Health Insurance Grievance Review

This Act requires a utilization review agent to, under certain circumstances, supply a provider of record upon request and an enrollee with notice of the enrollee's right to appeal and a written description of the appeals procedure at the time an adverse utilization review determination is made. It specifies that the exclusive right to review of a utilization review determination for an individual covered under an accident and sickness insurance policy or a health maintenance organization contract is through the accident and sickness insurer’s or health maintenance organization’s internal and external grievance procedures. It requires an accident and sickness insurer to establish and maintain an internal grievance procedure and an external grievance review procedure. It provides for expedited and standard reviews. It establishes requirements for independent review organizations to be certified by the state department of insurance and requires accident and sickness insurers to report certain information regarding grievances to the commissioner of the state department of insurance.

Submitted as:
Indiana
SB 365 (enrolled version)

Suggested Legislation

(Title, enacting clause, etc.)

Section 1. [Short Title.] This Act may be cited as “An Act Concerning Insurance Grievance Procedures and Utilization Review.”

Section 2. [Requirements When an Adverse Utilization Review is Made.]
(a) A utilization review agent shall make available to an enrollee, and to a provider of record upon request, at the time an adverse utilization review determination is made:
   (1) a written description of the appeals procedure by which an enrollee or a provider of record may appeal the utilization review determination by the utilization review agent; and
   (2) in the case of an enrollee covered under an accident and sickness policy or a health maintenance organization contract described in subsection (d), notice that the enrollee has the right to appeal the utilization review determination under Section 3 of this Act or [insert citation] and the toll free telephone number that the enrollee may call to request a review of the determination or obtain further information about the right to appeal.
(b) The appeals procedure provided by a utilization review agent must meet the following requirements:
   (1) On appeal, the determination not to certify an admission, a service, or a procedure as necessary or appropriate must be made by a health care provider licensed in the same discipline as the provider of record.
   (2) The determination of the appeal of a utilization review determination not to certify an admission, service, or procedure must be completed within [thirty (30)] days after:
      (i) the appeal is filed; and
      (ii) all information necessary to complete the appeal is received.
   (c) A utilization review agent shall provide an expedited appeals process for emergency or life threatening situations. The determination of an expedited appeal under the process required by this subsection shall be made by a physician and completed within [forty-eight (48)] hours after:
      (1) the appeal is initiated; and
(2) all information necessary to complete the appeal is received by the utilization review agent.

(d) If an enrollee is covered under an accident and sickness insurance policy as defined in Section 3 or a contract issued by a health maintenance organization as defined in [insert citation], the enrollee’s exclusive right to appeal a utilization review determination is provided under Section 3 or [insert citation], respectively.

(e) A utilization review agent shall make available upon request a written description of the appeals procedure that an enrollee or provider of record may use to obtain a review of a utilization review determination by the utilization review agent.

Section 3. [Internal Grievance Procedures.]

(1) As used in this section:

(a) “Accident and sickness insurance policy” means an insurance policy that provides [one or more of the kinds of insurance described in [insert citation]].

(b) The term does not include the following:

(I) Accident only, credit, dental, vision, Medicare supplement, long term care, or disability income insurance.

(II) Coverage issued as a supplement to liability insurance.

(III) Automobile medical payment insurance.

(IV) A specified disease policy issued as an individual policy.

(V) A limited benefit health insurance policy issued as an individual policy.

(VI) A short term insurance plan that:

(A) may not be renewed; and

(B) has a duration of not more than [six (6)] months.

(VII) A policy that provides a stipulated daily, weekly, or monthly payment to an insured during hospital confinement without regard to the actual expense of the confinement.

(VIII) Worker’s compensation or similar insurance.

(c) “Commissioner” refers to the [commissioner of the department of insurance].

(d) “Covered individual” means an individual who is covered under an accident and sickness insurance policy.

(e) “Department” refers to the [department of insurance].

(f) “External Grievance” means the independent review under of a grievance filed under Section 4 of this Act of a grievance filed under this section.

