Z-0223.1

HOUSE BILL 1066

State of Washington 64th Legislature 2015 Regular Session

By Representatives Tharinger, Moeller, Gregerson, Jinkins, Cody, and Riccelli; by request of Insurance Commissioner

Prefiled 01/05/15. Read first time 01/12/15. Referred to Committee on Health Care & Wellness.

AN ACT Relating to certified independent review organizations for addressing long-term care insurance disputes; and adding a new section to chapter 48.83 RCW.

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

NEW SECTION. **Sec. 1.** A new section is added to chapter 48.83 RCW to read as follows:

(1) The legislature declares there is a need for a process for the fair consideration of disputes relating to decisions by issuers that offer long-term care insurance to deny, modify, reduce, or terminate coverage of or payment for long-term care services for an insured. This process should consist of an internal appeals process and an independent review process. Therefore, an independent review process for long-term care insurance is created to be established and administered by the commissioner.

(2) The definitions in this subsection apply throughout this section unless the context clearly requires otherwise.

(a) "Independent review organization" means an organization that conducts independent reviews of long-term care decisions.

(b) "Certified independent review organization" means an independent review organization that has received certification from the office of the insurance commissioner.

(3) An insured or their appointed representative may seek review by a certified independent review organization of an issuer's decision to deny, modify, reduce, or terminate coverage of or payment for a long-term care service, after exhausting the issuer's internal appeals process and receiving a decision that is unfavorable to the insured, or after the issuer has exceeded the timelines for internal appeals described in the policy or as established by insurance regulation without good cause and without reaching a decision.

(4) The commissioner must establish and use a rotational registry system for the assignment of a certified independent review organization to each long-term care insurance dispute. The system must be flexible enough to ensure that a certified independent review organization has the expertise necessary to review the particular medical condition or service at issue in the dispute, and that any certified independent review organization does not have a conflict of interest that will influence its independence.

(5) Issuers must provide to the appropriate certified independent review organization, not later than the fifth business day after the date the issuer receives a request for review, a copy of:

(a) Any records of the insured that are relevant to the review;

(b) Any documents used by the issuer in making the determination to be reviewed by the certified independent review organization;

(c) Any documentation and written information submitted to the issuer in support of the appeal; and

(d) A list of each physician or provider who has provided care to the insured and who may have records relevant to the appeal. Health information or other confidential or proprietary information in the custody of an issuer may be provided to a certified independent review organization, subject to rules adopted by the commissioner.

(6) An insured or their appointed representative must be provided with at least five business days to submit to the certified independent review organization in writing additional information that the certified independent review organization must consider when conducting the external review. The certified independent review organization must forward any additional information submitted by an insured or their appointed representative to the issuer within one business day of receipt by the certified independent review organization.

(7) The reviewers from a certified independent review organization must make determinations regarding the medical necessity

or appropriateness of, and the application of the long-term care policy's coverage provisions to, services for an insured. "Reviewers," as used in this subsection, means physicians as well as experts in other areas pertinent to long-term care such as nursing. The reviewers' determinations must be based upon their expert judgment, after consideration of relevant medical, scientific, and cost-effectiveness evidence, and medical standards of practice in the state of Washington. Except as provided in this subsection, the certified independent review organization must ensure that determinations are consistent with the scope of covered benefits as outlined in the long-term care policy. Reviewers may override the policy's medical necessity or appropriateness standards if the standards are determined upon review to be unreasonable or inconsistent with sound, evidence-based practice.

(8) Once a request for an independent review determination has been made, the certified independent review organization must proceed to a final determination, unless requested otherwise by both the issuer and the insured or the insured's appointed representative.

(9) An insured, their appointed representative, a physician, or a provider may request an expedited external review if the insured's physician or provider reasonably determines that following the appeal process response times could seriously jeopardize the insured's life, health, or ability to regain maximum function. The decision regarding an expedited appeal must be made within seventy-two hours after the time the appeal is received by the issuer. An insured, their appointed representative, physician, or provider may also request expedited external review in situations when fairness and justice so require, such as when an insured will lose a desired long-term care provider prior to the completion of the normal appeal process, and will not likely have the option to return to that provider even if the external review is decided in favor of the insured.

(10) The certified independent review organization must make its decision to uphold or reverse the adverse benefit determination or final internal adverse benefit determination and notify the insured or their appointed representative and the issuer of the determination as expeditiously as possible but within not more than seventy-two hours after the receipt of the request for expedited external review. If the notice is not in writing, the certified independent review organization must provide written confirmation of the decision within forty-eight hours after the date of the notice of the decision.

(11) Issuers must timely implement the certified independent review organization's determination and must pay the certified independent review organization's charges.

(12) When an insured or their appointed representative requests independent review of a dispute under this section, and the dispute involves an issuer's decision to modify, reduce, or terminate an otherwise covered long-term care service that an insured is receiving at the time the request for review is submitted and the issuer's decision is based upon a finding that the long-term care service, or level of long-term care service, is no longer appropriate, the issuer must continue to provide the long-term care service if requested by the insured or their appointed representative until a determination is made under this section. If the determination affirms the issuer's decision, the insured may be responsible for the cost of the continued service.

(13) Each certified independent review organization must maintain written records and make them available upon request to the commissioner.

(14) A certified independent review organization may notify the office of the insurance commissioner if, based upon its review of disputes under this section, it finds a pattern of substandard or egregious conduct by an issuer.

(15) The commissioner must develop a reasonable maximum fee schedule that certified independent review organizations must use to assess issuers for conducting reviews.

(16)(a) The commissioner must adopt rules to implement this section after considering relevant standards adopted by national accreditation organizations, the Washington state department of health, and the national association of insurance commissioners.

(b) The rules adopted under this section must include provisions for the commissioner to certify independent review organizations and to terminate the certification of an independent review organization for failure to comply with the requirements for certification. The commissioner may review the operation and performance of a certified independent review organization in response to complaints or other concerns about compliance.

(17) This section is not intended to supplant any existing authority of the commissioner under this title to oversee and enforce issuer compliance with applicable statutes and rules.

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