Recommendations on Developing a Complaint Resolution Process for Health Plan Enrollees

Final Report to the Legislature

Minnesota Departments of Health & Commerce December 1998

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This report was required by Laws of Minnesota 1998, chapter 407, article 2, section 101.

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Members
Minnesota State Legislature

With this letter, we are transmitting to you our final report titled *Recommendations on Developing a Complaint Resolution Process for Health Plan Enrollees*.

This report was requested by the 1998 Legislature in Laws of Minnesota 1998, chapter 207, article 2, section 101. The legislation states that *[t]he commissioners of health and commerce shall . . . submit final recommendations to the legislature, including draft legislation on developing such a process.* The recommendations must also include a permanent method of financing the Office of Health Care Consumer Assistance, Advocacy and Information.

We wish to thank the work group that developed the options which were used as the basis for these recommendations. For further information about the recommendations and the draft legislation, please contact Kent Peterson, Minnesota Department of Health, at (651) 282-5616, fax (651) 282-5628, e-mail <kent.peterson@health.state.mn.us> or John Gross, Minnesota Department of Commerce, at (651) 296-6929, fax (651) 296-9434, e-mail <john.gross@state.mn.us>.

Sincerely,

Anne M. Barry, Commissioner
Minnesota Department of Health

David B. Gruenes, Commissioner
Minnesota Department of Commerce

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Introduction

During the 1998 session, legislation was passed requiring that the complaint process work group, which was established in 1997 by the Commissioners of Health and Commerce, continue to meet to develop a complaint resolution process for health plan companies to make available to enrollees as required under:

- Minnesota Statutes, section 62Q.105, which requires health plan companies to establish and make available an informal process for the resolution of enrollee complaints, including a mechanism for appeals of the health plan company decisions;
- Minnesota Statutes, section 62Q.11, which requires the Commissioners of Health and Commerce to make available dispute resolution processes for enrollee complaints against health plan companies; and
- Minnesota Statutes, section 62Q.30, which requires the Commissioners to make available an expedited fact finding and dispute resolution process for enrollee complaints against health plan companies.

The legislation also states that *[t]he commissioners of health and commerce shall . . . submit final recommendations to the legislature, including draft legislation on developing such a process by November 15, 1998.* (See Laws of Minnesota 1998, chapter 407, article 2, section 101.) The recommendations must include a permanent method of financing the Office of Health Care Consumer Assistance, Advocacy, and Information. This report contains our final recommendations to the legislature.

In undertaking this effort, it was the desire of the Departments that the group would be able to work together to create a system which is fair and reasonable from the perspective of consumers, purchasers, health plan companies, and regulators. The work group was not able to reach a consensus. Nonetheless, the Departments are submitting this report for the purposes of describing the issues and the options to consider. The report includes the recommendations of the Departments on specific issues. We have included draft legislation which incorporates the Departments' recommendations. (See Appendix A.)

Background

The 1997 Patient Protection Act directed the Commissioners of Health and Commerce, in consultation with the Consumer Advisory Board and other affected parties, to make recommendations to the 1998 legislature *on developing a complaint resolution process for health plan companies to make available for enrollees.* (Laws of Minnesota 1997, chapter 237, section 20.) Accordingly, in the fall of 1997, the Departments of Health and Commerce organized a work group of stakeholders for the purpose of developing those recommendations. The work group was facilitated by Roger Williams, an outside neutral party, from the Minnesota Office of Dispute Resolution. In organizing the work group, it was the goal of the Departments to bring together interested parties to work together in an effort to build consensus by identifying and addressing issues and concerns related to the development of a complaint resolution process. Approximately 30 persons actively participated in the sessions. The participants represented

many diverse interests and included appointees from consumers groups, health plans, indemnity insurers, self-insured employers, and the Departments of Health, Commerce, Human Services, and Employee Relations. The group was also assisted by legislative staff.

By late fall of 1997, there was general discussion by the group about whether a complaint process should include mechanisms for internal and external appeal, and that the role of the regulatory agencies should not be diminished. The group also agreed, generally, that enrollees should be able to access the external review appeal process following an adverse utilization review decision made pursuant to Minnesota Statutes, section 62M.06. As the discussion continued, however, the focus of the group turned to the creation of an office of health care consumer advocacy, and the group did not have enough time to resolve further details related to the complaint process. Therefore, the Departments recommended that the group continue to meet to develop recommendations for the development of a uniform complaint process to be presented to the legislature during the 1999 legislative session.

Accordingly, 1998 legislation was passed requiring that the work group continue to meet to develop a complaint resolution process for health plan companies to make available to enrollees as required under Minnesota Statutes, sections 62Q.105, 62Q.11, and 62Q.30. The legislation also mandates that the recommendations include a permanent method of financing the office of health care consumer assistance, advocacy, and information. (See Laws of Minnesota 1998, chapter 407, article 2, section 101.)

The complaint process work group was reconvened in May 1998, and the group met on June 8, July 13, August 10, September 9, September 28, October 26, and November 5, 1998. A list of members of the workgroup appears in Appendix B of this report. The legislative report submitted by the Departments of Health and Commerce in January of 1998 was used as a starting point when the group reconvened following the 1998 legislative session. A number of issues relative to both internal and external processes were discussed in detail by the workgroup. However, the group did not reach consensus regarding draft legislation. Furthermore, there were no votes taken to verify consensus on any specific issue.

Internal Process

Overlaps and inconsistencies exist between internal review processes provided under Chapter 62D, which applies to HMOs only, and Chapter 62M, which applies to utilization review organizations, including indemnity insurers and HMOs, but only to the extent those health plan companies are conducting utilization review under Chapter 62M. Furthermore, the requirements for indemnity insurers appear in Chapter 72A, Regulation of Trade Practices. This section of the report is intended to recommend changes which will make the internal processes for all health plan companies consistent and understandable.

62Q

Medical Appeals versus General Grievances

Language must be added to both Chapter 62Q and Chapter 62M to clarify that general complaints would be determined under the process provided in Chapter 62Q but that any appeal requiring a medical determination would be determined under the process provided under 62M.

Currently there is some confusion about whether disputes related to needed medical care are general complaints under Chapter 62D or appeals of medical determinations under Chapter 62M. When a dispute requires a medical determination, the work group discussed a process in which appeals of the matter should always be considered under procedures in Chapter 62M, regardless of whether the issue started as a general complaint or as a utilization review decision.

Procedures for Filing and Disclosure

Receipt of inquiries and complaints by telephone is a common customer service procedure for health plan companies. Therefore, the group discussed whether, in addition to filing a complaint in writing, an enrollee should be able to file a complaint over the telephone.

Those who oppose allowing complaints to be filed by telephone feel that it would burden the health plan companies with an unnecessary statutory mandate. They have pointed out that health plan companies typically conduct telephone customer service on complaints and there is no need to impose any statutory requirements related to complaints made by telephone. Those in favor of allowing this type of procedure dispute that the telephone inquiries and complaints are currently being documented and argue that many telephone inquiries and complaints are left undocumented and unresolved.

An advantage of allowing a complaint to be filed by telephone would be to permit documentation of the telephone inquiry and disclosure to the consumer of his options. Furthermore, procedures similar to those considered by the work group are mandatory for health plan companies which contract to provide prepaid medical assistance services and, based upon soon to be published Rules, all health maintenance organizations will be required to maintain records of complaints received by telephone.

