

HEALTH CARRIER GRIEVANCE PROCEDURE MODEL ACT

Table of Contents

Section 1.	Title
Section 2.	Purpose and Intent
Section 3.	Definitions
Section 4.	Applicability and Scope
Section 5.	Grievance Reporting Requirements
Section 6.	Grievance Review Procedures
Section 7.	First Level Reviews of Grievances Involving an Adverse Determination
Section 8.	Standard Reviews of Grievances Not Involving an Adverse Determination
Section 9.	Voluntary Level of Reviews of Grievances
Section 10.	Expedited Reviews of Grievances Involving an Adverse Determination
Section 11.	Regulations
Section 12.	Penalties
Section 13.	Separability
Section 14.	Effective Date

Section 1. Title

This Act shall be known and may be cited as the Health Carrier Grievance Procedure Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act in a regulation format. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as regulations.

Section 2. Purpose and Intent

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 grievances, as defined in this Act.

Drafting Note: States are strongly encouraged to adopt both this Health Carrier Grievance Procedure Model Act and the NAIC's Utilization Review and Benefit Determination Model Act. The Utilization Review and Benefit Determination Model Act sets out the process for making utilization review and benefit determinations with respect to requests for health care services. This Act assumes the existence of the utilization review and benefit determination process in the Utilization Review and Benefit Determination Model Act and adverse determinations made under that Act with respect to requests for health care services.

Drafting Note: The definition of "adverse determination" found in Section 3A of this Act has been revised to conform with the provisions of the federal Department of Labor (DOL) claims procedure final regulation (DOL final rule), as published in the *Federal Register*, Nov. 21, 2000, which establishes standards for the processing of claims for benefits under group health plans. Specifically, the definition of "adverse determination" was revised to be consistent with the term "adverse benefit determination" used in the DOL final rule in order to include determinations that may involve eligibility issues in addition to medical necessity issues and any other determination that results in a denial, reduction or termination of a benefit or a failure to provide payment, in whole or in part, for a benefit. The definition of "adverse determination" has been revised to include rescission of coverage determinations, as provided in the interim final rules on internal claims and appeals and external review processes, as published in the *Federal Register*, July 23, 2010.

Section 3. Definitions

For purposes of this Act:

- A. (1) "Adverse determination" means:
 - (a) A determination by a health carrier or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health carrier's health benefit plan upon application of any utilization review technique does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced or terminated or payment is not provided or made, in whole or in part, for the benefit;

- (b) The denial, reduction, termination or failure to provide or make payment, in whole or in part, for a benefit based on a determination by a health carrier or its designee utilization review organization of a covered person's eligibility to participate in the health carrier's health benefit plan; or
 - (c) Any prospective review or retrospective review determination that denies, reduces or terminates or fails to provide or make payment, in whole or in part, for a benefit.
- (2) "Adverse determination" includes a rescission of coverage determination.

Drafting Note: The DOL final rule uses the term "adverse benefit determination." This model act uses the term "adverse determination." The NAIC has chosen to continue to use the term "adverse determination" in this model act instead of using the DOL final rule's term "adverse benefit determination" because the term "adverse determination" is referenced in several other NAIC model acts in addition to this model act. If the terminology were changed, this would necessitate revising several NAIC model acts to reflect this change in terminology. The definition of "adverse determination" in Subsection A has been revised, however, to be consistent with the DOL final rule's definition for the term "adverse benefit determination." The definition of "adverse determination" has been revised to include rescission of coverage determinations, as provided in the interim final rules on internal claims and appeals and external review processes, published in the *Federal Register*, July 23, 2010.

- B. "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.
- C. "Authorized representative" means:
 - (1) A person to whom a covered person has given express written consent to represent the covered person for purposes of this Act;
 - (2) A person authorized by law to provide substituted consent for a covered person;
 - (3) A family member of the covered person or the covered person's treating health care professional when the covered person is unable to provide consent;
 - (4) A health care professional when the covered person's health benefit plan requires that a request for a benefit under the plan be initiated by the health care professional; or
 - (5) In the case of an urgent care request, a health care professional with knowledge of the covered person's medical condition.
- D. "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.
- E. "Certification" means a determination by a health carrier or its designee utilization review organization that a request for a benefit under the health carrier's health benefit plan has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.
- F. "Clinical peer" means a physician or other health care professional who holds a non-restricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

Drafting Note: States may wish to define "clinical peer" more broadly to include a health care professional who has demonstrable expertise to review a case, whether or not the reviewing professional is in the same or similar specialty as the health care professional who made the initial decision.

- G. "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by the health carrier to determine the medical necessity and appropriateness of health care services.
- H. "Closed plan" means a managed care plan that requires covered persons to use participating providers under the terms of the managed care plan.
- I. "Commissioner" means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term “commissioner” appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

- J. “Concurrent review” means utilization review conducted during a patient’s stay or course of treatment in a facility, the office of a health care professional or other inpatient or outpatient health care setting.

Drafting Note: The DOL final rule, which was unchanged by the interim final rules on internal claims and appeals and external review processes published in the *Federal Register*, July 23, 2010, uses the term “concurrent claim” instead of “concurrent review.” The DOL final rule does not define “concurrent claim.” However, given the use of the term in the substantive provisions of the DOL final rule and the way the term is used substantively in this model, the definition of “concurrent review,” as defined in Subsection J, is consistent with the term “concurrent claim.”

- K. “Covered benefits” or “benefits” means those health care services to which a covered person is entitled under the terms of a health benefit plan.
- L. “Covered person” means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.
- M. “Discharge planning” means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.
- N. “Emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person’s health or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

Drafting Note: The definition of “emergency medical condition” has been revised to reflect the definition of that term in the interim final rules on emergency services published in the *Federal Register* June 28, 2010.

- O. “Emergency services” means, with respect to an emergency medical condition:
- (1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
 - (2) Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at a hospital, to stabilize a patient.

Drafting Note: The definition of “emergency services” has been revised to reflect the definition of that term in the interim final rules on emergency services published in the *Federal Register* June 28, 2010.

- P. “Facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.
- Q. “Final adverse determination” means an adverse determination that has been upheld by the health carrier at the completion of the internal appeals process applicable under Section 7 or Section 10 of this Act or an adverse determination that with respect to which the internal appeals process has been deemed exhausted in accordance with section 6A(2) of this Act.

Drafting Note: The interim final rules on internal claims and appeals and external review processes, as published in the *Federal Register* July 23, 2010, use the term “final internal adverse determination.” For consistency with the NAIC Uniform Health Carrier External Review Model Act the term as been defined as “final adverse determination” in this Act.