(g) “Grievance” means any dissatisfaction expressed by or on behalf of a covered individual regarding:

(I) a determination that a proposed service is not appropriate or medically necessary;

(II) a determination that a proposed service is experimental or investigational;

(III) the availability of participating providers;

(IV) the handling or payment of claims for health care services; or

(V) matters pertaining to the contractual relationship between:

(A) a covered individual and an insurer; or

(B) a group policyholder and an insurer; and for which the covered individual has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

(h) “Grievance Procedure” means a written procedure established and maintained by an insurer for filing, investigating, and resolving grievances and appeals.

(i) “Insured” means:

(I) an individual whose employment status or other status except family dependency is the basis for coverage under a group accident and sickness insurance policy; or

(II) in the case of an individual accident and sickness insurance policy, the individual in whose name the policy is issued.
“Insurer” means any person who delivers or issues for delivery an accident and sickness insurance policy or certificate in this State.

(2) An insurer shall establish and maintain a grievance procedure that complies with the requirements of this section for the resolution of grievances initiated by a covered individual. The [commissioner] may examine the grievance procedure of any insurer. An insurer shall maintain all grievance records received by the insurer after the most recent examination of the insurer’s grievance procedure by the [commissioner].

(3) (a) An insurer shall provide timely, adequate, and appropriate notice to each insured of:

(I) the grievance procedure required under this section;

(II) the external grievance procedure required under Section 4 of this Act;

(III) information on how to file:

(A) a grievance under this section; and

(B) a request for an external grievance review under Section 4 of this Act;

and

(IV) a toll free telephone number through which a covered individual may contact the insurer at no cost to the covered individual to obtain information and to file grievances.

(b) An insurer shall prominently display on all notices to covered individuals the toll free telephone number and the address at which a grievance or request for external grievance review may be filed.

(4) (a) A covered individual may file a grievance orally or in writing.

(b) An insurer shall make available to covered individuals a toll free telephone number through which a grievance may be filed. The toll free telephone number must:

(I) be staffed by a qualified representative of the insurer;

(II) be available for at least [forty (40)] hours per week during normal business hours; and

(III) accept grievances in the languages of the major population groups served by the insurer.

(c) A grievance is considered to be filed on the first date it is received, either by telephone or in writing.

(5) (a) An insurer shall establish procedures to assist covered individuals in filing grievances.

(b) A covered individual may designate a representative to file a grievance for the covered individual and to represent the covered individual in a grievance under this section.

(6) (a) An insurer shall establish written policies and procedures for the timely resolution of grievances filed under this Act. The policies and procedures must include the following:

(I) an acknowledgment of the grievance, orally or in writing, to the covered individual within [five (5)] business days after receipt of the grievance.

(II) documentation of the substance of the grievance and any actions taken.

(III) an investigation of the substance of the grievance, including any aspects involving clinical care.

(IV) notification to the covered individual of the disposition of the grievance and the right to appeal.

(V) standards for timeliness in:

(A) responding to grievances; and

(B) providing notice to covered individuals of:

(i) the disposition of the grievance; and

(ii) the right to appeal; that accommodate the clinical urgency of the situation.

(b) An insurer shall appoint at least [one (1)] individual to resolve a grievance.

(c) A grievance must be resolved as expeditiously as possible, but not more than [twenty (20)] business days after receiving all information reasonably necessary to complete the review. If an insurer is unable to make a decision regarding the grievance within the [twenty (20)] day period due to circumstances beyond the insurer’s control, the insurer shall:
(I) Notify, before the [twentieth] business day, the covered individual in writing of the reason for the delay; and

(II) Issue a written decision regarding the grievance within an additional [ten (10)] business days.

(d) An insurer shall notify a covered individual in writing of the resolution of a grievance within [five (5)] business days after completing an investigation. The grievance resolution notice must include the following:

(I) The decision reached by the insurer.

(II) The reasons, policies, and procedures that are the basis of the decision.

(III) Notice of the covered individual's right to appeal the decision.

(IV) The department, address, and telephone number through which a covered individual may contact a qualified representative to obtain additional information about the decision or the right to appeal.

(7) (a) An insurer shall establish written policies and procedures for the timely resolution of appeals of grievance decisions. The procedures for registering and responding to oral and written appeals of grievance decisions must include the following:

(I) Written or oral acknowledgment of the appeal not more than [five (5)] business days after the appeal is filed.

(II) Documentation of the substance of the appeal and the actions taken.

