House Research Act Summary

CHAPTER: 239 **SESSION:** 1999 Regular Session

TOPIC: Uniform Complaint and Appeals Processes for Health Plan Companies and Utilization Review Organizations

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Overview

This bill establishes an external appeals process in chapter 62Q for adverse determinations made by health plan companies and sets requirements for internal appeals processes. It also consolidates, modifies, and adds requirements in chapter 62M for utilization review decisions made by utilization review organizations and procedures for standard appeals and expedited appeals of these decisions. To conform with these changes, the bill makes several modifications as necessary to related statutes.

Section

1 **Enrollee complaint system.** Amends § 62D.11, subd. 1. In a subdivision requiring all HMOs to establish and maintain a complaint system for enrollees, requires the complaint system to comply with the new complaint resolution procedures being established in chapter 62Q. Strikes language defining "provision of health services" and requiring HMOs to inform enrollees of certain information regarding how to appeal HMO internal appeal decisions.

2 **Geographic accessibility.** Adds § 62D.124. Establishes geographic accessibility requirements in statute for health maintenance organizations for primary care, mental health, general hospital, and other health services. Allows the commissioner of health to grant exceptions from these requirements if the HMO can demonstrate that the geographic accessibility requirements are not feasible in a particular service area or part of a service area. Specifies that the geographic accessibility requirements do not apply if the enrollee is

referred to a referral center for health care services. Also specifies that the geographic accessibility requirements for primary care, mental health, and general hospital services do not apply if the enrollee has chosen the health plan knowing that the plan does not have providers within 30 minutes or 30 miles of the enrollee, or to service areas approved before May 24, 1993. (The substance of these requirements are already in HMO rule, and this section moves them to statute. The requirements in this section that are new are (1) requiring the maximum travel

distance or time to obtain mental health services to be the lesser of 30 miles or 30 minutes to the nearest provider; and (2) specifying that two of the grounds for exemptions from the accessibility requirements apply only to primary care, mental health, and general hospital services.)

3 **Citation, jurisdiction, and scope.** Amends § 62M.01. Adds community integrated service networks (CISNs) and accountable provider networks (APNs) to the jurisdiction of chapter 62M (governing utilization review organizations and procedures). Specifies that the appeal procedures in chapter 62M are to be used for any complaint from an enrollee that, to be resolved, requires a medical determination to be made.

4 **Attending dentist.** Amends § 62M.02, subd. 3. In the definition of attending dentist, replaces the term "patient" with "enrollee." (This change is one of several terminology changes made throughout chapter 62M.)

5 **Attending health care professional.** Amends § 62M.02, subd. 4. Changes a term used throughout chapter 62M, from "attending physician" to "attending health care professional." Also specifies that this term includes only physicians, chiropractors, dentists, mental health professionals, podiatrists, and advanced practice nurses.

6 **Certification.** Amends § 62M.02, subd. 5. In the definition of certification, changes a term used from "health carrier" to "health plan company."

7 **Claims administrator.** Amends § 62M.02, subd. 6. Adds a reference to CISNs and APNs in the definition of claims administrator, and makes a change in terminology used.

8 **Claimant.** Amends § 62M.02, subd. 7. Makes a change in terminology used in the definition of claimant.

9 **Concurrent review.** Amends § 62M.02, subd. 9. Makes a change in terminology used in the definition of concurrent review.

10 **Discharge planning.** Amends § 62M.02, subd. 10. Makes a change in terminology used in the definition of discharge planning.

11 **Enrollee.** Amends § 62M.02, subd. 11. Modifies the definition of enrollee; the amended definition is similar to the definition of this term in chapter 62Q governing health plan companies.

12 **Health benefit plan.** Amends § 62M.02, subd. 12. Makes a change to terminology used in the definition of health benefit plan.

13 **Health plan company.** Adds subd. 12a to § 62M.02. Defines health plan company.

14 **Provider.** Amends § 62M.02, subd. 17. Makes a minor change to the definition of provider.

15 **Utilization review.** Amends § 62M.02, subd. 20. Makes a change in terminology used in the definition of utilization review. Also specifies that utilization review does not include a referral or participation in a referral process by a participating provider unless the provider is acting as a utilization review organization.

16 **Utilization review organization.** Amends § 62M.02, subd. 21. In the definition of utilization review organization, adds a reference to APNs.

17 **Licensed utilization review organization.** Amends § 62M.02, subd. 1. Specifies that an organization licensed under chapter 62T (governing APNs) is appropriately licensed to perform utilization review and must comply with the requirements for UROs in chapter 62M.

18 **Penalties and enforcements.** Amends § 62M.03, subd. 3. Requires utilization review organizations licensed under chapter 62T (accountable provider networks) to comply with chapter 62M as a condition of licensure as a URO.

