HEALTH CARRIER GRIEVANCE PROCEDURE MODEL ACT

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Section 3. Definitions

For purposes of this Act:

A. (1) "Adverse determination" means:

(a) A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;

(b) The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan; or

(c) Any prospective review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit.

(2) "Adverse determination" includes a rescission of coverage determination.

Drafting Note: The DOL final rule uses the term "adverse benefit determination." This model act uses the term "adverse determination." The NAIC has chosen to continue to use the term "adverse determination" in this model act instead of using the DOL final rule's term "adverse benefit determination" because the term "adverse determination" is referenced in several other NAIC model acts in addition to this model act. If the terminology were changed, this would necessitate revising several NAIC model acts to reflect this change in terminology. The definition of "adverse determination" in Subsection A has been revised, however, to be consistent with the DOL final

(5) In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.

D. "Case management" means a coordinated se

Drafting Note: The definition of "managed care plan" is intentionally broad in order to apply to health benefit plans using any type of requirement or incentive for enrollees to choose certain providers over others. Some states may wish to limit the definition by regulation to exclude plans having broad-based provider networks that meet specified standards. Such standards could i

FF. (1) "Retrospective review" means any review of a request for a benefit that is not a prospective review request.

(2) "Retrospective review" does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

Drafting Note: The DOL final rule, which was unchanged by the interim final rules on internal claims and appeals and external review processes published in the *Federal Register*, July 23, 2010, uses the term "post-service claim" instead of "retrospective review." The DOL final rule defines a "post-service claim" as "any claim for a benefit under a group health plan that is not a pre-service claim," as that term is defined under the DOL final rule. To reflect this broad definition of "post-service claim," the definition of "retrospective review," in Subsection FF, has been revised to be consistent with the definition of "post-service claim."

GG. "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care

KK. "Utilization review organization" means an entity that conducts utilization review, other than a health carrier performing utilization review for its own health benefit plans.

Section 4. Applicability and Scope

Except as otherwise specified, this Act shall apply to all health carriers offering a health benefit plan.

Drafting Note: States may wish to consider accreditation by a nationally recognized private accrediting entity, with established and maintained standards, as evidence of meeting some or all of this Act's requirements. Under such an approach, the accrediting entity will make available to the state its current standards to demonstrate that the entity's standards meet or exceed the state's requirements. The private accrediting entity shall file or provide the state with documentation that a health carrier has been accredited by the entity. A health carrier accredited by the private accrediting entity would then be deemed to have met the requiremed r*e* 3.4 (o)1.3 (f)-0.6 (t)2.6 (h)-0.6 (e)-1 (

(4) Resolution at each level of the grievance, if applicable;

(5) Date of resolution at each level, if applicable; and

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

E. The register shall be maintained in a manner that is reasonably clear and accessible to the commissioner.

F. (1) Subject to the provisions of Subsection A, a health carrier shall retain the register compiled for a calendar year for the longer of three (3) years or until the commissioner has adopted a final report of an examination that contains a review of the register for that calendar year.

(2) (a) A health carrier shall submit to the commissioner, at least annually, a report in the format specified by the commissioner.

(b) The report shall include for each type of health benefit plan offered by the health carrier

(i) The certificate of compliance required by Section 6 of this Act;

(ii) The number of covered lives;

(iii) The total number of grievances;

(iv) The number of grievances for which a covered person requested an additional voluntary grievance review pursuant to Section 9 of this Act;

(v) The number of

Section 6. Grievance Review Procedures

A. (1) Except as specified in Section 10 of this Act, a health carrier shall use written procedures for receiving and resolving grievances from covered persons, as provided in Sections 7, 8 and 9 of this Act.

(2) (a) Whenever a health carrier fails to adhere to the requirements of section 7 or section 10 of this Act with respect to receiving and resolving grievances involving an adverse determination, the covered person shall be deemed to have exhausted the provisions of this Act and may take action under subparagraph (b) of this paragraph.

(b) (i) A covered person may file a request for external review in accordance with the procedures outlined in [insert reference in state law equivalent to the Uniform Health Carrier External Review Model Act].