- R. “Grievance” means a written complaint or oral complaint if the complaint involves an urgent care request submitted by or on behalf of a covered person regarding:
- (1) Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

- (2) Claims payment, handling or reimbursement for health care services; or
 - (3) Matters pertaining to the contractual relationship between a covered person and a health carrier.
- S. (1) “Health benefit plan” means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Drafting Note: The Patient Protection and Affordable Care Act (Affordable Care Act) uses the term “health insurance coverage.” “Health benefit plan,” as defined in this model act, is intended to be consistent with the definition of “health insurance coverage” contained in HIPAA. Paragraphs (2), (3), (4), and (5) below track the language of HIPAA that addresses “excepted benefits,” i.e., those benefits that are excepted from the requirements of the Affordable Care Act.

- (2) “Health benefit plan” includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.
- (3) “Health benefit plan” does not include:
 - (a) Coverage only for accident, or disability income insurance, or any combination thereof;
 - (b) Coverage issued as a supplement to liability insurance;
 - (c) Liability insurance, including general liability insurance and automobile liability insurance;
 - (d) Workers’ compensation or similar insurance;
 - (e) Automobile medical payment insurance;
 - (f) Credit-only insurance;
 - (g) Coverage for on-site medical clinics; and
 - (h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.
- (4) “Health benefit plan” does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:
 - (a) Limited scope dental or vision benefits;
 - (b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
 - (c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.
- (5) “Health benefit plan” does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
 - (a) Coverage only for a specified disease or illness; or
 - (b) Hospital indemnity or other fixed indemnity insurance.

- (6) “Health benefit plan” does not include the following if offered as a separate policy, certificate or contract of insurance:
- (a) Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;
 - (b) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or
 - (c) Similar supplemental coverage provided to coverage under a group health plan.
- T. “Health care professional” means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

Drafting Note: States may wish to specify the licensed health professionals to whom this definition may apply (e.g., physicians, psychologists, nurse practitioners, etc.). This definition applies to individual health professionals, not corporate “persons.”

- U. “Health care provider” or “provider” means a health care professional or a facility.
- V. “Health care services” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.
- W. “Health carrier” means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

Drafting Note: The Affordable Care Act uses the term “health insurance issuer” instead of “health carrier.” The definition of “health carrier” is consistent with the term “health insurance issuer.”

Drafting Note: States that license health maintenance organizations pursuant to statutes other than the insurance statutes and regulations, such as the public health laws, will want to reference the applicable statutes instead of, or in addition to, the insurance laws and regulations.

- X. “Health indemnity plan” means a health benefit plan that is not a managed care plan.
- Y. (1) “Managed care plan” means a health benefit plan that requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use health care providers managed, owned, under contract with or employed by the health carrier.
- (2) “Managed care plan” includes:
- (a) A closed plan, as defined in Subsection H; and
 - (b) An open plan, as defined in Subsection AA.

Drafting Note: The definition of “managed care plan” is intentionally broad in order to apply to health benefit plans using any type of requirement or incentive for enrollees to choose certain providers over others. Some states may wish to limit the definition by regulation to exclude plans having broad-based provider networks that meet specified standards. Such standards could include minimum network participation requirements (e.g., at least 90% of the providers in the service area participate in the plan) and maximum payment differentials (e.g., the providers in the plan accept a discount of no more than 5% below reasonable and customary charges). The purpose of the exclusion is to exempt health benefit plans that are primarily fee-for-service arrangements, that do not purport to manage the utilization of health care services, and that do not require the safeguards provided to consumers under this Act.

- Z. “Network” means the group of participating providers providing services to a managed care plan.
- AA. “Open plan” means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan.

- BB. “Participating provider” means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from the health carrier.
- CC. “Person” means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.
- DD. “Prospective review” means utilization review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a health carrier’s requirement that the health care service or course of treatment, in whole or in part, be approved prior to its provision.

Drafting Note: The DOL final rule, which was unchanged by the interim final rules on internal claims and appeals external review processes published in the *Federal Register*, July 23, 2010, uses the term “pre-service claim” instead of “prospective review.” The DOL final rule defines a “pre-service claim” as “any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.” The definition of “prospective review,” as defined in Subsection DD, has been amended to be consistent with the intent of the definition of “pre-service claim” because both require prior approval of the benefit prior to its provision. The DOL final rule does not state what process the claimant must complete to obtain the approval, but, given the definition of “adverse benefit determination” in the DOL final rule, it is reasonable to conclude that performing utilization review would be an acceptable means to determine whether the provision of a health care service will be approved.

- EE. (1) “Rescission” means a cancellation or discontinuance of coverage under a health benefit plan that has a retroactive effect.
- (2) “Rescission” does not include a cancellation or discontinuance of coverage under a health benefit plan if:
 - (a) The cancellation or discontinuance of coverage has only a prospective effect; or
 - (b) The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Drafting Note: The definition of “rescission” is derived from the interim final regulations on rescissions published in the *Federal Register* June 28, 2010.

- FF. (1) “Retrospective review” means any review of a request for a benefit that is not a prospective review request.
- (2) “Retrospective review” does not include the review of a claim that is limited to veracity of documentation or accuracy of coding.

Drafting Note: The DOL final rule, which was unchanged by the interim final rules on internal claims and appeals and external review processes published in the *Federal Register*, July 23, 2010, uses the term “post-service claim” instead of “retrospective review.” The DOL final rule defines a “post-service claim” as “any claim for a benefit under a group health plan that is not a pre-service claim,” as that term is defined under the DOL final rule. To reflect this broad definition of “post-service claim,” the definition of “retrospective review,” in Subsection FF, has been revised to be consistent with the definition of “post-service claim.”

- GG. “Second opinion” means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the medical necessity and appropriateness of the initial proposed health care service.
- HH. “Stabilized” means, with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility or, with respect to a pregnant woman, the woman delivered, including the placenta.

Drafting Note: The definition of “stabilized” has been revised to reflect the definition of that term in the interim final rules on emergency services published in the *Federal Register* June 28, 2010.

- II. (1) “Urgent care request” means a request for a health care service or course of treatment with respect to which the time periods for making non-urgent care request determination:

- (a) Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or
 - (b) In the opinion of an attending health care professional with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.
- (2) (a) Except as provided in Subparagraph (b) of this paragraph, in determining whether a request is to be treated as an urgent care request, an individual acting on behalf of the health carrier shall apply the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
- (b) Any request that an attending health care professional with knowledge of the covered person's medical condition determines is an urgent care request within the meaning of Paragraph (1) shall be treated as an urgent care request.
- JJ. "Utilization review" means a set of formal techniques designed to monitor the use of or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.
- KK. "Utilization review organization" means an entity that conducts utilization review, other than a health carrier performing utilization review for its own health benefit plans.

