# ONE HUNDRED THIRD LEGISLATURE - FIRST SESSION - 2013
# COMMITTEE STATEMENT
# LB147

**Hearing Date:** Tuesday January 29, 2013
**Committee On:** Banking, Commerce and Insurance
**Introducer:** Gloor
**One Liner:** Adopt the Health Carrier External Review Act

**Roll Call Vote - Final Committee Action:**
Advanced to General File

**Vote Results:**

| | | |
|---|---|---|
| **Aye:** | 8 | Senators Campbell, Carlson, Christensen, Crawford, Gloor, Howard, Pirsch, Schumacher |
| **Nay:** | | |
| **Absent:** | | |
| **Present Not Voting:** | | |

| **Proponents:** | **Representing:** |
|---|---|
| Senator Mike Gloor | Introducer |
| Bruce Ramge | NE Department of Insurance |
| Jan McKenzie | NE Insurance Federation |
| **Opponents:** | **Representing:** |
| **Neutral:** | **Representing:** |

**Summary of purpose and/or changes:**
LB147 (Gloor), introduced at the request of the Director of Insurance, would adopt the Health Carrier External Review Act and amend various sections with regard to review of claims decisions made by health insurers. The bill would provide, section by section, as follows:

Health Carrier external review act
Section 1 would adopt a new section to specify that sections 1 to 18 of this act would be known as the Health Carrier External Review Act.

Section 2 would adopt a new section to declare that the purpose of the act is to provide standards for external review procedures that assure covered persons an independent review of an adverse determination.

Section 3 would adopt a new section to define terms for the purposes of the act. Adverse determination would be defined as a determination by a health carrier that a health care service does not meet the health carrier's requirements and so payment is denied, reduced, or terminated. This section would adopt definitions for ambulatory review, authorized representative, benefits, best evidence, case-control study, case management, case-series, certification, clinical review criteria, cohort study, concurrent review, covered person, director, discharge planning, disclose, emergency medical condition, emergency services, evidence-based standards, expert opinion, and facility. Final adverse determination would be defined as an adverse determination upheld by the health carrier at completion of the internal grievance procedures. This section would define health benefit plan, health care professional, health care provider, health care services, health carrier, health information, independent review organization, medical or scientific

evidence, prospective review, protected health information, randomized clinical trial, retrospective review, and second opinion. Utilization review would be defined as a set of formal techniques designed to monitor or evaluate health care services including ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. Utilization review organization would be defined as an entity conducting a utilization review other than a health carrier doing so on its own health benefit plans.

Section 4 would adopt a new section to specify that the act applies to all health carriers, but the act would not apply to policies providing coverage for specified diseases, credit, dental, disability income, hospital indemnity, long term care insurance, vision care, or any other limited supplemental benefit, or to a Medicare supplement policy, coverage under Medicare, Medicaid, or the Federal Employees Health Benefits Program, coverage under Chapter 55 of Title 10 of the U.S. Code (coverage for members of the military), coverage supplemental to liability insurance, workers' compensation, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault.

Section 5 would adopt a new section to require health carriers to notify covered persons of their right to request an external review when health carriers notify the covered person that the health carrier has completed an adverse determination or a final adverse determination and thereby denied a request for payment for a health care service. This section would specify the contents of the notice. This section would also require inclusion of information on a covered person's right to external review if the denial is based on a determination that the requested or recommended health care service or treatment is experimental or investigational. The notice must also include information on the right of the covered person to request an expedited external review if the covered person's treating physician certifies that the requested or recommended health care service or treatment would be significantly less effective if not promptly initiated.

Section 6 would adopt a new section to require that non-expedited requests for external review be submitted to the director of insurance, who may adopt a form for the request by rule and regulation. This section would specify that either a covered person or the covered person's "authorized representative" may make the request for external review.

