H-4340.1

HOUSE BILL 2865

State of Washington 55th Legislature 1998 Regular Session

By Representatives Dyer, Skinner, Murray and Cody

Read first time 01/21/98. Referred to Committee on Health Care.

AN ACT Relating to standards for the establishment and maintenance of health carrier grievance procedures and establishing a pilot program and study for external review of medical necessity claims under the public employees benefit plan; amending RCW 48.43.055; reenacting and amending RCW 41.05.075; adding a new section to chapter 48.43 RCW; creating a new section; and repealing RCW 48.46.100.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

NEW SECTION. **Sec. 1.** The purpose of this act is to provide standards for the establishment and maintenance of procedures by health carriers to assure that covered persons have the opportunity for the appropriate resolution of their grievances, as set forth in this act. The legislature intends to further describe the existing rights of covered persons to resolve grievances with their health carrier, and does not alter or limit the existing rights of covered persons.

NEW SECTION. **Sec. 2.** A new section is added to chapter 48.43 RCW to read as follows:

(1) Every health carrier shall use written procedures for receiving and resolving grievances from covered persons utilizing a two-level

internal grievance process. The provisions of chapter . . ., Laws of 1998 (this act) do not apply to utilization review reconsiderations that are resolved within five business days of the utilization review decision. Covered persons who remain dissatisfied with the utilization review reconsideration may submit a grievance. The health carrier's grievance processes shall include methods by which covered persons who are unable to file written grievances may notify the health carrier of a grievance orally or through another alternative mechanism so that a written grievance may be submitted on behalf of the covered person with health carrier assistance. At each level of review of a grievance, the health carrier shall include a person or persons with sufficient background and authority to deliberate the merits of the grievance and establish appropriate terms of resolution. The health carrier's medical director or a health care provider designated by the medical director shall be available to participate in the review of any grievance involving a clinical issue or issues. A grievance that, in addition, includes an issue of clinical quality of care as determined by the health carrier's medical director or his or her designee may be directed to the health carrier's quality assurance committee for review and comment. This section does not alter any protections afforded under statutes relating to confidentiality and nondiscoverability of quality assurance activities and information.

(2)(a) An inquiry or complaint that is resolved to the covered person's satisfaction by the health carrier at the time of the initial inquiry or complaint is not considered a grievance subject to the review, recording, and reporting requirements of this section.

(b) The health carrier is required to provide telephone access for purposes of presenting a grievance for review to covered persons unable to present a written grievance because of limited English proficiency, literacy problems, or disability. Each telephone number provided shall be toll free or collect within the health carrier's service area and provide reasonable access to the health carrier without undue delays during normal business hours.

(c) The health carrier shall provide reasonable assistance at all stages of the grievance process to covered persons with limited English proficiency, a literacy problem, or a disability.

(3)(a) A grievance may be submitted by a covered person or a representative acting on behalf of the covered person through written

authority to assure protection of the covered person's private information. A covered person wishing to have an authorized representative act on his or her behalf must provide the health carrier with written authorization in order to have that representative participate in any or all stages of the grievance process. Within three business days of receiving a grievance, the health carrier shall acknowledge in writing the receipt of the grievance and provide the grievance coordinator's name and/or title, phone number, and the address where additional information may be submitted by the covered person or authorized representative. The health carrier shall make a reasonable effort to contact the covered person or authorized representative to discuss the grievance prior to issuance of a written determination. The health carrier shall process the grievance in a reasonable length of time not to exceed thirty calendar days from receipt of the written grievance. If the grievance involves the collection of information from sources external to the health carrier and its participating providers, the health carrier has an additional fourteen calendar days to process the covered person's grievance. The time required to resolve the first-level review may be extended for a specified period if mutually agreed upon by the covered person or authorized representative and the health carrier.

(b) The health carrier shall provide the covered person, or authorized representative, with a written determination of its review within the time frame specified in (a) of this subsection. The written determination shall contain at a minimum:

(i) The health carrier's decision in plain language explaining the grievance determination and references to relevant policies, procedures, and contract terms in sufficient detail for the covered person or authorized representative to respond further to the health carrier's decision; and

(ii) When the health carrier's decision is not wholly favorable to the covered person, a description of the process to obtain a second-level grievance review of the decision, including the time frames required for submission of a request by the covered person or authorized representative, and notice of the opportunity to appear in person.

