Bill as Introduced

HB 640-FN – AS AMENDED BY THE HOUSE

20may99.....1120h

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.

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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Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

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 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.

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

Sen. Wheeler, Dist. 21
June 21, 1999
1999-1722s
01/09

Amendment to HB 640-FN

Amend the title of the bill by replacing it with the following:

AN ACT establishing certain standards of accountability for health maintenance organizations and other entities providing health insurance through a managed care system.

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

1 Statement of Purpose. The purpose and intent of this act is to strengthen protections for New Hampshire families who receive their medical care from managed care organizations by providing consumers with the information and tools consumers need to hold managed care organizations accountable for the health care treatment decisions they make.

2 Practice of Medicine; Medical Directors. Amend RSA 329:1 to read as follows:

329:1 Practice. Any person shall be regarded as practicing medicine under the meaning of this chapter who shall diagnose, treat, perform surgery, or prescribe any treatment of medicine for any disease or human ailment. "Surgery" means any procedure, including but not limited to laser, in which human tissue is cut, shaped, burned, vaporized, or otherwise structurally altered, except that this section shall not apply to any person to whom authority is given by any other statute to perform acts which might otherwise be deemed the practice of medicine. "Laser" means light amplification by stimulated emission of radiation. ***A medical director, as defined in RSA 420-J:3, XXV-a, shall be regarded as practicing medicine under the meaning of this chapter whenever:***

I. A medical necessity determination is made for which he or she is responsible under RSA 420-J:6, V or RSA 420-E:2-a;

II. The medical necessity determination denies authorization or payment for a covered health care service, supply or drug that the treating health care provider has prescribed; and

III. Such denial causes the covered person not to receive the health care service, supply or drug that the treating health care provider has prescribed.

3 New Section; Medical Directors Required. Amend RSA 420-E by inserting after section 2 the following new section:

420-E:2-a Medical Director. Every medical utilization review entity licensed by the department under this chapter shall employ a medical director licensed under RSA 329, who shall have final

responsibility for the utilization system and its administration and implementation, including utilization review decisions affecting health care services provided to beneficiaries.

4 New Paragraph; Definition Added. Amend RSA 420-J:3 by inserting after paragraph XXV the following new paragraph:

XXV-a. "Medical director" means a physician licensed under RSA 329 and employed by a health carrier or medical utilization review entity who is responsible for the utilization review techniques and methods of the health carrier or medical utilization review entity and their administration and implementation, including utilization review decisions affecting health care services provided to covered persons under a health benefit plan.

5 New Paragraph; Medical Director Required. Amend RSA 420-J:6 by inserting after paragraph IV the following new paragraph:

V. Each health carrier that conducts utilization review shall employ a medical director who shall have final responsibility for all utilization review techniques and methods and their administration and implementation, including utilization review decisions affecting health care services provided to covered persons under a health benefit plan.

6 Information Provided to Covered Persons. Amend RSA 420-J:5, II to read as follows:

II. A health carrier shall provide to consumers:

(a) A description of the ***internal*** grievance procedure ***required under RSA 420-J:5*** for adverse determinations and other matters [~~which~~] ***and a description of the process for obtaining external review under RSA 420-J:5-a. These descriptions*** 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. ***This statement shall also include a written explanation of any adverse determination, with the name and credentials of the health carrier medical director, 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. If the person making the adverse determination is not the medical director but a designee, then the name, credentials, board status, and state or states of current license shall also be provided for that person. Nothing in this section shall be construed to require a health carrier to provide proprietary information protected by third party contracts.***

(d) Staff assistance in filing a grievance.

(e) [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] ***Upon exhausting the second level grievance review process, a statement of the covered person's right to obtain an independent external review of the health carrier's determination. This shall include a description of the process for obtaining external review, a copy of the written procedures governing external review, including the required time frames for requesting external review, and notice of the conditions under which expedited external review is available.***

7 First Level Grievance; Names Required. Amend RSA 420-J:5, III(b)(1) to read as follows:

(1) The ***names,*** titles and qualifying credentials of the persons participating in the first level grievance review process.

8 Second Level Grievance; Names Required. 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 ***names and*** 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~~] ***420-J:5-a. The statement of appeal rights shall include a description of the process for obtaining external review of a determination, a copy of the written procedures governing external review, including the required time frames for requesting external review, and notice of the conditions under which expedited external review is available.***

9 Review Panel; Names Required. 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 ***names and*** 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] ***420-J:5-a. The statement of appeal rights shall include a description of the process for obtaining external review of a determination, a copy of the written procedures governing external review, including the required time frames for requesting external review, and notice of the conditions under which expedited external review is available.***

10 Expedited Internal Grievance Review. Amend RSA 420-J:5, VI(e) to read as follows:

(e) In any case where the expedited review process does not resolve a difference of opinion between the health carrier and the covered person or the provider acting on behalf of the covered person, the covered person or the provider acting on behalf of the covered person may submit a written grievance, unless the provider is prohibited from filing a grievance by federal or other state law. A health carrier shall review it as a second level grievance. In conducting the review, the health carrier shall [~~adhere to time frames that are reasonable under the circumstances~~] ***make a decision and notify the covered person as expeditiously as the covered person's medical condition requires, but in no event more than 72 hours after the grievance is submitted.***

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

III-a. "Authorized representative" means any person who has obtained express written consent to represent the covered person in an external review from:

(a) The covered person;

(b) A person authorized by law to provide substituted consent for a covered person; or

(c) A family member of the covered person when adherence to the requirement of express written consent is impracticable or would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

12 New Paragraph; Definition Added. Amend RSA 420-J:3 by inserting after paragraph XXIII the following new paragraph:

XXIII-a. "Independent review organization" means an entity that employs or contracts with clinical peers to conduct independent external reviews of health carrier determinations.

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

420-J:5-a External Review Process. The insurance department shall arrange for independent external review of certain health carrier determinations as follows:

I. A covered person shall have the right to independent external review of a health carrier determination when the following conditions apply:

(a) The subject of the request for external review is:

(1) An adverse determination; or

(2) A determination by the health carrier that a service, supply or drug is not a covered benefit, when the covered person is asserting that the service, supply or drug should be

considered covered for medical reasons. This shall include, but not be limited to, the following circumstances:

(A) a service, supply or drug is denied, reduced or terminated by the carrier because the health benefit plan does not cover experimental or investigational treatment, but the covered person asserts that the treatment in question should not be considered experimental or investigational.

(B) a service is denied, reduced or terminated by the carrier because the health benefit plan does not cover procedures that are performed for cosmetic reasons or for reasons of convenience, but the covered person asserts that the service is required for medical reasons rather than cosmetics or convenience.

(C) a referral is denied by the carrier because treatment by out-of-network providers is not covered unless the service in question cannot be provided within the carrier's network, and the covered person asserts that the network does not have providers with the appropriate clinical expertise for the service in question.

(D) a drug is denied by the carrier because it is not on the formulary list, but the covered person asserts that the drug is covered under the medical exception criteria.

(E) a service, supply or drug is denied because of a medically-based decision that a condition is preexisting, and the covered person disputes this.

(b) The covered person has completed the internal review procedures provided by the health carrier pursuant to RSA 420-J:5, III through VI, or the health carrier has agreed to submit the determination to independent external review prior to completion of internal review, or the covered person has requested first or second level, standard or expedited review and has not received a decision from the health carrier within the required time frames.

(c) The covered person or the covered person's authorized representative has submitted the request for external review in writing to the commissioner within 12 months of the date of the health carrier's second level denial decision provided pursuant to RSA 420-J:5, V or VI, or if the health carrier has failed to make a first or second level, standard or expedited review decision that is past due, within 12 months of the date the decision was due..

(d) Except in the case of a request for expedited review, the covered person or the covered person's authorized representative has paid to the commissioner a filing fee of $25 at the time of submitting the request for external review. However, the commissioner may waive the filing fee upon a showing of financial hardship.

(e) The health carrier determination does not relate to any category of health care services that is excluded from the external review provisions of this section pursuant to paragraph II.

(f) The request for external review is not based on a claim or allegation of provider malpractice, professional negligence, or other professional fault excluded from the external review

provisions of this section pursuant to paragraph III.

II. Determinations relating to the following health care services shall not be reviewed under this section, but shall be reviewed pursuant to the review processes provided by applicable federal or state law:

(a) Health care services provided 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.

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

(c) Health care services provided pursuant to a health plan not regulated by the state, such as self-funded plans administered by an administrative services organization or third-party administrator or federal employee benefit programs.

III. The external review procedures set forth in this section shall not be utilized to adjudicate claims or allegations of health care provider malpractice, professional negligence, or other professional fault against participating providers.

IV. Standard external review shall be conducted as follows:

(a) Within 7 days after the date of receipt of a request for external review, the commissioner shall complete a preliminary review of the request in order to determine whether:

(1) The individual is or was a covered person under the health benefit plan;

(2) The determination that is the subject of the request for external review meets the conditions of eligibility for external review stated in paragraph I; and

(3) The covered person has provided all the information and forms required by the commissioner that are necessary to process an external review.

(b) Upon completion of the preliminary review pursuant to subparagraph IV(a), the commissioner shall immediately notify the covered person or the covered person's authorized representative in writing:

(1) Whether the request is complete; and

(2) Whether the request has been accepted for external review.

(c) If the request for external review is accepted, the commissioner shall:

(1) Include in the notice provided to the covered person pursuant to subparagraph IV(b) a statement that if the covered person wishes to submit new or additional information or to present oral testimony via teleconference, such information shall be submitted, and the oral testimony must be scheduled and presented, within 20 days of the date of issuance of the notice.

(2) Immediately notify the health carrier in writing of the request for external review and its acceptance.

(d) If the request is not complete, the commissioner shall inform the covered person or the covered person's authorized representative what information or documents are needed to make the request complete.

(e) If the request for external review is not accepted, the commissioner shall inform the covered person or the covered person's authorized representative and the health carrier in writing of the reason for its non-acceptance.

(f) At the time a request for external review is accepted, the commissioner may select an independent review organization that is certified pursuant to paragraph VI to conduct the external review. If an independent review organization is not selected to conduct the review, then the policies and procedures established by the commissioner for selecting clinical peer reviewers and conducting the review shall meet the minimum qualifications established under paragraph VII for certification of independent review organizations.

(g) Within 10 days after the date of issuance of the notice provided pursuant to subparagraph IV(c)(2), the health carrier or its designated utilization review organization shall provide to the commissioner or the selected independent review organization and to the covered person all information in its possession that is relevant to the adjudication of the matter in dispute, including but not limited to:

(1) The terms of agreement of the health benefit plan, including the evidence of coverage, benefit summary or other similar document;

(2) All relevant medical records, including records submitted to the carrier by the covered person, the covered person's authorized representative, or the covered person's treating provider;

(3) A summary description of the applicable issues, including a statement of the health carrier's final determination;

(4) The clinical review criteria used and the clinical reasons for the determination;

(5) The relevant portions of the carrier's utilization management plan;

(6) Any communications between the covered person and the health carrier regarding the internal or external review; and

(7) All other documents, information, or criteria relied upon by the carrier in making its determination.

(h) In providing the information required in subparagraph IV(g), the health carrier may not present different reasons than those the health carrier or its designated utilization review organization communicated to the covered person upon internal review, unless the reasons relate to new information presented by the covered person or the covered person's authorized representative or treating provider subsequent to the internal review.

(i) Failure by the health carrier to provide the documents and information required in subparagraph IV(g) within the specified time frame shall not delay the conduct of the external review.

(j) The commissioner or the selected independent review organization shall review all of the information and documents received from the carrier pursuant to subparagraph IV(g) and any

other information submitted by the covered person or the covered person's authorized representative or treating provider pursuant to subparagraph IV(c)(1) and any testimony provided. The commissioner or the independent review organization shall consider anew all previously determined facts, allow the introduction of new information, and make a decision that is not bound by decisions or conclusions made by the health carrier during internal review. In addition to the information provided by the health carrier and the covered person or the covered person's authorized representative or treating provider, the commissioner or the independent review organization may consider the following in reaching a decision:

(1) The covered person's pertinent medical records;

(2) The treating health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other similar documents submitted by the health carrier, covered person, or the covered person's authorized representative or treating provider;

(4) Any applicable, generally accepted clinical practice guidelines, including those developed by the federal government, national or professional medical societies, boards and associations;

(5) Any applicable clinical review criteria developed and used by the health carrier or its designated utilization review organization;

(6) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts;

(7) Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's Library of Medicine for indexing or that are recognized by the Secretary of Health and Human Services under section 1861(t)(2) of the Social Security Act;

(8) Standard reference compendia; and

(9) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes.

(k) The commissioner or the selected independent review organization shall render a decision upholding or reversing the determination of the health carrier and notify the covered person or the covered person's authorized representative and the health carrier in writing within 20 days of the date that any new or additional information from the covered person is due pursuant to subparagraph IV(c)(1). This notice shall include a written review decision that contains a statement of the nature of the grievance, references to evidence or documentation considered in making the decision, findings of fact, and the clinical and legal rationale for the decision, including, as applicable, clinical review criteria and rulings of law. The decision shall have the same force and effect as a final order of the commissioner and shall be enforceable pursuant to the penalty provisions of RSA 420-J:14.

V. Expedited external review shall be conducted as follows:

(a) Expedited external review shall be available when the covered person's treating health care provider certifies to the commissioner that adherence to the time frames specified in paragraph IV would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

(b) Except to the extent that it is inconsistent with the provisions of this subsection, all requirements for the conduct of standard external review specified in paragraph IV shall apply to expedited external review.

(c) At the time the commissioner receives a request for an expedited external review, the commissioner shall immediately make a determination whether the request meets the standard set forth in subparagraph V(a) for expedited external review, as well as the reviewability requirements set forth in subparagraph IV(a). If these conditions are met, the commissioner shall immediately notify the health carrier. If the request is not complete, the commissioner shall immediately contact the covered person or the covered person's authorized representative and attempt to obtain the information or documents that are needed to make the request complete.

(d) The commissioner may select an independent review organization that is certified pursuant to paragraph VI to conduct the expedited external review. If an independent review organization is not selected to conduct the review, then the policies and procedures established by the commissioner for selecting clinical peer reviewers and conducting the review shall meet the minimum qualifications established under paragraph VII for certification of independent review organizations.

(e) The health carrier or its designated utilization review organization shall provide or transmit the documents and information specified in subparagraph IV(g) to the commissioner or the selected independent review organization by telephone, facsimile or any other available expeditious method within one day of receiving the commissioner's notice of the request for expedited external review pursuant to subparagraph V(c).

(f) When handling a review on an expedited basis, the commissioner or the selected independent review organization shall make a decision and notify the carrier and the covered person as expeditiously as the covered person's medical condition requires, but in no event more than 72 hours after the expedited external review is requested. The decision shall have the same force and effect as a final order of the commissioner and shall be enforceable pursuant to the penalty provisions of RSA 420-J:14.

(g) If the notice provided pursuant to subparagraph V(f) was not in writing, within 2 days after the date of providing that notice, the commissioner or the selected independent review organization shall:

(1) Provide written confirmation of the decision to the covered person or the covered person's authorized representative and the health carrier; and

(2) Include the information set forth in subparagraph IV(k).

(h) Reviews that the health carrier handled on an expedited basis in its internal review process shall be handled on an expedited basis in the external review process.

(i) An expedited external review shall not be provided for determinations made by the health carrier on a retrospective basis.

(j) Continuation of benefits pending expedited external review shall be provided when appropriate and as determined by the commissioner.

VI. The certification of independent review organizations shall be conducted as follows:

(a) The commissioner shall certify independent review organizations eligible to be selected to conduct external reviews under this section to ensure that an independent review organization satisfies the minimum qualifications established under paragraph VII.

(b) The commissioner shall develop an application form for initially certifying and recertifying independent review organizations to conduct external reviews.

(c) Independent review organizations wishing to be certified shall submit the application form and include all documentation and information necessary for the commissioner to determine whether the independent review organization satisfies the minimum qualifications established under paragraph VII.

(d) The commissioner may determine that accreditation by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations that meet or exceed the minimum qualifications established under paragraph VII is sufficient for certification under this paragraph.

(e) The commissioner shall maintain and periodically update a list of certified independent review organizations.

VII. To be certified under paragraph VI to conduct external reviews, an independent review organization shall meet the following minimum qualifications:

(a) It shall develop and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process.

(b) It shall establish and maintain a quality assurance program that:

(1) Ensures that external reviews are conducted within the specified time frames and required notices are provided in a timely manner;

(2) Ensures the selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization with suitable matching of reviewers to specific cases;

(3) Ensures the confidentiality of medical and treatment records; and

(4) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this section.

(c) It shall maintain a toll-free telephone service on a 24-hour, 7-day-a-week basis related to external reviews that is capable of accepting or recording information from, and providing appropriate instruction to callers.

(d) It shall agree to maintain and provide to the commissioner such information as may be required to fulfill the provisions and purposes of this section.

(e) It shall assign clinical peer reviewers to conduct external reviews who are physicians or other appropriate health care providers and who:

(1) Are experts in the treatment of the covered person's medical condition that is the subject of the external review;

(2) Are knowledgeable about the recommended health care service or treatment through actual clinical experience;

(3) 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 area or areas appropriate to the subject of the external review;

(4) Have no history or disciplinary actions or sanctions that have been taken or are pending by any hospital, governmental agency, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental or professional competence or moral character; and

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

(f) It shall be free of any conflict of interest. To meet this qualification, an independent review organization may not own or control or in any way be owned or controlled by a health carrier, a national, state or local trade association of health carriers, or a national state or local trade association of health care providers. In addition, in order to qualify to conduct an external review of a specific case, neither the independent review organization selected to conduct the external review nor any clinical peer reviewer assigned by the independent organization to conduct the external review may have a material professional, familial or financial interest in any of the following:

(1) The health carrier that is the subject of the external review;

(2) Any officer, director or management employee of the health carrier that is the subject of the external review;

(3) The health care provider or the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

(4) The facility at which the recommended health care service or treatment would be provided;

(5) The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the external review; or

(6) The covered person or the covered person's authorized representative.

(g) For the purpose of allowing in-state health care providers to act as clinical peer reviewers in the conduct of external reviews, 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 which is sufficient to preclude that provider from acting as a clinical peer reviewer, so long as the affiliation is disclosed to the covered person and the covered person has given his or her prior written consent.

(h) The following organizations shall not be eligible for certification to conduct external reviews:

(1) Professional or trade associations of health care providers;

(2) Subsidiaries or affiliates of such provider associations;

(3) Health carrier or health plan associations; and

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

VIII. A covered person shall:

(a) Be provided with timely and adequate notice of his or her rights with respect to external review.

(b) Have the right to be represented by any person, including the covered person's treating provider, and to otherwise make use of outside assistance during the review process, to receive a copy of all documents, all information, and all clinical review criteria or other standards relied upon by the health carrier in making its determination, and to present to the commissioner or the selected independent review organization any information, including new information not previously considered by the health carrier, which the covered person believes to be relevant to the adjudication of the matter in dispute, provided that such information is simultaneously provided to the health carrier.

(c) Be provided the opportunity, under standard external review, to present oral testimony to the independent review organization via teleconference. At any such hearing, the health carrier shall also have the opportunity to present oral testimony and to respond to issues raised.

(d) Be protected from retaliation for exercising the right to an independent external review under this section.

IX. The health carrier against which a request for external review is filed shall pay the cost of the external review. The commissioner shall ensure that such costs assessed to the health carrier are at all times reasonable in relation to the services provided. If the covered person is the prevailing party in the external review, the health carrier shall pay to the covered person the amount of any filing fee paid by the covered person.

X. The confidentiality of any health care information acquired or provided to the commissioner or an independent review organization shall be maintained, and the records, and

internal materials prepared for specific reviews by the commissioner or an independent review organization under this section shall be exempt from public disclosure under RSA 91-A.

XI. No independent review organization or clinical peer reviewer working on behalf of an independent review organization shall be liable for damages to any person for any opinions rendered during or upon completion of an external review conducted pursuant to this section, unless the opinion was rendered in bad faith or involved gross negligence.

XII. The right to external review under this section shall not be construed to change the terms of coverage under a health benefit plan.

XIII. When requested by the covered person, the commissioner shall provide consumer assistance in pursuing the internal grievance procedures and the external review process under RSA 420-J:5 and this section.

XIV. The commissioner shall report annually to the governor and the legislature on the number of grievances subjected to external review, the number of decisions resolved wholly or partially in favor of the covered person, the number of decisions resolved wholly or partially in favor of the health carrier, and any common themes or issues that may require legislative action.

XV. The commissioner shall report annually to the New Hampshire board of medicine the names of the medical directors responsible for determinations that resulted in external review and the outcomes of such external reviews.