(ii) In addition to item (i), a covered person is entitled to pursue any available remedies under State or federal law on the basis that the health carrier failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

(3) (a) Notwithstanding paragraph (2), the provisions of section 7 or section 10 of this Act shall not be deemed exhausted based on a *de minimus* violation that does not cause, and is not likely to cause, prejudice or harm to the covered person as long as the health carrier demonstrates that the violation was for good cause or due to matters beyond the control of the health carrier and that the violation occurred in the context of an ongoing, good faith exchange of information between the health .24 Tw -(c)2.3 (l0.6 (t)-(a)-2.e(i)-1.5 (8.5 (h)-0.6 (ea)- (r)-4.2 ( )-a.8 ( )-593(

(ii) In this case, within a reasonable time, after the independent reviewer or the court rejects the grievance involving an adverse determination for immediate review, but not exceeding ten (10) days, the health carrier shall provide to the covered person or, if applicable, the covered

(2) With respect to a grievance requesting a first level review of an adverse determination involving a prospective review request, the health carrier shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition, but no later than thirty (30) days after the date of the health carrier's receipt of the grievance requesting the first level review made pursuant to Subsection A.

(3) With respect to a grievance requesting a first level review of an adverse determination involving a retrospective review request, the health carrier shall notify and issue a decision within a reasonable period of time, but no later than sixty (60) days after the date of the health carrier's receipt of the grievance requesting the first level review made pursuant to Subsection A.

Drafting Note: In adopting Subsection F, states should be aware that the DOL final rule permits a group health plan to provide for two levels of mandatory review of an adverse determination involving a prospective review request and an adverse determination involving a retrospective review request. In the case of a prospective review request, a maximum of 15 days is provided for a benefit determination at each level. In the case of a retrospective review request a maximum of 30 days is provided for a benefit determination at each level. For example, if a covered person decides to request a review of an adverse determination involving a prospective review request, and the group health plan provides for two levels of mandatory review, the plan must make a benefit determination within a reasonable period of time, taking into account the medical circumstances, but not later than 15 days after receipt of the appeal. If that benefit request is again denied at the first level of mandatory review and the covered person appeals that denial to the second level of mandatory review, the plan must again make a determination within a reasonable period of time, taking into account the medical circumstances, but not later than 15 days after the plan's receipt of the covered person's second level review request.

Drafting Note:

(2)

Drafting Note: States should be aware that the DOL final rule sets out certain information that must be included in any notice to a

(b) The health carrier shall make the provisions of Subparagraph (a) of this paragraph known to the covered person or, if applicable, the covered person's authorized representative within three (3) working days after the date of receiving the grievance.

C. (1) Upon receipt of the grievance, a health carrier shall designate a person or persons to conduct the standard review of the grievance.

(2) The health carrier shall not designate the same person or persons to conduct the standard review of the grievance that denied the claim or handled the matter that is the subject of the grievance.

(3) The health carrier shall provide the covered person or, if applicable, the covered person's authorized representative with the name, address and telephone number of a person designated to coordinate the standard review on behalf of the health carrier.

D. (1) The health carrier shall notify in writing the covered person or, if applicable, the covered person's authorized representative of the decision within twenty (20) working days after the date of receipt of the request for a standard review of a grievance filed pursuant to Subsection B.

(2) (a) Subject to Subparagraph (b) of this paragraph, if, due to circumstances beyond the carrier's control, the health carrier cannot make a decision and notify the covered person or, if applicable, the covered person's authorized representative pursuant to Paragraph (1) within twenty (20) working days, the health carrier may take up to an addition.9 (pp (n)-0.6ayn6 ( )).9 ( )]TJ0.002, d6 ( )

(a) A description of the process to obtain an additional review of the standard review decision if the covered person wishes to request a voluntary review pursuant to Section 9 of this Act; and

(b) The written procedures governing the voluntary review, including any required time frame for the review; and

(6) Notice of the covered person's right, at any time, to contact the commissioner's office, including the telephone number and address of the commissioner's office.

Section 9. Voluntary Level of Reviews of Grievances

Drafting Note: Although this section requires health carriers that offer managed care plans to establish an additional voluntary fref

(c) Present the covered person's case to the review panel;

(d) Submit written comments, documents, records and other material relating to the request for benefits for the review panel to consider when conducting the review both before and, if applicable, at the review meeting;

(e) If applicable, ask questions of any representative of the health carrier on the review panel; and

(f) Be assisted or represented by an individual of the covered person's choice.