***Recommendation**: The Departments recommend that there be an expectation that the health plan companies provide full disclosure of options to enrollees who indicate by telephone that they have a concern or complaint, but to allow flexibility as to how health plan companies will accomplish this and meet the Commissioners' expectations in this regard.*

Timeframes and Notice Requirements for the Health Plan Company Decisions

The work group discussed two options for the timeframe within which the health plan company must make its initial decision on a complaint, and provide notification thereof to the complainant.

One option is similar to the timeframe currently required for HMOs under Chapter 62D. That is, the decision shall be made within 30 days unless there are circumstances beyond the health plan company's control. In this case, the enrollee is notified of the reason for delay and the health plan company is allowed another 14 days to make its decision. The other option is similar to the current language for appeal in Minnesota Statutes, chapter 62M. The timeframe under this option is less specific: it provides that a decision must be made within 45 days after receipt of all information reasonably necessary to make a decision.

***Recommendation**: The Departments recommend that the timeframe within which the health plan company must make its initial decision on a complaint, and provide notification thereof to the enrollee, be 30 days.*

Additional Internal Review

The work group discussed whether an enrollee should have the right to appeal an adverse complaint decision through a health plan company's internal appeals process, either in writing or by hearing. Also, there was discussion that a health plan company must notify a complainant of this process, including applicable time lines, when the complaint decision is adverse to the complainant.

The group also discussed whether the complainant has the right to proceed directly to an external appeals process without exhausting the health plan company's internal appeals process.

***Recommendation**: The Departments recommend an enrollee be allowed to proceed to an external appeals process only after exhausting the health plan company's statutorily mandated internal appeals process. This is consistent with the National Association of Insurance Commissioners' model act on grievance procedures.*

62M

Clarification of Medical Decisions in Chapter 62M

There is need to clarify the law to assure that all decisions on appeals requiring a medical determination will be made under medical review procedures in Chapter 62M, instead of under the procedures provided for general complaints under Chapter 62Q.

There is currently some confusion about whether appeals are being considered by HMOs as general complaints under Chapter 62D or as appeals of medical determinations under Chapter 62M. The work group discussed that when a dispute requires a medical determination, the matter should always be considered under procedures in Chapter 62M, regardless of whether the matter originally arose as a general complaint or from a utilization review decision.

Disclosure and Procedures for Filing

Disclosure of the process for obtaining certification or approval for coverage under utilization review needs to be clear and concise. The work group discussed that such disclosure shall be provided as a part of the certificate of coverage.

Procedures for Review Determinations

Every utilization review organization must have written procedures to ensure that all determinations and decisions are conducted in accordance with statutory requirements. Once the determination is made to certify or not to certify, notification must promptly be provided by telephone to the provider and enrollee. Written notification must then be sent, along with information about the right of appeal and the process for initiating this appeal.

For an expedited review determination, the work group discussed two standards. One definition followed the current Medicare appeal process, (expedited review determination if standard procedure would jeopardize the enrollee's life, health, or ability to regain maximum function) while the other option was to use current language found in Minnesota Statutes section 62M.06, subd. 2 (expedited appeal of determinations not to certify if the attending physician believes that the determination warrants immediate appeal).

Recommendation: *The Departments recommend using the language currently contained in section 62M.06, subdivision 2, which allows for an expedited review determination if the attending physician believes that the determination warrants immediate consideration. The attending physician is in the best position to determine whether the circumstances warrant an expedited review determination. Notification of the expedited determination decision should be provided within 72 hours of the initial request. Furthermore, additional language should be added requiring that if the utilization review organization and the claim administrator are separate entities, the utilization review organization must forward a notification of certification or determination not to certify to the appropriate claim administrator for the health benefit plan.*

Appeals of Determination Not to Certify

Currently, Utilization Review Organizations must provide a written procedure for appeals of determination not to certify, including the expedited appeal process. The group discussed whether to use the Medicare expedited appeal process language (if standard procedure would jeopardize the enrollee's life, health, or ability to regain maximum function) or the language currently contained in Minnesota Statutes §62M.06, subd. 2 (expedited appeal of determinations not to certify if the attending physician believes that the determination warrants immediate appeal).

Recommendation: *Like the expedited review determination process, the Departments recommend using the language currently contained in Minnesota Statutes §62M.06, subd. 2 (expedited appeal of determinations not to certify if the attending physician believes that the circumstances warrant immediate appeal).*

Current language has no time requirement requiring the utilization review organization to notify the enrollee, attending health care provider or their designee by telephone of his or her determination for this expedited appeal process. The group discussed adding language requiring this notification to be made no later than 72 hours after receiving the expedited appeal. With this notification, the enrollee must be informed of his or her right to submit an appeal to an external review process and the procedures for initiating this external appeal.

Time frames and Notice Requirements for Standard Appeal

The work group discussed two options for the time frame within which the health plan company must make its initial decision on a standard appeal, and provide notification thereof, to the enrollee or patient, attending health care provider and claim administrator.

One option is similar to the time frame currently required for each HMO under Chapter 62Q. The decision must be made within thirty days unless there are circumstances beyond the utilization review organization's control. Then the enrollee must be notified of the reason for the delay and the utilization review organization has an additional fourteen days.

The other option is similar to the current language for appeal in Minnesota Statutes section 62M.06. It provides that a decision must be made within forty-five days after receiving the required documentation on the appeal.

Recommendation: *The Departments recommend that the time frame within which the health plan company must make its decision on a standard appeal, and provide notification thereof, be 30 days.*

Second Appeal Options

There was discussion about whether a utilization review organization may establish and offer a second appeal process if the determination not to certify is not reversed through the standard appeal mechanism. If a utilization review organization offers a second appeal option, it must meet the requirements of the internal appeal process described in chapter 62Q.

There was also discussion suggesting that complainants not be required to exhaust a second appeal option, if it is offered, before submitting the appeal to an external appeal process.

Recommendation*: The Departments recommend that a health plan company be allowed to offer a second appeal option, as described above. The enrollee may chose to utilize the second appeal option, but should not be required to do so. Once an enrollee has gone through the standard appeal process, he or she may opt to proceed directly to the external process, even if the health plan company offers a second appeal option.*

When May an Enrollee Access the External Appeal Process?

This question must be resolved for issues that arise under either 62Q or 62M. Because an external appeal process could be costly, industry representatives argue that a consumer should be required to exhaust the standard internal appeal process before accessing the external appeal process. The Departments agree. The health plan company should have the opportunity to review its own decision, and make any corrections if appropriate, before being required to proceed to an external appeal process. In theory, the mere existence of the external appeal process will improve the quality of the internal appeal process, making the external appeal process necessary or attractive in fewer circumstances. However, the enrollee should not be required to exhaust any secondary internal appeals that are offered at the health plan company's option. And of course, a consumer may contact the appropriate state regulatory agency at any time.

Recommendation*: The Departments recommend that the consumer be required to exhaust one level of an internal appeal process prior to proceeding to the external appeal process, but the enrollee should not be required to go through a second internal appeal process offered at the health plan company's option.*

External Process

As noted earlier in this report, as early as last year (1997), the group discussed that a complaint resolution process which would include mechanisms for both internal and external appeal, and that the role of the regulatory agencies should not be diminished. There was also general discussion that enrollees should be able to access the external appeal process following an adverse utilization review decision made pursuant to Minnesota Statutes, section 62M.06.