14 New Paragraphs; Provider Contract Standards. Amend RSA 420-J:8 by inserting after paragraph VI the following new paragraphs:

VII. No contract between a health carrier and a participating provider shall contain any payment or reimbursement provision the terms of which create incentives for the provider to limit medically necessary care to covered persons. Nothing in this section shall be construed to prohibit the use of payment arrangements between a health carrier and a participating provider or provider group which involve capitation or withholds.

VIII. A health carrier shall provide to consumers, upon request, a description, in general terms, of the types of payment and reimbursement provisions contained in its contracts with participating providers. Such descriptions shall be set forth in clear, understandable language and shall, at a minimum, convey basic information about any financial incentives to providers that may directly or indirectly have the effect of reducing or limiting services to covered persons.

IX. Every contract between a health carrier and a participating provider shall provide that the health carrier may not remove a health care provider from its network or refuse to renew the health care provider with its network for advocating on behalf of a covered person for medically necessary care for the covered person.

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

16 Effective Date. This act shall take effect 60 days after its passage.

1999-1722s

AMENDED ANALYSIS

This bill creates an independent external consumer appeal process to review certain determinations made by managed care entities. The bill requires health carriers that conduct utilization review and licensed utilization review entities to employ a medical director and amends the definition of the practice of medicine to include the making of certain medical necessity determinations. The bill prohibits contracts between health carriers and participating providers from including provisions that create financial incentives to deny medically necessary care. The bill also requires that health insurers disclose certain information necessary for consumers to hold managed care entities accountable for health care treatment decisions.

Public Institutions, Health and Human Services
June 21, 1999
1999-1730s
01/09

Amendment to HB 640-FN

Amend the title of the bill by replacing it with the following:

AN ACT establishing certain standards of accountability for health maintenance organizations and other entities providing health insurance through a managed care system.

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

1 Statement of Purpose. The purpose and intent of this act is to strengthen protections for New Hampshire families who receive their medical care from managed care organizations by providing consumers with the information and tools consumers need to hold managed care organizations accountable for the health care treatment decisions they make.

2 Practice of Medicine; Medical Directors. Amend RSA 329:1 to read as follows:

329:1 Practice. Any person shall be regarded as practicing medicine under the meaning of this chapter who shall diagnose, treat, perform surgery, or prescribe any treatment of medicine for any disease or human ailment. "Surgery" means any procedure, including but not limited to laser, in which human tissue is cut, shaped, burned, vaporized, or otherwise structurally altered, except that this section shall not apply to any person to whom authority is given by any other statute to perform acts which might otherwise be deemed the practice of medicine. "Laser" means light amplification by stimulated emission of radiation. ***A medical director, as defined in RSA 420-J:3, XXV-a, shall be regarded as practicing medicine under the meaning of this chapter whenever:***

I. A medical necessity determination is made for which he or she is responsible under RSA 420-J:6, V or RSA 420-E:2-a;

II. The medical necessity determination denies authorization or payment for a covered health care service, supply or drug that the treating health care provider has prescribed; and

III. Such denial causes the covered person not to receive the health care service, supply or drug that the treating health care provider has prescribed.

3 New Section; Medical Directors Required. Amend RSA 420-E by inserting after section 2 the following new section:

420-E:2-a Medical Director. Every medical utilization review entity licensed by the department under this chapter shall employ a medical director licensed under RSA 329, who shall have final

responsibility for the utilization system and its administration and implementation, including utilization review decisions affecting health care services provided to beneficiaries.

4 New Paragraph; Definition Added. Amend RSA 420-J:3 by inserting after paragraph XXV the following new paragraph:

XXV-a. "Medical director" means a physician licensed under RSA 329 and employed by a health carrier or medical utilization review entity who is responsible for the utilization review techniques and methods of the health carrier or medical utilization review entity and their administration and implementation, including utilization review decisions affecting health care services provided to covered persons under a health benefit plan.

5 New Paragraph; Medical Director Required. Amend RSA 420-J:6 by inserting after paragraph IV the following new paragraph:

V. Each health carrier that conducts utilization review shall employ a medical director who shall have final responsibility for all utilization review techniques and methods and their administration and implementation, including utilization review decisions affecting health care services provided to covered persons under a health benefit plan.

6 Information Provided to Covered Persons. Amend RSA 420-J:5, II to read as follows:

II. A health carrier shall provide to consumers:

(a) A description of the ***internal*** grievance procedure ***required under RSA 420-J:5*** for adverse determinations and other matters [~~which~~] ***and a description of the process for obtaining external review under RSA 420-J:5-a. These descriptions*** 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. ***This statement shall also include a written explanation of any adverse determination, with the name and credentials of the health carrier medical director, 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. If the person making the adverse determination is not the medical director but a designee, then the name, credentials, board status, and state or states of current license shall also be provided for that person. Nothing in this section shall be construed to require a health carrier to provide proprietary information protected by third party contracts.***

(d) Staff assistance in filing a grievance.

(e) [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] ***Upon exhausting the second level grievance review process, a statement of the covered person's right to obtain an independent external review of the health carrier's determination. This shall include a description of the process for obtaining external review, a copy of the written procedures governing external review, including the required time frames for requesting external review, and notice of the conditions under which expedited external review is available.***

7 First Level Grievance; Names Required. Amend RSA 420-J:5, III(b)(1) to read as follows:

(1) The ***names,*** titles and qualifying credentials of the persons participating in the first level grievance review process.

8 Second Level Grievance; Names Required. 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 ***names and*** 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~~] ***420-J:5-a. The statement of appeal rights shall include a description of the process for obtaining external review of a determination, a copy of the written procedures governing external review, including the required time frames for requesting external review, and notice of the conditions under which expedited external review is available.***

9 Review Panel; Names Required. 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 ***names and*** 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] ***420-J:5-a. The statement of appeal rights shall include a description of the process for obtaining external review of a determination, a copy of the written procedures governing external review, including the required time frames for requesting external review, and notice of the conditions under which expedited external review is available.***

10 Expedited Internal Grievance Review. Amend RSA 420-J:5, VI(e) to read as follows:

(e) In any case where the expedited review process does not resolve a difference of opinion between the health carrier and the covered person or the provider acting on behalf of the covered person, the covered person or the provider acting on behalf of the covered person may submit a written grievance, unless the provider is prohibited from filing a grievance by federal or other state law. A health carrier shall review it as a second level grievance. In conducting the review, the health carrier shall [~~adhere to time frames that are reasonable under the circumstances~~] ***make a decision and notify the covered person as expeditiously as the covered person's medical condition requires, but in no event more than 72 hours after the grievance is submitted.***

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

III-a. "Authorized representative" means any person who has obtained express written consent to represent the covered person in an external review from:

(a) The covered person;

(b) A person authorized by law to provide substituted consent for a covered person; or

(c) A family member of the covered person when adherence to the requirement of express written consent is impracticable or would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

12 New Paragraph; Definition Added. Amend RSA 420-J:3 by inserting after paragraph XXIII the following new paragraph:

XXIII-a. "Independent review organization" means an entity that employs or contracts with clinical peers to conduct independent external reviews of health carrier determinations.

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

420-J:5-a External Review Process. The insurance department shall arrange for independent external review of certain health carrier determinations as follows:

I. A covered person shall have the right to independent external review of a health carrier determination when the following conditions apply:

(a) The subject of the request for external review is:

(1) An adverse determination; or

(2) A determination by the health carrier that a service, supply or drug is not a covered benefit, when the covered person is asserting that the service, supply or drug should be

considered covered for medical reasons. This shall include, but not be limited to, the following circumstances:

(A) a service, supply or drug is denied, reduced or terminated by the carrier because the health benefit plan does not cover experimental or investigational treatment, but the covered person asserts that the treatment in question should not be considered experimental or investigational.

(B) a service is denied, reduced or terminated by the carrier because the health benefit plan does not cover procedures that are performed for cosmetic reasons or for reasons of convenience, but the covered person asserts that the service is required for medical reasons rather than cosmetics or convenience.

(C) a referral is denied by the carrier because treatment by out-of-network providers is not covered unless the service in question cannot be provided within the carrier's network, and the covered person asserts that the network does not have providers with the appropriate clinical expertise for the service in question.

(D) a drug is denied by the carrier because it is not on the formulary list, but the covered person asserts that the drug is covered under the medical exception criteria.

(E) a service, supply or drug is denied because of a medically-based decision that a condition is preexisting, and the covered person disputes this.

(b) The covered person has completed the internal review procedures provided by the health carrier pursuant to RSA 420-J:5, III through VI, or the health carrier has agreed to submit the determination to independent external review prior to completion of internal review, or the covered person has requested first or second level, standard or expedited review and has not received a decision from the health carrier within the required time frames.

(c) The covered person or the covered person's authorized representative has submitted the request for external review in writing to the commissioner within 12 months of the date of the health carrier's second level denial decision provided pursuant to RSA 420-J:5, V or VI, or if the health carrier has failed to make a first or second level, standard or expedited review decision that is past due, within 12 months of the date the decision was due.

(d) Except in the case of a request for expedited review, the covered person or the covered person's authorized representative has paid to the commissioner a filing fee of $25 at the time of submitting the request for external review. However, the commissioner may waive the filing fee upon a showing of financial hardship.

(e) The health carrier determination does not relate to any category of health care services that is excluded from the external review provisions of this section pursuant to paragraph II.

(f) The request for external review is not based on a claim or allegation of provider malpractice, professional negligence, or other professional fault excluded from the external review

provisions of this section pursuant to paragraph III.

II. Determinations relating to the following health care services shall not be reviewed under this section, but shall be reviewed pursuant to the review processes provided by applicable federal or state law:

(a) Health care services provided 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.

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

(c) Health care services provided pursuant to a health plan not regulated by the state, such as self-funded plans administered by an administrative services organization or third-party administrator or federal employee benefit programs.

III. The external review procedures set forth in this section shall not be utilized to adjudicate claims or allegations of health care provider malpractice, professional negligence, or other professional fault against participating providers.

IV. Standard external review shall be conducted as follows:

(a) Within 7 days after the date of receipt of a request for external review, the commissioner shall complete a preliminary review of the request in order to determine whether:

(1) The individual is or was a covered person under the health benefit plan;

(2) The determination that is the subject of the request for external review meets the conditions of eligibility for external review stated in paragraph I; and

(3) The covered person has provided all the information and forms required by the commissioner that are necessary to process an external review.

(b) Upon completion of the preliminary review pursuant to subparagraph IV(a), the commissioner shall immediately notify the covered person or the covered person's authorized representative in writing:

(1) Whether the request is complete; and

(2) Whether the request has been accepted for external review.

(c) If the request for external review is accepted, the commissioner shall:

(1) Include in the notice provided to the covered person pursuant to subparagraph IV(b) a statement that if the covered person wishes to submit new or additional information or to present oral testimony via teleconference, such information shall be submitted, and the oral testimony must be scheduled and presented, within 20 days of the date of issuance of the notice.

(2) Immediately notify the health carrier in writing of the request for external review and its acceptance.

(d) If the request is not complete, the commissioner shall inform the covered person or the covered person's authorized representative what information or documents are needed to make the request complete.

(e) If the request for external review is not accepted, the commissioner shall inform the covered person or the covered person's authorized representative and the health carrier in writing of the reason for its non-acceptance.

(f) At the time a request for external review is accepted, the commissioner may select an independent review organization that is certified pursuant to paragraph VI to conduct the external review. If an independent review organization is not selected to conduct the review, then the policies and procedures established by the commissioner for selecting clinical peer reviewers and conducting the review shall meet the minimum qualifications established under paragraph VII for certification of independent review organizations.

(g) Within 10 days after the date of issuance of the notice provided pursuant to subparagraph IV(c)(2), the health carrier or its designated utilization review organization shall provide to the commissioner or the selected independent review organization and to the covered person all information in its possession that is relevant to the adjudication of the matter in dispute, including but not limited to:

(1) The terms of agreement of the health benefit plan, including the evidence of coverage, benefit summary or other similar document;

(2) All relevant medical records, including records submitted to the carrier by the covered person, the covered person's authorized representative, or the covered person's treating provider;

(3) A summary description of the applicable issues, including a statement of the health carrier's final determination;

(4) The clinical review criteria used and the clinical reasons for the determination;

(5) The relevant portions of the carrier's utilization management plan;

(6) Any communications between the covered person and the health carrier regarding the internal or external review; and

(7) All other documents, information, or criteria relied upon by the carrier in making its determination.

(h) In providing the information required in subparagraph IV(g), the health carrier may not present different reasons than those the health carrier or its designated utilization review organization communicated to the covered person upon internal review, unless the reasons relate to new information presented by the covered person or the covered person's authorized representative or treating provider subsequent to the internal review.

(i) Failure by the health carrier to provide the documents and information required in subparagraph IV(g) within the specified time frame shall not delay the conduct of the external review.

(j) The commissioner or the selected independent review organization shall review all of the information and documents received from the carrier pursuant to subparagraph IV(g) and any

other information submitted by the covered person or the covered person's authorized representative or treating provider pursuant to subparagraph IV(c)(1) and any testimony provided. The commissioner or the independent review organization shall consider anew all previously determined facts, allow the introduction of new information, and make a decision that is not bound by decisions or conclusions made by the health carrier during internal review. In addition to the information provided by the health carrier and the covered person or the covered person's authorized representative or treating provider, the commissioner or the independent review organization may consider the following in reaching a decision:

(1) The covered person's pertinent medical records;

(2) The treating health care professional's recommendation;

(3) Consulting reports from appropriate health care professionals and other similar documents submitted by the health carrier, covered person, or the covered person's authorized representative or treating provider;

(4) Any applicable, generally accepted clinical practice guidelines, including those developed by the federal government, national or professional medical societies, boards and associations;

(5) Any applicable clinical review criteria developed and used by the health carrier or its designated utilization review organization;

(6) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts;

(7) Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's Library of Medicine for indexing or that are recognized by the Secretary of Health and Human Services under section 1861(t)(2) of the Social Security Act;

(8) Standard reference compendia; and

(9) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes.

(k) The commissioner or the selected independent review organization shall render a decision upholding or reversing the determination of the health carrier and notify the covered person or the covered person's authorized representative and the health carrier in writing within 20 days of the date that any new or additional information from the covered person is due pursuant to subparagraph IV(c)(1). This notice shall include a written review decision that contains a statement of the nature of the grievance, references to evidence or documentation considered in making the decision, findings of fact, and the clinical and legal rationale for the decision, including, as applicable, clinical review criteria and rulings of law. The decision shall have the same force and effect as a final order of the commissioner and shall be enforceable pursuant to the penalty provisions of RSA 420-J:14.

V. Expedited external review shall be conducted as follows:

(a) Expedited external review shall be available when the covered person's treating health care provider certifies to the commissioner that adherence to the time frames specified in paragraph IV would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

(b) Except to the extent that it is inconsistent with the provisions of this subsection, all requirements for the conduct of standard external review specified in paragraph IV shall apply to expedited external review.

(c) At the time the commissioner receives a request for an expedited external review, the commissioner shall immediately make a determination whether the request meets the standard set forth in subparagraph V(a) for expedited external review, as well as the reviewability requirements set forth in subparagraph IV(a). If these conditions are met, the commissioner shall immediately notify the health carrier. If the request is not complete, the commissioner shall immediately contact the covered person or the covered person's authorized representative and attempt to obtain the information or documents that are needed to make the request complete.

(d) The commissioner may select an independent review organization that is certified pursuant to paragraph VI to conduct the expedited external review. If an independent review organization is not selected to conduct the review, then the policies and procedures established by the commissioner for selecting clinical peer reviewers and conducting the review shall meet the minimum qualifications established under paragraph VII for certification of independent review organizations.

(e) The health carrier or its designated utilization review organization shall provide or transmit the documents and information specified in subparagraph IV(g) to the commissioner or the selected independent review organization by telephone, facsimile or any other available expeditious method within one day of receiving the commissioner's notice of the request for expedited external review pursuant to subparagraph V(c).

(f) When handling a review on an expedited basis, the commissioner or the selected independent review organization shall make a decision and notify the carrier and the covered person as expeditiously as the covered person's medical condition requires, but in no event more than 72 hours after the expedited external review is requested. The decision shall have the same force and effect as a final order of the commissioner and shall be enforceable pursuant to the penalty provisions of RSA 420-J:14.

(g) If the notice provided pursuant to subparagraph V(f) was not in writing, within 2 days after the date of providing that notice, the commissioner or the selected independent review organization shall:

(1) Provide written confirmation of the decision to the covered person or the covered person's authorized representative and the health carrier; and

(2) Include the information set forth in subparagraph IV(k).

(h) Reviews that the health carrier handled on an expedited basis in its internal review process shall be handled on an expedited basis in the external review process.

(i) An expedited external review shall not be provided for determinations made by the health carrier on a retrospective basis.

(j) Continuation of benefits pending expedited external review shall be provided when appropriate and as determined by the commissioner.

VI. The certification of independent review organizations shall be conducted as follows:

(a) The commissioner shall certify independent review organizations eligible to be selected to conduct external reviews under this section to ensure that an independent review organization satisfies the minimum qualifications established under paragraph VII.

(b) The commissioner shall develop an application form for initially certifying and recertifying independent review organizations to conduct external reviews.

(c) Independent review organizations wishing to be certified shall submit the application form and include all documentation and information necessary for the commissioner to determine whether the independent review organization satisfies the minimum qualifications established under paragraph VII.

(d) The commissioner may determine that accreditation by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations that meet or exceed the minimum qualifications established under paragraph VII is sufficient for certification under this paragraph.

(e) The commissioner shall maintain and periodically update a list of certified independent review organizations.

VII. To be certified under paragraph VI to conduct external reviews, an independent review organization shall meet the following minimum qualifications:

(a) It shall develop and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process.

(b) It shall establish and maintain a quality assurance program that:

(1) Ensures that external reviews are conducted within the specified time frames and required notices are provided in a timely manner;

(2) Ensures the selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization with suitable matching of reviewers to specific cases;

(3) Ensures the confidentiality of medical and treatment records; and

(4) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this section.

(c) It shall maintain a toll-free telephone service on a 24-hour, 7-day-a-week basis related to external reviews that is capable of accepting or recording information from, and providing appropriate instruction to callers.

(d) It shall agree to maintain and provide to the commissioner such information as may be required to fulfill the provisions and purposes of this section.

(e) It shall assign clinical peer reviewers to conduct external reviews who are physicians or other appropriate health care providers and who:

(1) Are experts in the treatment of the covered person's medical condition that is the subject of the external review;

(2) Are knowledgeable about the recommended health care service or treatment through actual clinical experience;

(3) 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 area or areas appropriate to the subject of the external review;

(4) Have no history or disciplinary actions or sanctions that have been taken or are pending by any hospital, governmental agency, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental or professional competence or moral character; and

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

(f) It shall be free of any conflict of interest. To meet this qualification, an independent review organization may not own or control or in any way be owned or controlled by a health carrier, a national, state or local trade association of health carriers, or a national state or local trade association of health care providers. In addition, in order to qualify to conduct an external review of a specific case, neither the independent review organization selected to conduct the external review nor any clinical peer reviewer assigned by the independent organization to conduct the external review may have a material professional, familial or financial interest in any of the following:

(1) The health carrier that is the subject of the external review;

(2) Any officer, director or management employee of the health carrier that is the subject of the external review;

(3) The health care provider or the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

(4) The facility at which the recommended health care service or treatment would be provided;

(5) The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the external review; or

(6) The covered person or the covered person's authorized representative.

(g) For the purpose of allowing in-state health care providers to act as clinical peer reviewers in the conduct of external reviews, 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 which is sufficient to preclude that provider from acting as a clinical peer reviewer, so long as the affiliation is disclosed to the covered person and the covered person has given his or her prior written consent.

(h) The following organizations shall not be eligible for certification to conduct external reviews:

(1) Professional or trade associations of health care providers;

(2) Subsidiaries or affiliates of such provider associations;

(3) Health carrier or health plan associations; and

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

VIII. A covered person shall:

(a) Be provided with timely and adequate notice of his or her rights with respect to external review.

(b) Have the right to be represented by any person, including the covered person's treating provider, and to otherwise make use of outside assistance during the review process, to receive a copy of all documents, all information, and all clinical review criteria or other standards relied upon by the health carrier in making its determination, and to present to the commissioner or the selected independent review organization any information, including new information not previously considered by the health carrier, which the covered person believes to be relevant to the adjudication of the matter in dispute, provided that such information is simultaneously provided to the health carrier.

(c) Be provided the opportunity, under standard external review, to present oral testimony to the independent review organization via teleconference. At any such hearing, the health carrier shall also have the opportunity to present oral testimony and to respond to issues raised.

(d) Be protected from retaliation for exercising the right to an independent external review under this section.

IX. The health carrier against which a request for external review is filed shall pay the cost of the external review. The commissioner shall ensure that such costs assessed to the health carrier are at all times reasonable in relation to the services provided. If the covered person is the prevailing party in the external review, the health carrier shall pay to the covered person the amount of any filing fee paid by the covered person.

