ANALYSIS OF HOUSE BILL 2865

Resolving grievances against health carriers.

SPONSORS: Representatives Dyer and Skinner.

PURPOSE: To establish two levels of health carrier grievance procedures [GP] and a pilot program for external review of medical necessity claims under the public employees benefit plan.

BACKGROUND: The meaning of managed care varies among private and public purchasers, patients, carriers, and regulators. Although the term is referenced in no less than sixteen sections of state law, a statutory definition is lacking. The Insurance Commissioner defines "managed care plan," in recently adopted rules, as a "...plan that coordinates the provision of covered health care services to a covered person through the use of a primary care provider and a network." [WAC 284-43-130, effective 2/22/98] In a recently held legislative training session on managed care, the term was defined as "approaches to health services delivery and benefit design that integrate management and coordination of services with financing to influence utilization, cost, quality, and outcomes."

Although managed care organizations (MCO's), e.g., health maintenance organizations (HMO's), date back to the late 1920's, the real growth in managed care occurred over the past two decades; while MCO's had around six million enrollees in 1976, it is estimated that over 100 million Americans are enrolled in some form of managed care today.

In recent years, increasing pressure has been placed on MCO's from private and public purchasers to control costs, which has met with a corresponding pressure from enrollees and providers to assure quality and choice. The confluence of these vectors has resulted in a land-office business of quality assurance activities. The National Committee on Quality Assurance (NCQA), the Utilization Review Accreditation Committee (URAC), the National Association of Insurance Commissioners (NAIC), and other organizations have been rapidly developing standards to accredit MCO's based on quality measures. An explicit grievance procedure standard has been identified as a key component of a quality assurance program.

The medical necessity of a service, stay, or procedure is sometimes contentious. Presently, this issue is not addressed statutorily and is usually handled through a carrier's grievance procedures. Some consumer advocates have proposed an external review process for medical necessity review.

CURRENT LAW: There are five statutory references to enrollee grievances:

RCW 48.02.160 gives the Insurance Commissioner the special duty of "Providing assistance to...the public in obtaining information about insurance products and in resolving

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complaints…–

RCW 48.46.100 (repealed by HB 2865) requires each health maintenance organization to establish –…a grievance procedure to provide reasonable and effective resolution of complaints initiated by enrollee participants…–.

RCW 48.43.005(13) defines "Grievance" (see below).

RCW 48.43.095 requires carriers to provide enrollees upon request with A copy of all grievance procedures for claim or service denial and for dissatisfaction with care…..–

RCW 48.43.065 (as amended by HB 2865) requires each carrier to file with the commissioner its procedures for review and adjudication of complaints initiated by covered persons or health care providers.–

The Insurance Commissioner has not promulgated rules on grievance procedures.

SUMMARY:

Grievance defined

A written complaint submitted by or on behalf of a covered person regarding (a) denial of payment for medical services or nonprovision of medical services included in the covered person's health benefit plan, or (b) service delivery issues other than denial of payment for medical services or nonprovision of medical services, including dissatisfaction with medical care, waiting time for medical services, provider or staff attitude or demeanor, or dissatisfaction with service provided by the health carrier. [RCW 48.43.005(13)]

Utilization Review

The grievance procedure (GP) does not apply to a reconsideration of utilization review[1] resolved within 5 business days of the utilization review decision; however, if a covered person remains dissatisfied, a grievance may be submitted.

Requirements of a covered person filing a grievance.

To submit a grievance in any form, but include written authorization if using a representative.

Participate in grievance process

If unsatisfied with first level decision, file for second level grievance within 90 days of receipt of first level

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[1] defined as ***the prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider or facility, given or proposed to be given to an enrollee or group of enrollees.***– RCW 48.43.005(25)]

decision.

If unsatisfied with the second level grievance decision, the grievant may request binding mediation.

Requirements of the health carrier.

Establish written procedures for receiving and resolving grievances.

At each level of review, include staff with sufficient background and authority to address the grievance.

Make available the carrier's toll-free number for the review of any grievance involving clinical issues.

Provide toll-free collect telephone access for persons unable to represent a written grievance because of limited English proficiency, a communication problem, or disability.

Provide reasonable assistance to overcome disadvantages of the grievance process for persons with difficulties participating.

Issue written decisions that include: A statement of the carrier's understanding of the grievance; the decision in plain language explaining the grievance determination; references to relevant policies, procedures, contract terms, and (after second level) notice of the insurance commissioner's toll-free number and address.

First Level Grievance

Within 3 business days of receiving a grievance, the carrier must acknowledge receipt in writing.

The process shall not exceed 30 days from receipt of grievance, but if external information needs to be collected, the carrier may take an additional 14 days. Also, the period may be extended upon mutual agreement.

Second Level Grievance

If dissatisfied with the first level decision, the covered person must submit a written request for review within 90 days of receipt of first level decision.

The covered person is given an opportunity to appear in person before the representatives of the carrier.

The grievance must be processed within 30 days, but can be extended for a specified period if mutually agreed.

A review panel must be created comprising of representatives of the health carrier not otherwise participating in the first level review.

If unsatisfied with the second level decision, the covered person may submit the grievance to binding

mediation.

Expedited Review of a Grievance

This review is limited to cases where denial may seriously jeopardize the life or ultimate health care outcome of a covered person.

Carriers must appoint an appropriate health care provider to participate in expedited reviews and provide reasonable access to specialty providers who typically manage the issue under review.

All necessary information must be transmitted between the health carrier and covered person in the most expeditious method.

Carriers must make a decision and notify the covered person as expeditiously as the medical condition of the covered person requires, but no more than two business days or 72 hours.

Where the expedited review process does not resolve the grievance, the covered person may request a second level grievance review.

Filing with the Insurance Commissioner

Each health carrier must submit an annual report to the Commissioner, no later than March 31st which includes grievance information summarized in the following three categories: (1) managed medical assistance plans – commonly known as "health options"; (2) closed network plans; and (3) point of service/other. The report is to include: Number of each type of grievance and percentage closed at each level, length of time between filing of grievance and closure, nature of the grievances, access problems, and types of denials.

External Review Pilot Program

The administrator of the Health Care Authority (HCA) is authorized to provide contractual incentives to insuring entities, including the HCA's self-funded medical plans, who agree to participate in a voluntary two-year pilot program for independent external review of medical necessity grievances. The costs and benefits of external review and other processes for resolution of medical necessity grievances shall be studied by the Health Care Policy Technical Advisory Committee created in RCW 41.05.150. The study shall analyze existing processes, and any external review pilot programs initiated pursuant to this bill. An interim report shall be completed no later than September 1, 1999, and a final report no later than six months after completion of the pilot program outlined in this bill.