The National Association of Insurance Commissioners (NAIC) has drafted a model act to provide standards for the establishment and maintenance of procedures by health carriers to assure that covered persons have the opportunity for the appropriate resolution of their grievances. The NAIC model act is referred to as the "Health Carrier Grievance Procedure Model Act." The NAIC is working toward amending the model act to include an external grievance process. Although still in draft form, the work group used the NAIC draft amendments to help guide the discussion of the issues related to an external process. This report will discuss each issue raised by the NAIC draft amendments, as they were discussed by the work group. It also includes the Departments' recommendations on each issue.

What entities' decisions would be eligible for the external appeals process?

There was extensive discussions by the work group about whether the external appeals process should apply to all state regulated health plan companies, including indemnity insurers.

Recommendation: *The Departments recommend that an external appeal process apply to all state regulated health plan companies.*

Who may request an external appeal?

The following ideas were discussed by the group:

- Under 62Q, an appeal may be requested by the enrollee or an enrollee's designee, (enrollee's designee may be any consumer or provider acting on the consumer's behalf); and

- Under 62 M, an appeal may be requested by the enrollee, the enrollee's designee, or a health provider involved in the enrollee's care.

Recommendation: *The Departments recommend that an external appeal may be submitted by either the enrollee or the enrollee's designee.*

What types of decisions are eligible for external appeal?

The work group generally discussed that decisions involving claims (chapter 62Q) and medical necessity (chapter 62M) would be eligible for the external appeal process.

Recommendation: *The Departments recommend that all issues which relate to health care services or claims be eligible for external appeal. Issues that are not related to health care services or claims, such as claims based on fraudulent marketing practices or agent misrepresentation, should not be eligible for external appeal.*

Should there be a dollar threshold for external appeal, and if so, how much?

There was no general agreement during the discussion of this issue. However, the ideas discussed by the group were the following:

- No dollar threshold; or
- Impose a dollar threshold in an amount which would encourage the use of the external process for larger cases only.

Imposing a dollar threshold amount is one way to limit the number of disputes eligible for external appeal process. Industry representatives argue that imposing a dollar threshold amount would provide some assurance that the external appeal process would be used for meritorious claims only. On the other hand, it is not uncommon for a dispute involving a smaller dollar amount to be a recurring dispute. Furthermore, imposing a dollar limit would add a costly administrative complexity to the process.

Research done by the Georgetown University Institute for Health Care Research and Policy shows that the number of cases that have gone to an external appeal mechanism in the states that have instituted such a mechanism have been minimal. For example, in Michigan, there were only 49 cases that went to an external appeal mechanism in three and one half years; in Connecticut, there were only 18 cases that went to an external appeal mechanism in seven months. (See *Key Features of State and Medicare Programs for External Review of Health Plan Decisions*, Karen Pollitz, M.P.P., p. 6).

The NAIC model does not impose a dollar threshold for submission to some type of external appeal process. Rather, a dollar threshold could be one of the criteria used to determine the type of external appeal process that should be used.

Recommendation*: In the interests of providing a fair and accessible process, and also in order to maximize administrative economies, the Departments' recommendation is that no dollar threshold be imposed. If there is a dollar threshold amount imposed, we recommend that the amount be established at a level no higher than the costs of providing an external appeal.*

Should there be a cost-sharing requirement?

Requiring the consumer to contribute to the cost of an external appeal process is another way of limiting the use of the external appeal process to meritorious claims. Cost sharing could be accomplished by imposing a set filing fee or requiring the consumer to pay a percentage of the cost of the external appeal process. Either of these types of fees could be waived upon a showing

of hardship and/or reimbursable should the consumer prevail. Another option would be to require a consumer to share in the cost of the external appeal if the external appeal was decided in favor of the health plan company.

Under the NAIC model, there is no cost sharing requirement imposed upon the consumer.

The ideas discussed were the following:

- Impose a modest cost sharing requirement on the enrollee (less than $100 - allow for hardship exception; tie amount to inflation; tie fee to use of the internal process; and/or tie fee to outcome); or

- Impose no cost sharing requirement.

***Recommendation**: The Departments recommend that there be no cost sharing requirement at this time. The law could be amended at a later date if the external appeal system is in fact flooded with large numbers of non-meritorious appeals.*

Should exhaustion of internal appeals procedures be required before allowing access to the external appeals process?

Because an external appeal process could be costly, industry representatives argue that a consumer should be required to exhaust the internal appeal process before accessing the external appeal process. The Departments agree. The health plan company should have the opportunity to review its own decision, and make any corrections if appropriate, before being required to proceed to an external appeal process. In theory, the mere existence of the external appeal process will improve the quality of the internal review processes, making the external appeal process necessary or attractive in fewer circumstances. However, the enrollee should not be required to exhaust a second internal appeal option that is offered at the health plan company's option. And of course, a consumer may also contact the appropriate state regulatory agency at any time.

***Recommendation**: The Departments recommend that the consumer be required to exhaust the internal appeal process prior to proceeding to external review, but the enrollee should not be required to go through a second internal appeal processes offered at the health plan company's option.*

What type of review process will be used for an external appeal, will there be filing requirements, and who will chose the person or entity that will perform the external appeal?

A number of ideas were discussed by the group. The draft amendments to the NAIC model act provide no specific recommendations.

During the discussions, the Departments pointed out several principles that they felt were important to incorporate into an external appeal process:

- the enrollee/designee must make an active written request for review;
- the regulatory agencies must maintain regulatory functions and review all matters of law;
- the regulatory agencies may refer cases involving factual disputes to an independent decision maker for review; and
- the regulatory agencies determine proper mechanism for review.

Model #1: One model for an external appeal mechanism which was discussed by the group involves an administrative structure which would act as a funnel and direct the appeals through either a regulatory review mechanism or to a "decision maker." Under this model, the administrative structure would apply established criteria to determine which review mechanism is appropriate. (See Appendix C.) For example, if the resolution of the enrollee's complaint is a matter of applying the terms of an enrollee's contract and/or the relevant rules and statutes to undisputed facts, the review would be purely regulatory in nature and therefore, would be appropriate for regulatory agency review by the commissioner with jurisdiction. On the other hand, if the resolution of the enrollee's complaint requires the resolution of factual disputes, in addition to legal analysis, the issue would be appropriately funneled to the "decision maker." An inter-agency office could be established to conduct the external review of the cases referred to the "decision maker." Both the Departments of Health and Commerce could refer cases involving the resolution of factual disputes to the inter-agency office to conduct the external review. The interagency office would be under the joint authority of both Commissioners.

If a case referred to the inter-agency office involves complex medical issues, the "decision maker" will have the discretion to solicit an independent expert medical opinion, either from an individual expert, or in more complicated cases, a panel of experts. The "decision maker" will then consider the expert medical opinion in making its determination.

Model #2. Another model for external appeal which was discussed by the group would provide a number of mechanisms for an enrollee to appeal an adverse decision by a health plan company, including a regulatory review, independent medical review, arbitration, or litigation. Under this model, there would be statutory criteria, to be applied by the Departments, which must be met in order for arbitration and independent medical review organizations to be certified as external review organizations. Under this model, an enrollee would have the right to seek regulatory review at any time during the internal or external review process. (See Appendix D.)