X. The confidentiality of any health care information acquired or provided to the commissioner or an independent review organization shall be maintained, and the records, and

internal materials prepared for specific reviews by the commissioner or an independent review organization under this section shall be exempt from public disclosure under RSA 91-A.

XI. No independent review organization or clinical peer reviewer working on behalf of an independent review organization shall be liable for damages to any person for any opinions rendered during or upon completion of an external review conducted pursuant to this section, unless the opinion was rendered in bad faith or involved gross negligence.

XII. The right to external review under this section shall not be construed to change the terms of coverage under a health benefit plan.

XIII. When requested by the covered person, the commissioner shall provide consumer assistance in pursuing the internal grievance procedures and the external review process under RSA 420-J:5 and this section.

XIV. The commissioner shall report annually to the governor and the legislature on the number of grievances subjected to external review, the number of decisions resolved wholly or partially in favor of the covered person, the number of decisions resolved wholly or partially in favor of the health carrier, and any common themes or issues that may require legislative action.

XV. The commissioner shall report annually to the New Hampshire board of medicine the names of the medical directors responsible for determinations that resulted in external review and the outcomes of such external reviews.

14 New Paragraphs; Provider Contract Standards. Amend RSA 420-J:8 by inserting after paragraph VI the following new paragraphs:

VII. No contract between a health carrier and a participating provider shall contain any payment or reimbursement provision the terms of which create incentives for the provider to limit medically necessary care to covered persons. Nothing in this section shall be construed to prohibit the use of payment arrangements between a health carrier and a participating provider or provider group which involve capitation or withholds.

VIII. A health carrier shall provide to consumers, upon request, a description, in general terms, of the types of payment and reimbursement provisions contained in its contracts with participating providers. Such descriptions shall be set forth in clear, understandable language and shall, at a minimum, convey basic information about any financial incentives to providers that may directly or indirectly have the effect of reducing or limiting services to covered persons.

IX. Every contract between a health carrier and a participating provider shall provide that the health carrier may not remove a health care provider from its network or refuse to renew the health care provider with its network for advocating on behalf of a covered person for medically necessary care for the covered person.

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

16 Effective Date. This act shall take effect 60 days after its passage.

1999-1730s

AMENDED ANALYSIS

This bill creates an independent external consumer appeal process to review certain determinations made by managed care entities. The bill requires health carriers that conduct utilization review and licensed utilization review entities to employ a medical director and amends the definition of the practice of medicine to include the making of certain medical necessity determinations. The bill prohibits contracts between health carriers and participating providers from including provisions that create financial incentives to deny medically necessary care. The bill also requires that health insurers disclose certain information necessary for consumers to hold managed care entities accountable for health care treatment decisions.

Sen. Wheeler, Dist. 21
Sen. Squires, Dist. 12
January 13, 2000
2000-3077s
01/10

Amendment to HB 640-FN

Amend the title of the bill by replacing it with the following:

AN ACT establishing certain standards of accountability for health maintenance organizations and other entities providing health insurance through a managed care system.

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

1 New Paragraph; Medical Directors. Amend RSA 329:17 by inserting after paragraph III-a the following new paragraph:

III-b.(a) Any referral by the insurance commissioner under RSA 420-J:5-e, VII or any complaint which is reviewed and referred by the insurance commissioner pursuant to subparagraph (b) alleging that a medical director has committed misconduct as set forth in paragraph VI of this section shall be received and reviewed by the board in accordance with the provisions of this section for potential disciplinary action. For the purposes of this paragraph, "medical director" means a physician licensed under this chapter who is employed by a health carrier or medical utilization review entity and is responsible for the utilization review techniques and methods of the health carrier or medical utilization review entity and their administration and implementation.

(b) Any complaint received by the board regarding an insurance coverage decision by a medical director shall be forwarded by the board to the insurance commissioner for review.

2 Medical Review Subcommittee; Medical Director. Amend RSA 329:17, V-a to read as follows:

V-a. A medical review subcommittee of 7 members shall be nominated by the board of medicine and appointed by the governor and council. The subcommittee shall consist of one member of the board of medicine and 6 other persons, no more than 5 of whom shall be physicians, ***one of whom shall be a medical director as defined in paragraph III-b of this section***. Any public member of the subcommittee shall be a person who is not, and never was, a member of the medical profession or the spouse of any such person, and who does not have, and never has had, a material financial interest in either the provision of medical services or an activity directly related to medicine, including the representation of the board or profession for a fee at any time during the 5 years preceding appointment. The subcommittee members shall be appointed for 3-year terms, and shall serve no more than 2 terms. Upon referral by the board, the subcommittee shall review

disciplinary actions reported to the board under paragraphs II-V of this section, ***except that matters concerning a medical director involved in a current internal or external grievance pursuant to RSA 420-J shall not be reviewed until the grievance process has been completed.*** Following review of each case, the subcommittee shall make recommendations to the board. Funds shall be appropriated from the general fund for use by the subcommittee to investigate allegations under paragraphs I-V of this section. The board shall employ a physician as a medical review subcommittee administrator who shall serve at the pleasure of the board. The salary of the medical review subcommittee administrator shall be established by the board in accordance with duties, experience, and amount of time required for the position.

3 New Section; Medical Directors Required. Amend RSA 420-E by inserting after section 2 the following new section:

420-E:2-a Medical Director. Every medical utilization review entity licensed by the department under this chapter shall employ a medical director licensed under RSA 329.

4 New Paragraph; Definition Added. Amend RSA 420-J:3 by inserting after paragraph XXV the following new paragraph:

XXV-a. "Medical director" means a physician licensed under RSA 329 and employed by a health carrier or medical utilization review entity who is responsible for the utilization review techniques and methods of the health carrier or medical utilization review entity and their administration and implementation.

5 New Paragraph; Medical Director Required. Amend RSA 420-J:6 by inserting after paragraph IV the following new paragraph:

V. Each health carrier that conducts utilization review shall employ a medical director who shall have responsibility for all utilization review techniques and methods and their administration and implementation. Nothing in this section shall be construed to preclude a medical director from consulting with or relying on the advice of a physician licensed in this state or any other state. Nothing in this section shall be construed as creating any civil liability to the medical director for the medical director's alleged negligent performance of the aforementioned responsibilities for utilization review.

6 Information Provided to Covered Persons. Amend RSA 420-J:5, II(a) – (e) to read as follows:

(a) A description of the ***internal*** grievance procedure ***required under RSA 420-J:5*** for adverse determinations and other matters ~~[which]~~ ***and a description of the process for obtaining external review under RSA 420-J:5-a – RSA 420-J:5-e. These descriptions*** 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 ***and the process for obtaining external review. This statement shall also include a written explanation of any adverse determination, with the name and credentials of the health carrier medical director, 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. If the person making the adverse determination is not the medical director but a designee, then the credentials, board status, and state or states of current license shall also be provided for that person. Nothing in this section shall be construed to require a health carrier to provide proprietary information protected by third party contracts.***

(d) Staff assistance in filing ***an internal*** grievance.

(e) [~~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~~] ***Any clinical review criteria that are used by the health carrier or its designee utilization review entity as the basis of an adverse determination shall be disclosed to the treating provider and the covered person. Such disclosure shall be accompanied by the following notice: "The materials provided to you are criteria used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."***

7 Second Level Grievance; Notice Required. 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~~] ***420-J:5-a – RSA 420-J:5-e. The statement of appeal rights shall include a description of the process for obtaining external review of a determination, a copy of the written procedures governing external review, including the required time frames for requesting external review, and notice of the conditions under which expedited external***

review is available.

8 Review Panel; Notice Required. 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] ***420-J:5-a – RSA 420-J:5-e. The statement of appeal rights shall include a description of the process for obtaining external review of a determination, a copy of the written procedures governing external review, including the required time frames for requesting external review, and notice of the conditions under which expedited external review is available.***

9 Expedited Internal Grievance Review. Amend RSA 420-J:5, VI(e) to read as follows:

(e) In any case where the expedited review process does not resolve a difference of opinion between the health carrier and the covered person or the provider acting on behalf of the covered person, the covered person or the provider acting on behalf of the covered person may submit a written grievance, unless the provider is prohibited from filing a grievance by federal or other state law. A health carrier shall review it as a second level grievance. In conducting the review, the health carrier shall [~~adhere to time frames that are reasonable under the circumstances~~] ***make a decision and notify the covered person as expeditiously as the covered person's medical condition requires, but in no event more than 72 hours after the grievance is submitted.***

10 New Paragraph; Notice Required. Amend RSA 420-J:5, by inserting after paragraph IX the following new paragraph:

X. If the covered person has requested first or second level, standard or expedited review and the health carrier has not issued a decision within the required time frames, then the health carrier shall promptly provide the covered person with a statement of the covered person's right to file an external appeal as provided in RSA 420-J:5-a – RSA 420-J:5-e. The statement of appeal rights shall include a description of the process for obtaining external review of a determination, a copy of the written procedures governing external review, including the required time frames for requesting external review, and notice of the conditions under which expedited external review is available.

11 New Paragraph; Definition 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.

12 New Paragraph; Definition Added. Amend RSA 420-J:3 by inserting after paragraph XXIII the following new paragraph:

XXIII-a. "Independent review organization" means an entity that employs or contracts with clinical peers to conduct independent external reviews of health carrier determinations.

13 New Sections; External Review. Amend RSA 420-J by inserting after section 5 the following new sections:

420-J:5-a Right to External Review.

I. A covered person shall have the right to independent external review of a determination by a health carrier or its designee utilization review entity when all of the following conditions apply:

(a) The subject of the request for external review is an adverse determination;

(b) The covered person has completed the internal review procedures provided by the health carrier pursuant to RSA 420-J:5, III through VI, or the health carrier has agreed to submit the determination to independent external review prior to completion of internal review, or the covered person has requested first or second level, standard or expedited review and has not received a decision from the health carrier within the required time frames;

(c) The covered person or the covered person's authorized representative has submitted the request for external review in writing to the commissioner within 180 days of the date of the health carrier's second level denial decision provided pursuant to RSA 420-J:5, V or VI, or if the health carrier has failed to make a first or second level, standard or expedited review decision that is past due, within 180 days of the date the decision was due;

(d) The covered person's cost for the service, supply or drug that is the subject of the adverse determination is, or is anticipated in a 12-month period to be, equal to or in excess of $400;

(e) The health carrier determination does not relate to any category of health care services that is excluded from the external review provisions of this chapter pursuant to paragraph II; and

(f) The request for external review is not based on a claim or allegation of provider malpractice, professional negligence, or other professional fault excluded from the external review provisions of this chapter pursuant to paragraph III.

II. Determinations relating to the following health care services shall not be reviewed under this chapter, but shall be reviewed pursuant to the review processes provided by applicable federal or state law:

(a) Health care services provided 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.

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

(c) Health care services provided pursuant to a health plan not regulated by the state, such as self-funded plans administered by an administrative services organization or third-party administrator or federal employee benefit programs.

III. The external review procedures set forth in this chapter shall not be utilized to adjudicate claims or allegations of health care provider malpractice, professional negligence, or other professional fault against participating providers or medical directors.

420-J:5-b Standard External Review. Standard external review shall be conducted as follows:

I. Within 7 business days after the date of receipt of a request for external review, the commissioner shall complete a preliminary review of the request to determine whether:

(a) The individual is or was a covered person under the health benefit plan;

(b) The determination that is the subject of the request for external review meets the conditions of eligibility for external review stated in RSA 420-J:5-a, I; and

(c) The covered person has provided all the information and forms required by the commissioner that are necessary to process a request for an external review.

II. Upon completion of the preliminary review pursuant to paragraph I, the commissioner shall immediately notify the covered person or the covered person's authorized representative in writing:

(a) Whether the request is complete; and

(b) Whether the request has been accepted for external review.

III. If the request is not complete, the commissioner shall inform the covered person or the covered person's authorized representative what information or documents are needed to make the request complete and to process the request. The covered person or the covered person's authorized representative shall submit such information or documentation within 10 days of being notified that the request was incomplete.

IV. If the request for external review is accepted, the commissioner shall:

(a) Include in the notice provided to the covered person pursuant to paragraph II a statement that if the covered person wishes to submit new or additional information or to present oral testimony via teleconference, such information shall be submitted, and the oral testimony shall be scheduled and presented, within 20 days of the date of issuance of the notice. However, the notice shall also explain that oral testimony shall be permitted only in cases when the commissioner determines, based on evidence provided by the covered person, that it would not be feasible or appropriate to present only written testimony.

(b) Immediately notify the health carrier in writing of the request for external review and its acceptance.

V. If the request for external review is not accepted, the commissioner shall inform the covered person or the covered person's authorized representative and the health carrier in writing of the reason for its non-acceptance.

VI. At the time a request for external review is accepted, the commissioner shall select and retain an independent review organization that is certified pursuant to RSA 420-J:5-d, I to conduct the external review. The commissioner shall not select the same independent review organization for each external review, but shall rotate among the certified independent review organizations, using all organizations equally. The commissioner may select and retain an independent review organization regardless of the rotation if the commissioner determines that the use of such independent review organization is necessary for the fair adjudication of the case in question.

VII. Within 10 days after the date of issuance of the notice provided pursuant to subparagraph IV(b), the health carrier or its designated utilization review organization shall provide to the selected independent review organization and to the covered person all information in its possession that is relevant to the adjudication of the matter in dispute, including but not limited to:

(a) The terms of agreement of the health benefit plan, including the evidence of coverage, benefit summary or other similar document;

(b) All relevant medical records, including records submitted to the carrier by the covered person, the covered person's authorized representative, or the covered person's treating provider;

(c) A summary description of the applicable issues, including a statement of the health carrier's final determination;

(d) The clinical review criteria used and the clinical reasons for the determination;

(e) The relevant portions of the carrier's utilization management plan;

(f) Any communications between the covered person and the health carrier regarding the internal or external review; and

(g) All other documents, information, or criteria relied upon by the carrier in making its determination.

VIII. Failure by the health carrier or the covered person to provide the documents and information required in paragraph IV(a) or VII within the specified time frame shall not delay the conduct of the external review.

IX. The selected independent review organization shall review all of the information and documents received from the carrier pursuant to paragraph VII and any other information submitted by the covered person or the covered person's authorized representative or treating provider with the request for external review or pursuant to subparagraph IV(a) and any testimony provided. In addition to the information provided by the health carrier and the covered person or the covered person's authorized representative or treating provider, the independent review organization may consider any applicable, generally accepted clinical practice guidelines, studies or research, including

those developed or conducted by the federal government, national or professional medical societies, boards and associations. The independent review organization shall consider anew all previously determined facts, allow the introduction of new information, and make a decision that is not bound by decisions or conclusions made by the health carrier during internal review.

X. The selected independent review organization shall render a decision upholding or reversing the determination of the health carrier and notify the covered person or the covered person's authorized representative and the health carrier in writing within 20 days of the date that any new or additional information from the covered person is due pursuant to subparagraph IV(a). This notice shall include a written review decision that contains a statement of the nature of the grievance, references to evidence or documentation considered in making the decision, findings of fact, and the clinical and legal rationale for the decision, including, as applicable, clinical review criteria and rulings of law.

420-J:5-c Expedited External Review. Expedited external review shall be conducted as follows:

I. Expedited external review shall be available when the covered person's treating health care provider certifies to the commissioner that adherence to the time frames specified in RSA 420-J:5-b would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

II. Except to the extent that it is inconsistent with the provisions of this paragraph, all requirements for the conduct of standard external review specified in RSA 420-J:5-b shall apply to expedited external review.

III. At the time the commissioner receives a request for an expedited external review, the commissioner shall immediately make a determination whether the request meets the standard set forth in paragraph I for expedited external review, as well as the reviewability requirements set forth in RSA 420-J:5-b, I. If these conditions are met, the commissioner shall immediately notify the health carrier. If the request is not complete, the commissioner shall immediately contact the covered person or the covered person's authorized representative and attempt to obtain the information or documents that are needed to make the request complete.

IV. The commissioner shall select and retain an independent review organization that is certified pursuant to RSA 420-J:5-d, I to conduct the expedited external review.

V. The health carrier or its designated utilization review organization shall provide or transmit the documents and information specified in RSA 420-J:5-b, VII to the selected independent review organization by telephone, facsimile or any other available expeditious method within one business day of receiving the commissioner's notice of the request for expedited external review pursuant to paragraph III.

VI. When handling a review on an expedited basis, the selected independent review organization shall make a decision and notify the carrier and the covered person as expeditiously as

the covered person's medical condition requires, but in no event more than 72 hours after the expedited external review is requested.

VII. If the notice provided pursuant to paragraph VI was not in writing, within 2 business days after the date of providing that notice, the selected independent review organization shall:

(a) Provide written confirmation of the decision to the covered person or the covered person's authorized representative and the health carrier; and

(b) Include the information set forth in RSA 420-J:5-b, X.

VIII. An expedited external review shall not be provided for determinations made by the health carrier on a retrospective basis.

IX. A covered person shall not be held liable to either the health plan, the hospital, the physician, or the services provider for the cost of services in excess of the applicable copayment, coinsurance, or deductible incurred, pending the independent review organization's determination of an expediated external review.

420-J:5-d Certification of Independent Review Organizations.

I. The certification of independent review organizations shall be conducted as follows:

(a) The commissioner shall certify independent review organizations eligible to be selected to conduct external reviews under this section to ensure that an independent review organization satisfies the minimum qualifications established under paragraph II.

(b) The commissioner shall develop an application form for initially certifying and recertifying independent review organizations to conduct external reviews.

(c) Independent review organizations wishing to be certified shall submit the application form and include all documentation and information necessary for the commissioner to determine whether the independent review organization satisfies the minimum qualifications established under paragraph II.

(d) The commissioner may determine that accreditation by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations that meet or exceed the minimum qualifications established under paragraph II is sufficient for certification under this paragraph.

(e) The commissioner shall maintain and periodically update a list of certified independent review organizations.

(f) Whenever the commissioner determines that an independent review organization no longer satisfies the minimum qualifications established under paragraph II, the commissioner shall terminate the certification of the independent review organization and remove it from the list of certified independent review organizations that is maintained by the commissioner pursuant to subparagraph I(e).

II. To be certified under paragraph I to conduct external reviews, an independent review organization shall meet the following minimum qualifications:

(a) It shall develop and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process.

(b) It shall establish and maintain a quality assurance program that:

(1) Ensures that external reviews are conducted within the specified time frames and required notices are provided in a timely manner;

(2) Ensures the selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization with suitable matching of reviewers to specific cases;

(3) Ensures the confidentiality of medical and treatment records; and

(4) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this section.

(c) It shall agree to maintain and provide to the commissioner such information as may be required to fulfill the provisions and purposes of this section.

(d) It shall assign clinical peer reviewers to conduct external reviews who are physicians or other appropriate health care providers and who:

(1) Are experts in the treatment of the covered person's medical condition that is the subject of the external review;

(2) Are knowledgeable about the recommended health care service or treatment through actual clinical experience;

(3) 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 area or areas appropriate to the subject of the external review;

(4) Have no history or disciplinary actions or sanctions that have been taken or are pending by any hospital, governmental agency, or regulatory body; and

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

(e) It shall be free of any conflict of interest. To meet this qualification, an independent review organization may not own or control or in any way be owned or controlled by a health carrier, a national, state or local trade association of health carriers, or a national state or local trade association of health care providers. In addition, in order to qualify to conduct an external review of a specific case, neither the independent review organization selected to conduct the external review nor any clinical peer reviewer assigned by the independent organization to conduct the external review may have a material professional, familial or financial interest in any of the following:

(1) The health carrier that is the subject of the external review;

(2) Any officer, director or management employee of the health carrier that is the subject of the external review;

(3) The health care provider or the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

(4) The facility or institution at which the recommended health care service or treatment would be provided;

(5) The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the external review; or

(6) The covered person or the covered person's authorized representative.

(f) Its charges for services provided shall be competitive and reasonable.

(g) For the purpose of allowing in-state health care providers to act as clinical peer reviewers in the conduct of external reviews, 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 which is sufficient to preclude that provider from acting as a clinical peer reviewer, so long as the affiliation is disclosed to the covered person or the covered person's authorized representative.

(h) The following organizations shall not be eligible for certification to conduct external reviews:

(1) Professional or trade associations of health care providers;

(2) Subsidiaries or affiliates of such provider associations;

(3) Health carrier or health plan associations; and

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

420-J:5-e General Provisions Regarding External Review.

I. The health carrier against which a request for external review is filed shall pay the cost of the external review. Except under the circumstances described below in this paragraph, such costs shall not exceed $1,500. The commissioner shall notify the independent review organizations of the cost limitation for conducting an external review. The cost for an external review may exceed $1,500 if the commissioner determines an additional cost is necessary to ensure the fair adjudication of the case in question.

II. The external review decision of the independent review organization shall be binding on the health carrier and shall be enforceable by the commissioner pursuant to the penalty provisions of RSA 420-J:14. The external review decision of the independent review organization shall be binding on the covered person except to the extent the covered person has other remedies available under federal or state law. The external review process shall not be considered an adjudicative proceeding within the meaning of RSA 541-A, and the external review decision of the independent review organization shall not be subject to rehearing and appeal pursuant to RSA 541.