(III) Investigation of the substance of the appeal, including any aspects of clinical care involved.

(IV) Notification to the covered individual:

(A) of the disposition of an appeal; and

(B) that the covered individual may have the right to further remedies allowed by law.

(V) Standards for timeliness in:

(A) responding to an appeal; and

(B) providing notice to covered individuals of:

(i) the disposition of an appeal; and

(ii) the right to initiate an external grievance review under Section 4 of this Act; that accommodate the clinical urgency of the situation.

(b) In the case of an appeal of a grievance decision described in this section, an insurer shall appoint a panel of [one (1)] or more qualified people to resolve an appeal. The panel must include [one (1)] or more people who:

(I) have knowledge of the medical condition, procedure, or treatment at issue;

(II) are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment, or service;

(III) are not involved in the matter giving rise to the appeal or in the initial investigation of the grievance; and

(IV) do not have a direct business relationship with the covered individual or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the grievance.

(c) An appeal of a grievance decision must be resolved as expeditiously as possible reflecting the clinical urgency of the situation. However, an appeal must be resolved not later than [forty-five (45)] days after the appeal is filed.

(d) An insurer shall allow a covered individual the opportunity to:

(I) appear in person before; or

(II) if unable to appear in person, otherwise appropriately communicate with; the panel appointed under subsection (b).
(e) An insurer shall notify a covered individual in writing of the resolution of an appeal of a grievance decision within [five (5)] business days after completing the investigation. The appeal resolution notice must include the following:

(I) The decision reached by the insurer.

(II) The reasons, policies, and procedures that are the basis of the decision.

(III) Notice of the covered individual’s right to further remedies allowed by law, including the right to external grievance review by an independent review organization under Section 4 of this Act.

(IV) The department, address, and telephone number through which a covered individual may contact a qualified representative to obtain more information about the decision or the right to an external grievance review.

(8) An insurer may not take action against a provider solely on the basis that the provider represents a covered individual in a grievance filed under this section.

(9) (a) An insurer shall each year file with the [commissioner] a description of the grievance procedure of the insurer established under this section, including:

(I) the total number of grievances handled through the procedure during the preceding calendar year;

(II) a compilation of the causes underlying those grievances; and

(III) a summary of the final disposition of those grievances.

(b) The information required by subsection (a) must be filed with the [commissioner] on or before [March 1] of each year. The [commissioner] shall:

(I) make the information required to be filed under this section available to the public; and

(II) prepare an annual compilation of the data required under subsection (a) that allows for comparative analysis.

(c) The [commissioner] may require any additional reports as are necessary and appropriate for the [commissioner] to carry out the [commissioner's] duties under this section.

(10) The [department] may adopt rules under [insert citation] to implement this section.

Section 4. [External Review of Grievances.]

(1) As used in this section:

(a) “Accident and Sickness Insurance Policy” has the meaning set forth in Section 3 of this Act.

(b) “Appeal” means the procedure described in Section 3 of this Act.

(c) “Commissioner” refers to the [commissioner of the department of insurance].

(d) “Covered individual” has the meaning set forth in Section 3 of this Act.

(e) “Department” refers to the [department of insurance].

(f) “External grievance” means the independent review under this chapter of a grievance filed under Section 3 of this Act.

(g) “Grievance” has the meaning set forth in Section 3 of this Act.

(h) “Grievance procedure” has the meaning set forth in Section 3 of this Act.

(i) “Health care provider” means a person:

(I) that provides physician services as defined in [insert citation]; or

(II) who is licensed under [insert citation].

(j) “Insured” has the meaning set forth in Section 3 of this Act.

(k) “Insurer” has the meaning set forth in Section 3 of this Act.

(2) An insurer shall establish and maintain an external grievance procedure for the resolution of external grievances regarding:

(I) an adverse determination of appropriateness;

(II) an adverse determination of medical necessity; or
(III) a determination that a proposed service is experimental or investigational; made by an insurer or an agent of an insurer regarding a service proposed by the treating health care provider.