Recommendation: *The Departments recommend that an approach similar to model #1 be adopted. The Commissioners, however, should retain the ultimate decision making authority. This model would allow the regulatory agencies to appropriately and effectively conduct their*

regulatory functions, and it allows for an independent decision to resolve issues involving factual disputes. By serving as the channeling agent, the agencies would remain informed, in a timely manner, of all potential regulatory compliance issues. One benefit of this model is that it correlates with what is already being done by the regulatory agencies and will fit well within the existing administrative structures. Under this model, however, the cases which require the resolution of conflicting evidence, especially conflicting medical evidence, will be funneled to an interagency office. Such an office would be better suited to resolve these types of disputes than the regulatory agencies. As a part of the interagency external appeal process, each party will be able to present its version of the facts and arguments to the office. The office will determine the facts and make recommendations to the Commissioners. For cases involving complex medical issues, the office will have the authority to seek independent expert medical opinion. The inter-agency office should primarily be made up of existing staff of the departments.

How will the external appeals process be funded?

The NAIC model act does not address this issue. The ideas discussed were the following:

- An external appeal process could be funded with state funds---(tobacco settlement monies), and the costs to regulated plans would not be increased;
- Provide state funds for the start up costs of the program;
- No general fund appropriations.
- Fund external appeal process with state government special revenue funds.

Research shows that the direct costs per case for external review in states that have implemented such a mechanism has been nominal. (See *Key Features of State and Medicare Programs for External Review of Health Plan Decisions*, p. 20.)

***Recommendation**: There are a number of viable options for funding an external appeal process, including general fund appropriations and state government special revenue funds supported by industry fees. However, the Departments feel that decisions related to funding for an external appeal process are best left to the legislature.*

How will conflicts of interest be avoided?

Some of the most obvious conflicts of interest occur when a reviewer has a financial or familial affiliation with one of the parties involved in the dispute or where the reviewer is paid by the health plan company. The ideas discussed were the following:

- Any financial, professional, or familial affiliation between reviewer and any of the parties involved should be avoided.
- Protect anonymity of parties involved; and/or

- Protect anonymity of reviewer.

***Recommendation**: The Departments recommend that conflicts of interest be avoided by prohibiting any financial, professional, or familial affiliation between the reviewer and any of the parties involved in the dispute, and by protecting the anonymity of the parites involved and/or the reviewer.*

What standard of review will be used in the external process?

The ideas discussed were the following:

- *de novo* review, where either party may submit additional evidence;
- allow no additional evidence to be considered on appeal;

The NAIC model act provides that during the external review, the enrollee has the right to present his case to the decision maker, submit supporting material both before and at the review meeting, and be assisted or represented by a person of his choice.

***Recommendation**: The Departments recommend that the external process allow for a de novo review and that we follow the NAIC draft amendments on this issue.*

What time frames will be applied to the external appeals process?

***Recommendation**: The Departments recommend that the decision maker be required to issue a decision as soon as practical but in no case later than 30 days.*

Will the decision following the external review be binding on any and/or all parties?

Another issue to address is whether the decision made following the external review should be a binding decision, and if so, binding upon both parties or binding on the health plan company only. The ideas discussed were the following:

- The decision should not be binding on the consumer but should be binding on the health plan only; if the consumer is not satisfied with the outcome of the external review process, he or she could still chose to litigate thereafter; or
- Decision should be binding on both parties; neither party could chose to litigate following the external review process; or
- Decision should be binding on neither party.

Under the NAIC Model Act, the decision maker has the legal authority to bind the health plan company to its decision upon external review.

***Recommendation**: The Departments recommend that the decision following the external review be binding on both parties.*

Should attorneys' fees be awarded to an enrollee who prevails on the external appeal?

The ideas discussed were the following:

- Do not allow for award of attorney's fees; or
- Allow decision-maker discretion to award attorney's fees; or
- Automatic award of attorney's fees to consumer if they win on appeal.

The issue of attorney's fees is not addressed by the NAIC model act.

***Recommendation**: The Departments recommend that the decision-maker have limited and narrow discretion to award attorney's fees in favor of the consumer when, after considering all the relevant circumstances, such an award is warranted.*

Should the liability of the external reviewer be limited?

The ideas discussed were the following:

- The reviewer should be protected from liability for decisions made within the scope of the reviewer's duties; or
- Allow for liability for gross misconduct only.

This issue is not addressed in the NAIC.

***Recommendation**: The Departments recommend that language be included in statute which would provide immunity from civil liability to the decision maker (and its staff) for any action taken in good faith, within the scope of the reviewer's duties, and does not constitute willful or reckless misconduct.*

What types of data reporting requirements should be imposed for the external process?

Requiring data reporting will provide for accountability to the general public, as well as the regulators, for the decisions made and actions taken as a result of the external appeal process. The ideas discussed include the following:

- Allow external process to be non-public and require reporting of general numbers only; or

- Require reporting of synopsis of cases, but keep information on individuals non-public.

***Recommendation**: The Departments recommend that the external appeal process be non-public, but that there be a requirement that the summary data from the external process, including the numbers of cases heard and decided and final outcomes, be made available upon request.*

Implications for Indemnity Insurers and Self-Insureds

Every Minnesotan deserves a simple and efficient system where they can appeal their health care decision and complaints. Our goal is to create a better complaint resolution process that will not disrupt the current health care market; can be used by all enrollees, including those covered by self-insured employers; and is fair and equitable to all parties.

In proposing these new or modified statutes, we reviewed the current complaint processes that exist for the health maintenance organizations, the non-profit health service plans and insurance companies. By proposing the modification of these existing statutes, we have set forth a credible process for the establishment and maintenance of procedures by licensed health carriers to assure that a person covered by a regulated plan has an opportunity for appropriate resolution of his or her compliant or grievance.

The primary source of health care insurance coverage for all Minnesotans comes from three sources: self-insurance, private insurance and the government (through either Medicare or Medicaid). Approximately 29 percent of the market today is through self-insurance, another 38 percent through the fully insured market (health maintenance organizations, Blue Cross and Blue Shield, and insurance companies), approximately 24 percent through the government, and about 9 percent who are uninsured.

Under a fully-insured health plan, insurance companies or HMOs are paid premiums and assume the risk for insuring enrollees. Under a self-insurance plans, the employer pays covered medical expenses out of organization assets rather than purchase insurance. Thus, the employer assumes the risk of losses directly, rather than transferring the risk to a third party.

Based on current trends, there has been a shift toward employer self-insurance and away from the use of fully-insured plans in the private market. Second, there has been a shift within the health self-insured and fully insured segments of the private market toward managed health care (network of providers and pre-authorization).

It is important to monitor the continuing shift toward employer self-insurance and the private market because federal law exempts self-insured plans from state regulations. Self insured plans are regulated by the Employee Retirement Income Security Act Of 1974 (ERISA), which means that the individual employee must either complain to their employer or to the U.S. Department of Labor and not the state. Additionally, by not being able to regulate these self-insured employers, the burden of certain taxes and assessments (such as the assessment that funds the Minnesota Comprehensive Health Association) is distributed across a smaller base (small employers and individual health plans).

Each time a new health care mandated benefit is added, or a health carrier or the employer is required to implement a new administrative procedure, cost can increase or the employer becomes self-insured. Additionally, these changes in health care regulation have a potential to reduce competition by having national health carriers withdraw from the Minnesota market. Trying to comply with 50 different states' requirements can be time consuming and administratively costly. The withdrawal of any health carrier from Minnesota's health care market, especially in rural Minnesota, can be expensive to the enrollee in the form of less competition and variety of benefits, and increased premiums.

