

PROJECT HISTORY - 2010

UNIFORM HEALTH CARRIER EXTERNAL REVIEW MODEL ACT (#76)

1. Description of the Project, Issues Addressed, etc.

The revisions to the Uniform Health Carrier External Review Model Act add four new appendices:

- *Appendix A Model Notice of Appeal Rights*
- *Appendix B Model External Review Request Form*
- *Appendix C Model Independent Review Organization External Review Annual Report Form*
- *Appendix D Model Health Carrier External Review Annual Report Form*

This model law was adopted by the full NAIC membership in 2008. The purpose of the model was to establish a national standard and uniform approach for processing, conducting, and making external review determinations. Although approximately 47 states have adopted external review laws, there is no uniformity among the states regarding external review processes. This model provides for a single-option approach for external review. The model included a requirement that the Regulatory Framework (B) Task Force develop these appendices in an effort to promote uniformity among the states for these forms.

2. Name of Group Responsible for Drafting the Model and States Participating

The Regulatory Framework (B) Task Force of the Health Insurance and Managed Care (B) Committee drafted the model.

States Participating:

Nevada, Chair	Montana
Alabama	Nebraska
California	New Hampshire
Delaware	Ohio
Florida	Oregon
Idaho	Pennsylvania
Illinois	South Dakota
Indiana	Tennessee
Maine	Utah
Maryland	Vermont
Minnesota	Virginia
Mississippi	West Virginia
Missouri	Wisconsin

3. Project Authorized by What Charge and Date First Given to the Group

The project was authorized in 2005 by the following charge: Review issues surrounding internal appeals and external review with respect to regulatory modernization and determine whether national standards are appropriate. If so, recommend an appropriate vehicle to achieve goals. It was delegated to the Regulatory Framework Task Force in 2006. The model was adopted by the full NAIC membership in 2008. These model notices are to be considered guidelines to this model act.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The model was drafted by the Task Force. Numerous interested parties participated, including industry representatives, such as the America's Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association (BCBSA); and other interested parties, such as the National Association of Independent Review Organizations (NAIRO); Families USA; and the Council for Affordable Health Insurance (CAHI).

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

Drafts of the proposed model notices were distributed for comment prior to the 2008 Fall National Meeting. At the 2008 Fall National Meeting, the Task Force discussed the comments received on those drafts. Immediately following the 2009 Spring National Meeting, revised drafts of the proposed model notices were distributed for comment. At the 2009 Summer National Meeting, the Task Force discussed the comments received on these drafts. Following the 2009 Summer National Meeting, a third set of revised drafts were distributed for comment. The Task Force discussed the comments and adopted the model notices during a conference call on Oct. 13, 2009.

Comments were requested and were received and considered throughout the drafting process. In addition, all of the drafts of the proposed revisions were posted on the NAIC Web site. The comments were also posted on the NAIC Web site.

6. A Discussion of the Significant Issues (items of some controversy raised during the drafting process and the group's response)

There were no significant issues or items of controversy raised during the drafting process. All of the comments received were of a technical nature.

7. Any Other Important Information (e.g., amending an accreditation standard).

None.

PROJECT HISTORY - 2008

UNIFORM HEALTH CARRIER EXTERNAL REVIEW MODEL ACT #76)

1. Description of the Project, Issues Addressed, etc.

This model law was drafted to achieve a national standard and uniform approach for processing, conducting, and making external review determinations. Although over 45 states have adopted external review laws, there is no uniformity among the states regarding external review processes. This model provides for a single-option approach for external review.

In 2006, the full NAIC membership adopted the Health Policy Rate and Form Filing Model Act. That model was the result of one of two charges that the Committee had concerning regulatory modernization. The Committee's second charge was to review issues surrounding internal appeals and external review and make a determination on whether national standards for these processes were appropriate. This model completes part of this second charge. It will ensure uniformity among the states with respect to external review processes and procedures and, as a result, consumers will have the same or substantively similar regulatory protections available to them no matter where they reside.

Specifically, the model establishes a standard external review process that includes the following major provisions:

- All requests for external review must be filed with the commissioner within 4 months following the date of receipt of an adverse determination or final adverse determination.
- Upon receipt of the external review request, the commissioner notifies and forwards the request to the health carrier.
- The health carrier conducts a preliminary review of the request to determine if it is eligible for a full external review. Among the conditions that must be satisfied is whether the individual making the request is or was a covered person at the time the health care service in dispute was provided. The health carrier will also determine whether the health care service in dispute is a covered service.
- The commissioner has the authority to review and ultimately overturn a health carrier's determination that an external review request is ineligible for external review and require that it be referred to full external review.
- If the external review request is determined eligible for external review, the commissioner randomly assigns an independent review organization (IRO) to review the request. Specifically, the commissioner randomly assigns an approved IRO from those approved IROs qualified to conduct the particular review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination and other circumstances, including any conflict of interest concerns.
- The assigned IRO has 45 days after the date of receipt of the external review request to reach a standard external review decision.
- In reaching a decision, the IRO can review any information and documents it considers appropriate to the extent the information or documents are available. The IRO must also consider the opinion of the its clinical reviewer or reviewers after the reviewer or reviewers consider specified information and documents related to the external review request to the extent the information and documents are available and the reviewer or reviewers consider appropriate.
- In its written decision notice, the IRO must provide the principal reason or reasons for its decision, including what applicable, if any, evidence-based standards were a basis for its decision, the rationale for its decision and references to the evidence or documentation, including the evidence-based standards, considered in reaching its decision.

The model also includes provisions for an expedited external review and a standard and expedited external review of experimental or investigational treatment of adverse determinations or final adverse determinations.

