or a similar coverage definition);

(2) The enrollee is a member of the plan in good standing, and is otherwise eligible to receive covered benefits under the health plan;

(3) The enrollee has complied with the appeals procedures described in the evidence of coverage and disclosure form under the plan and has requested review and reconsideration by the grievance review committee pursuant to Section 56-32-210; and

(4) The proposed service or treatment would require the plan to incur one thousand dollars ($1,000) or more of expenditures to cover such service or treatment.

(b) The independent review process shall meet the following criteria:

(1) The plan shall offer all enrollees who meet the criteria in subsection (a) the opportunity to have the coverage denial reviewed under the

independent review process. The plan shall notify eligible enrollees in writing of the opportunity to request the independent review at the time of the final appeals decision to deny coverage. The enrollee may file a request for independent review with the plan no later than sixty (60) days after receiving such notification.

(2) The enrollee shall be required to pay a one-time fee of one hundred dollars ($100) toward the cost of the independent review, payable at the time the enrollee requests the independent review.

(3) The plan shall provide to the independent review entity a copy of the following documents within five (5) business days of the plan's receipt of a request by an enrollee or enrollee's physician for an independent review:

(A) Any information that was submitted to the plan by the enrollee or the enrollee's physician in support of the enrollee's request for coverage under the plan's appeals procedures. The confidentiality of any medical records submitted by the plan shall be maintained pursuant to applicable state and federal laws.

(B) A copy of the contract provisions upon which the denial of coverage was based, any other relevant documents used by the plan in determining whether the proposed service or treatment should be covered, and any statement by the plan explaining the reasons for the plan's decision not to provide coverage for the proposed service or treatment. The plan shall provide, upon request, a copy of documents required by this subparagraph, except for any legally privileged information, to the enrollee and the enrollee's physician. The independent review entity shall maintain the confidentiality of plan information identified as proprietary.

(4) The independent review entity shall notify the enrollee and the enrollee's physician of any additional medical information required to conduct the review within five (5) business days of receipt of the documentation required under paragraph (b)(3). The plan shall be notified of this request. The enrollee and the enrollee's physician shall submit the additional information, or an explanation of why the additional information is not being submitted, to the independent review entity and the plan within five (5) business days of the receipt of such a request. The plan may, at its discretion, determine that additional information provided by the enrollee or the enrollee's physician justifies a reconsideration of its coverage denial, and a subsequent decision by the plan to grant coverage shall terminate the independent review upon notification to the independent review entity. The enrollee shall be entitled to any refund of payment required under paragraph (b)(2) should the independent review be terminated under this paragraph.

(5) The independent review entity shall submit the expert determinations to the plan, the enrollee, and the enrollee's physician within thirty (30) days of the receipt of the request for review, except that for life-threatening conditions, as determined by the enrollee's physician, the

determinations shall be submitted within seven (7) days of the receipt of the request for review. At the request of the expert, the deadline shall be extended by up to five (5) business days for the consideration of additional information requested under paragraph (b)(3).

(6) The expert's determination shall be in written form and state the reasons the requested service or treatment should or should not be covered under the terms and conditions set forth in the evidence of coverage. The expert shall make determinations based on the applicable coverage documents, including any defined terms that are provided for thereunder, such as "medically necessary", and shall not expand the contractually agreed upon coverage. The expert's determinations shall specifically cite the relevant provisions in the evidence of coverage, the enrollee's specific medical condition, and the relevant documents provided pursuant to paragraph (b)(3), to support the expert's determination.

(7) The determinations of the expert reviewer shall be binding on the plan and the enrollee.

(8) The plan shall have written policies describing the independent review process. The plan shall disclose the availability of the independent review process and how enrollees may access the review process in the plan's evidence of coverage and disclosure forms.

(9) Coverage for the services required under this section shall be provided subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the plan. Nothing in this subdivision shall be construed to require the plan to pay for the services of a non-participating physician, that are not otherwise covered pursuant to the evidence of coverage under the plan.

(c) Plan may contract with only those independent review entities meeting the following requirements:

(1) Expert reviewers assigned by independent review entities must be physicians or other appropriate providers who meet the following minimum requirements:

(A) expert in the treatment of the enrollee's medical condition, and knowledgeable about the recommended service or treatment through actual clinical experience;

(B) hold a non-restricted license in a state of the United States, and for physicians, a current certification by a recognized American medical specialty board in the area(s) appropriate to the subject of review; and

(C) have no history of disciplinary actions or sanctions (including, but not limited to, loss of staff privileges or participation restriction) taken or pending by any hospital, government or regulatory body.

(2) The independent review entity shall not be a subsidiary of, nor in any way owned or controlled by, a health plan, a trade association of health plans, or a professional association of health care providers.