III. An independent review organization shall maintain all standards of confidentiality. The records and internal materials prepared for specific reviews by an independent review organization under this section shall be exempt from public disclosure under RSA 91-A.

IV. 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.

V. The right to external review under this chapter shall not be construed to change the terms of coverage under a health benefit plan nor shall the health carrier retaliate against the covered person for exercising his or her right to an independent external review.

VI. When requested by the covered person, the commissioner shall provide consumer assistance in pursuing the internal grievance procedures under RSA 420-J:5 and the external review process under RSA 420-J:5-a – 420-J:5-e.

VII. The commissioner shall report annually to the governor and the legislature on the number of grievances subjected to external review, the number of decisions resolved wholly or partially in favor of the covered person, and the number of decisions resolved wholly or partially in favor of the health carrier. Such reports shall also include a separate statement of the number of cases in which the external review was terminated as a result of a reversal by the health carrier of its adverse determination after the receipt of new or additional information from the covered person or the covered person's authorized representative and the number of cases in which the covered person and the health carrier agreed to resolve the dispute prior to a final determination by the independent review organization.

VIII. If, based on the evidence presented during the external review process, the commissioner determines that the health carrier's medical director, in the conduct of his or her duties, may have committed misconduct as set forth in RSA 329:17, VI, the commissioner shall document such findings and transmit them in a separate report to the board of medicine.

14 New Paragraphs; Provider Contract Standards. Amend RSA 420-J:8 by inserting after paragraph VII the following new paragraphs:

VIII. No contract between a health carrier and a participating provider shall contain any payment or reimbursement provision the terms of which creates an inducement for the provider to not provide medically necessary care to covered persons. Nothing in this section shall be construed to prohibit the use of payment arrangements between a health carrier and a participating provider or provider group which involve capitation, withholds or other arrangements.

IX. The health carrier shall provide to covered persons, in the evidence of coverage, a description for the types of financial arrangements contained in its contracts with participating providers. Such descriptions shall be set forth in clear, understandable language.

X. Every contract between a health carrier and a participating provider shall provide that the health carrier may not remove a health care provider from its network or refuse to renew the

health care provider with its network for participating in a covered person's internal grievance procedure or external review.

15 New Paragraph; Clinical Review Criteria. Amend RSA 420-J:6 by inserting after paragraph IV the following new paragraph:

V. The clinical review criteria used by the health carrier or its designee utilization review entity shall be:

(a) Developed with input from appropriate actively practicing practitioners in the health carrier's service area;

(b) Updated at least biennially and as new treatments, applications and technologies emerge.

(c) Developed in accordance with the standards of national accreditation entities;

(d) Based on current, nationally accepted standards of medical practice; and

(e) If practicable, evidence-based.

16 Clinical Review Criteria. RSA 420-E:4 VI is repealed and reenacted to read as follows:

VI. Any clinical review criteria that are utilized shall be:

(a) Developed with input from appropriate actively practicing practitioners in the health carrier's service area;

(b) Updated at least biennially and as new treatments, applications and technologies emerge;

(c) Developed in accordance with the standards of national accreditation entities;

(d) Based on current, nationally accepted standards of medical practice; and

(e) If practicable, evidence-based.

17 Repeal. RSA 420-J:5, VIII and IX, relative to external process and annual report, are repealed.

18 Effective Date. This act shall take effect 180 days after its passage.

2000-3077s

AMENDED ANALYSIS

This bill creates an independent external consumer appeal process to review certain determinations made by managed care entities. The bill requires health carriers that conduct utilization review and licensed utilization review entities to employ a medical director who shall be licensed as a physician. The bill prohibits contracts between health carriers and participating providers from including provisions that create financial incentives to deny medically necessary care. The bill requires that health insurers disclose certain information necessary for consumers to hold managed care entities accountable for health care treatment decisions. The bill also extends the jurisdiction of the board of medicine to include disciplinary action over medical directors for misconduct.

Sen. Wheeler, Dist. 21
Sen. Squires, Dist. 12
January 13, 2000
2000-3079s
01/09

Amendment to HB 640-FN

Amend the title of the bill by replacing it with the following:

AN ACT establishing certain standards of accountability for health maintenance organizations and other entities providing health insurance through a managed care system.

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

1 New Paragraph; Medical Directors. Amend RSA 329:17 by inserting after paragraph III-a the following new paragraph:

III-b.(a) Any referral by the insurance commissioner under RSA 420-J:5-e, VII or any complaint alleging that a medical director has committed misconduct as set forth in paragraph VI of this section shall be received and reviewed by the board in accordance with the provisions of this section for potential disciplinary action. For the purposes of this paragraph, "medical director" means a physician licensed under this chapter who is employed by a health carrier or medical utilization review entity and is responsible for the utilization review techniques and methods of the health carrier or medical utilization review entity and their administration and implementation.

(b) Any complaint received by the board regarding an insurance coverage decision by a medical director shall be forwarded by the board to the insurance commissioner for review.

2 Medical Review Subcommittee; Medical Director. Amend RSA 329:17, V-a to read as follows:

V-a. A medical review subcommittee of 7 members shall be nominated by the board of medicine and appointed by the governor and council. The subcommittee shall consist of one member of the board of medicine and 6 other persons, no more than 5 of whom shall be physicians, ***one of whom shall be a medical director as defined in paragraph III-b of this section***. Any public member of the subcommittee shall be a person who is not, and never was, a member of the medical profession or the spouse of any such person, and who does not have, and never has had, a material financial interest in either the provision of medical services or an activity directly related to medicine, including the representation of the board or profession for a fee at any time during the 5 years preceding appointment. The subcommittee members shall be appointed for 3-year terms, and shall serve no more than 2 terms. Upon referral by the board, the subcommittee shall review disciplinary actions reported to the board under paragraphs II-V of this section, ***except that***

matters concerning a medical director involved in a current internal or external grievance pursuant to RSA 420-J shall not be reviewed until the grievance process has been completed. Following review of each case, the subcommittee shall make recommendations to the board. Funds shall be appropriated from the general fund for use by the subcommittee to investigate allegations under paragraphs I-V of this section. The board shall employ a physician as a medical review subcommittee administrator who shall serve at the pleasure of the board. The salary of the medical review subcommittee administrator shall be established by the board in accordance with duties, experience, and amount of time required for the position.

3 New Section; Medical Directors Required. Amend RSA 420-E by inserting after section 2 the following new section:

420-E:2-a Medical Director. Every medical utilization review entity licensed by the department under this chapter shall employ a medical director licensed under RSA 329.

4 New Paragraph; Definition Added. Amend RSA 420-J:3 by inserting after paragraph XXV the following new paragraph:

XXV-a. "Medical director" means a physician licensed under RSA 329 and employed by a health carrier or medical utilization review entity who is responsible for the utilization review techniques and methods of the health carrier or medical utilization review entity and their administration and implementation.

5 New Paragraph; Medical Director Required. Amend RSA 420-J:6 by inserting after paragraph IV the following new paragraph:

V. Each health carrier that conducts utilization review shall employ a medical director who shall have responsibility for all utilization review techniques and methods and their administration and implementation. Nothing in this section shall be construed to preclude a medical director from consulting with or relying on the advice of a physician licensed in this state or any other state. Nothing in this section shall be construed as creating any civil liability to the medical director for the medical director's alleged negligent performance of the aforementioned responsibilities for utilization review.

6 Information Provided to Covered Persons. Amend RSA 420-J:5, II(a) – (e) to read as follows:

(a) A description of the ***internal*** grievance procedure ***required under RSA 420-J:5*** for adverse determinations and other matters [~~which~~] ***and a description of the process for obtaining external review under RSA 420-J:5-a – RSA 420-J:5-e. These descriptions*** 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 ***and the process for obtaining external review. This statement shall also include a written explanation of any adverse determination, with the name and credentials of the health carrier medical director, 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. If the person making the adverse determination is not the medical director but a designee, then the credentials, board status, and state or states of current license shall also be provided for that person. Nothing in this section shall be construed to require a health carrier to provide proprietary information protected by third party contracts.***

(d) Staff assistance in filing ***an internal*** grievance.

(e) [~~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~~] ***Any clinical review criteria that are used by the health carrier or its designee utilization review entity as the basis of an adverse determination shall be disclosed to the treating provider and the covered person. Such disclosure shall be accompanied by the following notice: "The materials provided to you are criteria used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."***

7 Second Level Grievance; Notice Required. 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~~] ***420-J:5-a – RSA 420-J:5-e. The statement of appeal rights shall include a description of the process for obtaining external review of a determination, a copy of the written procedures governing external review, including the required time frames for requesting external review, and notice of the conditions under which expedited external***

review is available.

8 Review Panel; Notice Required. 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] ***420-J:5-a – RSA 420-J:5-e. The statement of appeal rights shall include a description of the process for obtaining external review of a determination, a copy of the written procedures governing external review, including the required time frames for requesting external review, and notice of the conditions under which expedited external review is available.***

9 Expedited Internal Grievance Review. Amend RSA 420-J:5, VI(e) to read as follows:

(e) In any case where the expedited review process does not resolve a difference of opinion between the health carrier and the covered person or the provider acting on behalf of the covered person, the covered person or the provider acting on behalf of the covered person may submit a written grievance, unless the provider is prohibited from filing a grievance by federal or other state law. A health carrier shall review it as a second level grievance. In conducting the review, the health carrier shall [~~adhere to time frames that are reasonable under the circumstances~~] ***make a decision and notify the covered person as expeditiously as the covered person's medical condition requires, but in no event more than 72 hours after the grievance is submitted.***

10 New Paragraph; Notice Required. Amend RSA 420-J:5, by inserting after paragraph IX the following new paragraph:

X. If the covered person has requested first or second level, standard or expedited review and the health carrier has not issued a decision within the required time frames, then the health carrier shall promptly provide the covered person with a statement of the covered person's right to file an external appeal as provided in RSA 420-J:5-a – RSA 420-J:5-e. The statement of appeal rights shall include a description of the process for obtaining external review of a determination, a copy of the written procedures governing external review, including the required time frames for requesting external review, and notice of the conditions under which expedited external review is available.

11 New Paragraph; Definition 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.

12 New Paragraph; Definition Added. Amend RSA 420-J:3 by inserting after paragraph XXIII the following new paragraph:

XXIII-a. "Independent review organization" means an entity that employs or contracts with clinical peers to conduct independent external reviews of health carrier determinations.

13 New Sections; External Review. Amend RSA 420-J by inserting after section 5 the following new sections:

420-J:5-a Right to External Review.

I. A covered person shall have the right to independent external review of a determination by a health carrier or its designee utilization review entity when all of the following conditions apply:

(a) The subject of the request for external review is an adverse determination;

(b) The covered person has completed the internal review procedures provided by the health carrier pursuant to RSA 420-J:5, III through VI, or the health carrier has agreed to submit the determination to independent external review prior to completion of internal review, or the covered person has requested first or second level, standard or expedited review and has not received a decision from the health carrier within the required time frames;

(c) The covered person or the covered person's authorized representative has submitted the request for external review in writing to the commissioner within 180 days of the date of the health carrier's second level denial decision provided pursuant to RSA 420-J:5, V or VI, or if the health carrier has failed to make a first or second level, standard or expedited review decision that is past due, within 180 days of the date the decision was due;

(d) The covered person's cost for the service, supply or drug that is the subject of the adverse determination is, or is anticipated in a 12-month period to be, equal to or in excess of $400;

(e) The health carrier determination does not relate to any category of health care services that is excluded from the external review provisions of this chapter pursuant to paragraph II; and

(f) The request for external review is not based on a claim or allegation of provider malpractice, professional negligence, or other professional fault excluded from the external review provisions of this chapter pursuant to paragraph III.

II. Determinations relating to the following health care services shall not be reviewed under this chapter, but shall be reviewed pursuant to the review processes provided by applicable federal or state law:

(a) Health care services provided 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.

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

(c) Health care services provided pursuant to a health plan not regulated by the state, such as self-funded plans administered by an administrative services organization or third-party administrator or federal employee benefit programs.

III. The external review procedures set forth in this chapter shall not be utilized to adjudicate claims or allegations of health care provider malpractice, professional negligence, or other professional fault against participating providers or medical directors.

420-J:5-b Standard External Review. Standard external review shall be conducted as follows:

I. Within 7 business days after the date of receipt of a request for external review, the commissioner shall complete a preliminary review of the request to determine whether:

(a) The individual is or was a covered person under the health benefit plan;

(b) The determination that is the subject of the request for external review meets the conditions of eligibility for external review stated in RSA 420-J:5-a, I; and

(c) The covered person has provided all the information and forms required by the commissioner that are necessary to process a request for an external review.

II. Upon completion of the preliminary review pursuant to paragraph I, the commissioner shall immediately notify the covered person or the covered person's authorized representative in writing:

(a) Whether the request is complete; and

(b) Whether the request has been accepted for external review.

III. If the request is not complete, the commissioner shall inform the covered person or the covered person's authorized representative what information or documents are needed to make the request complete and to process the request. The covered person or the covered person's authorized representative shall submit such information or documentation within 10 days of being notified that the request was incomplete.

IV. If the request for external review is accepted, the commissioner shall:

(a) Include in the notice provided to the covered person pursuant to paragraph II a statement that if the covered person wishes to submit new or additional information or to present oral testimony via teleconference, such information shall be submitted, and the oral testimony shall be scheduled and presented, within 20 days of the date of issuance of the notice. However, the notice shall also explain that oral testimony shall be permitted only in cases when the commissioner determines, based on evidence provided by the covered person, that it would not be feasible or appropriate to present only written testimony.

(b) Immediately notify the health carrier in writing of the request for external review and its acceptance.

V. If the request for external review is not accepted, the commissioner shall inform the covered person or the covered person's authorized representative and the health carrier in writing of the reason for its non-acceptance.

VI. At the time a request for external review is accepted, the commissioner shall select and retain an independent review organization that is certified pursuant to RSA 420-J:5-d, I to conduct the external review. The commissioner shall not select the same independent review organization for each external review, but shall rotate among the certified independent review organizations, using all organizations equally. The commissioner may select and retain an independent review organization regardless of the rotation if the commissioner determines that the use of such independent review organization is necessary for the fair adjudication of the case in question.

VII. Within 10 days after the date of issuance of the notice provided pursuant to subparagraph IV(b), the health carrier or its designated utilization review organization shall provide to the selected independent review organization and to the covered person all information in its possession that is relevant to the adjudication of the matter in dispute, including but not limited to:

(a) The terms of agreement of the health benefit plan, including the evidence of coverage, benefit summary or other similar document;

(b) All relevant medical records, including records submitted to the carrier by the covered person, the covered person's authorized representative, or the covered person's treating provider;

(c) A summary description of the applicable issues, including a statement of the health carrier's final determination;

(d) The clinical review criteria used and the clinical reasons for the determination;

(e) The relevant portions of the carrier's utilization management plan;

(f) Any communications between the covered person and the health carrier regarding the internal or external review; and

(g) All other documents, information, or criteria relied upon by the carrier in making its determination.

VIII. Failure by the health carrier or the covered person to provide the documents and information required in paragraph IV(a) or VII within the specified time frame shall not delay the conduct of the external review.

IX. The selected independent review organization shall review all of the information and documents received from the carrier pursuant to paragraph VII and any other information submitted by the covered person or the covered person's authorized representative or treating provider with the request for external review or pursuant to subparagraph IV(a) and any testimony provided. In addition to the information provided by the health carrier and the covered person or the covered person's authorized representative or treating provider, the independent review organization may consider any applicable, generally accepted clinical practice guidelines, studies or research, including

those developed or conducted by the federal government, national or professional medical societies, boards and associations. The independent review organization shall consider anew all previously determined facts, allow the introduction of new information, and make a decision that is not bound by decisions or conclusions made by the health carrier during internal review.

X. The selected independent review organization shall render a decision upholding or reversing the determination of the health carrier and notify the covered person or the covered person's authorized representative and the health carrier in writing within 20 days of the date that any new or additional information from the covered person is due pursuant to subparagraph IV(a). This notice shall include a written review decision that contains a statement of the nature of the grievance, references to evidence or documentation considered in making the decision, findings of fact, and the clinical and legal rationale for the decision, including, as applicable, clinical review criteria and rulings of law.

420-J:5-c Expedited External Review. Expedited external review shall be conducted as follows:

I. Expedited external review shall be available when the covered person's treating health care provider certifies to the commissioner that adherence to the time frames specified in RSA 420-J:5-b would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

II. Except to the extent that it is inconsistent with the provisions of this paragraph, all requirements for the conduct of standard external review specified in RSA 420-J:5-b shall apply to expedited external review.

III. At the time the commissioner receives a request for an expedited external review, the commissioner shall immediately make a determination whether the request meets the standard set forth in paragraph I for expedited external review, as well as the reviewability requirements set forth in RSA 420-J:5-b, I. If these conditions are met, the commissioner shall immediately notify the health carrier. If the request is not complete, the commissioner shall immediately contact the covered person or the covered person's authorized representative and attempt to obtain the information or documents that are needed to make the request complete.

IV. The commissioner shall select and retain an independent review organization that is certified pursuant to RSA 420-J:5-d, I to conduct the expedited external review.

V. The health carrier or its designated utilization review organization shall provide or transmit the documents and information specified in RSA 420-J:5-b, VII to the selected independent review organization by telephone, facsimile or any other available expeditious method within one business day of receiving the commissioner's notice of the request for expedited external review pursuant to paragraph III.

VI. When handling a review on an expedited basis, the selected independent review organization shall make a decision and notify the carrier and the covered person as expeditiously as

the covered person's medical condition requires, but in no event more than 72 hours after the expedited external review is requested.

VII. If the notice provided pursuant to paragraph VI was not in writing, within 2 business days after the date of providing that notice, the selected independent review organization shall:

(a) Provide written confirmation of the decision to the covered person or the covered person's authorized representative and the health carrier; and

(b) Include the information set forth in RSA 420-J:5-b, X.

VIII. An expedited external review shall not be provided for determinations made by the health carrier on a retrospective basis.

IX. A covered person shall not be held liable to either the health plan, the hospital, the physician, or the services provider for the cost of services in excess of the applicable copayment, coinsurance, or deductible incurred, pending the independent review organization's determination of an expediated external review.

420-J:5-d Certification of Independent Review Organizations.

I. The certification of independent review organizations shall be conducted as follows:

(a) The commissioner shall certify independent review organizations eligible to be selected to conduct external reviews under this section to ensure that an independent review organization satisfies the minimum qualifications established under paragraph II.

(b) The commissioner shall develop an application form for initially certifying and recertifying independent review organizations to conduct external reviews.

(c) Independent review organizations wishing to be certified shall submit the application form and include all documentation and information necessary for the commissioner to determine whether the independent review organization satisfies the minimum qualifications established under paragraph II.

(d) The commissioner may determine that accreditation by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations that meet or exceed the minimum qualifications established under paragraph II is sufficient for certification under this paragraph.

(e) The commissioner shall maintain and periodically update a list of certified independent review organizations.

(f) Whenever the commissioner determines that an independent review organization no longer satisfies the minimum qualifications established under paragraph II, the commissioner shall terminate the certification of the independent review organization and remove it from the list of certified independent review organizations that is maintained by the commissioner pursuant to subparagraph I(e).

II. To be certified under paragraph I to conduct external reviews, an independent review organization shall meet the following minimum qualifications:

(a) It shall develop and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process.

(b) It shall establish and maintain a quality assurance program that:

(1) Ensures that external reviews are conducted within the specified time frames and required notices are provided in a timely manner;

(2) Ensures the selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization with suitable matching of reviewers to specific cases;

(3) Ensures the confidentiality of medical and treatment records; and

(4) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this section.

(c) It shall agree to maintain and provide to the commissioner such information as may be required to fulfill the provisions and purposes of this section.

(d) It shall assign clinical peer reviewers to conduct external reviews who are physicians or other appropriate health care providers and who:

(1) Are experts in the treatment of the covered person's medical condition that is the subject of the external review;

(2) Are knowledgeable about the recommended health care service or treatment through actual clinical experience;

(3) 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 area or areas appropriate to the subject of the external review;

(4) Have no history or disciplinary actions or sanctions that have been taken or are pending by any hospital, governmental agency, or regulatory body; and

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

(e) It shall be free of any conflict of interest. To meet this qualification, an independent review organization may not own or control or in any way be owned or controlled by a health carrier, a national, state or local trade association of health carriers, or a national state or local trade association of health care providers. In addition, in order to qualify to conduct an external review of a specific case, neither the independent review organization selected to conduct the external review nor any clinical peer reviewer assigned by the independent organization to conduct the external review may have a material professional, familial or financial interest in any of the following:

(1) The health carrier that is the subject of the external review;

(2) Any officer, director or management employee of the health carrier that is the subject of the external review;

(3) The health care provider or the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

(4) The facility or institution at which the recommended health care service or treatment would be provided;

(5) The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the external review; or

(6) The covered person or the covered person's authorized representative.