19 **Responsibility for obtaining certification.** Amends § 62M.04, subd. 1. Requires health plan

companies that include utilization review requirements to provide a clear and concise description of the utilization review process to its enrollees in the policy, subscriber contract, or certificate of coverage. Makes a minor change in terminology.

20 **Information upon which utilization review is conducted.** Amends § 62M.04, subd. 2. In a subdivision specifying the information utilization review organizations may use when making decisions, makes a change to terminology used.

21 **Data elements.** Amends § 62M.04, subd. 3. In a subdivision listing the data elements a utilization review organization is allowed to obtain to decide whether to certify a procedure, makes changes to terminology used.

22 **Additional information.** Amends § 62M.04, subd. 4. In a subdivision specifying the circumstances under which a utilization review organization may request additional information, makes changes to terminology used.

23 **Procedures for review determination.** Amends § 62M.05. Modifies procedures governing utilization review determinations, and creates an expedited review determination process.

Subd. 1. Written procedures. Deletes a reference to section 72A.201, subd. 4a; with this change, a utilization review organization (URO) needs to conduct reviews in compliance with chapter 62M only.

Subds. 2 and 3. Makes a change in terminology and a technical change.

Subd. 3a. Standard review determination. Requires an initial determination on all requests for utilization review to be communicated to the enrollee and provider within ten business days of the request, if all information reasonably needed to make the decision has been made available to the URO. (This requirement is in current law and is being moved from another paragraph.) Makes changes to terminology used and technical changes. Specifies that written notice of determinations not to certify must inform the enrollee and the attending health care professional of the right to appeal to the internal appeal process for utilization review determinations in chapter 62M and the procedure for initiating the appeal. (This requirement is being moved from another section.)

Subd. 3b. Expedited review determination. Requires an expedited process for making initial UR determinations to be used if the attending health care professional believes that an expedited determination is needed. Requires notifications of expedited initial determinations to be made as quickly as the enrollee's medical condition requires, but no later than 72 hours after the initial request. If the determination is not to certify, requires the URO to also notify the enrollee and attending professional of the right to appeal to the expedited internal appeal process for utilization review determinations in chapter 62M and the procedure for initiating an appeal.

Subd. 4. Failure to provide necessary information. Makes changes to terminology used.

Subd. 5. Notification to claims administrator. If the URO and claims administrator are separate entities, requires the URO to forward a notification of the decision to certify or not to certify to the claims administrator.

24 **Appeals of determinations not to certify.** Amends § 62M.06. Modifies the standard and expedited appeals processes for decisions by utilization review organizations not to certify.

Subd. 1. Procedures for appeal. Makes minor changes and changes in terminology used. Strikes language that is being moved to another section.

Subd. 2. Expedited appeal. If an enrollee pursues an expedited appeal, requires the URO to notify the enrollee and attending professional by phone of its determination as quickly as the enrollee's medical condition requires, but no later than 72 hours after receiving the expedited appeal. If the determination not to certify is not reversed through the expedited appeal, requires the URO to give the enrollee and attending professional, as soon as practical, information on the

right to appeal the decision to the external appeal process in chapter 62Q. Strikes language allowing expedited appeals not resolved to be resubmitted through the standard appeal process.

Subd. 3. Standard appeal. In the standard appeal process, requires a URO to notify the enrollee, health care professional, and claims administrator of its determination on the appeal within 30 days of receiving the notice of appeal (under current law, a URO must give notice of its decision within 45 days after receiving the required documentation for the appeal). Allows a URO to take up to 14 additional days to notify the relevant individuals of its determination if it cannot make a determination within 30 days, due to circumstances beyond its control. Requires advance notice to the enrollee and others if additional days beyond the 30 days are needed. If an initial determination is not reversed on appeal, requires the URO to include in its notification the right to submit an appeal to the external review process in chapter 62Q and the procedure for initiating the external process. Also makes terminology changes.

Subd. 4. Notification to claims administrator. Makes technical changes.

25 **Prior authorization of services.** Amends § 62M.07. Changes cross-references.

26 **Physician reviewer involvement.** Amends § 62M.09, subd. 3. Makes a change to terminology used.

27 **Reviews during normal business hours.** Amends § 62M.10, subd. 2. Makes a change to terminology used.

28 **Oral requests for information.** Amends § 62M.10, subd. 5. Makes changes to terminology used.

29 **Availability of criteria.** Amends § 62M.10, subd. 7. Makes a change to terminology used.

30 **Prohibition of inappropriate incentives.** Amends § 62M.12. Makes a change to terminology used and a technical change.