Section 7 would adopt a new section to require that, except for an expedited review, a covered person cannot request an external review until after the covered person has exhausted the health carrier's internal grievance process set forth in the Health Carrier Grievance Procedure Act, Chapter 44 article 73, unless the covered person has a medical condition for which completing the expedited internal grievance process would negatively impact the covered person's health and, at the same time, the covered person files the request for an expedited external review, the covered person files for an expedited internal grievance review; or the health carrier agrees to waive the exhaustion requirement. A covered person may be deemed to have exhausted the internal grievance process if the covered person has filed a grievance with the carrier under the internal grievance process, but has not received a decision on the grievance within thirty days after filing the grievance.

Section 8 would adopt a new section to set forth the procedure and requirements for conducting non-expedited external reviews under the act. It would allow covered persons to file a request for external review within four months of an adverse determination or final adverse determination and require the director to send a copy to the health carrier within one business day. Within five business days, the health carrier would be required to complete a preliminary review determining coverage of the individual, coverage of the health care service, compliance with exhaustion requirements, and provision of all information, and provide notice to the covered person and director within one business day. This determination would be subject to appeal by the covered person to the director. This section would require the director to assign an independent review organization within one day and specify that the independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review or internal grievance process. Covered persons would be allowed to provide additional documentation to the independent review organization. Within five business days the health carrier would be required to submit documentation to the independent review organization. This section would allow the health carrier to reconsider its decision and terminate the external review. This section would require that the independent review organization consider the covered person's medical records, attending health care professional's recommendation, consulting reports, documents submitted, terms of coverage under the health benefit plan, appropriate practice guidelines, clinical review criteria, and the opinion of the independent review organization's clinical reviewer. This section would require the independent review organization to make a determination within 45 days, and provide notice to the covered person, the health carrier, and the director. This

section would require the notice to include a general description of the reason for review, dates of activities, reason and rationale for the decision and references to the evidence considered in reaching its decision. This section would require the director to assign independent review organizations on a random basis.

Section 9 would adopt a new section to set forth the procedures for conducting an expedited external review under the act. An expedited review could be made if the adverse determination involves a medical condition for which the time frame for the completion of an expedited internal review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The director would be required to send the notice to the health carrier immediately, and require an immediate determination of reviewability and notification of the determination by the health carrier; this determination would be subject to appeal by the covered person and to being overturned by the director. Upon receipt of the notice, the director would be required to immediately assign an independent review organization and notify the health carrier. This section would specify that the independent review organization is not bound by any decisions or conclusions reached during the health carrier's utilization review or internal grievance process. This section would require that the independent review organization consider the covered person's medical records, attending health care professional's recommendation, consulting reports, documents submitted, terms of coverage under the health benefit plan, appropriate practice guidelines, clinical review criteria, and the opinion of the independent review organization's clinical reviewer. This section would require the independent review organization to make a determination within as expeditiously as the covered person's medical condition requires, but no longer than 72 hours, and notify to the covered person, the health carrier, and the director. This section would require the independent review organization within 48 hours to provide written confirmation of the decision, and include a general description of the reason for review, dates of activities, reason and rationale for the decision and references to the evidence considered in reaching its decision. This section would specify that an expedited external review may not be provided for a retrospective adverse or final adverse determination. This section would require the director to assign of independent review organizations on a random basis.