Section 4. Applicability and Scope

Except as otherwise specified, this Act shall apply to all health carriers offering a health benefit plan.

Drafting Note: States may wish to consider accreditation by a nationally recognized private accrediting entity, with established and maintained standards, as evidence of meeting some or all of this Act's requirements. Under such an approach, the accrediting entity will make available to the state its current standards to demonstrate that the entity's standards meet or exceed the state's requirements. The private accrediting entity shall file or provide the state with documentation that a health carrier has been accredited by the entity. A health carrier accredited by the private accrediting entity would then be deemed to have met the requirements of the relevant sections of this Act where comparable standards exist. States should periodically review a health carrier's private accreditation and eligibility for deemed compliance.

Drafting Note: The provisions of this Act are consistent with the provisions in the interim final regulations on internal claims and appeals and external review processes, as published in the *Federal Register* July 23, 2010 and, as those regulations were amended by the interim final regulations published in the *Federal Register* June 24, 2011. However, states should be aware that the Affordable Care Act's preemption standards permit States to impose more stringent, consumer protection requirements.

Section 5. Grievance Reporting and Recordkeeping Requirements

- A. (1) A health carrier shall maintain written records to document all grievances received, including the notices and claims associated with the grievances, during a calendar year (the register).
 - (2) (a) Notwithstanding the provisions under Subsection F, a health carrier shall maintain the records required under Paragraph (1) for at least six (6) years related to the notices provided under Section 7H and Section 10H of this Act.
 - (b) The health carrier shall make the records available for examination by covered persons and the commissioner and appropriate federal oversight agency upon request.
- B. A request for a first level review of a grievance involving an adverse determination shall be processed in compliance with Section 7 of this Act shall be included in the register.
- C. A request for an additional voluntary review of a grievance involving an adverse determination that may be conducted pursuant to Section 9 of this Act shall be included in the register.
- D. For each grievance the register shall contain, at a minimum, the following information:
- (1) A general description of the reason for the grievance;

Drafting Note: The commissioner may wish to prescribe specific categories. If so, they should be listed here. In prescribing categories the commissioner should refer to the NAIC's Model Regulation for Complaint Records to be Maintained Pursuant to the NAIC Unfair Trade Practices Act to ensure that the prescribed categories are consistent with that regulation.

- (2) The date received;
 - (3) The date of each review or, if applicable, review meeting;
 - (4) Resolution at each level of the grievance, if applicable;
 - (5) Date of resolution at each level, if applicable; and
 - (6) Name of the covered person for whom the grievance was filed.
- E. The register shall be maintained in a manner that is reasonably clear and accessible to the commissioner.
- F. (1) Subject to the provisions of Subsection A, a health carrier shall retain the register compiled for a calendar year for the longer of three (3) years or until the commissioner has adopted a final report of an examination that contains a review of the register for that calendar year.
- (2) (a) A health carrier shall submit to the commissioner, at least annually, a report in the format specified by the commissioner.
 - (b) The report shall include for each type of health benefit plan offered by the health carrier
 - (i) The certificate of compliance required by Section 6 of this Act;
 - (ii) The number of covered lives;
 - (iii) The total number of grievances;
 - (iv) The number of grievances for which a covered person requested an additional voluntary grievance review pursuant to Section 9 of this Act;
 - (v) The number of grievances resolved at each level, if applicable, and their resolution;
 - (vi) The number of grievances appealed to the commissioner of which the health carrier has been informed;
 - (vii) The number of grievances referred to alternative dispute resolution procedures or resulting in litigation; and
 - (viii) A synopsis of actions being taken to correct problems identified.

Drafting Note: This section requires health carriers to maintain detailed written records and imposes specific reporting requirements with respect to all grievances, including grievances involving an adverse determination. The DOL final rule, as published in the *Federal Register*, Nov. 21, 2000, did not include such requirements. However, the interim final rules related on internal claims and appeals and external review processes, as published in the *Federal Register*, July 23, 2010, revised the DOL final rule to include a requirement that records of all claims and notices associated with the internal claims and appeals processes be retained for at least six years. The revisions to this section reflect this new recordkeeping requirement.

Section 6. Grievance Review Procedures

- A. (1) Except as specified in Section 10 of this Act, a health carrier shall use written procedures for receiving and resolving grievances from covered persons, as provided in Sections 7, 8 and 9 of this Act.
- (2) (a) Whenever a health carrier fails to adhere to the requirements of section 7 or section 10 of this Act with respect to receiving and resolving grievances involving an adverse determination, the covered person shall be deemed to have exhausted the provisions of this Act and may take action under subparagraph (b) of this paragraph.

- (b) (i) A covered person may file a request for external review in accordance with the procedures outlined in [insert reference in state law equivalent to the Uniform Health Carrier External Review Model Act].
 - (ii) In addition to item (i), a covered person is entitled to pursue any available remedies under State or federal law on the basis that the health carrier failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.
 - (3) (a) Notwithstanding paragraph (2), the provisions of section 7 or section 10 of this Act shall not be deemed exhausted based on a *de minimus* violation that does not cause, and is not likely to cause, prejudice or harm to the covered person as long as the health carrier demonstrates that the violation was for good cause or due to matters beyond the control of the health carrier and that the violation occurred in the context of an ongoing, good faith exchange of information between the health carrier and the covered person.
 - (b) The exception provided in subparagraph (a) of this paragraph does not apply if the violation is part of a pattern or practice of violations by the health carrier.
 - (c) (i) A covered person may request a written explanation of the violation from the health carrier.
 - (ii) The health carrier shall:
 - (I) Provide the written explanation within ten (10) days of receiving the request; and
 - (II) Include in the written explanation a specific description of its bases, if any, for asserting that the violation does not deem the provisions of this Act to be exhausted.
 - (d) (i) If an independent reviewer or a court of competent jurisdiction rejects the grievance involving an adverse determination for immediate review on the basis that the health carrier met the requirements of the exception provided in subparagraph (a) of this paragraph, the covered person has the right to resubmit and pursue a review of the grievance under this Act.
 - (ii) In this case, within a reasonable time, after the independent reviewer or the court rejects the grievance involving an adverse determination for immediate review, but not exceeding ten (10) days, the health carrier shall provide to the covered person or, if applicable, the covered person's authorized representative notice of the opportunity to resubmit and, as appropriate, pursue a review of the grievance under this Act].
 - (iii) For purposes of calculating the time period for re-filing the benefit request or claim under this subparagraph, the time period shall begin to run upon the covered person's or, if applicable, the covered person's authorized representative receipt of the notice of opportunity to resubmit.
- B. (1) A health carrier shall file a copy of the procedures required under Subsection A, including all forms used to process requests made pursuant to Section 7, 8 and 9 of this Act, with the commissioner. Any subsequent material modifications to the documents also shall be filed.
- (2) The commissioner may disapprove a filing received in accordance with Paragraph (1) that fails to comply with this Act or applicable regulations.