(4)(a) A health carrier shall provide a second-level grievance review for those covered persons who are dissatisfied with the first-level grievance review decision and who submit a written request for

review within ninety days of receipt of the carrier's first-level grievance decision. The second-level review process shall include an opportunity for the covered person or authorized representative to appear in person before the representative or representatives of the health carrier. The covered person or authorized representative must ask for a personal appearance in the written request for a second-level review.

(b) The health carrier shall process the grievance in a reasonable length of time, not to exceed thirty calendar days from receipt of the request for a second-level review. The time required to resolve the second-level review may be extended for a specified period if mutually agreed upon by the covered person or authorized representative and the health carrier.

(c) A health carrier's procedures for conducting a second-level review must include the following:

(i) The second-level review panel shall be comprised of representatives of the health carrier not otherwise participating in the first-level review. If the grievance involves a clinical issue or issues, the health carrier shall appoint a health care provider qualified to assess the clinical considerations of the case, not previously involved with the grievance under review, and who does not have a material financial interest in the outcome of the review;

(ii) The review panel shall schedule the review meeting to reasonably accommodate the covered person or authorized representative and not unreasonably deny a request for postponement of the review requested by the covered person or authorized representative of the covered person; and

(iii) The health carrier shall notify the covered person or authorized representative in writing at least fourteen calendar days in advance of the scheduled review date unless a shorter time frame is agreed to by the health carrier and the covered person.

The review meeting shall be held at a location within the health carrier's service area that is reasonably accessible to the covered person or authorized representative of the covered person. In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person or authorized representative the opportunity to communicate with the review panel, at the health carrier's expense, by conference call, video conferencing, or other appropriate technology as determined by the health carrier.

(d) The health carrier shall issue a written decision to the covered person or authorized representative within five business days of completing the review meeting. The decision shall include:

(i) A statement of the health carrier's understanding of the nature of the grievance and all pertinent facts;

(ii) The health carrier's decision in plain language explaining the grievance determination and references to relevant policies, procedures, and contract terms; and

(iii) Notice of the insurance commissioner's toll-free number and address.

(e) Determination of a grievance at the second level of review that is unfavorable to the covered person may be submitted by the covered person or authorized representative to nonbinding mediation or another available, mutually agreeable dispute resolution procedure. Mediation shall be conducted under mediation rules similar to those of the American arbitration association, the center for public resources, the judicial arbitration and mediation service, RCW 7.70.100, or any other rules of mediation agreed to by the parties.

(5) Each health carrier as defined in this chapter shall file with the commissioner its procedures for review and adjudication of grievances initiated by covered persons.

(6) The health carrier shall maintain accurate records in a grievance log of each grievance to include the following:

(a) A description of the grievance, the date received by the health carrier, and the name and identification number of the covered person; and

(b) A statement as to which level of the grievance procedure the grievance has been brought, the date at which it was brought to each level, the decision reached at each level, and a summary description of the rationale for the decision.

(7) Each health carrier shall submit an annual report to the commissioner no later than March 31st and make its grievance log available to the commissioner for inspection upon request. The annual report shall not include information that identifies specific persons.

(a) The annual report shall include a summary of the following, broken down into the following three categories: Managed medical assistance plans, commonly known as "healthy options"; closed network plans; and point of service/other:

(i) The total number of grievances received in the reporting year;

(ii) The number of closed grievances in each of the categories listed in (b) of this subsection;

(iii) The number and percentage of grievances in each of the categories listed in (b) of this subsection in which the health carrier's initial decision is upheld and the number and percentage in which the initial decision is reversed at the closure of the grievance;

(iv) The number and percentage of all grievances that are closed at the first level of review;

(v) The number and percentage that are closed at the second level of review; and

(vi) The average length of time between filing of a grievance and closure of the grievance.

(b) A health carrier must report each grievance according to the nature of the grievance. The nature of the grievance shall be determined according to the categories listed in this subsection. The health carrier must report each grievance in one category only, and must have a system that allows the health carrier to report accurately in the specified categories and to clearly identify how internal grievance log categories related to the reporting categories specified in this subsection. If a grievance could fit in more than one category, a health carrier shall report the grievance in the category established in this subsection that the health carrier determines to be the most appropriate for the grievance. The categories of grievances are as follows:

(i) Access problems, including timeliness and the availability of a provider;

(ii) Denials based on medical necessity;

(iii) Denials based on other coverage issues, including denials based on the service being out of plan, out of area, or not a covered benefit;

(iv) Eligibility;

(v) Clinical quality of care;

(vi) Referral issues;

(vii) Emergency services; and

(viii) Administrative and quality of business service issues with the health carrier.