We want to provide standards for the establishment and maintenance of procedures by licensed health carriers to assume that the covered person has opportunity for appropriate resolution of their complaint or grievance. For most health carriers, the proposed legislative changes will cause very little disruption of the current health care market, since most health carriers already have an internal appeal process and are in compliance with the utilization review organization requirements. However, a few national carriers might find these proposed changes to be an additional administrative burden and exit Minnesota's health care market. This may reduce competition, especially in rural Minnesota. Therefore, although we must move ahead, we must do so cautiously.

Repealers

If legislation is passed incorporating the recommendations contained in this report, it would also be appropriate to repeal Minnesota Statutes 1998, sections 62D.11, subdivisions 1b and 2; 62Q.105; 62Q.11; 62Q.30 and Minnesota Rules, parts 4685.0100, subparts 4 and 4a; and 4685.1700. (See p. 34 of draft legislation contained in appendix A.)

Funding for the Consumer Assistance Office

The work group did not address the issue of funding of the newly created Office of Health Care Consumer Assistance, Advocacy, and Information. The Departments recommend, however, that the new office be funded with a general fund appropriation. The office will be accessible to all

Minnesotans, including those who receive their health care benefits through employer self-insured plans. In contrast to the funding for the cost of an inter-agency external appeal process, the Departments feel that it would not be appropriate to fund the Office of Health Care Consumer Assistance, Advocacy, and Information by the assessment of fees on state regulated plans only.

Summary of Recommendations

The Departments have made a number of recommendations throughout this report. The recommended changes relative to the internal appeal process, if adopted, will serve to clarify the law, and eliminate current overlapping and inconsistencies. Furthermore, the creation of an external appeal process which incorporates many of the principles upon which the draft amendments to the National Association of Insurance Commissioners (NAIC) model act are based will provide a fair and cost-effective method for independent review of health plan company decisions.

The specific recommendations relative to internal review of enrollee complaints are as follows:

1. The Departments recommend that there be an expectation that the health plan companies provide full disclosure of options to enrollees who indicate by telephone that they have a concern or complaint, but allow flexibility as to how health plan companies will accomplish this and meet the Commissioners' expectations in this regard.

2. The Departments recommend that the timeframe within which the health plan company must make its initial decision on a complaint, and provide notification thereof, be 30 days.

3. The Departments recommend an enrollee be allowed to proceed to an external appeal process only after exhausting the health plan company's internal appeal process. This is consistent with the National Association of Insurance Commissioners' model act.

4. The Departments recommend using the language currently contained in Minnesota Statutes, section 62M.06, subdivision 2, which allows for an expedited review determination if the attending physician believes that the determination warrants immediate consideration. The attending physician is in the best position to determine whether the circumstances warrant an expedited review determination. Notification of the expedited determination decision should be provided within 72 hours of the initial request. Furthermore, additional language should be added requiring that if the utilization review organization and the claim administrator are separate entities, the utilization review organization must forward a notification of certification or determination not to certify to the appropriate claim administrator for the health benefit plan.

5. Like the expedited review determination process, the Departments recommend using the language currently contained in Minnesota Statutes, section 62M.06, subdivision 2 (expedited appeal of determinations not to certify if the attending physician believes that the circumstances warrant immediate appeal).

6. The Departments recommend that the time frame within which the health plan company must make its decision on a standard appeal, and provide notification thereof, be 30 days.

7. The Departments recommend that a health plan company be allowed to offer a second appeal option. The enrollee may chose to utilize the second appeal option, but should not be required to do so. Once an enrollee has gone through the first internal appeal process, he or she may opt to proceed directly to the external appeal process, even if the health plan company offers a second appeal option.

8. The Departments recommend that the consumer be required to exhaust one level of an internal appeal process prior to proceeding to the external appeal process, but the enrollee should not be required to go through a second internal appeal process offered at the health plan company's option.

The Departments also recommend that an external appeal mechanism be created, incorporating specific principles, as follows:

9. The Departments recommend that an external appeal process apply to all state regulated health plan companies.

10. The Departments recommend that an external appeal may be submitted by either the enrollee or the enrollee's designee.

11. The Departments recommend that all issues which relate to health care services or claims be eligible for external appeal. Issues that are not related to health care services or claims, such as claims based on fraudulent marketing practices or agent misrepresentation, should not be eligible for external appeal.

12. In the interests of providing a fair and accessible process , and also in order to maximize administrative economies, the Departments' recommendation is that no dollar threshold be imposed. If there is a dollar threshold amount imposed, we recommend that the amount be established at a level no higher than the costs of providing an external appeal.

13. The Departments recommend that there be no cost sharing requirement at this time. The law could be amended at a later date if the external appeal system is flooded with large numbers of non-meritorious appeals.

14. The Departments recommend that the consumer be required to exhaust the internal appeal process prior to proceeding to external review, but the enrollee should not be required to go through an second internal appeal process offered at the health plan company's option.

15. The Departments recommend that an approach similar to model #1 be adopted. The Commissioners, however, should retain the ultimate decision making authority. This model would allow the regulatory agencies to appropriately and effectively conduct their regulatory functions, and it allows for an independent decision to resolve issues involving

factual disputes. By serving as the channeling agent, the agencies would remain informed, in a timely manner, of all potential regulatory compliance issues. One benefit of this model is that it correlates with what is already being done by the regulatory agencies and will fit well within the existing administrative structures. Under this model, however, the cases which require the resolution of conflicting evidence, especially conflicting medical evidence, will be funneled to an interagency office. Such an office would be better suited to resolve these types of disputes than the regulatory agencies. As a part of the interagency external appeal process, each party will be able to present its version of the facts and arguments to the office. The office will determine the facts and make recommendations to the Commissioners. For cases involving complex medical issues, the office will have the authority to seek independent expert medical opinion. The inter-agency office should primarily be made up of existing staff of the departments.

16. There are a number of viable options for funding an external appeal process, including general fund apropriations and state government special revenue funds supported by industry fees. However, the Departments feel tha decisions related to funding for an external appeal process are best left to the legislature.

17. The Departments recommend that conflicts of interest be avoided by prohibiting any financial, professional, or familial affiliation between the reviewer and any of the parties involved in the dispute, and by protecting the anonymity of the parties involved and/or the reviewer.

18. The Departments recommend that the external process allow for a de novo review and that we follow the NAIC draft amendments on this issue.

19. The Departments recommend that the decision maker be required to issue a decision as soon as practical but in no case later than 30 days.

20. The Departments recommend that the decision following the external review be binding on both parties.

21. The Departments recommend that the inter-agency office have limited and narrow discretion to award attorney's fees in favor of the consumer when, after considering all the relevant circumstances, such an award is warranted.

22. The Departments recommend that language be included in statute which would provide immunity from civil liability to the decision maker (and its staff) for any action taken in good faith, within the scope of the reviewer's duties, and does not constitute willful or reckless misconduct.

23. The Departments recommend that the external appeal process be non-public, but that there be a requirement that the summary data from the external process, including the numbers of cases heard and decided and final outcomes, be made available upon request.

Appendix A

A bill for an act

relating to health; establishing a uniform complaint resolution process for health plan companies; establishing an external appeal process; appropriating money; amending Minnesota Statutes 1998, sections 62D.11, subdivision 1; 62M.01; 62M.02; 62M.03; 62M.04; 62M.05; 62M.06; 62M.07; 62M.08; 62M.09; 62M.10; 62M.11; 62M.12; 62M.13; 62M.14; 62M.15; 62M.16; and 72A.201, subdivisions 4 and 4a; proposing coding for new law in Minnesota Statutes, chapter 62Q; repealing Minnesota Statutes 1998, sections 62D.11, subdivisions 1b and 2; 62Q.105; 62Q.11; and 62Q.30; Minnesota Rules, parts 4685.0100, subparts 4 and 4a; and 4685.1700.