(3) (a) An external grievance procedure established under this section must:

(I) allow a covered individual or a covered individual's representative to file a written request with the insurer for an external grievance review of the insurer's appeal resolution under Section 3 of this Act not more than [forty-five (45)] days after the covered individual is notified of the resolution; and

(II) provide for:

(A) an expedited external grievance review for a grievance related to an illness, disease, condition, injury, or a disability if the time frame for a standard review would seriously jeopardize the covered individual's:

(i) life or health; or

(ii) ability to reach and maintain maximum function; or

(B) a standard external grievance review for a grievance not described in clause (A). A covered individual may file not more than [one (1)] external grievance of an insurer’s appeal resolution under this section.

(b) Subject to the requirements of subsection (d), when a request is filed under subsection (a), the insurer shall:

(I) select a different independent review organization for each external grievance filed under this section from the list of independent review organizations that are certified by the [department] under this section; and

(II) rotate the choice of an independent review organization among all certified independent review organizations before repeating a selection.

(c) The independent review organization chosen under subsection (b) shall assign a medical review professional who is board certified in the applicable specialty for resolution of an external grievance.

(d) The independent review organization and the medical review professional conducting the external review under this section may not have a material professional, familial, financial, or other affiliation with any of the following:

(I) The insurer.

(II) Any officer, director, or management employee of the insurer.

(III) The health care provider or the health care provider’s medical group that is proposing the service.

(IV) The facility at which the service would be provided.

(V) The development or manufacture of the principal drug, device, procedure, or other therapy that is proposed by the treating health care provider.

(VI) The covered individual requesting the external grievance review.

(e) A covered individual may be required to pay not more than [twenty-five (25)] dollars of the costs associated with the services of an independent review organization under this section. All additional costs must be paid by the insurer.

(4) (a) A covered individual who files an external grievance under this section shall:

(I) not be subject to retaliation for exercising the covered individual’s right to an external grievance under this section;

(II) be permitted to utilize the assistance of other individuals, including health care providers, attorneys, friends, and family members throughout the review process;

(III) be permitted to submit additional information relating to the proposed service throughout the review process; and

(IV) cooperate with the independent review organization by:

(i) providing any requested medical information; or

(ii) authorizing the release of necessary medical information.

(b) An insurer shall cooperate with an independent review organization selected under this section by promptly providing any information requested by the independent review organization.
(5) (a) An independent review organization shall:

(I) for an expedited external grievance filed under this section within [three (3)]

business days after the external grievance is filed; or

(II) for a standard appeal filed under this section, within [fifteen (15)] business days

after the appeal is filed; make a determination to uphold or reverse the insurer’s appeal resolution under

Section 3 of this Act based on information gathered from the covered individual or the covered individual’s
designee, the insurer, and the treating health care provider, and any additional information that the

independent review organization considers necessary and appropriate.

(b) When making the determination under this section, the independent review organization

shall apply:

(I) standards of decision making that are based on objective clinical evidence; and

(II) the terms of the covered individual’s accident and sickness insurance policy.

(c) The independent review organization shall notify the insurer and the covered individual of

the determination made under this section:

(I) for an expedited external grievance filed under this section, within [twenty-four

(24)] hours after making the determination; and

(II) for a standard external grievance filed under this section, within [seventy-two

(72)] hours after making the determination.

(6) A determination made under this section is binding on the insurer.

(7) (a) If, at any time during an external review performed under this section, the covered

individual submits information to the insurer that is relevant to the insurer’s resolution under Section 3 of this

Act and was not considered by the insurer under Section 3 of this Act.

(I) the insurer may reconsider the resolution under Section 3 of this Act; and

(II) if the insurer chooses to reconsider, the independent review organization shall

cease the external review process until the reconsideration under subsection (b) is completed.

(b) If the insurer reconsiders under subsection (a)(I), an insurer to which information is

submitted under subsection (a) shall reconsider the resolution under Section 3 of this Act based on the

information and notify the covered individual of the insurer’s decision:

(I) within [seventy-two (72)] hours after the information is submitted for a

reconsideration related to an illness, disease, condition, injury, or disability that would seriously jeopardize

the covered individual's:

(i) life or health; or

(ii) ability to reach and maintain maximum function; or

(II) within [fifteen (15)] days after the information is submitted for a reconsideration

not described in subdivision (1).

(c) If a decision reached under subsection (b) is adverse to the covered individual, the covered

individual may request that the independent review organization resume the external review under this

section.