31 **Applicability of other chapter requirements.** Amends § 62M.15. Requires utilization review organizations to meet the requirements of chapters 62Q and 62T if applicable, in addition to the requirements of the other chapters listed.

32 **Dispute resolution by commissioner.** Amends § 62Q.106. Strikes a reference to a section in chapter 62Q being repealed.

33 **Cooperation.** Amends § 62Q.19, subd. 5a. Strikes a cross-reference to a section in chapter 62Q being repealed.

34 **Definitions.** Adds § 62Q.68. For a series of sections establishing requirements for complaint resolution processes, defines the terms complaint and complainant. Specifies that the sections establishing an internal complaint resolution process and a system for appeals do not apply to insurance companies licensed under chapter 60A or nonprofit health service plan corporations that provide dental or vision coverage only.

35 **Complaint resolution.** Adds § 62Q.69. Requires health plan companies to have internal complaint resolution procedures, establishes procedures for filing complaints, and establishes requirements for notification of complaint decisions.

Subd. 1. Establishment. Requires a health plan company to establish and maintain an internal complaint resolution process to resolve complaints filed by complainants.

Subd. 2. Procedures for filing a complaint. Allows complainants to file complaints either by telephone or in writing. If the complaint is made orally and is resolved adversely to the complainant, or if the oral complaint is not resolved to the complainant's satisfaction within ten days, the health plan company must inform the complainant that the complaint may be submitted in writing. Also requires the health plan company to offer to provide the complainant with assistance in filing the complaint, and to provide that assistance upon request. Lists the

information that the complaint form must include. Upon receipt of a written complaint, requires the health plan company to notify the complainant within ten business days that the complaint was received, unless the complaint is resolved within that time. Requires health plan companies to provide a clear description of how to submit a complaint and notice that help in filing a complaint is available.

Subd. 3. Notification of complaint decisions. Requires a health plan company to notify the complainant in writing of its decision and reasoning as soon as practical, but no later than 30 days after receiving the written complaint. Allows a health plan company to take up to 14 additional days to notify relevant individuals of its decision if it cannot make a decision within 30 days, due to circumstances beyond its control. Requires advance notice to the complainant if additional days beyond the 30 days are needed. If the decision is adverse to the complainant, requires the notification to tell the complainant of the right to appeal the decision to the internal appeal process. Also requires the notification to tell the complainant of the right to submit the complaint at any time to either the commissioner of health or the commissioner of commerce.

36 **Appeal of the complaint decision.** Adds § 62Q.70. Establishes internal appeal procedures for complaint decisions.

Subd. 1. Establishment. Requires a health plan company to establish an internal appeal process for reviewing health plan company decisions on complaints. Specifies that the people authorized to resolve or recommend the resolution of internal appeals must not be solely the same people who make the initial decisions about complaints. Requires the internal process to allow the receipt of testimony, explanations, and other information.

Subd. 2. Procedures for filing an appeal. If a complainant notifies a health plan company of a decision to appeal through the internal appeal process, requires the health plan company to give the complainant the option of appealing either in writing or through a hearing.

Subd. 3. Notification of appeal decisions. If the complainant appeals in writing, requires a health plan company to give a complainant written notice of the appeal decision and all key findings within 30 days of receiving the complainant's written notice of appeal. If the complainant appeals by hearing, requires written notice of the appeal decision and all key findings within 45 days of the health plan company's receipt of the complainant's written notice of appeal. If the appeal decision is adverse to the complainant, requires the notice to advise the complainant of the right to submit the appeal decision to the external review process. Allows the complainant to request a complete summary of the appeal decision.

37 **Notice to enrollees.** Adds § 62Q.71. Requires health plan companies to give enrollees a clear, concise description of complaint resolution procedures and procedures used for utilization review, as part of the member handbook, subscriber contract, certificate of coverage, or other document if the health plan company does not have a member handbook. Lists the information that the description must include.

38 **Recordkeeping; reporting.** Adds § 62Q.72. Requires health plan companies to keep records of all enrollee complaints for the past five years and their resolutions, and to make them available to the appropriate commissioner upon request. Permits insurance companies licensed under chapter 60A to instead comply with the recordkeeping requirements of section 72A.20, subdivision 30. Requires health plan companies to submit data on the number and types of complaints not resolved within 30 days (30 business days for insurance companies licensed under chapter 60A) to the appropriate commissioner. Requires the commissioner to make this information available to the public on request.

39 **External review of adverse determinations.** Adds § 62Q.73. Establishes procedures for external reviews of adverse determinations of enrollee complaints to the commissioner of health or commerce.

Subd. 1. Definition. Defines an adverse determination as a complaint decision that relates to a health care service or claim that was appealed and that was decided adversely to the complainant; any initial determination not to certify that was appealed and in which the initial decision was not reversed; or any decision made by an indemnity insurance carrier in which a service was denied based on medical necessity.