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

Section 1. Minnesota Statutes 1998, section 62D.11, subdivision 1, is amended to read:

Subdivision 1. [ENROLLEE COMPLAINT SYSTEM.] Every health maintenance organization shall establish and maintain a complaint system, as required under ~~section 62Q.105~~ sections 62Q.66 to 62Q.70 to provide reasonable procedures for the resolution of written complaints initiated by or on behalf of enrollees concerning the provision of health care services. ~~"Provision of health services" includes, but is not limited to, questions of the scope of coverage, quality of care, and administrative operations. The health maintenance organization must inform enrollees that they may choose to use arbitration to appeal a health maintenance organization's internal appeal decision. The health maintenance organization must also inform enrollees that they have the right to use~~

~~arbitration to appeal a health maintenance organization's internal appeal decision not to certify an admission, procedure, service, or extension of stay under section 62M.06. If an enrollee chooses to use arbitration, the health maintenance organization must participate.~~

Sec. 2. Minnesota Statutes 1998, section 62M.01, is amended to read:

62M.01 [CITATION, JURISDICTION, AND SCOPE.]

Subdivision 1. [POPULAR NAME.] Sections 62M.01 to 62M.16 may be cited as the "Minnesota utilization review act of 1992."

Subd. 2. [JURISDICTION.] Sections 62M.01 to 62M.16 apply to any insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network licensed under chapter 62N; an accountable provider network operating under chapter 62T; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended; a third party administrator licensed under section 60A.23, subdivision 8, that provides utilization review services for the administration of benefits under a health benefit plan as defined in section 62M.02; or any entity performing utilization review on behalf of a business entity in this state pursuant to a health benefit plan covering a Minnesota resident.

Subd. 3. [SCOPE.] ~~Sections 62M.02, 62M.07, and 62M.09, subdivision 4, apply to prior authorization of services.~~ Nothing in sections 62M.01 to 62M.16 applies to review of claims after submission to determine eligibility for benefits under a health benefit plan. The appeal procedure described in section 62M.06 applies to any complaint as defined under section 62Q.66, subdivision 2, that requires a medical determination in its

resolution.

Sec. 3. Minnesota Statutes 1998, section 62M.02, is amended to read:

62M.02 [DEFINITIONS.]

Subdivision 1. [TERMS.] For the purposes of sections 62M.01 to 62M.16, the terms defined in this section have the meanings given them.

Subd. 2. [APPEAL.] "Appeal" means a formal request, either orally or in writing, to reconsider a determination not to certify an admission, extension of stay, or other health care service.

Subd. 3. [ATTENDING DENTIST.] "Attending dentist" means the dentist with primary responsibility for the dental care provided to ~~a patient~~ an enrollee.

Subd. 4. [ATTENDING ~~PHYSICIAN~~ HEALTH CARE PROFESSIONAL.] "Attending ~~physician~~ health care professional" means the ~~physician~~ health care professional with primary responsibility for the care provided to ~~a patient~~ an enrollee in a hospital or other health care facility.

Subd. 5. [CERTIFICATION.] "Certification" means a determination by a utilization review organization that an admission, extension of stay, or other health care service has been reviewed and that it, based on the information provided, meets the utilization review requirements of the applicable health plan and the health ~~carrier~~ plan company will then pay for the covered benefit, provided the preexisting limitation provisions, the general exclusion provisions, and any deductible, copayment, coinsurance, or other policy requirements have been met.

Subd. 6. [CLAIMS ADMINISTRATOR.] "Claims administrator" means an entity that reviews and determines whether to pay claims to enrollees~~, physicians, hospitals, or others~~ or providers based on the contract provisions of the health plan contract. Claims administrators may include insurance companies licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a

health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network licensed under chapter 62N; an accountable provider network operating under chapter 62T; a fraternal benefit society operating under chapter 64B; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended.

Subd. 7. [CLAIMANT.] "Claimant" means the enrollee ~~or covered person~~ who files a claim for benefits or a provider of services who, pursuant to a contract with a claims administrator, files a claim on behalf of an enrollee or covered person.

Subd. 8. [CLINICAL CRITERIA.] "Clinical criteria" means the written policies, decision rules, medical protocols, or guidelines used by the utilization review organization to determine certification.

Subd. 9. [CONCURRENT REVIEW.] "Concurrent review" means utilization review conducted during ~~a patient's~~ an enrollee's hospital stay or course of treatment and has the same meaning as continued stay review.

Subd. 10. [DISCHARGE PLANNING.] "Discharge planning" means the process that assesses ~~a patient's~~ an enrollee's need for treatment after hospitalization in order to help arrange for the necessary services and resources to effect an appropriate and timely discharge.

Subd. 11. [ENROLLEE.] "Enrollee" means an individual ~~who has elected to contract for, or participate in, a health benefit plan for enrollee coverage or for dependent coverage~~ covered by a health benefit plan and includes an insured policyholder, subscriber contract holder, member, covered person, or certificate holder.

Subd. 12. [HEALTH BENEFIT PLAN.] "Health benefit plan" means a policy, contract, or certificate issued by a health ~~carrier to an employer or individual~~ plan company for the coverage of medical, dental, or hospital benefits. A health

benefit plan does not include coverage that is:

(1) limited to disability or income protection coverage;

(2) automobile medical payment coverage;

(3) supplemental to liability insurance;

(4) designed solely to provide payments on a per diem, fixed indemnity, or nonexpense incurred basis;

(5) credit accident and health insurance issued under chapter 62B;

(6) blanket accident and sickness insurance as defined in section 62A.11;

(7) accident only coverage issued by a licensed and tested insurance agent; or

(8) workers' compensation.

Subd. 12a. [HEALTH PLAN COMPANY.] "Health plan company" means a health plan company as defined in section 62Q.01, subdivision 4, and includes an accountable provider network operating under chapter 62T.

Subd. 13. [INPATIENT ADMISSIONS TO HOSPITALS.] "Inpatient admissions to hospitals" includes admissions to all acute medical, surgical, obstetrical, psychiatric, and chemical dependency inpatient services at a licensed hospital facility, as well as other licensed inpatient facilities including skilled nursing facilities, residential treatment centers, and free standing rehabilitation facilities.

Subd. 14. [OUTPATIENT SERVICES.] "Outpatient services" means procedures or services performed on a basis other than as an inpatient, and includes obstetrical, psychiatric, chemical dependency, dental, and chiropractic services.

Subd. 15. [PRIOR AUTHORIZATION.] "Prior authorization" means utilization review conducted prior to the delivery of a service, including an outpatient service.

Subd. 16. [PROSPECTIVE REVIEW.] "Prospective review" means utilization review conducted prior to an enrollee's inpatient stay.

Subd. 17. [PROVIDER.] "Provider" means a licensed health care facility, physician, or other health care professional that

delivers health care services to an enrollee ~~or covered person~~.

Subd. 18. [QUALITY ASSESSMENT PROGRAM.] "Quality assessment program" means a structured mechanism that monitors and evaluates a utilization review organization's program and provides management intervention to support compliance with the requirements of this chapter.

Subd. 19. [RECONSIDERATION REQUEST.] "Reconsideration request" means an initial request by telephone for additional review of a utilization review organization's determination not to certify an admission, extension of stay, or other health care service.