(f) Its charges for services provided shall be competitive and reasonable.

(g) For the purpose of allowing in-state health care providers to act as clinical peer reviewers in the conduct of external reviews, 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 which is sufficient to preclude that provider from acting as a clinical peer reviewer, so long as the affiliation is disclosed to the covered person or the covered person's authorized representative.

(h) The following organizations shall not be eligible for certification to conduct external reviews:

(1) Professional or trade associations of health care providers;

(2) Subsidiaries or affiliates of such provider associations;

(3) Health carrier or health plan associations; and

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

420-J:5-e General Provisions Regarding External Review.

I. The health carrier against which a request for external review is filed shall pay the cost of the external review. Except under the circumstances described below in this paragraph, such costs shall not exceed $1,500. The commissioner shall notify the independent review organizations of the cost limitation for conducting an external review. The cost for an external review may exceed $1,500 if the commissioner determines an additional cost is necessary to ensure the fair adjudication of the case in question.

II. The external review decision of the independent review organization shall be binding on the health carrier and shall be enforceable by the commissioner pursuant to the penalty provisions of RSA 420-J:14. The external review decision of the independent review organization shall be binding on the covered person except to the extent the covered person has other remedies available under federal or state law. The external review process shall not be considered an adjudicative proceeding within the meaning of RSA 541-A, and the external review decision of the independent review organization shall not be subject to rehearing and appeal pursuant to RSA 541.

III. An independent review organization shall maintain all standards of confidentiality. The records and internal materials prepared for specific reviews by an independent review organization under this section shall be exempt from public disclosure under RSA 91-A.

IV. 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.

V. The right to external review under this chapter shall not be construed to change the terms of coverage under a health benefit plan nor shall the health carrier retaliate against the covered person for exercising his or her right to an independent external review.

VI. When requested by the covered person, the commissioner shall provide consumer assistance in pursuing the internal grievance procedures under RSA 420-J:5 and the external review process under RSA 420-J:5-a – 420-J:5-e.

VII. The commissioner shall report annually to the governor and the legislature on the number of grievances subjected to external review, the number of decisions resolved wholly or partially in favor of the covered person, and the number of decisions resolved wholly or partially in favor of the health carrier. Such reports shall also include a separate statement of the number of cases in which the external review was terminated as a result of a reversal by the health carrier of its adverse determination after the receipt of new or additional information from the covered person or the covered person's authorized representative and the number of cases in which the covered person and the health carrier agreed to resolve the dispute prior to a final determination by the independent review organization.

VIII. If, based on the evidence presented during the external review process, the commissioner determines that the health carrier's medical director, in the conduct of his or her duties, may have committed misconduct as set forth in RSA 329:17, VI, the commissioner shall document such findings and transmit them in a separate report to the board of medicine.

14 New Paragraphs; Provider Contract Standards. Amend RSA 420-J:8 by inserting after paragraph VII the following new paragraphs:

VIII. No contract between a health carrier and a participating provider shall contain any payment or reimbursement provision the terms of which creates an inducement for the provider to not provide medically necessary care to covered persons. Nothing in this section shall be construed to prohibit the use of payment arrangements between a health carrier and a participating provider or provider group which involve capitation, withholds or other arrangements.

IX. The health carrier shall provide to covered persons, in the evidence of coverage, a description for the types of financial arrangements contained in its contracts with participating providers. Such descriptions shall be set forth in clear, understandable language.

X. Every contract between a health carrier and a participating provider shall provide that the health carrier may not remove a health care provider from its network or refuse to renew the

health care provider with its network for participating in a covered person's internal grievance procedure or external review.

15 New Paragraph; Clinical Review Criteria. Amend RSA 420-J:6 by inserting after paragraph IV the following new paragraph:

V. The clinical review criteria used by the health carrier or its designee utilization review entity shall be:

(a) Developed with input from appropriate actively practicing practitioners in the health carrier's service area;

(b) Updated at least biennially and as new treatments, applications and technologies emerge.

(c) Developed in accordance with the standards of national accreditation entities;

(d) Based on current, nationally accepted standards of medical practice; and

(e) If practicable, evidence-based.

16 Clinical Review Criteria. RSA 420-E:4 VI is repealed and reenacted to read as follows:

VI. Any clinical review criteria that are utilized shall be:

(a) Developed with input from appropriate actively practicing practitioners in the health carrier's service area;

(b) Updated at least biennially and as new treatments, applications and technologies emerge;

(c) Developed in accordance with the standards of national accreditation entities;

(d) Based on current, nationally accepted standards of medical practice; and

(e) If practicable, evidence-based.

17 Repeal. RSA 420-J:5, VIII and IX, relative to external process and annual report, are repealed.

18 Effective Date. This act shall take effect 180 days after its passage.

2000-3079s

AMENDED ANALYSIS

This bill creates an independent external consumer appeal process to review certain determinations made by managed care entities. The bill requires health carriers that conduct utilization review and licensed utilization review entities to employ a medical director who shall be licensed as a physician. The bill prohibits contracts between health carriers and participating providers from including provisions that create financial incentives to deny medically necessary care. The bill requires that health insurers disclose certain information necessary for consumers to hold managed care entities accountable for health care treatment decisions. The bill also extends the jurisdiction of the board of medicine to include disciplinary action over medical directors for misconduct.

Public Institutions, Health and Human Services
January 19, 2000
2000-3137s
01/10

Amendment to HB 640-FN

Amend the title of the bill by replacing it with the following:

AN ACT establishing certain standards of accountability for health maintenance organizations and other entities providing health insurance through a managed care system.

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

1 New Paragraph; Medical Directors. Amend RSA 329:17 by inserting after paragraph III-a the following new paragraph:

III-b.(a) Any referral by the insurance commissioner under RSA 420-J:5-e, VII or any complaint alleging that a medical director has committed misconduct as set forth in paragraph VI of this section shall be received and reviewed by the board in accordance with the provisions of this section for potential disciplinary action. For the purposes of this paragraph, "medical director" means a physician licensed under this chapter who is employed by a health carrier or medical utilization review entity and is responsible for the utilization review techniques and methods of the health carrier or medical utilization review entity and their administration and implementation.

(b) Any complaint received by the board regarding an insurance coverage decision by a medical director shall be forwarded by the board to the insurance commissioner for review.

2 Medical Review Subcommittee; Medical Director. Amend RSA 329:17, V-a to read as follows:

V-a. A medical review subcommittee of 7 members shall be nominated by the board of medicine and appointed by the governor and council. The subcommittee shall consist of one member of the board of medicine and 6 other persons, no more than 5 of whom shall be physicians, ***one of whom shall be a medical director as defined in paragraph III-b of this section***. Any public member of the subcommittee shall be a person who is not, and never was, a member of the medical profession or the spouse of any such person, and who does not have, and never has had, a material financial interest in either the provision of medical services or an activity directly related to medicine, including the representation of the board or profession for a fee at any time during the 5 years preceding appointment. The subcommittee members shall be appointed for 3-year terms, and shall serve no more than 2 terms. Upon referral by the board, the subcommittee shall review disciplinary actions reported to the board under paragraphs II-V of this section, ***except that matters concerning a medical director involved in a current internal or external grievance***

pursuant to RSA 420-J shall not be reviewed until the grievance process has been completed. Following review of each case, the subcommittee shall make recommendations to the board. Funds shall be appropriated from the general fund for use by the subcommittee to investigate allegations under paragraphs I-V of this section. The board shall employ a physician as a medical review subcommittee administrator who shall serve at the pleasure of the board. The salary of the medical review subcommittee administrator shall be established by the board in accordance with duties, experience, and amount of time required for the position.

3 New Section; Medical Directors Required. Amend RSA 420-E by inserting after section 2 the following new section:

420-E:2-a Medical Director. Every medical utilization review entity licensed by the department under this chapter shall employ a medical director licensed under RSA 329.

4 New Paragraph; Definition Added. Amend RSA 420-J:3 by inserting after paragraph XXV the following new paragraph:

XXV-a. "Medical director" means a physician licensed under RSA 329 and employed by a health carrier or medical utilization review entity who is responsible for the utilization review techniques and methods of the health carrier or medical utilization review entity and their administration and implementation.

5 New Paragraph; Medical Director Required. Amend RSA 420-J:6 by inserting after paragraph IV the following new paragraph:

V. Each health carrier that conducts utilization review shall employ a medical director who shall have responsibility for all utilization review techniques and methods and their administration and implementation. Nothing in this section shall be construed to preclude a medical director from consulting with or relying on the advice of a physician licensed in this state or any other state. Nothing in this section shall be construed as creating any civil liability to the medical director for the medical director's alleged negligent performance of the aforementioned responsibilities for utilization review.

6 Information Provided to Covered Persons. Amend RSA 420-J:5, II(a) – (e) to read as follows:

(a) A description of the ***internal*** grievance procedure ***required under RSA 420-J:5*** for adverse determinations and other matters [~~which~~] ***and a description of the process for obtaining external review under RSA 420-J:5-a – RSA 420-J:5-e. These descriptions*** 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 ***and the process for***

obtaining external review. This statement shall also include a written explanation of any adverse determination, with the name and credentials of the health carrier medical director, 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. If the person making the adverse determination is not the medical director but a designee, then the credentials, board status, and state or states of current license shall also be provided for that person. Nothing in this section shall be construed to require a health carrier to provide proprietary information protected by third party contracts.

(d) Staff assistance in filing *an internal* grievance.

(e) ~~[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]~~ *Any clinical review criteria that are used by the health carrier or its designee utilization review entity as the basis of an adverse determination shall be disclosed to the treating provider and the covered person. Such disclosure shall be accompanied by the following notice: "The materials provided to you are criteria used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."*

7 Second Level Grievance; Notice Required. 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~~] *420-J:5-a – RSA 420-J:5-e. The statement of appeal rights shall include a description of the process for obtaining external review of a determination, a copy of the written procedures governing external review, including the required time frames for requesting external review, and notice of the conditions under which expedited external review is available.*

8 Review Panel; Notice Required. 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] ***420-J:5-a – RSA 420-J:5-e. The statement of appeal rights shall include a description of the process for obtaining external review of a determination, a copy of the written procedures governing external review, including the required time frames for requesting external review, and notice of the conditions under which expedited external review is available.***

9 Expedited Internal Grievance Review. Amend RSA 420-J:5, VI(e) to read as follows:

(e) In any case where the expedited review process does not resolve a difference of opinion between the health carrier and the covered person or the provider acting on behalf of the covered person, the covered person or the provider acting on behalf of the covered person may submit a written grievance, unless the provider is prohibited from filing a grievance by federal or other state law. A health carrier shall review it as a second level grievance. In conducting the review, the health carrier shall [~~adhere to time frames that are reasonable under the circumstances~~] ***make a decision and notify the covered person as expeditiously as the covered person's medical condition requires, but in no event more than 72 hours after the grievance is submitted.***

10 New Paragraph; Notice Required. Amend RSA 420-J:5, by inserting after paragraph IX the following new paragraph:

X. If the covered person has requested first or second level, standard or expedited review and the health carrier has not issued a decision within the required time frames, then the health carrier shall promptly provide the covered person with a statement of the covered person's right to file an external appeal as provided in RSA 420-J:5-a – RSA 420-J:5-e. The statement of appeal rights shall include a description of the process for obtaining external review of a determination, a copy of the written procedures governing external review, including the required time frames for requesting external review, and notice of the conditions under which expedited external review is available.

11 New Paragraph; Definition 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.

12 New Paragraph; Definition Added. Amend RSA 420-J:3 by inserting after paragraph XXIII the following new paragraph:

XXIII-a. "Independent review organization" means an entity that employs or contracts with clinical peers to conduct independent external reviews of health carrier determinations.

13 New Sections; External Review. Amend RSA 420-J by inserting after section 5 the following new sections:

420-J:5-a Right to External Review.

I. A covered person shall have the right to independent external review of a determination by a health carrier or its designee utilization review entity when all of the following conditions apply:

(a) The subject of the request for external review is an adverse determination;

(b) The covered person has completed the internal review procedures provided by the health carrier pursuant to RSA 420-J:5, III through VI, or the health carrier has agreed to submit the determination to independent external review prior to completion of internal review, or the covered person has requested first or second level, standard or expedited review and has not received a decision from the health carrier within the required time frames;

(c) The covered person or the covered person's authorized representative has submitted the request for external review in writing to the commissioner within 180 days of the date of the health carrier's second level denial decision provided pursuant to RSA 420-J:5, V or VI, or if the health carrier has failed to make a first or second level, standard or expedited review decision that is past due, within 180 days of the date the decision was due;

(d) The covered person's cost for the service, supply or drug that is the subject of the adverse determination is, or is anticipated in a 12-month period to be, equal to or in excess of $400;

(e) The health carrier determination does not relate to any category of health care services that is excluded from the external review provisions of this chapter pursuant to paragraph II; and

(f) The request for external review is not based on a claim or allegation of provider malpractice, professional negligence, or other professional fault excluded from the external review provisions of this chapter pursuant to paragraph III.

II. Determinations relating to the following health care services shall not be reviewed under this chapter, but shall be reviewed pursuant to the review processes provided by applicable federal or state law:

(a) Health care services provided 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.

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

(c) Health care services provided pursuant to a health plan not regulated by the state, such as self-funded plans administered by an administrative services organization or third-party administrator or federal employee benefit programs.

III. The external review procedures set forth in this chapter shall not be utilized to adjudicate claims or allegations of health care provider malpractice, professional negligence, or other professional fault against participating providers or medical directors.

420-J:5-b Standard External Review. Standard external review shall be conducted as follows:

I. Within 7 business days after the date of receipt of a request for external review, the commissioner shall complete a preliminary review of the request to determine whether:

(a) The individual is or was a covered person under the health benefit plan;

(b) The determination that is the subject of the request for external review meets the conditions of eligibility for external review stated in RSA 420-J:5-a, I; and

(c) The covered person has provided all the information and forms required by the commissioner that are necessary to process a request for an external review.

II. Upon completion of the preliminary review pursuant to paragraph I, the commissioner shall immediately notify the covered person or the covered person's authorized representative in writing:

(a) Whether the request is complete; and

(b) Whether the request has been accepted for external review.

III. If the request is not complete, the commissioner shall inform the covered person or the covered person's authorized representative what information or documents are needed to make the request complete and to process the request. The covered person or the covered person's authorized representative shall submit such information or documentation within 10 days of being notified that the request was incomplete.

IV. If the request for external review is accepted, the commissioner shall:

(a) Include in the notice provided to the covered person pursuant to paragraph II a statement that if the covered person wishes to submit new or additional information or to present oral testimony via teleconference, such information shall be submitted, and the oral testimony shall be scheduled and presented, within 20 days of the date of issuance of the notice. However, the notice shall also explain that oral testimony shall be permitted only in cases when the commissioner determines, based on evidence provided by the covered person, that it would not be feasible or appropriate to present only written testimony.

(b) Immediately notify the health carrier in writing of the request for external review and its acceptance.

V. If the request for external review is not accepted, the commissioner shall inform the covered person or the covered person's authorized representative and the health carrier in writing of the reason for its non-acceptance.

VI. At the time a request for external review is accepted, the commissioner shall select and retain an independent review organization that is certified pursuant to RSA 420-J:5-d, I to conduct the external review. The commissioner shall not select the same independent review organization for each external review, but shall rotate among the certified independent review organizations, using all organizations equally. The commissioner may select and retain an independent review organization regardless of the rotation if the commissioner determines that the use of such independent review organization is necessary for the fair adjudication of the case in question.

VII. Within 10 days after the date of issuance of the notice provided pursuant to subparagraph IV(b), the health carrier or its designated utilization review organization shall provide to the selected independent review organization and to the covered person all information in its possession that is relevant to the adjudication of the matter in dispute, including but not limited to:

(a) The terms of agreement of the health benefit plan, including the evidence of coverage, benefit summary or other similar document;

(b) All relevant medical records, including records submitted to the carrier by the covered person, the covered person's authorized representative, or the covered person's treating provider;

(c) A summary description of the applicable issues, including a statement of the health carrier's final determination;

(d) The clinical review criteria used and the clinical reasons for the determination;

(e) The relevant portions of the carrier's utilization management plan;

(f) Any communications between the covered person and the health carrier regarding the internal or external review; and

(g) All other documents, information, or criteria relied upon by the carrier in making its determination.

VIII. Failure by the health carrier or the covered person to provide the documents and information required in paragraph IV(a) or VII within the specified time frame shall not delay the conduct of the external review.

IX. The selected independent review organization shall review all of the information and documents received from the carrier pursuant to paragraph VII and any other information submitted by the covered person or the covered person's authorized representative or treating provider with the request for external review or pursuant to subparagraph IV(a) and any testimony provided. In addition to the information provided by the health carrier and the covered person or the covered person's authorized representative or treating provider, the independent review organization may consider any applicable, generally accepted clinical practice guidelines, studies or research, including those developed or conducted by the federal government, national or professional medical societies, boards and associations. The independent review organization shall consider anew all previously

determined facts, allow the introduction of new information, and make a decision that is not bound by decisions or conclusions made by the health carrier during internal review.

X. The selected independent review organization shall render a decision upholding or reversing the determination of the health carrier and notify the covered person or the covered person's authorized representative and the health carrier in writing within 20 days of the date that any new or additional information from the covered person is due pursuant to subparagraph IV(a). This notice shall include a written review decision that contains a statement of the nature of the grievance, references to evidence or documentation considered in making the decision, findings of fact, and the clinical and legal rationale for the decision, including, as applicable, clinical review criteria and rulings of law.

420-J:5-c Expedited External Review. Expedited external review shall be conducted as follows:

I. Expedited external review shall be available when the covered person's treating health care provider certifies to the commissioner that adherence to the time frames specified in RSA 420-J:5-b would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function.

II. Except to the extent that it is inconsistent with the provisions of this paragraph, all requirements for the conduct of standard external review specified in RSA 420-J:5-b shall apply to expedited external review.

III. At the time the commissioner receives a request for an expedited external review, the commissioner shall immediately make a determination whether the request meets the standard set forth in paragraph I for expedited external review, as well as the reviewability requirements set forth in RSA 420-J:5-b, I. If these conditions are met, the commissioner shall immediately notify the health carrier. If the request is not complete, the commissioner shall immediately contact the covered person or the covered person's authorized representative and attempt to obtain the information or documents that are needed to make the request complete.

IV. The commissioner shall select and retain an independent review organization that is certified pursuant to RSA 420-J:5-d, I to conduct the expedited external review.

V. The health carrier or its designated utilization review organization shall provide or transmit the documents and information specified in RSA 420-J:5-b, VII to the selected independent review organization by telephone, facsimile or any other available expeditious method within one business day of receiving the commissioner's notice of the request for expedited external review pursuant to paragraph III.

VI. When handling a review on an expedited basis, the selected independent review organization shall make a decision and notify the carrier and the covered person as expeditiously as the covered person's medical condition requires, but in no event more than 72 hours after the expedited external review is requested.

VII. If the notice provided pursuant to paragraph VI was not in writing, within 2 business days after the date of providing that notice, the selected independent review organization shall:

(a) Provide written confirmation of the decision to the covered person or the covered person's authorized representative and the health carrier; and

(b) Include the information set forth in RSA 420-J:5-b, X.

VIII. An expedited external review shall not be provided for determinations made by the health carrier on a retrospective basis.

IX. A covered person shall not be held liable to either the health plan, the hospital, the physician, or the services provider for the cost of services in excess of the applicable copayment, coinsurance, or deductible incurred, pending the independent review organization's determination of an expediated external review.

420-J:5-d Certification of Independent Review Organizations.

I. The certification of independent review organizations shall be conducted as follows:

(a) The commissioner shall certify independent review organizations eligible to be selected to conduct external reviews under this section to ensure that an independent review organization satisfies the minimum qualifications established under paragraph II.

(b) The commissioner shall develop an application form for initially certifying and recertifying independent review organizations to conduct external reviews.

(c) Independent review organizations wishing to be certified shall submit the application form and include all documentation and information necessary for the commissioner to determine whether the independent review organization satisfies the minimum qualifications established under paragraph II.

(d) The commissioner may determine that accreditation by a nationally recognized private accrediting entity with established and maintained standards for independent review organizations that meet or exceed the minimum qualifications established under paragraph II is sufficient for certification under this paragraph.

(e) The commissioner shall maintain and periodically update a list of certified independent review organizations.

(f) Whenever the commissioner determines that an independent review organization no longer satisfies the minimum qualifications established under paragraph II, the commissioner shall terminate the certification of the independent review organization and remove it from the list of certified independent review organizations that is maintained by the commissioner pursuant to subparagraph I(e).

II. To be certified under paragraph I to conduct external reviews, an independent review organization shall meet the following minimum qualifications:

(a) It shall develop and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process.