(c) For purposes of this subsection:

(i) "Closed network plan" means an employer group or individual plan that requires covered persons to use network providers under the

terms of the plan except under very limited circumstances such as for emergencies outside the service area; and

(ii) "Closed grievance" means a grievance in which a determination has been made and the determination either is not or cannot be appealed within the health carrier's grievance procedure, or the health carrier determines that the complainant is no longer pursuing the grievance.

(8) A notice of the availability and the requirements of the grievance procedure, including the address where a written grievance may be filed, shall be included in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided by the health carrier to its enrollees.

The notice shall include a toll-free or collect telephone number for a covered person to obtain a verbal explanation of the grievance procedure.

(9) Information about how to access the grievance process shall also be provided to covered persons: At least annually; upon written denial; upon written notice of a reduction or termination of requested services; at each stage of the grievance process if a denial is issued; and upon request.

(10) A health carrier shall establish written procedures for the expedited review of a grievance involving a situation where the time to resolve a grievance according to the procedures set forth in this section would seriously jeopardize the life or ultimate health care outcome of a covered person. A request for an expedited review may be submitted orally or in writing by a covered person or authorized representative. A health carrier's procedures for establishing an expedited review process shall include the following:

(a) The health carrier shall appoint an appropriate health care provider to participate in expedited reviews and shall provide reasonable access to specialty providers who typically manage the issue under review.

(b) All necessary information, including the health carrier's decision, shall be transmitted between the health carrier and the covered person or authorized representative by telephone, facsimile, or the most expeditious method available as determined by the health carrier.

(c) A health carrier shall make a decision and notify the covered person or authorized representative of the covered person as expeditiously as the medical condition of the covered person requires,

but no more than two business days or seventy-two hours, whichever is less after the request for expedited review is received by the health carrier.

(d) A health carrier shall provide written confirmation of an expedited review decision within two business days of providing notification of that decision to the enrollee, if the initial notification was not in writing. The written notification shall contain the provisions required in subsection (3)(b) of this section pertaining to a first-level grievance review.

(e) In any case where the expedited review process does not resolve the grievance, the covered person or authorized representative may request a second-level grievance review. In conducting the second-level grievance review, the health carrier shall adhere to time frames that are reasonable under the circumstances, but in no event to exceed the time frames specified in subsection (4) of this section pertaining to second-level grievance review.

Sec. 3. RCW 48.43.055 and 1995 c 265 s 20 are each amended to read as follows:

Each health carrier as defined under RCW 48.43.005 shall file with the commissioner its procedures for review and adjudication of complaints initiated by covered persons or health care providers. Procedures filed under this section shall provide a fair review for consideration of complaints. Every health carrier shall provide reasonable means whereby ((~~any person~~)) a health care provider aggrieved by actions of the health carrier may be heard in person or by their authorized representative on their written request for review. If the health carrier fails to grant or reject such request within thirty days after it is made, the complaining ((~~person~~)) health care provider may proceed as if the complaint had been rejected. A complaint that has been rejected by the health carrier may be submitted to nonbinding mediation. Mediation shall be conducted pursuant to mediation rules similar to those of the American arbitration association, the center for public resources, the judicial arbitration and mediation service, RCW 7.70.100, or any other rules of mediation agreed to by the parties.

Sec. 4. RCW 41.05.075 and 1994 sp.s. c 9 s 724, 1994 c 309 s 3, and 1994 c 153 s 6 are each reenacted and amended to read as follows:

(1) The administrator shall provide benefit plans designed by the board through a contract or contracts with insuring entities, through self-funding, self-insurance, or other methods of providing insurance coverage authorized by RCW 41.05.140.

(2) The administrator shall establish a contract bidding process that:

(a) Encourages competition among insuring entities;

(b) Maintains an equitable relationship between premiums charged for similar benefits and between risk pools including premiums charged for retired state and school district employees under the separate risk pools established by RCW 41.05.022 and 41.05.080 such that insuring entities may not avoid risk when establishing the premium rates for retirees eligible for medicare;

(c) Is timely to the state budgetary process; and

(d) Sets conditions for awarding contracts to any insuring entity.