Subd. 20. [UTILIZATION REVIEW.] "Utilization review" means the evaluation of the necessity, appropriateness, and efficacy of the use of health care services, procedures, and facilities, by a person or entity other than the attending ~~physician~~ health care professional, for the purpose of determining the medical necessity of the service or admission. Utilization review also includes review conducted after the admission of the enrollee. It includes situations where the enrollee is unconscious or otherwise unable to provide advance notification. ~~Utilization review does not include the imposition of a requirement that services be received by or upon referral from a participating provider.~~

Subd. 21. [UTILIZATION REVIEW ORGANIZATION.] "Utilization review organization" means an entity including but not limited to an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; a community integrated service network licensed under chapter 62N; an accountable provider network operating under chapter 62T; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title

section 1103, as amended; a third party administrator
ensed under section 60A.23, subdivision 8, which conducts
lization review and determines certification of an admission,
ension of stay, or other health care services for a Minnesota
ident; or any entity performing utilization review that is
liated with, under contract with, or conducting utilization
ew on behalf of, a business entity in this state.

Sec. 4. Minnesota Statutes 1998, section 62M.03, is
ded to read:

62M.03 [COMPLIANCE WITH STANDARDS.]

Subdivision 1. [LICENSED UTILIZATION REVIEW ORGANIZATION.]
nning January 1, 1993, any organization that meets the
nition of utilization review organization in section 62M.02,
ivision 21, must be licensed under chapter 60A, 62C, 62D,
62T, or 64B, or registered under this chapter and must
ly with sections 62M.01 to 62M.16 and section 72A.201,
ivisions 8 and 8a. Each licensed community integrated
ice network or health maintenance organization that has an
oyed staff model of providing health care services shall
y with sections 62M.01 to 62M.16 and section 72A.201,
visions 8 and 8a, for any services provided by providers
contract.

Subd. 2. [NONLICENSED UTILIZATION REVIEW ORGANIZATION.] An
ization that meets the definition of a utilization review
ization under section 62M.02, subdivision 21, that is not
sed in this state that performs utilization review services
innesota residents must register with the commissioner of
rce and must certify compliance with sections 62M.01 to
5.

Initial registration must occur no later than January 1,
The registration is effective for two years and may be
ed for another two years by written request. Each
ation review organization registered under this chapter
notify the commissioner of commerce within 30 days of any
in the name, address, or ownership of the organization.

ubd. 3. [PENALTIES AND ENFORCEMENTS.] If a utilization

review organization fails to comply with sections 62M.01 to 62M.16, the organization may not provide utilization review services for any Minnesota resident. The commissioner of commerce may issue a cease and desist order under section 45.027, subdivision 5, to enforce this provision. The cease and desist order is subject to appeal under chapter 14. A nonlicensed utilization review organization that fails to comply with the provisions of sections 62M.01 to 62M.16 is subject to all applicable penalty and enforcement provisions of section 72A.201. Each utilization review organization licensed under chapter 60A, 62C, 62D, 62N, 62T, or 64B shall comply with sections 62M.01 to 62M.16 as a condition of licensure.

Sec. 5. Minnesota Statutes 1998, section 62M.04, is amended to read:

62M.04 [STANDARDS FOR UTILIZATION REVIEW PERFORMANCE.]

Subdivision 1. [RESPONSIBILITY FOR OBTAINING CERTIFICATION.] A health benefit plan that includes utilization review requirements must specify the process for notifying the utilization review organization in a timely manner and obtaining certification for health care services. Each health plan company must provide a clear and concise description of this process to an enrollee as part of the policy, subscriber contract, or certificate of coverage. In addition to the enrollee, the utilization review organization must allow any ~~licensed hospital, physician or the physician's~~ provider or provider's designee, or responsible patient representative, including a family member, to fulfill the obligations under the health plan.

A claims administrator that contracts directly with providers for the provision of health care services to enrollees may, through contract, require the provider to notify the review organization in a timely manner and obtain certification for health care services.

Subd. 2. [INFORMATION UPON WHICH UTILIZATION REVIEW IS CONDUCTED.] If the utilization review organization is conducting routine prospective and concurrent utilization review,

utilization review organizations must collect only the information necessary to certify the admission, procedure of treatment, and length of stay.

(a) Utilization review organizations may request, but may not require~~,-hospitals,-physicians,-or-other~~ providers to supply numerically encoded diagnoses or procedures as part of the certification process.

(b) Utilization review organizations must not routinely request copies of medical records for all patients reviewed. In performing prospective and concurrent review, copies of the pertinent portion of the medical record should be required only when a difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay.

(c) Utilization review organizations may request copies of medical records retrospectively for a number of purposes, including auditing the services provided, quality assurance review, ensuring compliance with the terms of either the health benefit plan or the provider contract, and compliance with utilization review activities. Except for reviewing medical records associated with an appeal or with an investigation or audit of data discrepancies, ~~health-care~~ providers must be reimbursed for the reasonable costs of duplicating records requested by the utilization review organization for retrospective review unless otherwise provided under the terms of the provider contract.

Subd. 3. [DATA ELEMENTS.] Except as otherwise provided in sections 62M.01 to 62M.16, for purposes of certification a utilization review organization must limit its data requirements to the following elements:

(a) Patient information that includes the following:

(1) name;

(2) address;

(3) date of birth;

(4) sex;

(5) social security number or patient identification number;

(6) name of health ~~carrier~~ plan company or health plan; and

(7) plan identification number.

(b) Enrollee information that includes the following:

(1) name;

(2) address;

(3) social security number or employee identification number;

(4) relation to patient;

(5) employer;

(6) health benefit plan;

(7) group number or plan identification number; and

(8) availability of other coverage.

(c) Attending ~~physician or provider~~ health care professional information that includes the following:

(1) name;

(2) address;

(3) telephone numbers;

(4) degree and license;

(5) specialty or board certification status; and

(6) tax identification number or other identification number.

(d) Diagnosis and treatment information that includes the following:

(1) primary diagnosis with associated ICD or DSM coding, if available;

(2) secondary diagnosis with associated ICD or DSM coding, if available;

(3) tertiary diagnoses with associated ICD or DSM coding, if available;

(4) proposed procedures or treatments with ICD or associated CPT codes, if available;

(5) surgical assistant requirement;

(6) anesthesia requirement;

(7) proposed admission or service dates;

(8) proposed procedure date; and

(9) proposed length of stay.

(e) Clinical information that includes the following:

(1) support and documentation of appropriateness and level of service proposed; and

(2) identification of contact person for detailed clinical information.

(f) Facility information that includes the following:

(1) type;

(2) licensure and certification status and DRG exempt status;

(3) name;

(4) address;

(5) telephone number; and

(6) tax identification number or other identification number.

(g) Concurrent or continued stay review information that includes the following:

(1) additional days, services, or procedures proposed;

(2) reasons for extension, including clinical information sufficient for support of appropriateness and level of service proposed; and

(3) diagnosis status.

(h) For admissions to facilities other than acute medical or surgical hospitals, additional information that includes the following:

(1) history of present illness;

(2) patient treatment plan and goals;

(3) prognosis;

(4) staff qualifications; and

(5) 24-hour availability of staff.

Additional information may be required for other specific review functions such as discharge planning or catastrophic case management. Second opinion information may also be required, when applicable, to support benefit plan requirements.