(3) Neither the expert reviewer, nor the independent review entity, has any material professional, familial, or financial conflict of interest with any of the following:

(A) The plan;

(B) Any officer, director, or management employee of the plan;

(C) The physician, the physician's medical group, or the independent practice association (IPA) proposing the service or treatment;

(D) The institution at which the service or treatment would be provided; and

(E) The development or manufacture of the principal drug, device, procedure, or other therapy proposed for the enrollee whose treatment is under review.

(4) The term "conflict of interest" shall not be interpreted to include a contract under which an academic medical center, or other similar medical research center, provides health services to plan enrollees, except as subject to the requirement of subparagraphs (c)(3)(D); affiliations which are limited to staff privileges at a health facility; or an expert reviewer's participation as a contracting plan provider where the expert is affiliated with an academic medical center, or other similar medical research center, that is acting as an independent review entity under this section.

(5) The independent review entity shall have a quality assurance mechanism in place that ensures the timeliness and quality of the reviews, the qualifications and independence of the experts; and the confidentiality of medical records and review materials.

(d) An independent review entity and an expert reviewer assigned by the entity to conduct a review under this section is not liable for damages arising from the determinations made pursuant to this section. This subdivision does not apply to an act or omission of the independent review entity that is made in bad faith or that involves gross negligence.

SECTION 2. Nothing in this act shall affect or apply to the TennCare program.

SECTION 3. This act shall take effect January 1, 1999, the public welfare requiring it.

(1) Evaluate the effectiveness of private review agents; and

(2) Determine if the utilization review programs are in compliance with the provisions of this section and applicable regulations.

15-10B-17.

(b) (1) In addition to the provisions of subsection (a) of this section, the [D> Secretary <D] [A> COMMISSIONER <A] may impose an administrative penalty of up to [D> $1,000 <D] [A> $5,000 <A] for a violation of any provision of this subtitle.

(2) The [D> Secretary <D] [A> COMMISSIONER <A] shall adopt regulations to provide standards for the imposition of an administrative penalty under paragraph (1) of this subsection.

15-10B-18.

(a) Any person aggrieved by a final decision of the [D> Secretary <D] [A> COMMISSIONER <A] in a contested case under this subtitle may take a direct judicial appeal.

[D> SUBTITLE 10C. MEDICAL DIRECTORS. <D]

[D> 15-10C-01. <D]

[D> (A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.
<D]

[D> (B) "CARRIER" MEANS: <D]

[D> (1) AN INSURER; <D]

[D> (2) A NONPROFIT HEALTH SERVICE PLAN; <D]

[D> (3) A HEALTH MAINTENANCE ORGANIZATION; <D]

[D> (4) A DENTAL PLAN ORGANIZATION; OR <D]

[D> (5) ANY OTHER PERSON THAT PROVIDES HEALTH BENEFIT PLANS SUBJECT TO
REGULATION BY THE STATE. <D]

[D> (C) "HEALTH CARE FACILITY" MEANS: <D]

[D> (1) A HOSPITAL AS DEFINED IN Section 19-301 OF THE HEALTH - GENERAL ARTICLE; OR <D]

[D> (2) AN AMBULATORY SURGICAL FACILITY AS DEFINED IN Section 19-3B-01 OF
THE HEALTH - GENERAL ARTICLE. <D]

[D> (D) "HEALTH CARE SERVICE" MEANS ANY HEALTH OR MEDICAL

III b) The independent external review organization shall submit the determination to the commissioner, the plan, and the covered person within 30 business days of the receipt of the request for review. ***Provided, however, that reversal of the internal review decision made by the health plan shall be without prejudice to the health plan when the independent review organization certifies that*** ~~such~~ ***documentation*** when it has received new information ~~in~~ the submitted information

1. ***represents a material change upon which the independent review agent*** ~~based~~ ***based its adverse determination or upon which the managed care plan based its denial and***
2. ***has been made available to the health plan in a manner which*** ~~provided~~ Failed to provide ***the plan with sufficient time, not less than three (3) business days, to consider such documentation, and amend or confirm the adverse determination.***

add to line 26 page (4)

The ~~independent~~ external review organization shall consider anew all previously determined facts, allow the introduction of new Relevant information and make a decision that is ~~in no way~~ not bound by decisions or conclusions made by the health carrier during internal review.

Add to page 9 List (10)

4/21/99 HB 640

suggested language:

III. (2) Requirements for reviewers ...

(B) Hold a non-restricted license in a state of the United States, and for physicians, a current certification by a specialty board recognized by the American Board of Medical Specialties in the areas appropriate to the subject of review.