(3) The administrator shall establish a requirement for review of utilization and financial data from participating insuring entities on a quarterly basis.

(4) The administrator shall centralize the enrollment files for all employee and retired or disabled school employee health plans offered under chapter 41.05 RCW and develop enrollment demographics on a plan-specific basis.

(5) All claims data shall be the property of the state. The administrator may require of any insuring entity that submits a bid to contract for coverage all information deemed necessary including subscriber or member demographic and claims data necessary for risk assessment and adjustment calculations in order to fulfill the administrator’s duties as set forth in this chapter.

(6) All contracts with insuring entities for the provision of health care benefits shall provide that the beneficiaries of such benefit plans may use on an equal participation basis the services of practitioners licensed pursuant to chapters 18.22, 18.25, 18.32, 18.53, 18.57, 18.71, 18.74, 18.83, and 18.79 RCW, as it applies to registered nurses and advanced registered nurse practitioners. However, nothing in this subsection may preclude the administrator from establishing appropriate utilization controls approved pursuant to RCW 41.05.065(2)(a), (b), and (d).

(7) Beginning in January 1990, and each January thereafter until January 1996, the administrator shall publish and distribute to each

school district a description of health care benefit plans available through the authority and the estimated cost if school district employees were enrolled.

(8) The administrator may provide contractual incentives to insuring entities 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 in accord with the provisions of RCW 41.05.150. The pilot program shall involve an external review mechanism subject to the following requirements and with the following characteristics:

(a) The process is available to enrolled state employees and their dependents who have been denied coverage for otherwise covered services based on a determination by the insuring entity that the proposed service or treatment does not meet the administrator's definition of medical necessity; the service is not considered experimental or investigational by the plan; the enrollee has complied with and exhausted the insuring entity's grievance procedure; and the proposed service or treatment involves an otherwise covered service that would amount to ten thousand dollars or more in expense to the enrollee in a twelve-month period;

(b) The insuring entity must notify eligible enrollees in writing of the opportunity to request external review as part of the notification of final grievance determinations;

(c) The administrator shall certify as eligible the external review entity or entities, and shall assure that eligible cases are randomly assigned for review if more than one review entity is certified;

(d) Costs of the external review shall be borne by the insuring entity;

(e) The recommendations of the expert reviewer shall be binding on the insuring entity;

(f) The administrator shall assure that any external review entity has the following qualifications:

(i) Reviewers must be licensed physicians or other appropriate state-regulated health care providers knowledgeable about the recommended service or treatment through five years' actual clinical experience in the preceding ten years, and have no history of disciplinary action or sanctions taken or pending by any hospital, government, or regulatory body; and

(ii) Neither the expert reviewer nor the external review entity may have any material professional, immediate familial, or material financial interest with any of the following: The insuring entity; any officer, director, or management employee of the insuring entity; the provider proposing the service or treatment, the provider's medical group, or the independent practice association; the institution at which the service or treatment would be provided; the development or manufacture of the principal drug, device, or procedure or other therapy proposed for coverage; or any person in the enrollee's immediate family;

(g) The external review entity shall be required to complete reviews within thirty days unless the administrator extends the review period in exceptional circumstances;

(h) The external review entity must have a quality assurance mechanism in place that ensures the timeliness and quality of reviews; the qualifications, impartiality, and freedom from conflict of interest of the expert reviewers; and the confidentiality of medical records and review materials;

(i) An external review entity and any expert reviewers assigned by the entity shall not be liable for damages arising from determinations made in good faith pursuant to this section;

(j) The administrator, with consultation of the health care policy technical advisory committee authorized in RCW 41.05.150, shall commission a study of procedures utilized to resolve medical necessity grievances by enrolled participants in state employee coverage provided through insuring entities and self-funding arrangements. The study shall analyze existing processes, and any external review pilot programs initiated pursuant to this subsection. An interim report shall be produced no later than September 1, 1999, and a final report shall be produced no later than six months after completion of the pilot program outlined in this subsection; and

(k) For the purpose of this subsection, "insuring entity" includes self-funded medical plans offered for the benefit of state employees and their dependents.

NEW SECTION. **Sec. 5.** RCW 48.46.100 and 1975 1st ex.s. c 290 s 11 are each repealed.

--- END ---