- C. In addition to Subsection B, a health carrier shall file annually with the commissioner, as part of its annual report required by Section 5 of this Act, a certificate of compliance stating that the health carrier has established and maintains, for each of its health benefit plans, grievance procedures that fully comply with the provisions of this Act.
- D. A description of the grievance procedures required under this section shall be set forth in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage provided to covered persons.
- E. The grievance procedure documents shall include a statement of a covered person's right to contact the commissioner's office or ombudsman's office for assistance at any time. The statement shall include the telephone number and address of the commissioner or ombudsman's office.

Drafting Note: States may need to revise subsection E above to reflect whatever office or offices established in their state pursuant to section 2793 of PHSA to provide assistance to individuals with internal claims and appeals and external review processes.

Section 7. First Level Reviews of Grievances Involving an Adverse Determination

Drafting Note: This section is intended to satisfy the "full and fair review" requirements of section 503 of the Employee Retirement Income Security Act of 1974 (ERISA), as set out in the DOL final rule. Specifically, under those requirements, employee welfare benefit plans, in accordance with regulations of the Department of Labor (DOL final rule), as published in the *Federal Register*, Nov. 21, 2000, must provide adequate notice in writing to every participant or beneficiary whose claim for benefits under the plan has been denied. The notice must set forth the specific reasons for the denial (known as an adverse benefit determination) and written in a manner calculated to be understood by the participant. In addition, under section 503 of ERISA, plans must afford any participant, whose claim for benefits has been denied, a full and fair review by the appropriate named fiduciary of that adverse determination. Section 9 of this Act, which establishes a voluntary review procedure for grievances that involve an adverse determination, is intended to be an additional review procedure that covered persons may voluntarily use to resolve an adverse determination that remains in dispute at the completion of the first level review under this section prior to seeking judicial or other available remedies. Section 9 of this Act is not intended to be, and should not be considered, part of the "full and fair review" of an adverse benefit determination that plans are required to afford participants pursuant to section 503 of ERISA, as set out in the DOL final rule.

- A. Within 180 days after the date of receipt of a notice of an adverse determination sent pursuant to [insert reference in state law equivalent to the Utilization Review and Benefit Determination Model Act], a covered person or the covered person's authorized representative may file a grievance with the health carrier requesting a first level review of the adverse determination.
- B.
 - (1) The health carrier shall provide the covered person with the name, address and telephone number of a person or organizational unit designated to coordinate the first level review on behalf of the health carrier.
 - (2)
 - (a) In providing for a first level review under this section, the health carrier shall ensure that the review is conducted in a manner under this section to ensure the independence and impartiality of the individuals involved in making the first level review decision.
 - (b) In ensuring the independence and impartiality of individuals involved in making the first level review decision, the health carrier shall not make decisions related to such individuals regarding hiring, compensation, termination, promotion or other similar matters based upon the likelihood that the individual will support the denial of benefits.
- C.
 - (1)
 - (a) In the case of an adverse determination involving utilization review, the health carrier shall designate an appropriate clinical peer or peers of the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. The clinical peer shall not have been involved in the initial adverse determination.
 - (b) In designating an appropriate clinical peer or peers pursuant to Subparagraph (a) of this paragraph, the health carrier shall ensure that, if more than one clinical peer is involved in the review, a majority of the individuals reviewing the adverse determination are health care professionals who have appropriate expertise.

Drafting Note: States should be aware that, with respect to appeals of adverse determinations that are based in whole or in part on a medical judgment, the DOL final rule requires group health plans to consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Paragraph (1) is more stringent than the DOL final rule. It requires health carriers to designate a clinical peer or peers of the same or similar specialty to review the adverse determination. Based on the preemption standards of ERISA and the DOL final rule, however, states may impose more stringent requirements. Therefore, the NAIC has chosen to retain the provisions of Paragraph (1).

- (2) In conducting a review under this section, the reviewer or reviewers shall take into consideration all comments, documents, records and other information regarding the request for services submitted by the covered person or the covered person’s authorized representative, without regard to whether the information was submitted or considered in making the initial adverse determination.
- D.
- (1) (a) A covered person does not have the right to attend, or to have a representative in attendance, at the first level review, but the covered person or, if applicable, the covered person’s authorized representative is entitled to:
 - (i) Submit written comments, documents, records and other material relating to the request for benefits for the reviewer or reviewers to consider when conducting the review; and
 - (ii) Receive from the health carrier, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the covered person’s request for benefits.
 - (b) For purposes of Subparagraph (a)(ii) of this paragraph, a document, record or other information shall be considered “relevant” to a covered person’s request for benefits if the document, record or other information:
 - (i) Was relied upon in making the benefit determination;
 - (ii) Was submitted, considered or generated in the course of making the adverse determination, without regard to whether the document, record or other information was relied upon in making the benefit determination;
 - (iii) Demonstrates that, in making the benefit determination, the health carrier or its designated representatives consistently applied required administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons; or
 - (iv) Constitutes a statement of policy or guidance with respect to the health benefit plan concerning the denied health care service or treatment for the covered person’s diagnosis, without regard to whether the advice or statement was relied upon in making the benefit determination.
 - (2) The health carrier shall make the provisions of Paragraph (1) known to the covered person or, if applicable, the covered person’s authorized representative within three (3) working days after the date of receipt of the grievance.

Drafting Note: Paragraph (2) requires a health carrier to inform a covered person or the covered person’s authorized representative of the health carrier’s appeal procedures within three working days after the date the health carrier receives the grievance. The DOL final rule does not include such a requirement. However, based on the preemption standards of ERISA and the DOL final rule, states may impose more stringent requirements. Therefore, the NAIC has chosen to retain the provisions of Paragraph (2).

Drafting Note: States that have adopted the NAIC Utilization Review and Benefit Determination Model Act may want to consider whether to include the requirements of Paragraph (2) because of the notice requirements contained in that model act.