Subd. 2. Exception. Specifies that the external review section does not apply to governmental programs, except that a governmental program recipient may request an expert medical opinion be arranged by an external review entity and that the cost of review must be paid by the commissioner of human services. Defines governmental programs as prepaid MA, MinnesotaCare, prepaid GAMC, and Medicare.

Subd. 3. Right to external review. Allows any enrollee, or any person acting on behalf of any enrollee, who has received an adverse determination to submit a written request for external review to the commissioner of health or commerce, as appropriate. Establishes a $25 filing fee, and allows the fee to be waived in cases of financial hardship. Requires the health plan company to participate and to bear any costs above the filing fee. Specifies that the commissioner is not required to independently investigate an adverse determination.

Subd. 4. Contract. Directs the commissioner of administration to consult with the commissioners of health and commerce and then contract for the provision of independent external reviews of all adverse determinations. Requires the contract to ensure that fees for services rendered are reasonable.

Subd. 5. Criteria. Lists the criteria that an entity must satisfy to obtain the contract for conducting external reviews. Also requires the commissioner of administration to take into consideration, in awarding the contract, any national accreditation standards for external review entities.

Subd. 6. Process. Requires the external review entity to provide immediate notice to the enrollee and the health plan company when it receives a request for an external review. Within ten business days, requires the health plan company and enrollee to provide the entity with any information they wish to have considered. Allows an enrollee to be assisted or represented by a person of the enrollee's choice. Requires any aspect of a review involving a medical determination to be performed by a health care professional with appropriate expertise. Requires external reviews to be completed as soon as practical, but not later than 40 days after receiving the request, and requires the entity to promptly send written notice of the decision and reasons for it to the enrollee, health plan company, and relevant commissioner.

Subd. 7. Standards of review. Requires an external review of any adverse determination that does not require a medical determination to be based on whether the determination was in compliance with the enrollee's health benefit plan. Reviews of determinations made by HMOs requiring medical determinations must be based on whether the determination was consistent with the definition of medically necessary care in HMO rule. Reviews of determinations made by non-HMO health plan companies must be based on whether the determination was consistent with the definition of medically necessary care in chapter 62Q, applicable to mental health coverage.

Subd. 8. Effects of external review. Specifies that decisions are nonbinding on the enrollee and binding on the health plan company. Allows the health plan company to ask for judicial review of the decision, on the ground that the decision was arbitrary and capricious or involved an abuse of discretion.

Subd. 9. Immunity from civil liability. Extends immunity from civil liability to any person who participates in external review, for actions that are not willful or reckless misconduct, taken in good faith, and within the scope of the person's duties.

Subd. 10. Data reporting. Requires the commissioners to make available to the public, on request, summary data on decisions made under this section.

40 **Complaint system.** Amends § 62T.04. Modifies a cross-reference in a section governing a complaint system for APNs.

41 **Standards for preauthorization approval.** Amends § 72A.201, subd. 4a. Modifies a cross-reference in a section governing the procedures under which a decision to approve or deny requested benefits for policies of accident and sickness insurance must be processed.

42 **Duties of the commissioner of health.** Amends § 256B.692, subd. 2. Requires counties that participate in county-based purchasing to assure the commissioner of health that the county will meet the requirements for internal and external reviews of adverse determinations in chapter 62Q, and strikes cross-references to sections in chapter 62Q being repealed.

43 **Repealer.** Paragraph (a) repeals sections 62D.11, subds. 1b and 2 (expedited resolutions of complaints for HMOs).

Paragraph (b) repeals sections 62Q.105 and 62Q.30 (requiring health plan companies to establish complaint procedures and expedited fact-finding and dispute resolution processes by July 1, 1999); and 62Q.11 (dispute resolution procedures to be available to settle disputes with health plan companies).

Paragraph (c) repeals Minnesota Rules, parts 4685.0100, subp. 4 and 4a (definitions in HMO rules); and 4685.1700 (requirements for HMO complaint systems).

Paragraph (d) repeals Minnesota Rules, part 4685.1010, subp. 3 (geographic accessibility requirements for HMOs).

44 **Effective date.** Establishes effective dates:

Most provisions are effective April 1, 2000 and apply to contracts issued or renewed on or after that date. Requires the commissioner of health or commerce to grant an extension of up to three months to any health plan company or URO that cannot comply with these sections by the effective date, due to circumstances beyond its control.

Makes section 43, paragraph (b) effective July 1, 1999.

Makes the sections on geographic access requirements for HMOs effective January 1, 2000, to apply to contracts issued or renewed on or after that date.