(b) It shall establish and maintain a quality assurance program that:

(1) Ensures that external reviews are conducted within the specified time frames and required notices are provided in a timely manner;

(2) Ensures the selection of qualified and impartial clinical peer reviewers to conduct external reviews on behalf of the independent review organization with suitable matching of reviewers to specific cases;

(3) Ensures the confidentiality of medical and treatment records; and

(4) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this section.

(c) It shall agree to maintain and provide to the commissioner such information as may be required to fulfill the provisions and purposes of this section.

(d) It shall assign clinical peer reviewers to conduct external reviews who are physicians or other appropriate health care providers and who:

(1) Are experts in the treatment of the covered person's medical condition that is the subject of the external review;

(2) Are knowledgeable about the recommended health care service or treatment through actual clinical experience;

(3) 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 area or areas appropriate to the subject of the external review;

(4) Have no history or disciplinary actions or sanctions that have been taken or are pending by any hospital, governmental agency, or regulatory body; and

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

(e) It shall be free of any conflict of interest. To meet this qualification, an independent review organization may not own or control or in any way be owned or controlled by a health carrier, a national, state or local trade association of health carriers, or a national state or local trade association of health care providers. In addition, in order to qualify to conduct an external review of a specific case, neither the independent review organization selected to conduct the external review nor any clinical peer reviewer assigned by the independent organization to conduct the external review may have a material professional, familial or financial interest in any of the following:

(1) The health carrier that is the subject of the external review;

(2) Any officer, director or management employee of the health carrier that is the subject of the external review;

(3) The health care provider or the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

(4) The facility or institution at which the recommended health care service or treatment would be provided;

(5) The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the covered person whose treatment is the subject of the external review; or

(6) The covered person or the covered person's authorized representative.

(f) Its charges for services provided shall be competitive and reasonable.

(g) For the purpose of allowing in-state health care providers to act as clinical peer reviewers in the conduct of external reviews, 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 which is sufficient to preclude that provider from acting as a clinical peer reviewer, so long as the affiliation is disclosed to the covered person or the covered person's authorized representative.

(h) The following organizations shall not be eligible for certification to conduct external reviews:

(1) Professional or trade associations of health care providers;

(2) Subsidiaries or affiliates of such provider associations;

(3) Health carrier or health plan associations; and

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

420-J:5-e General Provisions Regarding External Review.

I. The health carrier against which a request for external review is filed shall pay the cost of the external review. Except under the circumstances described below in this paragraph, such costs shall not exceed $1,500. The commissioner shall notify the independent review organizations of the cost limitation for conducting an external review. The cost for an external review may exceed $1,500 if the commissioner determines an additional cost is necessary to ensure the fair adjudication of the case in question.

II. The external review decision of the independent review organization shall be binding on the health carrier and shall be enforceable by the commissioner pursuant to the penalty provisions of RSA 420-J:14. The external review decision of the independent review organization shall be binding on the covered person except to the extent the covered person has other remedies available under federal or state law. The external review process shall not be considered an adjudicative proceeding within the meaning of RSA 541-A, and the external review decision of the independent review organization shall not be subject to rehearing and appeal pursuant to RSA 541.

III. An independent review organization shall maintain all standards of confidentiality. The records and internal materials prepared for specific reviews by an independent review organization under this section shall be exempt from public disclosure under RSA 91-A.

IV. 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.

V. The right to external review under this chapter shall not be construed to change the terms of coverage under a health benefit plan nor shall the health carrier retaliate against the covered person for exercising his or her right to an independent external review.

VI. When requested by the covered person, the commissioner shall provide consumer assistance in pursuing the internal grievance procedures under RSA 420-J:5 and the external review process under RSA 420-J:5-a – 420-J:5-e.

VII. The commissioner shall report annually to the governor and the legislature on the number of grievances subjected to external review, the number of decisions resolved wholly or partially in favor of the covered person, and the number of decisions resolved wholly or partially in favor of the health carrier. Such reports shall also include a separate statement of the number of cases in which the external review was terminated as a result of a reversal by the health carrier of its adverse determination after the receipt of new or additional information from the covered person or the covered person's authorized representative and the number of cases in which the covered person and the health carrier agreed to resolve the dispute prior to a final determination by the independent review organization.

VIII. If, based on the evidence presented during the external review process, the commissioner determines that the health carrier's medical director, in the conduct of his or her duties, may have committed misconduct as set forth in RSA 329:17, VI, the commissioner shall document such findings and transmit them in a separate report to the board of medicine.

14 New Paragraphs; Provider Contract Standards. Amend RSA 420-J:8 by inserting after paragraph VII the following new paragraphs:

VIII. No contract between a health carrier and a participating provider shall contain any payment or reimbursement provision the terms of which creates an inducement for the provider to not provide medically necessary care to covered persons. Nothing in this section shall be construed to prohibit the use of payment arrangements between a health carrier and a participating provider or provider group which involve capitation, withholds or other arrangements.

IX. The health carrier shall provide to covered persons, in the evidence of coverage, a description for the types of financial arrangements contained in its contracts with participating providers. Such descriptions shall be set forth in clear, understandable language.

X. Every contract between a health carrier and a participating provider shall provide that the health carrier may not remove a health care provider from its network or refuse to renew the health care provider with its network for participating in a covered person's internal grievance procedure or external review.

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2000-30137s

AMENDED ANALYSIS

This bill creates an independent external consumer appeal process to review certain determinations made by managed care entities. The bill requires health carriers that conduct utilization review and licensed utilization review entities to employ a medical director who shall be licensed as a physician. The bill prohibits contracts between health carriers and participating providers from including provisions that create financial incentives to deny medically necessary care. The bill requires that health insurers disclose certain information necessary for consumers to hold managed care entities accountable for health care treatment decisions. The bill also extends the jurisdiction of the board of medicine to include disciplinary action over medical directors for misconduct.

Committee Minutes

Date: JUNE 21, 1999
Time: 3:00 PM
Room: LOB 102

The Senate Committee on Public Institutions/Health Human Services held a hearing on the following:

HB 640-FN relative to grievance procedures of managed care organizations.

Members of Committee present: Senator Wheeler
Senator Krueger
Senator Pignatelli

The Vice-Chair, Senator Katie Wheeler, opened the hearing.

Representative John Hunt, Ches. D. 10: Thank you Madame Chairman. For the record my name is John Hunt, Cheshire 10, Rindge and I bring forth a bill that's very important to me. When I set out this year, a year ago working on my campaign and shaping my message that I wanted to get through to my constituents that one of my corner pieces of my campaign was my commitment to passing an external grievance procedure bill this session. I bring in front of you the bill that has gone through the Commerce Committee with, I would say, a very extensive review. The Committee literally went over it word by word, making corrections and adjustments and I think it came out with an excellent bill. I am very proud to have my name on this bill in it's current form.

I realize that there is another bill, SB 199, which also deals with external grievance and it resides currently in the Commerce Committee. The Commerce Committee is diligently working on that amendment as we speak. They are supposed to be back at it again this afternoon. We all know we are running out of time for this session and whether the final compromises can be hammered out in the meantime is a great concern for me. I would hope that we don't get bogged down on political redderick over what I would call a secondary issue from what I think is the most important piece, which is the concept of external grievance because external grievance ensures the consumer, the patient gets the issue, whatever the problem they had, gets it solved. Regardless of whether someone doesn't like the way the decision is being made at an HMO or whether some people want to go through the Board

of Medicine or some other investigory process, those would take time consuming and extensive work and not necessarily going to be cost-effective either to the premium payers or the patient. The external grievance process guarantees that a consumer, the patient, gets their problem solved in a timely fashion and gets healthy, which is what we really want for New Hampshire citizens.

So I hope you will support the bill in it's current form and expeditiously get it out of committee so that we can move forward. I thank you for the opportunity to speak.

Senator Katherine W. Wheeler, D. 21: Thank you. Questions for Representative Hunt? Representative Hunt, I don't want to make you testify for 10 or 12 hours or anything but since you've been working hard in Commerce on 199, is it simple enough for you to describe the external grievance process differences between 640 and 199?

Representative Hunt: My understanding, actually, is that a lot of what was put in 199 was taken from this bill when it comes to the external grievance process. The critical differences are, there is a fee difference. Senate Bill 199 does charge a $25 fee where this is no fee to the consumer. There is a limit in terms of what kind of review. This bill has a paper review because that is much more expeditious and whereas the 199 does allow through oral review which does extend the time. There is a cap of how much the expense of that review can cost. Again, ~~not~~ to get the right answer done quickly rather than dragging it out and running up the costs and obviously would effect premiums. In terms of the external grievances, that's some of the major differences. I think the only other issue was how the review body is chosen and in this particular bill we did have the company because that's what most of the states have done, is the company usually chooses from a list that has been approved by the Insurance Department. In the 199 the Insurance Department chooses it. I think that is a delay. I think a compromise in between would be that the Department has already approved the list and that the company must choose randomly, you know let's go through the list and select 3 out of whatever has been approved by the Department so that people can ensure that they're not sending all the business to just one on the list.

Senator Katherine W. Wheeler, D. 21: By the company you mean the insurer?

Representative Hunt: The HMO.

Senator Katherine W. Wheeler, D. 21: The HMO.

Representative Hunt: I think a compromise there would be some kind of randomness to ensure that the consumer doesn't think that the HMO was choosing 1 external review organization over any of the other ones because they were getting the answers that they wanted. I think that's worth visiting. But other than that in terms of the external grievance process I think there are no big, major changes. Obviously the most controversial piece in 199 is the practice of medicine, the phraseology. What I was attempting to do was to take the little step, a measured step. It's a step that many states are taking right now. No state has ever talked about the practice of medicine. That is a very new animal and I would like to let you know, the Commerce Committee does have a bill that Representative Pilliod put in, I believe it's HB 637 which the Commerce Committee did re-refer so we are looking at that issue of practice of medicine and trying to decide where the balance there is but without belaboring it too much, I would just say that my concern of passing that legislation at this point in time is that I don't know the full consequences of introducing this whole investigory process of the Board of Medicine into the HMO practice. This is something we've never done. Normally the Insurance Department has oversight of HMO's. We've never had Board of Medicine oversight. I don't understand and necessarily appreciate some of the process the Board of Medicine might go through let alone concerned that given the number of decisions a medical director makes and now to say to the medical director that now you have to be thinking as though you were the doctor, what will be the impact that will have on the overall state in the HMO's? you could argue that if the medical director was treating a case as though he was the practicing physician that all the savings the HMO's were attempting to get would be lost because then he would be practicing the same defense of medicine as the primary care physician or the specialist. Some people would argue that would raise premiums 20%. Before we go make that decision we need to make sure we feel comfortable that we're not going to have such a negative impact on health insurance in the state.

Senator Katherine W. Wheeler, D. 21: Thank you. Any further questions? Thank you Representative Hunt. Martha did you wish to testify? I have the sign-up sheet but I'd be happy to put you on it if you wish to testify.

Representative Clark: Not at this particular time. I may change my mind.

Senator Katherine W. Wheeler, D. 21: Alright. Yvonne Nanasi representing BlueCross BlueShield of New Hampshire.

Yvonne Nanasi, Director of Government Relations, BlueCross BlueShield: Written testimony handed in. **See Attachment A and B.**

Senator Katherine W. Wheeler, D. 21: Any questions? Thank you Yvonne. I will put my glasses on and look at these. It's very helpful to have that. Nobody who signed up below the line checked the box. Is that because you truly don't want to speak or did you not know what our procedure is? In other words, does Betsy Andrews Parker wish to speak?

Betsy Andrews Parker, NH Citizens Alliance: I submitted testimony. **See Attachment C.**

Senator Katherine W. Wheeler, D. 21: That's all right. You can decide later if you want to speak. I'm assuming that Lisah Carpenter is the same thing and Tom Bunnell? I guess I'll go to Alex who did check the box, in concept.

Alex Feldvebel, NH Department of Insurance: Thank you Madame Chairman. My name is Alex Feldvebel, appearing on behalf of the Insurance Department and we support the idea that this year we ought to have established in statute a process for external review of health plan decisions. So we support HB 640 in concept in that that's what it sets out to do, however, we would prefer to see the version of external review that is included in SB 199. Because the important thing to accomplish is to put into place a process for external review of HMO decisions that inspire consumer confidence that it's a truly fair and impartial process.

There's a number of differences between SB 199 and 640 which (inaudible) in favor of SB 199 in terms of consumer confidence. The most important one is the issue that has already been brought up a number of times. The issue of who should have the power to select the independent review of an organization. If the consumer is to have confidence that it is truly an impartial review process, it shouldn't be the health plan that selects the independent review organization (IRO). Most states that have set up independent review process do not have the health plan select the IRO. As well the NAIC model, the National Association of Insurance Commissioners, model explanation is still in development, has various different options and I happen to serve on the working group that is developing that model, they recently did add, after much debate, an option #3 which would allow the health plan itself in selecting the IRO. That's definitely not the preferred option and they are intending to include this as a option only if there are special provisions in addition to guarantee the neutrality of the IRO.

The problem that you have when the IRO is being selected by the health plan is that it creates a financial conflict of interest for the IRO. Here they are being selected and paid by the health plan and so they're naturally going to

have the concern that their decision making process is not appreciated by the health plan and they may be out of business.

So, that's one of the major concerns in setting up a review process that's going to inspire consumer confidence. There are a number of other issues as well. The question of whether there should be an amount in controversy requirement, a threshold. Most states that have set up independent review process have not included an amount in controversy requirement, although it's true that a number of the states which recently set up the process have included this requirement. The problem is that sometimes the dollar value of medical service doesn't really represent the human value of the medical service. So, you could have a consumer who wants to appeal a denial that's very important to that consumer and could be very important to that consumer's health, although it might not represent an expenditure that exceeds $500 for example. It's controversial to use this kind of requirement, I think.

I'll just end it there.

Senator Katherine W. Wheeler, D. 21: Alex. I have a question, the phone probably rang at the same time you were saying this. Who is, right now, allowing health plans to select the IRO?

Mr. Feldvebel: Yvonne, I think, has done the research on that.

Senator Katherine W. Wheeler, D. 21: I just wanted you to repeat what you had said. "Some...

Mr. Feldvebel: Most states do not.

Senator Katherine W. Wheeler, D. 21: Some states are, is that what you said?

Mr. Feldvebel: Some states are. Yeah.

Senator Katherine W. Wheeler, D. 21: That's alright. That's all.

Mr. Feldvebel: I could tell you that looking at a study that was commissioned by the Keyser Family Foundation in November and was published of November of 1998, and it lists 13 states that they looked at who have laws in place for external review. On page 28 of their study, other the 13 three of them allow the health plan to select the IRO.

Senator Katherine W. Wheeler, D. 21: Thank you very much. Senator Krueger, do you by any chance have any questions for Alex? I don't think Senator Krueger has any questions. (laughter)

Senator Patricia Krueger, D. 16: No. We're doing nine things here but I know exactly what's going on.

Senator Katherine W. Wheeler, D. 21: I'm sure you do. Thank you very much Alex. Don Dickey from DHHS.

Don Dickey, NH Department of Health and Human Services: Madame Chairman, member of the Committee. My name is Don Dickey and we support some external review legislation because we think this is essential for enhancing consumer trust in HMO's. We all know that HMO's in our region enjoy quite high consumer satisfaction yet we also have a sense that some kind of safeguards are needed to address the kinds of problems that we read about in the papers on a regular basis. The interest of the Department has been in seeing legislation that balances the interest, the need on the one hand for consumers to have tools in information that they need to protect their rights but to do so in a way that doesn't impose an unreasonable cost burden on HMO's.

We've been very impressed with the work of the Commerce Committee, I'd like to say. The sub-committee work sessions have been very thorough. Sub-committee Chair has been willing to entertain other points of view and often incorporated those view points and I think the outcome is that many good things can be said about HB 640. However, we do have some concerns with provisions and it's really in the same area as that people testifying before have mentioned.

First, we think it is important that the Department of Insurance, not the health plans, have through the primary role in the selection and contracting of independent review organizations. Our perspective on this is formed by the health planning work that the Department has been involved in and I think you have all heard that over the last 3 years we've had extensive conversations with people around the state about issues in healthcare and one of those issues was the need for some kind of mediation of disputes between HMO's and health plans. There was concern about having some kind of consumer assistance program which the House Commerce Committee and the Senate has provided and then the other piece was this piece. Something to mediate the concerns and one of the messages or the main message that came through for that was that people were using words more than independent. They put it in words like "impartial", "trustworthy", "unassailably neutral". I think there was a sense from people that they really

thought it was important that there be no financial interest or even a perception of a financial interest and that the entity would have the expertise and objectivity to really carefully weigh each side. I think the Keyser Report that Alex mentioned, in talking about the 13 states that it studied, one of the key points in that report is that health plans and everybody across the board felt that the IRO process was essentially unassailably neutral, that decisions were going both ways evenly. I think that's why very few states have external grievance appeals where HMO's have a broad authority to contract with the IRO. I think where they do have that power to contract it is properly circumscribed so that there isn't that perception or that potential problem.

Second, we're not in favor of the $500 amount in controversy threshold. The purpose of this is to ensure the process is not over utilized and prevent trivial and frivolous claims. However, I think only two or three have any threshold at all and other state's experience does not suggest that frivolous claims are being brought. I think that's the point. I may be wrong on the exact number there but there is not evidence that there's a problem with frivolous claims.

Finally, we think the $1500 cost limitation, the limitation on the cost is not appropriate. I believe in the Senate Hearing we heard one of the HMO's and I think it was Harvard Pilgrim talking about that they've used this process and they gave the example of very difficult, thorny issue and they had to go on for quite a long time. In that case, and I would imagine the cost of that review was over $1500. So, while it's very important, clearly, to keep a restrain the costs on these, to have sort of an arbitrary cap on each individual hearing doesn't make sense to me and I think there could be, or to us and I think there could be more effective ways serve that interest in constraining cost.

Moving beyond external review, one concern we have, well it's not a concern with 640, the advantage of the Senate Bill is that it does address other areas that are not addressed in 640. That's kind of getting beyond 640.

So while we think it is very good legislation in many respects, we would like to see, that's our position on those issues.

Senator Katherine W. Wheeler, D. 21: Thank you very much for testifying. Any questions? Seeing none, thank you. Those are the only boxes that were checked but there are other people in the room and also Representative Martha Fuller-Clark....

Representative Martha Fuller-Clark, Rock, D. 36: Thank you very much. For the record I'm Representative Martha Fuller-Clark and I'm here to speak

on HB 640. I think that you have heard that a lot of good work was done on this bill in revising and improving the external review process. It is my understanding (turn over tape) in the House were to this Committee and were adopted into Senate Bill 199 in the areas where they really did make an improvement with regard to both the process and consumer confidence. I don't think it's incumbent to adopt 640 in it's entirety because there are, as you have heard, some remaining concerns and they do have to do with the amount in controversy. They have to do with the IRO selection process and I would have to agree that what we're striving here for is legislation that will improve consumer confidence and make it clear that there is a fear of impartial process and I think in that we need to be certain all the way along that there is clearly an arms length distance between the appeal process and the HMO for whom the appeal is being brought on behalf of the consumer.

One issue that we haven't talked about is regard with the right to have oral testimony in certain circumstances and I know that we have been working on an amended version to SB 199 that does set forth some clearer standards because those have not been defined in either 640 or SB 199 that exists now. Certainly in 640 that process doesn't exist at all. So, again I think the measuring stick for this legislation, which is really supposed to help the consumer, is to make sure that we have as many of those pieces in place to make that process work for the consumer and, of course, at the same time to ensure that there's a minimal financial impact on the healthcare industry. I believe that when everything is said and done SB 199 achieves that in a better form. Thank you.

Senator Katherine W. Wheeler, D. 21: Thank you. Are there questions for Representative Fuller-Clark? Seeing none, thank you very much. Representative Taylor, did you wish to...

Representative Kathleen Taylor, Straf., D. 11: I have nothing to add.

Senator Katherine W. Wheeler, D. 21: Former Senate President Bartlett.

Bill Bartlett: Thank you Madame Chairperson. I apologize for my attire but the Legislative Golf Tournament was this morning. For the record I'm Bill Bartlett, Jr. of S&H/Murphy and we represent Harvard Pilgrim Healthcare and we're in support of 640. I was interested to see the external review question of who decided they should do that, whether it should be the Insurance Department or it should be approved by the Insurance Department or selected by the HMO's. If that is the only problem this Committee will see with 640 then I suggest that you could probably find an amendment that would solve that problem. The rest of the items here that Harvard Pilgrim has had internal review and we believe in external review and we feel that

along as HB 640 has brought forth a method which is quick, calls for expedited review if necessary and it can be done in a proper manner. I think it would be timed good to have it and the advantage to having one like that to try that without the threat of going to court and suits and other things and I think that 640 does what the general public wants it to do. If they have a problem (door closing) they know whether they have healthcare coverage and payment or not and it does it in a short time and I think that's most important rather than wait for some other method which might mean 2 to 3 years in the court system. That's the end of my testimony and I thank you very much.