- E. For purposes of calculating the time periods within which a determination is required to be made and notice provided under Subsection F, the time period shall begin on the date the grievance requesting the review is filed with the health carrier in accordance with the health carrier’s procedures established pursuant to Section 6 of this Act for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

- F. (1) A health carrier shall notify and issue a decision in writing or electronically to the covered person or, if applicable, the covered person's authorized representative within the time frames provided in Paragraph (2) or (3).
- (2) With respect to a grievance requesting a first level review of an adverse determination involving a prospective review request, the health carrier shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition, but no later than thirty (30) days after the date of the health carrier's receipt of the grievance requesting the first level review made pursuant to Subsection A.
- (3) With respect to a grievance requesting a first level review of an adverse determination involving a retrospective review request, the health carrier shall notify and issue a decision within a reasonable period of time, but no later than sixty (60) days after the date of the health carrier's receipt of the grievance requesting the first level review made pursuant to Subsection A.

Drafting Note: In adopting Subsection F, states should be aware that the DOL final rule permits a group health plan to provide for two levels of mandatory review of an adverse determination involving a prospective review request and an adverse determination involving a retrospective review request. In the case of a prospective review request, a maximum of 15 days is provided for a benefit determination at each level. In the case of a retrospective review request a maximum of 30 days is provided for a benefit determination at each level. For example, if a covered person decides to request a review of an adverse determination involving a prospective review request, and the group health plan provides for two levels of mandatory review, the plan must make a benefit determination within a reasonable period of time, taking into account the medical circumstances, but not later than 15 days after receipt of the appeal. If that benefit request is again denied at the first level of mandatory review and the covered person appeals that denial to the second level of mandatory review, the plan must again make a determination within a reasonable period of time, taking into account the medical circumstances, but not later than 15 days after the plan's receipt of the covered person's second level review request.

Drafting Note: The interim final regulations on internal claims and appeals published in the *Federal Register* July 23, 2010, requires health carriers for individual health benefit plans to require the claimant to complete only one level of internal review before issuing a final adverse determination.

- G. (1) Prior to issuing a decision in accordance with the timeframes provided in subsection F, the health carrier shall provide free of charge to covered person, or the covered person's authorized representative, any new or additional evidence, relied upon or generated by the health carrier, or at the direction of the health carrier, in connection with the grievance sufficiently in advance of the date the decision is required to be provided to permit the covered person, or the covered person's authorized representative, a reasonable opportunity to respond prior to that date.
- (2) Before the health carrier issues or provides notice of a final adverse determination in accordance with the timeframes provided in subsection F that is based on new or additional rationale, the health carrier shall provide the new or additional rationale to the covered person, or the covered person's authorized representative, free of charge as soon as possible and sufficiently in advance of the date the notice of final adverse determination is to be provided to permit the covered person, or the covered person's authorized representative a reasonable opportunity to respond prior to that date.

H. The decision issued pursuant to Subsection F shall set forth in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized representative:

- (1) The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);
- (2) Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider and, if applicable, the claim amount;
- (3) A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. For purposes of this paragraph, a health carrier: (a) shall provide to the covered person or, if applicable, the covered person's authorized representative, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse determination; and (b) shall not consider a request for the diagnosis code and treatment information, in itself, to be a request for external review pursuant to [insert reference in state law equivalent to the Uniform Health Carrier External Review Model Act];

- (4) A statement of the reviewers' understanding of the covered person's grievance;
- (5) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position;
- (6) A reference to the evidence or documentation used as the basis for the decision;
- (7) For a first level review decision issued pursuant to Section F that upholds the grievance:
 - (a) The specific reason or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in reaching the denial;
 - (b) The reference to the specific plan provisions on which the determination is based;
 - (c) A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as the term "relevant" is defined in Subsection D(1)(b), to the covered person's benefit request;
 - (d) If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the final adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the final adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;
 - (e) If the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request; and
 - (f) If applicable, instructions for requesting:
 - (i) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the final adverse determination, as provided in Subparagraph (d) of this paragraph; and
 - (ii) The written statement of the scientific or clinical rationale for the determination, as provided in Subparagraph (e) of this paragraph;
- (8) If applicable, a statement indicating:
 - (a) A description of the process to obtain an additional voluntary review of the first level review decision, if the covered person wishes to request a voluntary review pursuant to Section 9 of this Act;
 - (b) The written procedures governing the voluntary review, including any required time frame for the review;
 - (c) A description of the procedures for obtaining an independent external review of the final adverse determination pursuant to [insert reference in state law equivalent to the Uniform Health Carrier External Review Model Act] if the covered person decides not to file for an additional voluntary review of the first level review decision involving an adverse determination; and

Drafting Note: The language in Subparagraph (c) should be adopted by states that have enacted an external review law equivalent to the NAIC Uniform Health Carrier External Review Model Act and, in accordance with that law, permit a covered person to file a request for external review after completion of one level of the health carrier's internal grievance review process. Those states that have enacted an external review law equivalent to the NAIC Uniform Health Carrier External Review Model Act, but require the covered person to complete more than one level of a health carrier's internal grievance review process prior to filing a request for external review, should not adopt the language in Subparagraph (c). Instead, these states may want to modify the language in this paragraph to provide covered persons with specific notice of this exhaustion requirement. States should be aware that in accordance with the interim final rules on internal claims and appeals and external review processes, as published in the *Federal Register*, July 23, 2010, for individual health insurance coverage, health carriers for individual health benefit plans may only require covered persons to complete one level of internal review.

- (d) The covered person's right to bring a civil action in a court of competent jurisdiction;
- (9) If applicable, the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner."; and
- (10) Notice of the covered person's right to contact the commissioner's office or ombudsman's office for assistance with respect to any claim, grievance or appeal at any time, including the telephone number and address of the commissioner's office or ombudsman's office.

Drafting Note: States may need to revise paragraph (10) above to reflect whatever office or offices established in their state pursuant to section 2793 of PHSA to provide assistance to individuals with internal claims and appeals and external review processes.

Drafting Note: States that have established an appeals procedure in the office of the commissioner may wish to use the following provision in Paragraph (10): "Notice of the covered person's right to appeal the decision to the commissioner. The notice shall contain the telephone number and address of the commissioner's office."

Drafting Note: States should be aware that the DOL final rule sets out certain information that must be included in any notice to a claimant that involves an adverse benefit determination. Some of the information required to be provided in the notice under Subsection H, particularly the information required in Subsection H(1), (4), (5) and (6) is not specifically required by the DOL final rule. For example, the DOL final rule does not require group health plans to automatically provide the title and qualifying credentials of medical experts participating in the first level review, as provided in Subsection H(1). The DOL final rule requires group health plans to provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the claimant's adverse benefit determination. The DOL final rule does not address the other requirements in Subsection H(4) through (6). Based on the preemption standards of ERISA and the DOL final rule, however, states may impose more stringent requirements. Therefore, in revising this section, the NAIC has chosen to retain the provisions in Subsection H.