Section 10 would adopt a new section to set forth the procedures for conducting external reviews of an adverse determination denying coverage based on the grounds that the health care service is experimental or investigational. This section would set standards for such reviews on both an expedited and a non-expedited basis. This section would allow covered persons to file a request for external review with the director within four months after receipt of a notice of an adverse determination or final adverse determination. Alternately, a covered person could request an expedited external review of a determination if the covered person's treating physician certifies that the health care service would be significantly less effective if not promptly initiated. Under an expedited review the director would be required to send the notice to the health carrier immediately, and require an immediate determination of reviewability and notification of the determination by the health carrier; this determination would be subject to appeal by the covered person and to being overturned by the director. For an expedited review the director would be required to immediately assign an independent review organization and notify the health carrier, which would be required to send all necessary documents. For non-expedited reviews, this section would require the director to send a copy of the request to the health carrier within one business day. Within five business days, the health carrier would be required to complete a preliminary review determining coverage of the individual, coverage of the health care service, non-exclusion of the benefit under the health benefit plan, certification by the treating physician that standard treatments are not effective or appropriate and there is no standard treatment more beneficial, and the recommendation of the treating physician compliance with exhaustion requirements, and provision of all necessary information. Within one business day the health carrier must inform the covered person and the director whether the request is complete and eligible for external review; this determination would be subject to appeal by the covered person and to being overturned by the director. Once reviewability has been determined for a non-expedited review, this section would require the director to assign an independent review organization from the list of approved organizations within one day of this determination and notify covered persons that they may provide additional documentation to the independent review organization. Within one business day the assigned independent review organization would be required to select clinical reviewers. Health carriers would be required to submit the data on which their decision was based. If the information is not provided, the independent review organization may reverse the health carrier's decision. Clinical reviewers would be required to review information submitted by the covered person and submit it to the health carrier. This section would allow the health carrier to reconsider its decision and terminate the external review. Clinical reviewers would be required to provide an opinion within 20 days of selection, or in the case of an expedited review as expeditiously as possible but

within 5 days, and include the elements required in the section. This section would require the clinical reviewers to consider factors set forth in the act for reaching a decision. This section would require the independent review organization to make a decision within 20 days, or in the case of an expedited review, 48 hours of receipt of the opinion of the clinical reviewer or reviewers. If a majority of clinical reviewers cannot agree on a decision, an additional clinical reviewer would be selected. Once a decision is reached, the covered person would be notified of the decision. This section would require that the assignment of independent review organizations by the director be made on a random basis.

Section 11 would adopt a new section to specify that an external review decision is binding on the health carrier and a covered person unless the health carrier has other remedies available under state law, and prohibits a covered person from refilling a request for external review involving the same adverse determination.

Section 12 would adopt a new section to require the director to approve independent review organizations under the act, under standards set forth in the section. Independent review organizations would be required to be nationally accredited, unless there is no accrediting organization, and to submit an application form with a fee. Approval would be effective for two years, unless it no longer meets the minimum requirements.

Section 13 would adopt a new section to adopt standards for independent review organizations and clinical reviewers. Independent review organizations would be required to maintain policies and procedures to govern external review processes that include a quality assurance mechanism, a toll free telephone service, and data maintenance agreements, and to maintain written procedures to ensure that it is unbiased. Clinical reviewers would be required to be physicians or other appropriate health care providers meeting qualifications set for in the act. This section would prohibit ownership of an independent review organization by a health carrier, and would prohibit an independent review organization from having a material conflict of interest with a health carrier subject to review, provider, hospital, developer or manufacturer of a therapy at issue in the external review. This section would presume compliance by an independent review organization accredited by a nationally recognized private accrediting entity.

Section 14 would adopt a new section to shield independent review organizations, or their clinical reviewers, employees, agents, or contractors from liability in damages for opinions rendered or acts or omissions under the act unless the opinion or act was in bad faith or involved gross negligence.

Section 15 would adopt a new section to adopt standards for the collection and maintenance of data by independent review organizations on a state and health carrier basis. This section would authorize the director to require aggregate reports on the external reviews performed. Under the section, written records would be required to be retained for at least three years.

Section 16 would adopt a new section to require that health carriers against which a request for external review is filed pay the cost of the independent review organization for conducting the external review.

Section 17 would adopt a new section to require health carriers to describe external review procedures in the evidence of coverage provided to covered persons in a format prescribed by the director. The description would include a statement of the right to request an external review of an adverse determination or final adverse determination, and explain the external review is available to review specified issues. The statement would also be required to inform the covered person that the covered person would be required to release required medical records.

Section 18 would adopt a new section to specify that the Health Carrier External Review Act applies to any claim submitted on and after January 1, 2014.

Section 19 would outright repeal section 44-7309, which provides for second-level grievance review under the Health Carrier Grievance Procedure Act. Under the federal Patient Protection and Affordable Care Act, states are only allowed one level of internal grievance review, and so this second level is preempted under federal law.

Mike Gloor, Chairperson