Senator Katherine W. Wheeler, D. 21: Senator Krueger.

Senator Patricia Krueger, D. 16: Thank you very much. I just wanted you to recap for me, in one more sentence, would you see a definite influence in 2 factors: The timeframe that someone on an external of client/patient of would have would be an advantage of this legislation? Number 1, that's what I heard you say. And number 2, that if the system itself is more expeditious?

Mr. Bartlett: I think 640 is more expeditious because it does cause people to go forward with a procedure and that I think it is possible under SB 199 that we could wind up 2 or 3 years in court. I think it's important for the patient and their family to find out whether they're going to get their medical bills paid early on while they're recovering and not 2 or 3 years later.

Senator Patricia Krueger, D. 16: Thank you very much.

Senator Katherine W. Wheeler, D. 21: Any other questions? Seeing no questions, thank you very much for your testimony. Is there anyone else in the room who would like to testify on HB 640. Former Commerce Committee Chair Packard.

Bonnie Packard, Orr & Reno, Tufts Health Plan: Thank you. While I do not wish to testify I did give to Senator Squires that yellow folder and that is the testimony of Lisa Swenson who is the General Manager and Vice President of Tufts Health Plan. **See Attachment D.** Tufts Health Plan wholeheartedly supports HB 640 and feel that the process which took place in the House before the House Commerce Committee when we went through HB 640 word by word, line by line in anticipation of not only members of the House Commerce Committee but all interested parties was an extremely fair process and we appreciate the graciousness of the Chairman of the House Commerce Committee and the members of the House sub-committee for the input that so many people were allowed to have in the process. Thank you.

Senator Katherine W. Wheeler, D. 21: Thank you very much. Betsy.

Betsy Andrews Parker, NH Citizens Alliance: See Attachment C.

Senator Katherine W. Wheeler, D. 21: Thank you.

Senator Patricia Krueger, D. 16: Madame Chair. May I then follow-up and ask a question of Betsy?

Senator Katherine W. Wheeler, D. 21: Betsy would you mind coming up?

Senator Patricia Krueger, D. 16: One sentence question. One sentence answer if you don't mind. It is my impression from what you just said that you were not in favor of this?

Ms. Parker: No. We have been working with the Commerce Committee.

Senator Patricia Krueger, D. 16: You are in favor of this?

Ms. Parker: We are not in favor of 640 because we feel the differences between 640 and that of 199 are significant.

Senator Patricia Krueger, D. 16: Given that you are not, how would you, again, very briefly, how would you then justify the fact that 640 certainly is a more expeditious method of a client bringing forth an external claim? I seem to come back to that a lot because I do have grave concerns about the length of time.

Ms. Parker; About the time you can file a complaint or the length of time it takes for you to have a complaint go through because both require that you exhaust the internal appeals process and then there are provisions laid forth in both bills for an external review as well as a regular independent review.

Senator Patricia Krueger, D. 16: One last question. When I study charts and I study the information, I looked at the bill I noted because I was concerned about the appeal process in 199 as compared to 640 and I found that it seemed to me, and that's what I'm looking for, a correction, that the external review process in 640 would be more timely, which you don't think so.

Ms. Parker: I think there are equal comparisons. I think 199 lays out better to be used for the amount of time a person has to file the appeal, how you choose an IRO, who is choosing the IRO. The fact that there is no threshold amount, that's the better independent review process and I think that the

review process in 199 is a fair process, an autonomy process for that of the consumer.

Senator Patricia Krueger, D. 16: Thank you.

Senator Katherine W. Wheeler, D. 21: Any further questions? Thank you very much. Is there anyone else in the room who wishes to testify? Seeing none I will close the hearing on HB 640.

Hearing closed at 3:44 pm.

Respectfully submitted,

Merideth Chandler,
Committee Secretary

Attachment A

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

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Manchester, NH 03111-0001
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Matthew Thornton Health Plan
A subsidiary of Blue Cross and Blue Shield of New Hampshire

P.O. Box 9514
Manchester, NH 03108-9514
603-695-1100

June 21, 1999

Senate Insurance Committee

Re: HB 640 - Independent External Review Process
Submitted by: Yvonne Nanasi, BCBSNH Director of Government Relations

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

Numerous states have passed legislation that provides for some type of independent external review process. 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 on the basis of medical necessity. Also, it provides for the consumer to be represented and submit information to the external review entity.

In easily understood language, HB 640, details the responsibilities of the health plan, the Department of Insurance and the consumer.

Comments Regarding the Differences between SB 199 and HB 640

Some states, such as Hawaii, did not build into their external review legislation specific time frames and process details. Subsequently, the implementation became 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 external reviews.

In almost all states, external review is performed by independent clinically matched 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. HB 640 avoids imposing extensive administrative costs on the regulatory agency while maintaining a review by independent clinically matched experts that have been certified by the Department of Insurance. This legislative session, the states of Iowa, Indiana and Oklahoma enacted

an independent review organization selection process that mirrors HB 640.

Several states have enacted this process with a filing fee for consumers and a claim cost threshold for qualifying for the external review process. The rationale for these "entry into the process" requirements includes discouraging the "harassment factor" and making the cost of the review worthwhile for the plan who is paying for the review and the consumer who is seeking an "independent expert's opinion" at little or no cost.

HB 640 does not have a filing fee requirement. Instead it provides for a claim cost threshold. We believe that a reasonable claims cost threshold is a less burdensome approach than a filing fee for all parties involved - the consumer, the Commissioner and the plan.

Additional Provisions of SB 199 Absent from HB 640

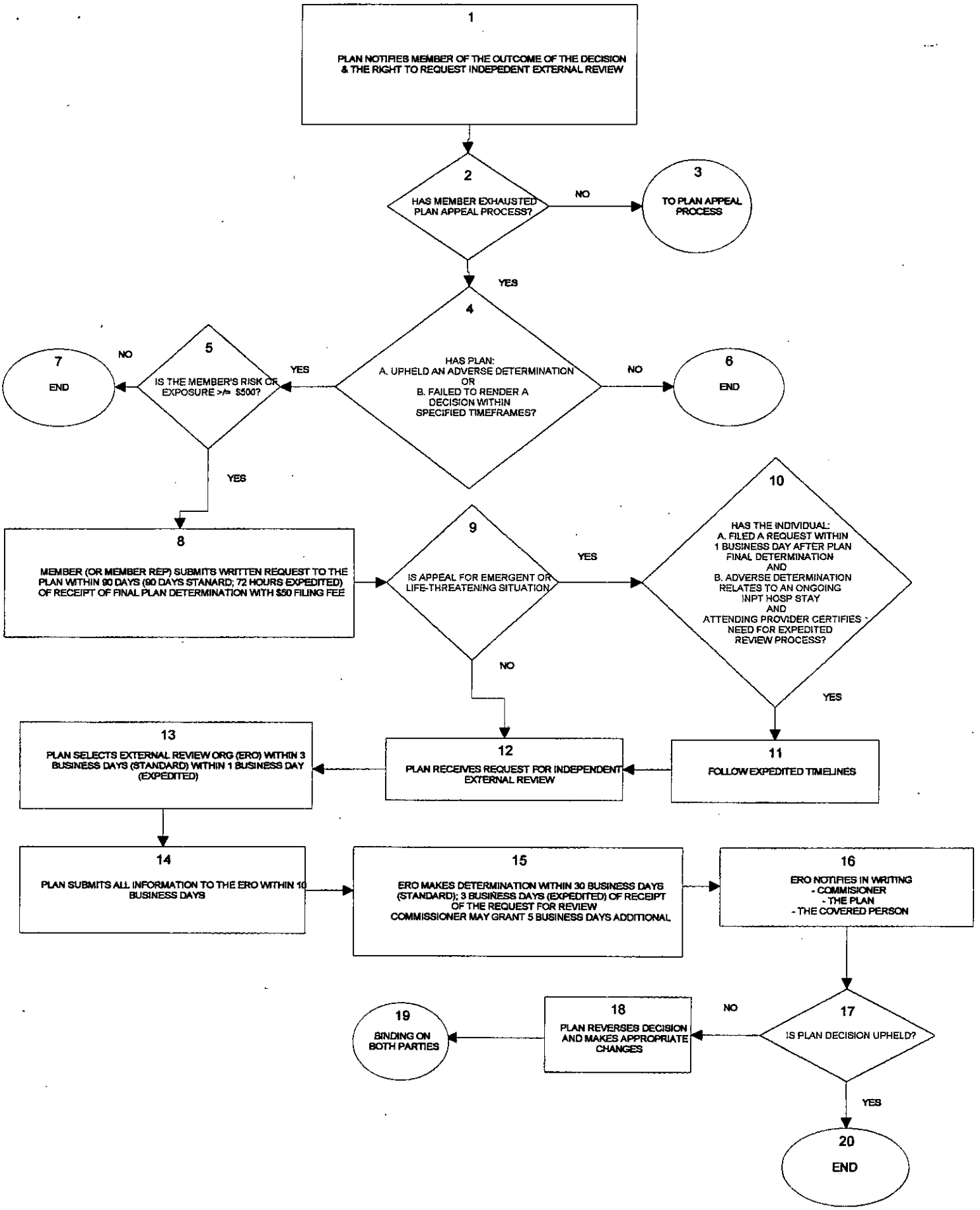
Legislating a uniform independent external review process to address consumer concerns and reinforcing plan accountability is a far better alternative than the medical director "practice of medicine" provisions of SB 199. The "practice of medicine" provisions of SB 199 will encourage overutilization, necessitate health plan intrusion into the medical confidentiality of consumers and increase the cost of health insurance without adding to the quality of care or ensuring positive treatment outcomes.

The medical director provisions of SB 199 do not solve the real challenge facing consumers, health care providers and health plans. They will not further provide medical treatment decision makers with information that they can rely upon to make the best decisions possible at the earliest possible stage, so that their knowledge about what is proven and effective is able to keep pace with the constant advances in medical practice.

BCBSNH believes that much more needs to be done in the area of outcomes research and medical technology assessment. HB 640 will facilitate that process. SB 199 will create a chilling effect on that process. We ask you to support HB 640 and would be grateful for an opportunity to work with you on any modifications or additions.

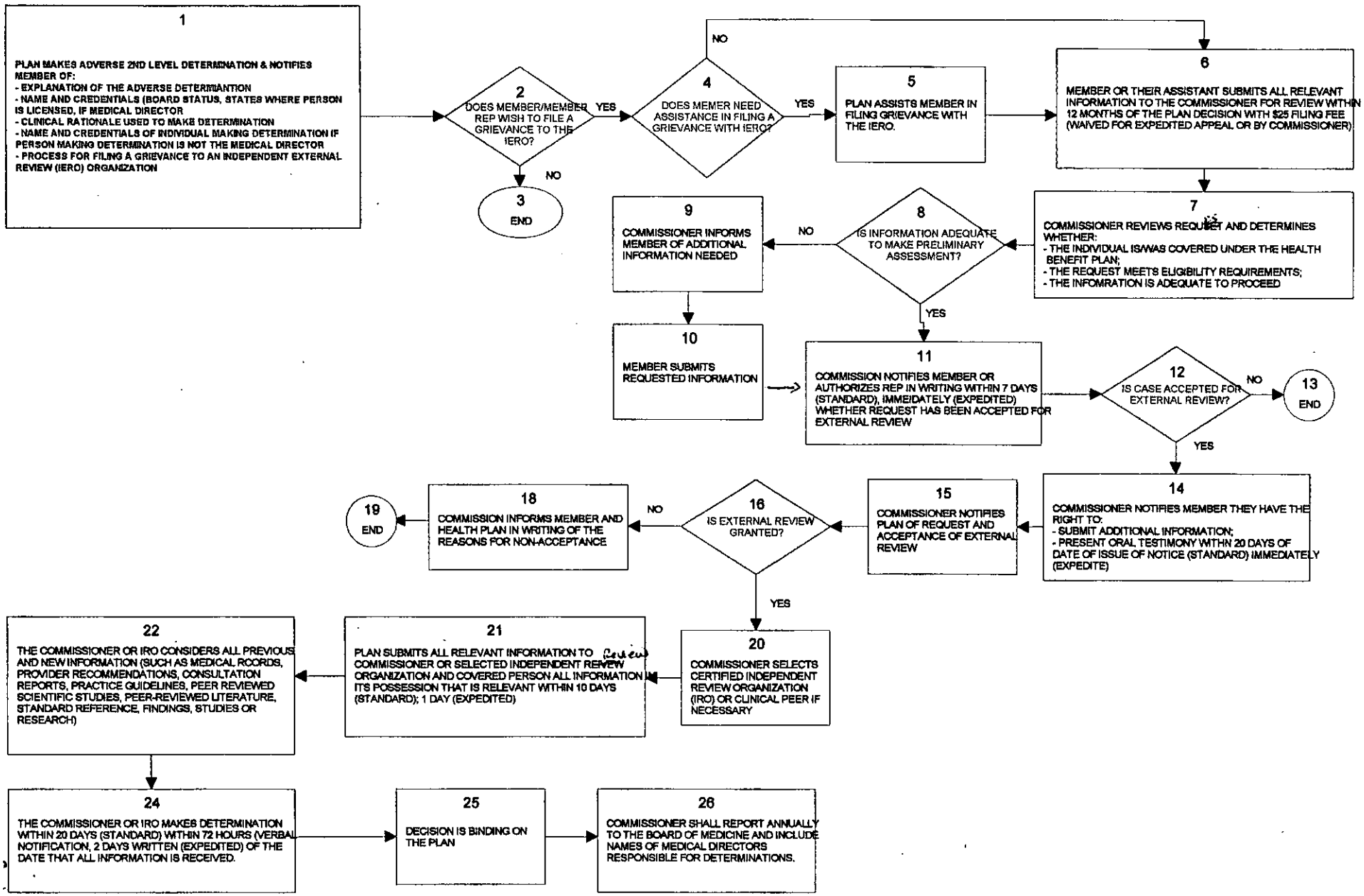
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HOUSE BILL 640 - EXTERNAL GRIEVANCE PROCESS