- I. (1) A health carrier shall provide the notice required under subsection H in a culturally and linguistically appropriate manner in accordance with federal regulations.
- (2) To be considered to meet the requirements of paragraph (1), the health carrier shall:
 - (a) Provide oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests and claims and appeals in any applicable non-English language;
 - (b) Provide, upon request, a notice in any applicable non-English language; and
 - (c) Include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the carrier.
- (3) For purposes of this subsection, with respect to any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten (10) percent or more of the population residing in the county is literate only in the same non-English language, as determined in published federal guidance.

Section 8. Standard Reviews of Grievances Not Involving an Adverse Determination

Drafting Note: States should be aware that this section is not required under the DOL final rule published in the *Federal Register*, Nov. 21, 2000 or the interim final rules on internal claims and appeals and external review processes published in the *Federal Register*, July 23, 2010.

- A. A health carrier shall establish written procedures for a standard review of a grievance that does not involve an adverse determination.

- B. (1) The procedures shall permit a covered person or the covered person's authorized representative to file a grievance that does not involve an adverse determination with the health carrier under this section.
- (2) (a) A covered person does not have the right to attend, or to have a representative in attendance at the standard review, but the covered person or the covered person's authorized representative is entitled to submit written material for the person or persons designated by the carrier pursuant to Subsection C to consider when conducting the review.
- (b) The health carrier shall make the provisions of Subparagraph (a) of this paragraph known to the covered person or, if applicable, the covered person's authorized representative within three (3) working days after the date of receiving the grievance.
- C. (1) Upon receipt of the grievance, a health carrier shall designate a person or persons to conduct the standard review of the grievance.
- (2) The health carrier shall not designate the same person or persons to conduct the standard review of the grievance that denied the claim or handled the matter that is the subject of the grievance.
- (3) The health carrier shall provide the covered person or, if applicable, the covered person's authorized representative with the name, address and telephone number of a person designated to coordinate the standard review on behalf of the health carrier.
- D. (1) The health carrier shall notify in writing the covered person or, if applicable, the covered person's authorized representative of the decision within twenty (20) working days after the date of receipt of the request for a standard review of a grievance filed pursuant to Subsection B.
- (2) (a) Subject to Subparagraph (b) of this paragraph, if, due to circumstances beyond the carrier's control, the health carrier cannot make a decision and notify the covered person or, if applicable, the covered person's authorized representative pursuant to Paragraph (1) within twenty (20) working days, the health carrier may take up to an additional ten (10) working days to issue a written decision.
- (b) A health carrier may extend the time for making and notifying the covered person or, if applicable, the covered person's authorized representative in accordance with Subparagraph (a) of this paragraph, if, on or before the twentieth working day after the date of receiving the request for a standard review of a grievance, the health carrier provides written notice to the covered person or, if applicable, the covered person's authorized representative of the extension and the reasons for the delay.
- E. The written decision issued pursuant to Subsection D shall contain:
 - (1) The titles and qualifying credentials of the person or persons participating in the standard review process (the reviewers);
 - (2) A statement of the reviewers' understanding of the covered person's grievance;
 - (3) The reviewers' decision in clear terms and the contract basis in sufficient detail for the covered person to respond further to the health carrier's position;
 - (4) A reference to the evidence or documentation used as the basis for the decision;
 - (5) If applicable, a statement indicating:
 - (a) A description of the process to obtain an additional review of the standard review decision if the covered person wishes to request a voluntary review pursuant to Section 9 of this Act; and

- (b) The written procedures governing the voluntary review, including any required time frame for the review; and
- (6) Notice of the covered person's right, at any time, to contact the commissioner's office, including the telephone number and address of the commissioner's office.

Section 9. Voluntary Level of Reviews of Grievances

Drafting Note: Although this section requires health carriers that offer managed care plans to establish an additional voluntary review process for its managed care plans, the decision to file a request for the additional voluntary review of a grievance involving an adverse determination rests solely within the discretion of the covered person. This section is intended to be an optional additional level of review that the covered person may voluntarily use to resolve the issue in dispute after receiving an adverse determination upon completion of the review conducted under Section 7 of this Act. This section is not intended to be, and should not be considered to be, part of the requirements for the "full and fair review" of claim denials (known as adverse benefit determinations) under Section 503 of ERISA, as specified in the DOL final rule. As such, this section is not required to be included in any internal claims and appeals process for purposes of complying with the DOL final rule published in the *Federal Register*, Nov. 21, 2000 or the interim final rules on internal claims and appeals and external review processes published in the *Federal Register*, July 23, 2010.

- A. (1) A health carrier that offers managed care plans shall establish a voluntary review process for its managed care plans to give those covered persons who are dissatisfied with the first level review decision made pursuant to Section 7 of this Act, or who are dissatisfied with the standard review decision made pursuant to Section 8 of this Act, the option to request an additional voluntary review, at which the covered person or the covered person's authorized representative has the right to appear in person at the review meeting before designated representatives of the health carrier.
- (2) This section shall not apply to health indemnity plans.
- B. (1) A health carrier required by this section to establish a voluntary review process shall provide covered persons or their authorized representatives with notice pursuant to Section 7G(6) or Section 8E(5) of this Act, as appropriate, of the option to file a request with the health carrier for an additional voluntary review of the first level review decision received under Section 7 of this Act or the standard review decision received under Section 8 of this Act.
- (2) Upon receipt of a request for an additional voluntary review, the health carrier shall send notice to the covered person or, if applicable, the covered person's authorized representative of the covered person's right to:
 - (a) Request, within the time frame specified in Paragraph (3)(a), the opportunity to appear in person before a review panel of the health carrier's designated representatives;
 - (b) Receive from the health carrier, upon request, copies of all documents, records and other information that is not confidential or privileged relevant to the covered person's request for benefits;
 - (c) Present the covered person's case to the review panel;
 - (d) Submit written comments, documents, records and other material relating to the request for benefits for the review panel to consider when conducting the review both before and, if applicable, at the review meeting;
 - (e) If applicable, ask questions of any representative of the health carrier on the review panel; and
 - (f) Be assisted or represented by an individual of the covered person's choice.
- (3) (a) A covered person or the authorized representative of the covered person wishing to request to appear in person before the review panel of the health carrier's designated representatives shall make the request to the health carrier within five (5) working days after the date of receipt of the notice sent in accordance with Paragraph (2).