(4) Conflict of interest ....

Affiliation with a hospital, an institution, an academic medical center or a health carrier provider network may not be interpreted to be a conflict of interest.

doesnot, In at itself, Constitute a conflict of Interest

The commissioner may in specific cases, determine that

Voting Sheets

HOUSE COMMITTEE ON COMMERCE

EXECUTIVE SESSION on HB 640-FN

BILL TITLE: **relative to grievance procedures of managed care organizations.**

DATE: May 11, 1999

LOB ROOM: 302

Amendments:

Sponsor: Rep. Herman — OLS Document #: 1120h — Adopted

Sponsor: Rep. — OLS Document #:

Sponsor: Rep. — OLS Document #:

Motions: (OTP) OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep. Herman

Seconded by Rep. Belanger

Vote: 13-1 (Please attach record of roll call vote.)

Motions: OTP, (OTP/A), ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep. Herman

Seconded by Rep. McGough

Vote: 13-1 (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: No

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. Tim S. McGough, Acting Clerk

HOUSE COMMITTEE ON COMMERCE

EXECUTIVE SESSION on HB

BILL TITLE: HB 640

DATE: 5-11-99

LOB ROOM: 302

Amendments:

Sponsor: Rep. Herman OLS Document #: 1120h Adopted/Failed

Sponsor: Rep. _____ OLS Document #: _____ Adopted/Failed

Sponsor: Rep. _____ OLS Document #: _____ Adopted/Failed

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.) On amend. 1120h

Moved by Rep. Herman

Seconded by Rep. Belanger

Vote: 13-1 (Please attach record of roll call vote.)

Motions: OTP, OTP/A, ITL, Re-Refer, Interim Study (Please circle one.)

Moved by Rep. Herman

Seconded by Rep. McGough

Vote: _____ (Please attach record of roll call vote.)

CONSENT CALENDAR VOTE: _____

(Vote to place on Consent Calendar must be unanimous.)

Statement of Intent: Refer to Committee Report

Respectfully submitted,

Rep. ~~Sheila T. Francoeur, Clerk~~ Jim McGough, Acting Clerk

COMMERCE 1999 SESSION

HB640 Bill #

Public Hearings _____ Executive Session 5-11-99

COMMITTEE REPORT: OTP/A

	YEAS	NAYS
Hunt, John B, Chairman		
Herman, Keith R, V Chairman	✓	
Tsiros, William B		
Belanger, Ronald J	✓	
Francoeur, Sheila T, Clerk		
McGough, Tim S	✓	
Avery, Stephen G	✓	
Kenney, Joseph D		
Langley, Jane S	✓	
Pappas, Marc P	✓	
Dalianis, Griffin T		
DiFruscia, Anthony R		
Marshall, Gene B	✓	
Clark, Martha Fuller	✓	
Crosby, Toni M		
Russell, Ronald G	✓	
Reardon, Tara G	✓	
Vachon, Dennis P	✓	
Taylor, Kathleen N	✓	
Curran, James C		
Garrish, Linda L		✓
Keye, Harvey	✓	
TOTAL VOTE	13	1

Appeared in Favor	Appeared in Opposition

COMMERCE 1999 SESSION

HB 640 Bill #

Public Hearings Executive Session 5-11-99

COMMITTEE REPORT: OTP as amd. 1120h

	YEAS	NAYS
Hunt, John B, Chairman		
Herman, Keith R, V Chairman	✓	
Tsiros, William B		
Belanger, Ronald J	✓	
Francoeur, Sheila T, Clerk		
McGough, Tim S	✓	
Avery, Stephen G	✓	
Kenney, Joseph D		
Langley, Jane S	✓	
Pappas, Marc P	✓	
Dalianis, Griffin T		
DiFruscia, Anthony R		
Marshall, Gene B	✓	
Clark, Martha Fuller	✓	
Crosby, Toni M		
Russell, Ronald G	✓	
Reardon, Tara G	✓	
Vachon, Dennis P	✓	
Taylor, Kathleen N	✓	
Curran, James C		
Garrish, Linda L		✓
Keye, Harvey	✓	
TOTAL VOTE	13	1

Appeared in Favor	Appeared in Opposition

Committee Report

COMMITTEE REPORT

COMMITTEE: **Commerce**

BILL NUMBER: **HB 640-FN**

TITLE: relative to grievance procedures of managed care organizations.