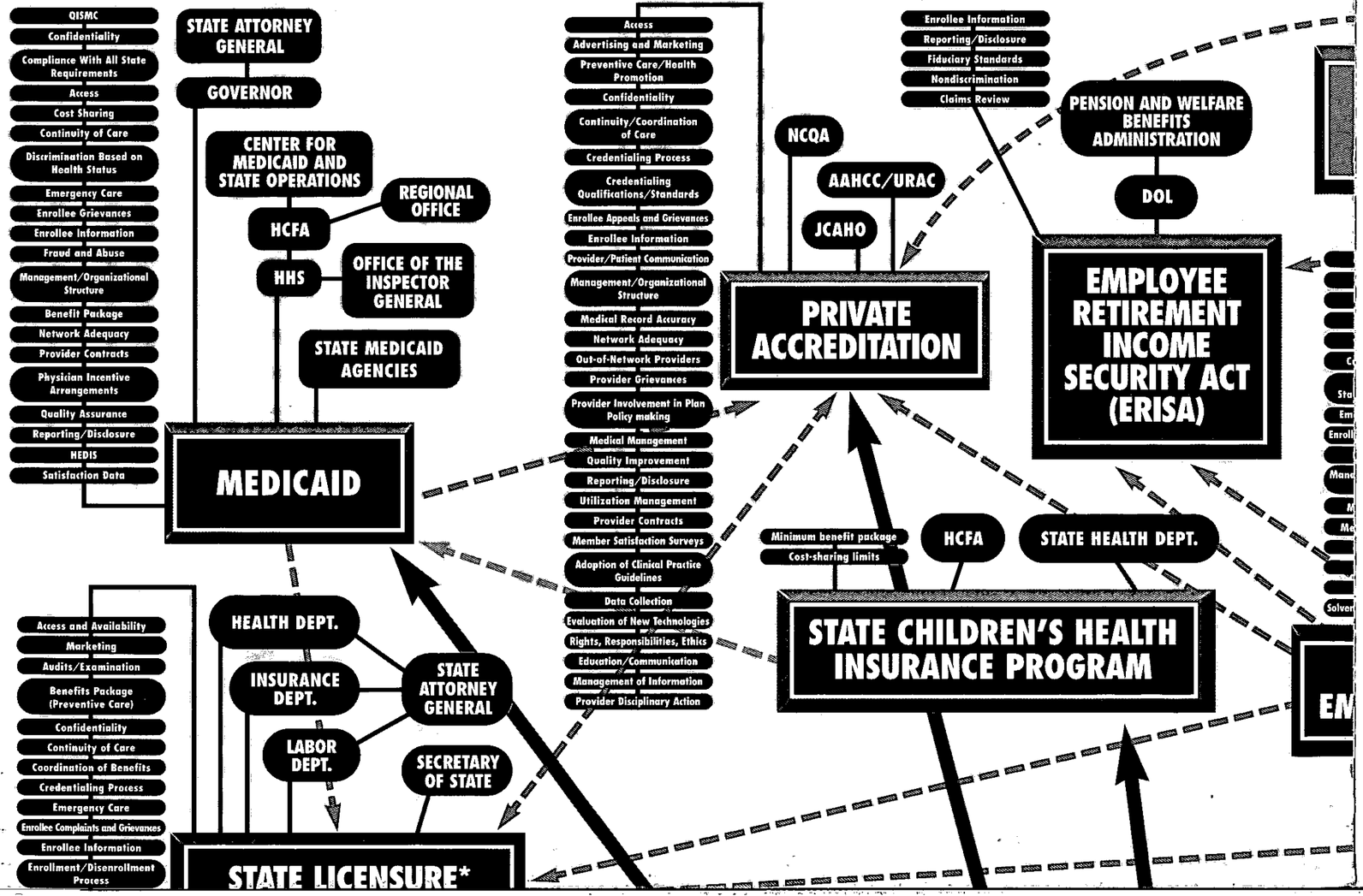


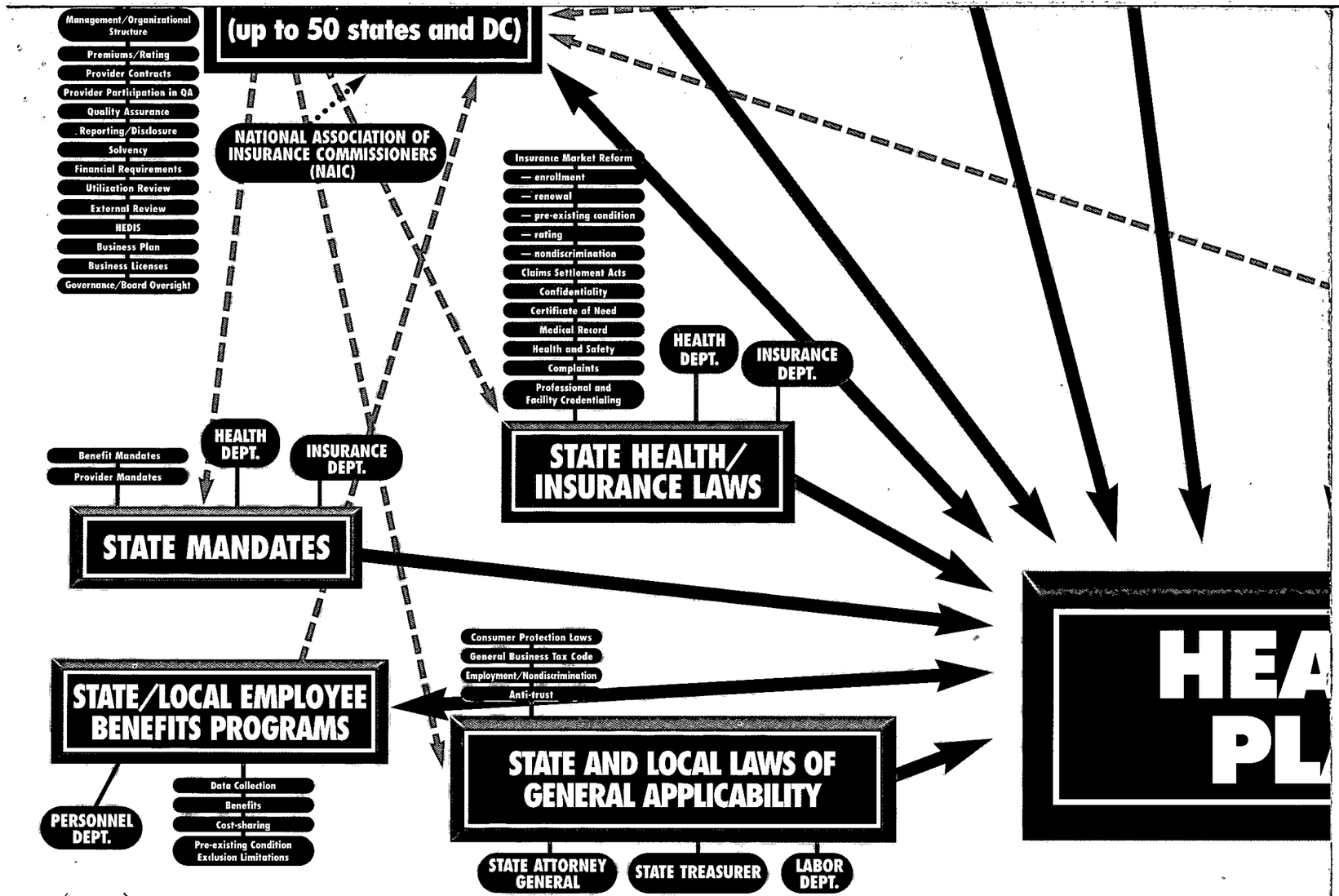
SENATE BILL 199 EXTERNAL CONSUMER APPEAL PROCESS

BILL VERSION 05/20/99



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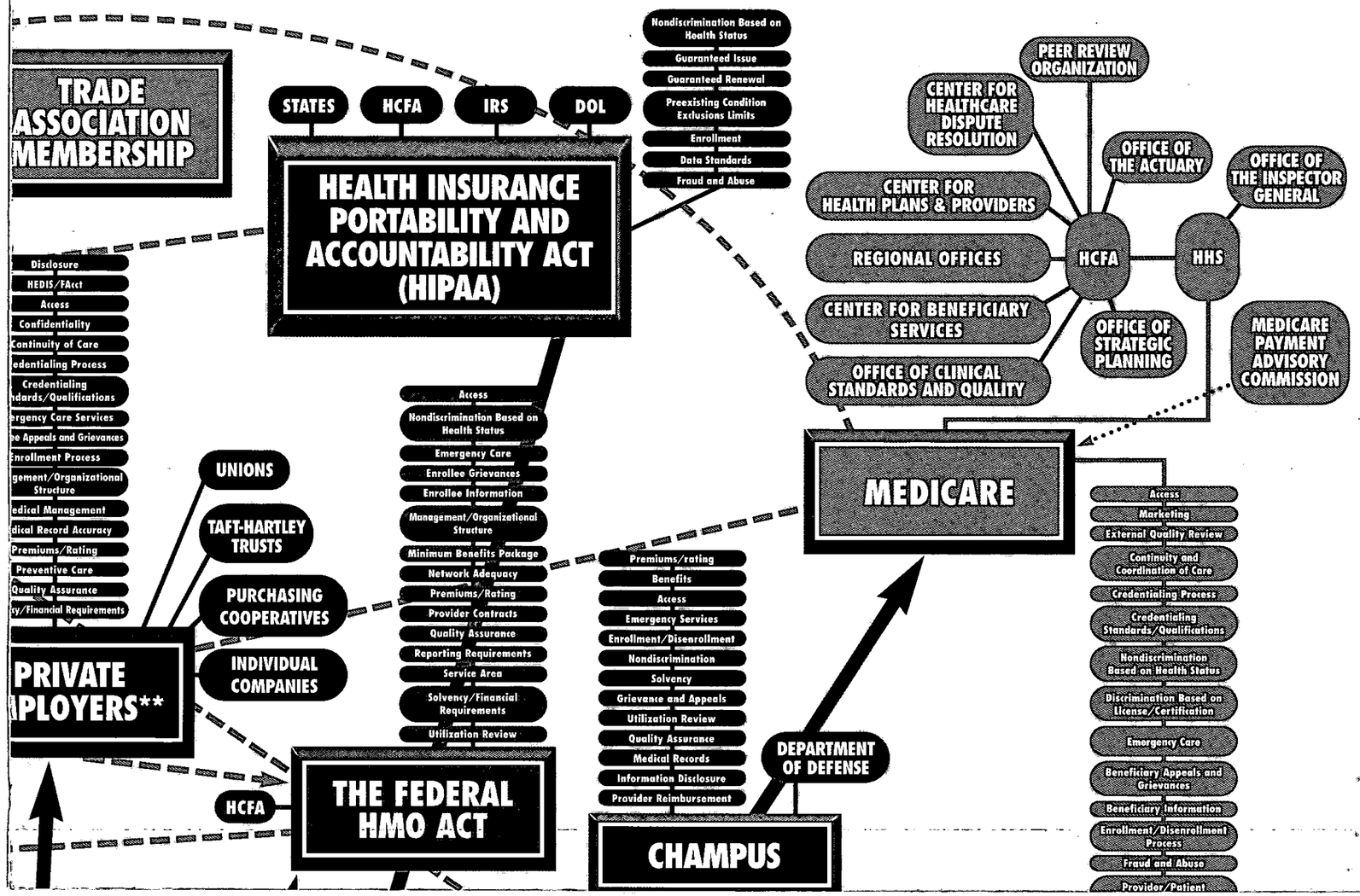


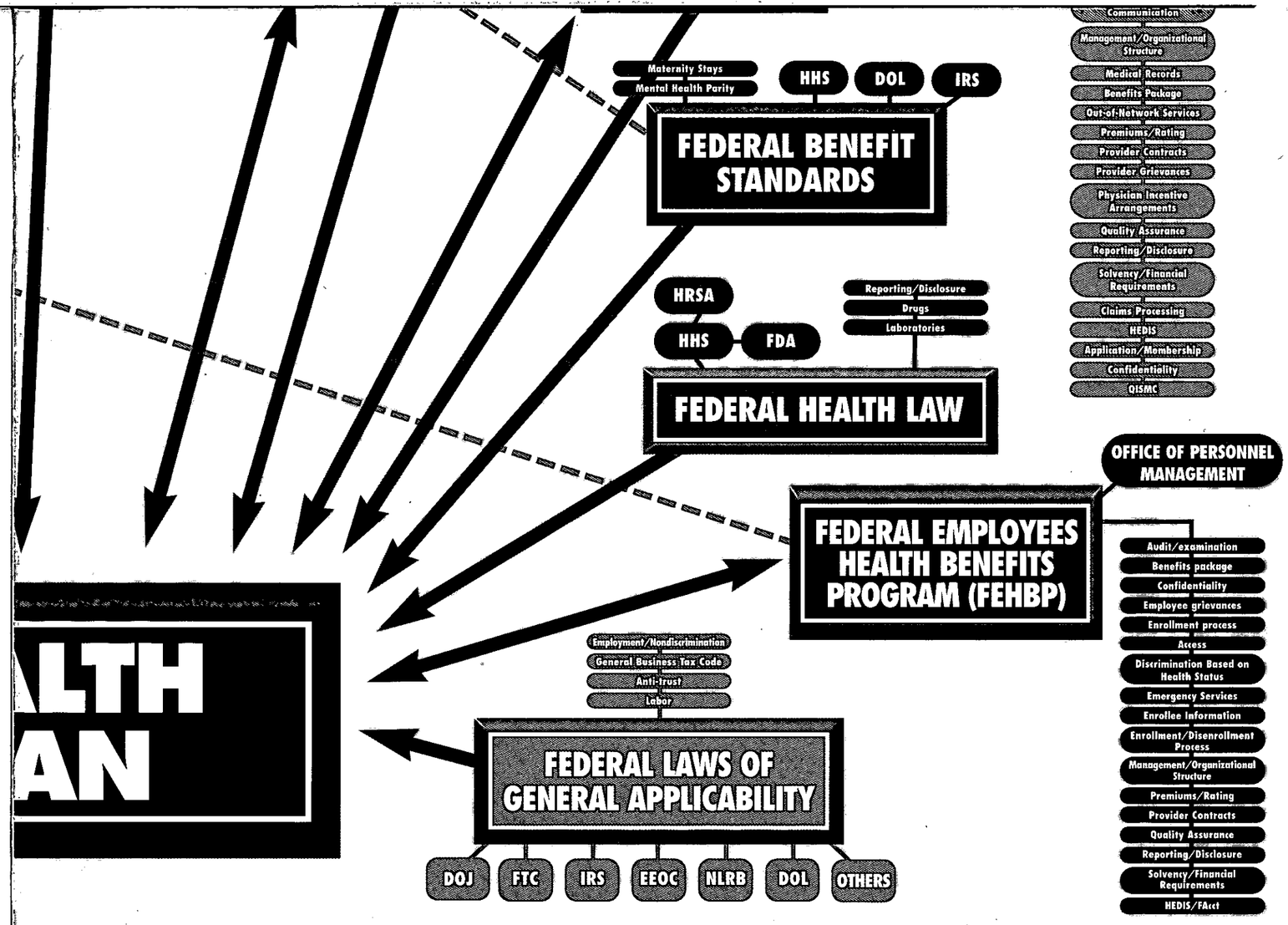
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Attachment C

New Hampshire Citizens Alliance

June 21, 1999

Dear Chairman Squires and Members of the Committee,

I am writing on behalf of over 5,000 New Hampshire consumers who I represent through New Hampshire Citizens Alliance and who support amending HB 640 with SB 199, the HMO Accountability Act.

The independent, external review set forth in SB 199 encompasses regulations from the National Commission on Quality Assurance (NCQA) and the National Association of Insurance Commissioners (NAIC); both are health insurance industry regulators. Using the recommended standards from these organizations, the external review process is fair not only to consumers, but to managed care plans as well. Unlike HB 640, the review process of SB 199 is free of conflict, permits either the health plan member or his/her representative to initiate the independent review process, has an opportunity for a hearing via teleconferencing, discloses the member's right to an appeal process, can waive the small filing fee, and does not have a threshold for the health plan member's cost for the amount in controversy. In addition, there are reasonable timelines set forth for all parties and there are provisions requiring an expedited process for serious and life-threatening circumstances.

SB 199 is designed to give consumers the information and tools they need to protect themselves and their families. By amending HB 640 with SB 199, you will give NH residents the comfort of knowing that there are protections in place should the need arise and that these protections will not impose an undue burden on the managed care industry. This is critical in a constantly changing health care market.

I urge you to amend HB 640 with SB 199 and send a message to NH consumers that their health and welfare are protected. If I can be of assistance, please feel free to contact me at 225-2097. Thank you for your time.

Sincerely,

Betsey Andrews Parker

Betsey Andrews Parker, MPH.
Health Care Organizer

4 Park Street, Suite 403 • Concord, NH 03301
phone: (603) 225-2097 • fax: (603) 228-3360 • email: nhca@neaction.org

Attachment D

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TUFTS Health Plan

June 15, 1999

The Honorable James W. Squires, Chair
Senate Public Institutions, Health and Human Services Committee
Room 102
Legislative Office Building
Concord, New Hampshire 03301

Dear Mr. Chairman:

On behalf of the Tufts Health Plan, I 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 established with the appropriate expertise and independence to add additional protections for patients in a proactive way. A well-designed 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, a well-designed independent review system 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.

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

Furthermore, Tufts Health Plan is a member of The American Association of Health Plans (AAHP). The American Association of Health Plans 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 effective appeals systems as a means to achieve fast, fair and efficient dispute resolution. The AAHP supports allowing consumers to appeal medical necessity decisions to well-designed independent review.

For these reasons, Tufts Health Plan supports HB 640 and 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 E. Swenson
Vice President and General Manager

Speakers

SENATE PI-HHS COMMITTEE

Date 6/21/99 Time 2:40 PM Public Hearing on HB640

Appearing in FAVOR: (Please print) **Please check box at left to speak.**

Speaking?	Name	Address	Representing
☒	Yvonne Naraway		BCBSNH.
☒	Alex Feldvebel (in concept)		NH DOI
☐	ANTHONY JULIANO	125 AIRPORT RD CONCORD	NH ASSOC OF HEALTH UNDERWRITERS
☐	Erik Taylor		Healthsource
☐	Bonnie D. Packard	3 Executive Park Dr. The Eagle Sq.	Tufts Health Plan
=> ☒	John B. Hunt	Rindge	Cheshire 10
☐	Lisa McDunnigle	Concord	NH Hmo Association
☒	DON Dickey (in concept)		NH DHHS
☒	Bill Bartlett, Harvard Pilgrim		
☐			

Appearing in OPPOSITION: (Please Print) **Please check box at left to speak.**

☐	Betsey Andrews Parker	4 Park St. Suite 403, Concord, NH	NH Citizen Alliance
☐	Lisa L. Carpenter	114 N. Main Street Concord	NH Nurses' Assoc. NH Nurse Practitioners Assoc.
☐	TOM BUNNELL	GOVERNOR'S OFFICE STATE HOUSE	
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Testimony



Healthsource.
A CIGNA HealthCare Company

June 21, 1999

The Honorable James Squires
Chairman, Committee on Public Institutions, Health and Human Services
Legislative Office Building
Concord, NH 03301

RE: HB 640

Dear Senator Squires:

I am writing to express Healthsource New Hampshire's support for HB 640, which establishes an independent grievance process for consumers in managed care organizations. Throughout the debate over independent grievance, Healthsource has voiced our desire to create a system which minimizes conflicts of interest, gives consumers access to medical experts throughout the country for disputes over issues of medical necessity, and provides an incentive for all parties to contain costs. We believe HB 640 accomplishes these objectives.

Given the Legislature's expressed desire to have health plans' assume the cost of independent reviews, it is difficult to develop a system that will be viewed as truly free of conflicts. However, by giving the Department of Insurance the ability to certify independent review organizations (IROs) and, thereby, control who we are able to contract with, HB 640 does reduce potential conflicts and gives DOI oversight of the process. In addition, allowing health plans to contract with certified IROs will allow us to negotiate appropriate rates and keep costs at appropriate levels.

Healthsource believes it is important that any independent review process give consumers, physicians and health plans access to the best medical experts, whether they are in New Hampshire, New York or California. By allowing access to medical experts around the country, we are confident independent reviews will improve the quality of care provided throughout the entire health care system in New Hampshire. In addition, we are pleased that the House included language creating an additional DOI conflict review for those cases that utilize an in-state provider for independent review.

Finally, while the quality of the independent review process is paramount, all parties should be interested in keeping costs low. In addition to the contracting incentives noted above, HB 640 provides a cap on the cost of independent reviews. While this cap does limit costs, it is well above the $300 - $500 average cost per review quoted by the Department of Insurance throughout the discussion of HB 640.

Thank you for your consideration of my comments, and please contact me with any questions.

Sincerely,



Erik Taylor
Director of Government Affairs

NEW HAMPSHIRE STATE LEGISLATIVE COMMITTEE

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12 Green Road
Raymond, NH 03077
(603) 895-9451

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Newport, NH 03773
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CAPITAL CITY TASK FORCE COORDINATOR
Edward Brueggemann
60 Winding Pond Road
Londonderry, NH 03053
(603) 434-4725

Testimony before the Senate Committee on
Public Institutions , Health & Human Services

My name is Edward Brueggemann. I live in Londonderry and have lived in NH for 28 years. I am here today as a volunteer for AARP and it's State Legislative Committee.. AARP is a national organization of persons over 50 years of age with over 190,000 members in NH, approximately 18 % of the states population. Fully 1/3 of our membership is still in the work force. A large percentage of our membership secures health services through HMOs.

AARP supports Senator Wheeler's Amendment as it stands. The New Hampshire State Legislative Committee of AARP has been fully involved in the compromise process that has taken place over the past several months and believes that Senator Wheeler's Amendment should go forward unchanged. AARP believes that Medical Directors' decisions are not just insurance decisions, but are medical decisions as well, and therefore oversight by the Board of Medicine is appropriate. We are convinced that concerns about increased liability for Medical Directors are unsubstantiated. Whereas Senator Wheelers' amendment does provide for Medical Director accountability, it also provides mechanisms to protect them, including changes in RSA 329:17V which:

1) Adds a Medical Director to the Board of Medicine's Medical Review Subcommittee, and
2) Assures that any medical director involved in a current grievance shall not be reviewed until the grievance process has been completed.

AARP respectfully encourages this Committee to move Senator Wheeler's Amendment forward without change.

I thank you for the opportunity to share our views with you and hope you will be able to meet our expectations for HMO accountability and responsibility.

Dec. 7, 1999

Committee Report

Date: June 21, 1999 Time: 3:00 PM

The Senate Committee on Public Institutions/Health Human Services held its hearing in Room 102, LOB, Concord, New Hampshire.

BILL NO.: HB 640-FN TITLE: relative to grievance procedures of managed care organizations

Members of the Committee present: Senator Wheeler
Senator Krueger
Senator Pignatelli

Those appearing in favor:

Name and Address Representing

See Attached.

Those appearing in opposition:

Name and Address Representing

See Attached.

REPORT OF THE COMMITTEE:

- ☐ Ought to Pass
- ☒ Ought to Pass w/ Amendment
- ☐ Inexpedient to Legislate
- ☐ Rereferred
- ☐ Interim Study
- ☐ Continued Hearing
- ☐ Postponed Hearing

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Date: JUNE 21, 1999

THE COMMITTEE ON Public Institutions/Health Human Services

to which was referred House Bill 640-FN

AN ACT relative to grievance procedures of managed care organizations.

VOTE: 4-2 Majority

1999-1730s

Having considered the same, report the same with the following amendment and recommend that the bill: **AS AMENDED OUGHT TO PASS.**

Senator Katie Wheeler
For the Majority

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Date: JUNE 21, 1999

THE COMMITTEE ON Public Institutions/Health Human Services

to which was referred House Bill 640-FN

AN ACT relative to grievance procedures of managed care organizations.

VOTE: 2-4 Minority

Having considered the same, report the same without amendment and recommend that the bill: **OUGHT TO PASS.**

Senator Patricia Krueger
For the Minority

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Date: JANUARY 18, 2000

THE COMMITTEE ON Public Institutions/Health Human Services

to which was referred House Bill 640-FN

AN ACT relative to grievance procedures of managed care organizations.

VOTE: 4-0

2000-3137s

Having considered the same, report the same with the following amendment and recommend that the bill: **AS AMENDED OUGHT TO PASS.**

Senator Katie Wheeler
For the Committee

|HB640 Docket

Bill Title: (New Title) establishing certain standards of accountability for health maintenance organizations and other entities providing health insurance through a managed care system.

Date	Body	Description
2/16/1999	H	Introduced and ref to Commerce; HJ20, p329
3/2/1999	H	Copy to Chairman on 3/2/1999 due on
3/4/1999	H	Hearing Mar 23 10:00 Rm302,LOB
3/31/1999	H	Subcom work session Apr 6 11:00 Rm302,LOB
4/6/1999	H	Subcom work session Apr 7 10:00 Rm302,LOB
4/8/1999	H	Subcom work session Apr 13 3:00 Rm302,LOB
4/15/1999	H	Subcom work session Apr 20 10:30 Rm302,LOB
4/15/1999	H	Subcom work session Apr 21 10:30 Rm302,LOB
4/28/1999	H	Subcom work session May 5 9:00 Rm302,LOB
5/6/1999	H	Subcom work session May 11 9:45 Rm302,LOB
5/11/1999	H	Maj Report OTP/AM for May 20 (vote 13-1;Reg)
5/11/1999	H	Prop Comm Am{1120}; HC50, p1254-1257
5/20/1999	H	Comm Am, AA VV; Passed with Am VV; HJ54, p1446-1449 + 1502
5/27/1999	S	Introduction and referring to Public Institutions, Health & Human Services; SJ 21, P 568
6/2/1999	S	Hearing, 6/15/99, Room 102, LOB, 2:40 p.m.
6/7/1999	S	Rescheduled Hearing, 6/22/99, Room 102, LOB, 2:40 p.m.
6/11/1999	S	Rescheduled Hearing, 6/21/99, Room 102, LOB, 2:40 p.m.
6/22/1999	S	Committee Majority Report, Ought to Pass W/Amendment, 6/24/99
6/22/1999	S	Committee Majority Amendment, {1730}, (New Title), SC41, Pg.3
6/22/1999	S	Committee Minority Report, Ought to Pass, 6/24/99
6/24/1999	S	Senator Trombly moved it to be Special Ordered to June 29, MA, VV; SJ 25, Pg. 648
6/25/1999	S	Committee Majority Report, Ought to Pass W/Amendment, 6/29/99
6/25/1999	S	Committee Majority Amendment, (1730), (New Title), SC42
6/25/1999	S	Committee Minority Report, Ought to Pass, 6/29/99 SC42
6/29/1999	S	Sen. Wheeler Moved Rerefer, MA, VV; SJ 26, Pg. 682-691
1/31/2000	S	Committee Report, Ought to Pass with Amendment {3137}, [New Title], 2/3/2000 ; SC8, Pg.19
2/3/2000	S	Ought to Pass with Amendment {3137}[New Title], AA, VV, OT3rdg, MA, VV; SJ 2, Pg.58-67
2/17/2000	H	House Concurred with Sen Am, Rep Hunt MA VV; HJ18, p481
2/17/2000	S	Enrolled; SJ 4, Pg.116
2/24/2000	H	Enrolled; HJ22, p617
3/7/2000	H	Signed by the Governor on 3/7/2000 Eff: 9/3/2000 Chap: 0018