- (b) The covered person's right to a fair review shall not be made conditional on the covered person's appearance at the review.
- C.
 - (1)
 - (a) With respect to a voluntary review of a first level review decision made pursuant to Section 7 of this Act, a health carrier shall appoint a review panel to review the request.
 - (b) In conducting the review, the review panel shall take into consideration all comments, documents, records and other information regarding the request for benefits submitted by the covered person or the covered person's authorized representative pursuant to Subsection B(2), without regard to whether the information was submitted or considered in reaching the first level review decision.
 - (c) The panel shall have the legal authority to bind the health carrier to the panel's decision.
 - (2)
 - (a) Except as provided in Subparagraph (b) of this paragraph, a majority of the panel shall be comprised of individuals who were not involved in the in the first level review decision made pursuant to Section 7 of this Act.
 - (b) An individual who was involved with the first level review decision may be a member of the panel or appear before the panel to present information or answer questions.
 - (c) The health carrier shall ensure that a majority of the individuals conducting the additional voluntary review of the first level review decision made pursuant to Section 7 of this Act are health care professionals who have appropriate expertise.
 - (d) Except, when such a reviewing health care professional is not reasonably available, in cases where there has been a denial of a health care service, the reviewing health care professional shall not:
 - (i) Be a provider in the covered person's health benefit plan; and
 - (ii) Have a financial interest in the outcome of the review.
- D.
 - (1)
 - (a) With respect to a voluntary review of a standard review decision made pursuant to Section 8 of this Act , a health carrier shall appoint a review panel to review the request.
 - (b) The panel shall have the legal authority to bind the health carrier to the panel's decision.
 - (2)
 - (a) Except as provided in Subparagraph (b) of this paragraph, a majority of the panel shall be comprised of employees or representatives of the health carrier who were not involved in the standard review decision made pursuant to Section 8 of this Act.
 - (b) An employee or representative of the health carrier who was involved with the standard review decision may be a member of the panel or appear before the panel to present information or answer questions.
- E.
 - (1)
 - (a) Whenever a covered person or the covered person's authorized representative requests within the time frame specified in Subsection B(3)(a) the opportunity to appear in person before the review panel appointed pursuant to Subsection C or Subsection D, the procedures for conducting the review shall include the provisions described in this paragraph.

Drafting Note: Subsection E(1)(a) requires a covered person affirmatively to exercise the option to request a review meeting. A state may prefer to require a health carrier to provide a meeting unless a covered person acts to waive that right.

- (b)
 - (i) The review panel shall schedule and hold a review meeting within forty-five (45) working days after the date of receipt of the request.

- (ii) The covered person or, if applicable, the covered person's authorized representative shall be notified in writing at least fifteen (15) working days in advance of the date of the review meeting.
- (iii) The health carrier shall not unreasonably deny a request for postponement of the review made by the covered person or the covered person's authorized representative.
- (c) The review meeting shall be held during regular business hours at a location reasonably accessible to the covered person or, if applicable, the covered person's authorized representative.
- (d) In cases where a face-to-face meeting is not practical for geographic reasons, a health carrier shall offer the covered person or, if applicable, the covered person's 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.
- (e) If the health carrier desires to have an attorney present to represent the interests of the health carrier, the health carrier shall notify the covered person or, if applicable, the covered person's authorized representative at least fifteen (15) working days in advance of the date of the review meeting that an attorney will be present and that the covered person may wish to obtain legal representation of his or her own.

Drafting Note: States may want to require the covered person or, if applicable, the covered person's authorized representative to notify the health carrier in advance of the review meeting date if the covered person plans to bring an attorney to the review meeting.

- (f) The review panel shall issue a written decision, as provided in Subsection F, to the covered person or, if applicable, the covered person's authorized representative within five (5) working days of completing the review meeting.
- (2) Whenever the covered person or, if applicable, the covered person's authorized representative does not request the opportunity to appear in person before the review panel within the specified timeframe provided under Subsection B(3)(a), the review panel shall issue a decision and notify the covered person or, if applicable, the covered person's authorized representative of the decision, as provided in Subsection F, in writing or electronically, within forty-five (45) working days after the earlier of:
 - (a) The date the covered person or the covered person's authorized representative notifies the health carrier of the covered person's decision not to request the opportunity to appear in person before the review panel; or
 - (b) The date on which the covered person's or the covered person's authorized representative's opportunity to request to appear in person before the review panel expires pursuant to Subsection B(3)(a).
- (3) For purposes of calculating the time periods within which a decision is required to be made and notice provided under Paragraphs (1) and (2), the time period shall begin on the date the request for an additional voluntary review is filed with the health carrier in accordance with the health carrier's procedures established pursuant to Section 6 of this Act for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

F. A decision issued pursuant to Subsection E shall include:

- (1) The titles and qualifying credentials of the members of the review panel;
- (2) A statement of the review panel's understanding of the nature of the grievance and all pertinent facts;

- (3) The rationale for the review panel’s decision;
- (4) A reference to evidence or documentation considered by the review panel in making that decision;
- (5) In cases concerning a grievance involving an adverse determination:
 - (a) The instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; and
 - (b) If applicable, a statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to [insert reference in state law equivalent to the Uniform Health Carrier External Review Model Act]; and

Drafting Note: Subparagraph (b) should be adopted by states that have enacted an external review law equivalent to the NAIC Health Carrier External Review Model Act. States that have not enacted such a law should not adopt the language in Subparagraph (b).

- (6) Notice of the covered person’s right to contact the commissioner’s office or ombudsman’s office for assistance with respect to any claim, grievance or appeal at any time, including the telephone number and address of the commissioner’s office or ombudsman’s office.

Drafting Note: States may need to revise paragraph (6) above to reflect whatever office or offices established in their state pursuant to section 2793 of PHSA to provide assistance to individuals with internal claims and appeals and external review processes.

Drafting Note: States that have established an appeals procedure in the office of the commissioner may wish to use the following provision in Paragraph (6): “Notice of the covered person’s right to appeal the decision to the commissioner. The notice shall contain the telephone number and address of the commissioner’s office.”

Section 10. Expedited Reviews of Grievances Involving An Adverse Determination

- A. A health carrier shall establish written procedures for the expedited review of urgent care requests of grievances involving an adverse determination.
- B. In addition to Subsection A, a health carrier shall provide expedited review of a grievance involving an adverse determination with respect to concurrent review urgent care requests involving an admission, availability of care, continued stay or health care service for a covered person who has received emergency services, but has not been discharged from a facility.
- C. The procedures shall allow a covered person or the covered person’s authorized representative to request an expedited review under this section orally or in writing.
- D. A health carrier shall appoint an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. The clinical peer or peers shall not have been involved in making the initial adverse determination.