(3) (a) A covered person or the authorized representative of the covered person wishing to request to appear in person before the review panel of the health carrier's designated representatives shall make the request to the health carrier within five (5) working days after the date of receipt of the notice sent in accordance with Paragraph (2).

(b) The covered person's right to a fair re
covered person's appearance at the re

C. (1) (a) With respect to a voluntary reviev
pursuant to Section 7 of this Act, a he
review the request.

(b) In conducting the review, the revie
comments, documents, records and c
benefits submitted by the covered p
representative pursuant to Subsecti
information was submitted or cons
decision.

(c) The panel shall have the legal authori
decision.

(2) (a) Except as provided in Subparagraph
panel shall be comprised of individua
level review decision made pursuant t

(b) An individual who was involved with
member of the panel or appear be
answer questions.

(c) The health carrier shall ensure that a
additional voluntary review of the fir
Section 7 of this Act are health c
expertise.

(d) Except, when such a reviewing he
available, in cases where there has b
reviewing health care professional sha

(i) Be a provider in the covered person's health benefit plan; and

(ii) Have a financial interest in the outcome of the review.

D. (1) (a) With respect to a voluntary review of a standard review decision made pursuant to Section 8 of this Act , a health carrier shall appoint a review panel to review the request.

(b) The panel shall have the legal authority to bind the health carrier to the panel's decision.

(2) (a)

(e)

(5) In cases concerning a grievance involving an adverse determination:

(a) The instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; and

(b) If applicable, a statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to [insert reference in state law equivalent to the Uniform Health Carrier External Review Model Act]; and

Drafting Note: Subparagraph (b) should be adopted by states that have enacted an external review law equivalent to the NAIC Health Carrier External Review Model Act. States that have not enacted such a law should not adopt the language in Subparagraph (b).

(6) Notice of the covered person's right to contact the commissioner's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time, including the telephone number and address of the commissioner's office or ombudsman's office.

Drafting Note: States may need to revise paragraph (6) above to reflect whatever office or offices established in their state pursuant to section 2793 of PHSA to provide assistance to individuals with internal claims and appeals and external review processes.

Drafting Note: States that have established an appeals procedure in the office of the commissioner may wish to use the following provision in Paragraph (6): "Notice of the covered person's right to appeal the decision to the commissioner's office and how to initiate the appeal."

E. In an expedited review, all necessary information, including the health carrier's decision, shall be transmitted between the health carrier and the covered person or, if applicable, the covered person's authorized representative by telephone, facsimile or the most expeditious method available.

F. (1) An expedited review decision shall be made and the covered person or, if applicable, the covered persrsrsroErv((o)xDj0rion sbM Td[((v)-1.6i(o)x [49TJ0.12-0.6 (v)-1.6l fpeditee icac-1.9

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

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

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

(g) If the decision involves a final adverse determination, the notice shall provide:

(i) The specific reasons or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in reaching the denial;

(ii) Reference to the specific plan provisions on which the determination is based;

(iii) A derTjEM (en6MCID 11 6 (i)-1.n (a)-2.a -1.224 Td( )TMC t0ID 11 9r)-m0.8 (d)1r d d a

(vii) A statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to [insert reference in state law equivalent to the Uniform Health Carrier External Review Model Act];

Drafting Note: The language in Item (vii) should be adopted by states that have enacted an external review law equivalent to the NAIC Uniform Health Carrier External Review Model Act. States that have not enacted such a law should not adopt the language in Item (vii).

(viii) A statement indicating the covered person's right to bring a civil action in a court of competent jurisdiction;

(ix) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner."; and

(x) A notice of the covered person's right to contact the commissioner's office or ombudsman's office for assistance with respect to the any claim, grievance or appeal at any time, including the telephone number and address of the commissioner's office or ombudsman's office.

Drafting Note: States may need to revise item (x) above to reflect whatever office or offices established in their state pursuant to section 2793 of PHSA to provide assistance to individuals with internal claims and appeals and external review processes.

Drafting Note: States that have established an appeals procedure in the office of the commissioner may wish to use the following