In addition, the model also provides a streamlined method of approving IROs eligible to conduct external reviews. An IRO is eligible to conduct external reviews if it is accredited by a nationally recognized private accrediting entity that the commissioner has determined has IRO accreditation standards that are equivalent to or exceed the minimum requirements in the model act. Any IRO that has such accreditation is presumed in compliance with the model act's minimum requirements to be eligible to conduct external reviews. The commissioner must initially review and periodically review the IRO accreditation standards to ensure that those standards are and continue to be equivalent or exceed the model act's minimum requirements. The commissioner may, however, rely on a review conducted by the NAIC. The model also requires IROs to be unbiased. IROs must establish and maintain written procedures to ensure that they are unbiased.

2. Name of Group Responsible for Drafting the Model and States Participating

The Regulatory Framework (B) Task Force of the Health Insurance and Managed Care (B) Committee drafted the model.

States Participating:

Wisconsin, Chair	Missouri
California	Montana
Colorado	Nebraska
Delaware	Nevada
Florida	Ohio
Idaho	Oregon
Illinois	Rhode Island
Indiana	South Dakota
Iowa	Utah
Kansas	Vermont
Kentucky	Virginia
Maine	West Virginia

3. Project Authorized by What Charge and Date First Given to the Group

The project was authorized in 2005 by the following charge: Review issues surrounding internal appeals and external review with respect to regulatory modernization and determine whether national standards are appropriate. If so, recommend an appropriate vehicle to achieve goals. It was delegated to the Regulatory Framework Task Force in 2006. At the 2007 Summer National Meeting, Executive/Plenary approved the Health Insurance and Managed Care (B) Committee’s model law development request related to this charge.

4. A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated

The model was drafted by the Task Force. Numerous interested parties participated, including industry representatives, such as the America’s Health Insurance Plans (AHIP) and the Blue Cross and Blue Shield Association (BCBSA); accrediting body representatives, such as URAC and the National Committee on Quality Assurance (NCQA); the National Association of Independent Review Organizations (NAIRO); provider representatives, such as the American Medical Association (AMA) and the American Psychiatric Association (APA); and other interested parties, such as the Council for Affordable Health Insurance (CAHI).

5. A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)

Beginning with the NAIC 2006 Winter National Meeting, drafts of the proposed revisions were reviewed and discussed at each National Meeting. The Task Force also held an informational hearing on the several issues related to the proposed model at the NAIC 2007 Spring National Meeting. Those issues included the use of evidence-based medicine in making external review decisions, the accreditation of independent review organizations (IROs) to conduct external review and the appropriate external review regulatory structure to be used to conduct external reviews. Comments were requested and were received and considered throughout the drafting process. In addition, all of the drafts of the proposed revisions were posted on the NAIC Web site. The comments were also posted on the NAIC Web site.

6. A Discussion of the Significant Issues (items of some controversy raised during the due process and the group’s response)

The Task Force discussed and resolved a few significant issues during the drafting process.

The existing NAIC Health Carrier External Review Model Act includes three options that states can choose from in establishing an external review process. The options range from an approach that provides for extensive commissioner involvement under which the commissioner receives all external review requests, conducts the preliminary review to determine if the request is eligible for external review and, after considering the IRO’s recommendation, makes the final external review determination to an approach that provides for very limited commissioner involvement under which the health carrier receives all external review requests and the IRO conducts the preliminary review for eligibility and makes the

final external review determination. As such, one general issue discussed at the beginning of the drafting process concerned the degree of involvement of the commissioner in the external review process. In considering this issue, the Task Force also considered two related issues: (1) whether the commissioner or the consumer should select the IRO to conduct the external review; and (2) whether the health carrier, the IRO or the commissioner should conduct the preliminary review to determine whether an external request is eligible for a full external review.

After extensive discussion and debate during several meetings, the Task Force settled on something in between. It decided that the commissioner should receive all external review requests. The Task Force also decided that the health carrier should conduct the preliminary review of each external request for eligibility but gave the commissioner the authority to overturn a health carrier's ineligibility determination. In reaching this decision, the Task Force reasoned that the health carrier has the information necessary to decide whether: (1) the person is or was covered under the health benefit plan at the time the health care service in dispute was provided; (2) the health care service that is the subject of the adverse determination or final adverse determination is a covered service; (3) the covered person has exhausted the health carrier's internal review process, if applicable; and (4) all of the necessary forms have been provided. Also, IROs have medical expertise, not coverage expertise. The Task Force also reasoned that it was not efficient for the commissioner to conduct the preliminary review. For some states, there could be staffing and financial resource issues if the commissioner was required to conduct the preliminary review.

The Task Force also decided that it would be in the best interest of consumers if the commissioner selected the IRO. At the request of interested parties, however, the Task Force added language requiring the commissioner to select the IRO on a random basis among approved IROs qualified to conduct the particular external review based on the nature of the health care service that is the subject of the adverse determination or final adverse determination, including any conflict of interest considerations.

The Task Force also had extensive discussions on the appropriate use and consideration of evidence-based standards in reaching an external review decision. The AMA and the APA both raised concerns about requiring IROs to consider evidence-based standards in reaching an external review decision. They also raised concerns about the definition of "best evidence" and how this definition ranks "expert opinion" last in the list of what would be considered "best evidence." The Task Force decided to leave the definition of "best evidence" unchanged and the provisions in the proposed model concerning what information the IRO must consider in reaching an external review decision. This provision requires the IRO to consider evidence-based standards in reaching a decision but does not limit the IRO to basing a decision on these standards. The IRO can consider other standards, as it deems appropriate, and even base its decision on these other standards. However, the Task Force did decide to include specific language requiring the IRO to consider the opinion of its clinical reviewers in reaching an external review decision.

7. Any Other Important Information (e.g., amending an accreditation standard).

None.