Drafting Note: States should be aware that, with respect to appeals of adverse benefit determinations that are based in whole or in part on a medical judgment, the DOL final rule requires group health plans to consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Subsection D is more stringent than the DOL final rule. It requires health carriers to designate a clinical peer or peers of the same or similar specialty to review the adverse determination. Based on the preemption standards of ERISA and the DOL final rule, however, states may impose more stringent requirements. Therefore, the NAIC has chosen to retain the provisions of Subsection D.

- E. In an expedited review, all necessary information, including the health carrier’s decision, shall be transmitted between the health carrier and the covered person or, if applicable, the covered person’s authorized representative by telephone, facsimile or the most expeditious method available.
- F.
 - (1) An expedited review decision shall be made and the covered person or, if applicable, the covered person’s authorized representative shall be notified of the decision in accordance with Subsection H as expeditiously as the covered person’s medical condition requires, but in no event more than seventy-two (72) hours after the receipt of the request for the expedited review.
 - (2) If the expedited review is of a grievance involving an adverse determination with respect to a concurrent review urgent care request, the service shall be continued without liability to the covered person until the covered person has been notified of the determination.

Drafting Note: If the expedited review is of a grievance involving an adverse determination with respect to a concurrent review request, Paragraph (2) requires that the health care service that is the subject of the adverse determination be continued without liability to the covered person until the covered person has been notified of the determination. The DOL final rule does not include such a requirement. However, based on the preemption standards of ERISA and the DOL final rule, states may impose more stringent requirements. Therefore, the NAIC has chosen to retain the provisions of Paragraph (2).

- G. For purposes of calculating the time periods within which a decision is required to be made under Subsection F, the time period within which the decision is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established pursuant to Section 6 of this Act for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.
- H. (1) A notification of a decision under this section shall, in a manner calculated to be understood by the covered person or, if applicable, the covered person's authorized representative, set forth:
- (a) The titles and qualifying credentials of the person or persons participating in the expedited review process (the reviewers);
 - (b) Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider and, if applicable, the claim amount;
 - (c) A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. For purposes of this subparagraph, a health carrier: (i) shall provide to the covered person or, if applicable, the covered person's authorized representative, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse determination; and (ii) shall not consider a request for the diagnosis code and treatment information, in itself, to be a request for external review pursuant to [insert reference in state law equivalent to the Uniform Health Carrier External Review Model Act];
 - (d) A statement of the reviewers' understanding of the covered person's grievance;
 - (e) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position;
 - (f) A reference to the evidence or documentation used as the basis for the decision; and
 - (g) If the decision involves a final adverse determination, the notice shall provide:
 - (i) The specific reasons or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as a description of the health carrier's standard, if any, that was used in reaching the denial;
 - (ii) Reference to the specific plan provisions on which the determination is based;
 - (iii) A description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;
 - (iv) If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;

- (v) If the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;
- (vi) If applicable, instructions for requesting:
 - (I) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination in accordance with Item (iv); or
 - (II) The written statement of the scientific or clinical rationale for the adverse determination in accordance with Item (v);
- (vii) A statement describing the procedures for obtaining an independent external review of the adverse determination pursuant to [insert reference in state law equivalent to the Uniform Health Carrier External Review Model Act];

Drafting Note: The language in Item (vii) should be adopted by states that have enacted an external review law equivalent to the NAIC Uniform Health Carrier External Review Model Act. States that have not enacted such a law should not adopt the language in Item (vii).

- (viii) A statement indicating the covered person's right to bring a civil action in a court of competent jurisdiction;
- (ix) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner.;" and
- (x) A notice of the covered person's right to contact the commissioner's office or ombudsman's office for assistance with respect to the any claim, grievance or appeal at any time, including the telephone number and address of the commissioner's office or ombudsman's office.

Drafting Note: States may need to revise item (x) above to reflect whatever office or offices established in their state pursuant to section 2793 of PHSA to provide assistance to individuals with internal claims and appeals and external review processes.

Drafting Note: States that have established an appeals procedure in the office of the commissioner may wish to use the following provision in Item (x): "Notice of the covered person's right to appeal the decision to the commissioner. The notice shall contain the telephone number and address of the commissioner's office."

Drafting Note: States should be aware that the DOL final rule sets out certain information that must be included in any notice to a claimant that involves an adverse benefit determination. Some of the information required to be provided in a notice under Subsection H(1), particularly the information required in Subsection H(1)(a) and (d) through (f), is not specifically required by the DOL final rule. For example, the DOL final rule does not require group health plans to automatically provide the title and qualifying credentials of medical experts participating in the first level review, as provided in Subsection H(1)(a). The DOL final rule requires group health plans to provide for the identification of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the claimant's adverse benefit determination. The DOL final rule does not address the other requirements in Subsection H(1)(a) and (d) through (f). Based on the preemption standards of ERISA and the DOL final rule, however, states may impose more stringent requirements. Therefore, in revising this section, the NAIC has chosen to retain the provisions in Subsection H(1).

- (2) (a) A health carrier shall provide the notice required under this section in a culturally and linguistically appropriate manner in accordance with federal regulations.
- (b) To be considered to meet the requirements of subparagraph (a) of this paragraph, the health carrier shall:
 - (i) Provide oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests and claims and appeals in any applicable non-English language;

- (ii) Provide, upon request, a notice in any applicable non-English language; and
 - (iii) Include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the carrier.
- (c) For purposes of this paragraph, with respect to any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten (10) percent or more of the population residing in the county is literate only in the same non-English language, as determined in published federal guidance.
- (3) (a) A health carrier may provide the notice required under this section orally, in writing or electronically.
- (b) If notice of the adverse determination is provided orally, the health carrier shall provide written or electronic notice of the adverse determination within three (3) days following the oral notification.

Section 11. Regulations

The commissioner may, after notice and hearing, promulgate reasonable regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 12. Penalties

A violation of this Act shall [insert appropriate administrative penalty from state law].

Section 13. Separability

If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 14. Effective Date

This Act shall be effective [insert date].

Chronological Summary of Action (all references are to the Proceedings of the NAIC).

1996 Proc. 2nd Quarter 10, 30, 732, 769, 794-802 (adopted).
2002 Proc. 4th Quarter 281, 347-363 (amended and reprinted, adopted by task force).
2003 Proc. 1st Quarter 174-175 (adopted by parent committee).
2003 Proc. 2nd Quarter 12, 15 (adopted by Plenary).
2010 Proc. 3rd Quarter, Vol. I, 115, 119, 130, 241, 606, 740-970 (amended).
2012 Proc. 1st Quarter, Vol. I, 98, 113, 116, 276-344 (amended).