(d) If an insurer to which information is submitted under subsection (a) chooses not to

reconsider the insurer’s resolution under Section 3 of this Act, the insurer shall forward the submitted

information to the independent review organization within [two (2)] business days after the insurer’s receipt

of the information.

(8) This section does not add to or otherwise change the terms of coverage included in a policy,
certificate, or contract under which a covered individual receives health care benefits under [insert citation].

(9) (a) The [department] shall establish and maintain a process for annual certification of

independent review organizations.

(b) The [department] shall certify a number of independent review organizations determined

by the department to be sufficient to fulfill the purposes of this section.

(c) An independent review organization must meet the following minimum requirements for

certification by the [department]:
(I) Medical review professionals assigned by the independent review organization to perform external grievance reviews under this section:

(A) must be board certified in the specialty in which a covered individual's proposed service would be provided;

(B) must be knowledgeable about a proposed service through actual clinical experience;

(C) must hold an unlimited license to practice in a state of the United States; and

(D) must not have any history of disciplinary actions or sanctions, including:

(i) loss of staff privileges; or

(ii) restriction on participation; taken or pending by any hospital, government, or regulatory body.

(II) The independent review organization must have a quality assurance mechanism to ensure the:

(A) timeliness and quality of reviews;

(B) qualifications and independence of medical review professionals;

(C) confidentiality of medical records and other review materials; and

(D) satisfaction of covered individuals with the procedures utilized by the independent review organization, including the use of covered individual satisfaction surveys.

(III) The independent review organization must file with the [department] the following information on or before [March 1] of each year:

(A) The number and percentage of determinations made in favor of covered individuals.

(B) The number and percentage of determinations made in favor of insurers.

(C) The average time to process a determination.

(D) Any other information required by the [department].

The information required under this subdivision must be specified for each insurer for which the independent review organization performed reviews during the reporting year.

(IV) Any additional requirements established by the [department].

(d) The [department] may not certify an independent review organization that is

(I) A professional or trade association of health care providers or a subsidiary or an affiliate of a professional or trade association of health care providers.

(II) An insurer, health maintenance organization, or health plan association, or a subsidiary or an affiliate of an insurer, health maintenance organization, or health plan association.

(e) The [department] may suspend or revoke an independent review organization’s certification if the [department] finds that the independent review organization is not in substantial compliance with the certification requirements under this section.

(f) The [department] shall make available to insurers a list of all certified independent review organizations.

(g) The [department] shall make the information provided to the [department] under subsection (c) (III) available to the public in a format that does not identify individual covered individuals.

(10) Except as provided in this section, documents and other information created or received by the independent review organization or the medical review professional in connection with an external grievance review under this section:

(a) are not public records;

(b) may not be disclosed under [insert citation]; and

(c) must be treated in accordance with confidentiality requirements of state and federal law.

(11) An insurer shall each year file with the [commissioner] a description of the grievance procedure of the insurer established under this section, including:
(I) the total number of external grievances handled through the procedure during the
preceding calendar year;

(II) a compilation of the causes underlying those grievances; and

(III) a summary of the final disposition of those grievances; for each independent
review organization used by the insurer during the reporting year.

(b) The information required by subsection (a) must be filed with the [commissioner] on or
before [March 1] of each year. The [commissioner] shall:

(I) make the information required to be filed under this section available to the
public; and

(II) prepare an annual compilation of the data required under subsection (a) that
allows for comparative analysis.

(c) The [commissioner] may require any additional reports as are necessary and appropriate
for the [commissioner] to carry out the [commissioner's] duties under this article.

(12) (a) An independent review organization is immune from civil liability for actions taken in
good faith in connection with an external review under this section.

(b) The work product or determination, or both, of an independent review organization under
this chapter are admissible in a judicial or administrative proceeding. However, the work product or
determination, or both, do not, without other supporting evidence, satisfy a party's burden of proof or
persuasion concerning any material issue of fact or law.

(13) If a covered individual has the right to an external review of a grievance under Medicare, the
covered individual may not request an external review of the same grievance under this section.

(14) The [department] may adopt rules under [insert citation] to implement this section.

(15) (a) The information required under sections 3.9 and 4.11 of this Act must be filed beginning
[March 1, 2003].

(b) This section expires [June 30, 2005].