DATE: May 11, 1999 CONSENT CALENDAR YES ☐ NO ☒

☐ OUGHT TO PASS

☒ OUGHT TO PASS WITH AMENDMENT

☐ INEXPEDIENT TO LEGISLATE

☐ RE-REFER

☐ REFER TO COMMITTEE FOR INTERIM STUDY
(Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

HB 640-FN creates an external appeals process for consumers to access when an insurance claim is denied based on a medically necessary determination from the insurer. Today, policyholders have a right to an internal review only. Many believe this internal process has an inherent conflict of interest since the insurance company reviews themselves. This new external process brings an independent panel, certified by the New Hampshire Insurance Department, to review adverse determinations. This is a tremendous step forward in addressing the concerns of managed care. The amendment replaces the entire bill. This bill requires the managed care plan to inform subscribers about this new external appeal. Managed care plans must pay for the appeal and assume all costs of processing the external appeal. There is no fee required of the consumer. Managed care plans must select an independent review agency from a list certified by the Insurance Commissioner. All certified external review agencies must have clinically matched medical professionals to review the case, which have no conflict of interest to the case. The bill requires an expedited appeal process for the life-threatening situations.

This process provides consumers an easy to access, non-judicial, no cost external review. The committee believes this version will have little, if any, effect on insurance premiums. The committee worked hard to develop a bill which considers all viewpoints and has elements from other states and national standards. There are other bills, still in process, which deal with external review. The Commerce Committee is committed to ensuring an external appeal process becomes law in New Hampshire.

Vote 13-1.

Rep. Keith R. Herman
FOR THE COMMITTEE

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT

Commerce

HB 640-FN, relative to grievance procedures of managed care organizations. OUGHT TO PASS WITH AMENDMENT

Rep. Keith R. Herman for **Commerce:** HB 640-FN creates an external appeals process for consumers to access when an insurance claim is denied based on a medically necessary determination from the insurer. Today, policyholders have a right to an internal review only. Many believe this internal process has an inherent conflict of interest since the insurance company reviews themselves. This new external process brings an independent panel, certified by the New Hampshire Insurance Department, to review adverse determinations. This is a tremendous step forward in addressing the concerns of managed care. The amendment replaces the entire bill. This bill requires the managed care plan to inform subscribers about this new external appeal. Managed care plans must pay for the appeal and assume all costs of processing the external appeal. There is no fee required of the consumer. Managed care plans must select an independent review agency from a list certified by the Insurance Commissioner. All certified external review agencies must have clinically matched medical professionals to review the case, which have no conflict of interest to the case. The bill requires an expedited appeal process for the life-threatening situations.

This process provides consumers an easy to access, non-judicial, no cost external review. The committee believes this version will have little, if any, effect on insurance premiums. The committee worked hard to develop a bill which considers all viewpoints and has elements from other states and national standards. There are other bills, still in process, which deal with external review. The Commerce Committee is committed to ensuring an external appeal process becomes law in New Hampshire. Vote 13-1.

Herman

COMMITTEE REPORT

COMMITTEE: COMMERCE

BILL NUMBER: HB 640

TITLE:

DATE: 5-11-99 CONSENT CALENDAR YES ☐ NO ☑

☐ OUGHT TO PASS

☑ OUGHT TO PASS WITH AMENDMENT

☐ INEXPEDIENT TO LEGISLATE

☐ RE-REFER

☐ REFER TO COMMITTEE FOR INTERIM STUDY
(Available only in second year of biennium.)

STATEMENT OF INTENT
(Include Committee Vote)

HB 640 creates an External Appeals process for consumers to access when an insurance claim is denied based on a medically necessary determination from the insurer. Today, ~~consumer~~ policy holders have a right to an internal review only. Many believe this internal process has an inherent conflict of interest since the insurance company reviews themself. This new external process brings an independent panel, certified by the NH Insurance dept., to review adverse determinations. This is a tremendous step forward in ~~protecting~~ addressing the concerns of managed care.

Vote 13-1

Rep. [signature]
FOR THE COMMITTEE

Over

Original: House Clerk
cc: Committee Bill file

USE ANOTHER REPORT FOR MINORITY REPORT

The Amendment replaces the entire bill. This bill requires the managed care plan to inform subscribers about this new external appeal. Managed care plans must pay for the appeal and assume all costs of processing the external appeal. There is no fee required of the consumer. Managed care plans must select an independent review agency from a list ~~of~~ certified by the Insurance commissioner. All certified external review agencies must have clinically matched medical professionals to review the case which have no conflict of interest to the case. The bill requires a expedited appeal process for life-threatening situations.

This process provides consumers an easy to access, non-judicial, no cost external review. The committee beleives this version will have little (if any) ~~increase~~ effect on insurance premiums. The committee worked hard to develop a bill which considers all viewpoints and has elements from other states and National standards. There are other bills, still in process, which deal with external review. The commerce committee is committed to ensuring an external appeal process becomes law in NH.

SBH