One Hundred Third Legislature - First Session - 2013

Introducer's Statement of Intent

LB147

Chairperson: Senator Mike Gloor

Committee: Banking, Commerce and Insurance

Date of Hearing: January 29, 2013

The following constitutes the reasons for this bill and the purposes which are sought to be accomplished thereby:

LB147 is a bill introduced at the request of the Nebraska Department of Insurance.

This bill would adopt the Health Carrier External Review Act and thereby implement a federal mandate, imposed pursuant to the new federal Patient Protection and Affordable Care Act, to adopt a process for external review of internal decision making by health carriers. This will allow policyholders to have an independent review of decision making in such areas as admission, availability of care, and continued stay. The federal mandate requires state adoption of laws consistent with the most current version of the National Association of Insurance Commissioners Model Act. In states that do not, the federal government administers the provisions.

The bill would adopt the Health Carrier External Review Act, declare the purpose of the act, and define terms. The bill would apply to all health carriers, but not to policies providing more limited benefits such as specified disease, hospital indemnity or Medicare supplement policies. (Sections 1 through 4 of the bill)

The bill would require health carriers to notify covered persons of the right to request an external review, specify the contents of the notice, and specifically notify the availability of expedited review in certain cases. Except for an expedited review, the bill would specifically require a covered person to exhaust the health carrier’s internal grievance process unless the health carrier has not issued a written decision within thirty days or waived the exhaustion requirement. (Sections 5 through 7 of the bill)

The bill would require for non-expedited external reviews, within five business days, and immediately for an expedited review, the health carrier to complete a preliminary review, subject to appeal to the director. The bill would require the director to assign an independent review organization within one day, immediately for an expedited review, and specify that the independent review organization is not bound by any decisions of utilization review or internal grievance process. Both parties would be allowed to provide additional documentation to the independent review organization. Health carriers could reconsider a

decision and terminate the external review. The bill would require consideration of the covered person's medical records, attending health care professional's recommendation, consulting reports, and other information. The independent review organization would be required to make a determination within 45 days, or in the case of an expedited review expeditiously as the covered person's medical condition requires, but no longer than 72 hours, and provide notice to the covered person, the health carrier, and the director. The notice would 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. Independent review organizations would be assigned on a random basis. (Sections 8 and 9 of the bill)

The bill adopts a different process for external review of decisions denying coverage on the grounds that the health care service is experimental or investigational. A covered person could request an expedited external review of a determination if the treating physician certifies that the 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 by the health carrier subject to an appeal to the director. The health carrier would have five days to complete this review in a non-expedited 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. The bill would require consideration of factors set forth in the act. The bill 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, a covered person would be notified of the decision. (Section 10 of the bill)

The bill would specify that a decision is binding unless the health carrier has other remedies available under state law, and prohibits a covered person from re-filing a request for external review. The bill would also 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 and submit an application form with a fee. Approval would be effective for two years, unless it no longer meets the minimum requirements. (Sections 11 and 12 of the bill)

The bill would adopt standards for independent review organizations and clinical reviewers. Independent review organizations would be required to maintain policies governing external review processes. Clinical reviewers would be required to be physicians or other appropriate health care providers meeting qualifications set for in the Act. The bill prohibits ownership of an independent review organization by a health carrier, a material conflict of interest with a health carrier subject to review, or a provider at issue in the external review. The bill would presume compliance by an independent review organization accredited by a nationally recognized private accrediting entity. (Section 13 of the bill)

The bill would shield independent review organizations from liability in damages for opinions under the act unless it was in bad faith or involved gross negligence. The bill would also adopt standards for data maintenance and collection. The bill would also authorize the director to require aggregate reports on the external reviews performed. Written records would be required to be retained for at least three years. (Sections 14 and 15 of the bill)

The bill would require that health carriers pay the cost of the independent review organization. The bill would also require health carriers to describe external review procedures in evidence of coverage it provides to covered persons as prescribed by the act. (Sections 16 and 17 of the bill)

The bill would specify that the Health Carrier External Review Act applies to any claim submitted on and after January 1, 2014. The bill would also 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. (Sections 18 and 19 of the bill)

Principal Introducer: _____

Senator Mike Gloor