Subd. 4. [ADDITIONAL INFORMATION.] A utilization review organization may request information in addition to that described in subdivision 3 when there is significant lack of

agreement between the utilization review organization and the ~~health-care~~ provider regarding the appropriateness of certification during the review or appeal process. For purposes of this subdivision, "significant lack of agreement" means that the utilization review organization has:

(1) tentatively determined through its professional staff that a service cannot be certified;

(2) referred the case to a physician for review; and

(3) talked to or attempted to talk to the attending ~~physician~~ health care professional for further information.

Nothing in sections 62M.01 to 62M.16 prohibits a utilization review organization from requiring submission of data necessary to comply with the quality assurance and utilization review requirements of chapter 62D or other appropriate data or outcome analyses.

Subd. 5. [SHARING OF INFORMATION.] To the extent allowed under sections 72A.49 to 72A.505, a utilization review organization shall share all available clinical and demographic information on individual patients internally to avoid duplicate requests for information from enrollees or providers.

Sec. 6. Minnesota Statutes 1998, section 62M.05, is amended to read:

62M.05 [PROCEDURES FOR REVIEW DETERMINATION.]

Subdivision 1. [WRITTEN PROCEDURES.] A utilization review organization must have written procedures to ensure that reviews are conducted in accordance with the requirements of this chapter ~~and section 72A.201, subdivision 4a~~.

Subd. 2. [CONCURRENT REVIEW.] A utilization review organization may review ongoing inpatient stays based on the severity or complexity of the ~~patient's~~ enrollee's condition or on necessary treatment or discharge planning activities. Such review must not be consistently conducted on a daily basis.

Subd. 3. [NOTIFICATION OF DETERMINATIONS.] A utilization review organization must have written procedures for providing notification of its determinations on all certifications in accordance with ~~the following:~~ this section.

Subd. 3a. [STANDARD REVIEW DETERMINATION.]

(a) Notwithstanding subdivision 3b, an initial determination on all requests for utilization review must be communicated to the provider and enrollee in accordance with this subdivision within ten business days of the request provided that all information reasonably necessary to make a decision on the request has been made available to the utilization review organization.

(b) When an initial determination is made to certify, notification must be provided promptly by telephone to the provider. The utilization review organization shall send written notification to the ~~hospital, attending physician or applicable service provider within ten business days of the determination in accordance with section 72A.201, subdivision 4a,~~ provider or shall maintain an audit trail of the determination and telephone notification. For purposes of this subdivision, "audit trail" includes documentation of the telephone notification, including the date; the name of the person spoken to; the enrollee ~~or patient~~; the service, procedure, or admission certified; and the date of the service, procedure, or admission. If the utilization review organization indicates certification by use of a number, the number must be called the "certification number."

~~(b)~~ (c) When a an initial determination is made not to certify ~~a hospital or surgical facility admission or extension of a hospital stay, or other service requiring review determination~~, notification must be provided by telephone within one working day after making the ~~decision~~ determination to the attending ~~physician~~ health care professional and hospital ~~must be notified by telephone~~ and a written notification must be sent to the hospital, attending ~~physician~~ health care professional, and enrollee ~~or patient~~. The written notification must include the principal reason or reasons for the determination and the process for initiating an appeal of the determination. Upon request, the utilization review organization shall provide the ~~attending physician or~~ provider or enrollee with the criteria used to determine the necessity, appropriateness, and

efficacy of the health care service and identify the database, professional treatment parameter, or other basis for the criteria. Reasons for a determination not to certify may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the ~~attending physician~~ provider or enrollee.

(d) When an initial determination is made not to certify, the written notification must include the right to appeal the determination and the process for initiating an appeal.

Subd. 3b. [EXPEDITED REVIEW DETERMINATION.] (a) An expedited initial determination must be utilized if the attending health care professional believes that an expedited determination is warranted.

(b) Notification of an expedited initial determination to either certify or not to certify must be provided to the hospital, the attending health care professional, and enrollee as expeditiously as the enrollee's medical condition requires but no later than 72 hours from the initial request. When an expedited initial determination is made not to certify, the utilization review organization must also notify the enrollee and the attending health care professional of the right to an expedited appeal and the procedure for initiating an appeal.

Subd. 4. [FAILURE TO PROVIDE NECESSARY INFORMATION.] A utilization review organization must have written procedures to address the failure of a ~~health care~~ provider~~, patient~~ or enrollee~~, or representative of either~~ to provide the necessary information for review. If the ~~patient~~ enrollee or provider will not release the necessary information to the utilization review organization, the utilization review organization may deny certification in accordance with its own policy or the policy described in the health benefit plan.

Subd. 5. [NOTIFICATION TO CLAIMS ADMINISTRATOR.] If the utilization review organization and the claims administrator are separate entities, the utilization review organization must forward, electronically or in writing, a notification of certification or determination not to certify to the appropriate

claims administrator for the health benefit plan.

Sec. 7. Minnesota Statutes 1998, section 62M.06, is amended to read:

62M.06 [APPEALS OF DETERMINATIONS NOT TO CERTIFY.]

Subdivision 1. [PROCEDURES FOR APPEAL.] A utilization review organization must have written procedures for appeals of determinations not to certify ~~an admission, procedure, service, or extension of stay~~. The right to appeal must be available to the enrollee ~~or designee~~ and to the attending ~~physician~~ health care professional. ~~The right of appeal must be communicated to the enrollee or designee or to, the attending physician health care provider, or their designee, whomever initiated the original certification request, at the time that the original determination is communicated.~~

Subd. 2. [EXPEDITED APPEAL.] (a) When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review, ~~and the attending physician believes that the determination warrants immediate appeal~~ and the attending health care professional believes that the determination warrants an expedited appeal, the utilization review organization must ensure that the enrollee and the attending ~~physician~~ health care professional, ~~enrollee, or designee has~~ have an opportunity to appeal the determination over the telephone on an expedited basis. In such an appeal, the utilization review organization must ensure reasonable access to its consulting physician or health care provider. ~~Expedited appeals that are not resolved may be resubmitted through the standard appeal process.~~

(b) The utilization review organization shall notify the enrollee and attending health care professional by telephone of its determination on the expedited appeal as expeditiously as the enrollee's medical condition requires but no later than 72 hours after receiving the expedited appeal.

(c) If the determination not to certify is not reversed through the expedited appeal, the utilization review organization must include in its notification the right to

submit the appeal to the external appeal process described in section 62Q.71 and the procedure for initiating the process. This information must be provided in writing to the enrollee and the attending health care professional as soon as practical.

Subd. 3. [STANDARD APPEAL.] The utilization review organization must establish procedures for appeals to be made either in writing or by telephone.

(a) ~~Each~~ A utilization review organization shall notify in writing the enrollee ~~or patient~~, attending ~~physician~~ health care professional, and claims administrator of its determination on the appeal ~~as soon as practical, but in no case later than 45 days after receiving the required documentation on the appeal~~ within 30 days upon receipt of the notice of appeal.

(b) The documentation required by the utilization review organization may include copies of part or all of the medical record and a written statement from the attending health care ~~provider~~ professional.

(c) Prior to upholding the ~~original decision~~ initial determination not to certify for clinical reasons, the utilization review organization shall conduct a review of the documentation by a physician who did not make the ~~original~~ initial determination not to certify.

(d) The process established by a utilization review organization may include defining a period within which an appeal must be filed to be considered. The time period must be communicated to the ~~patient,~~ enrollee~~, or~~ and attending ~~physician~~ health care professional when the initial determination is made.

(e) An attending ~~physician~~ health care professional or enrollee who has been unsuccessful in an attempt to reverse a determination not to certify shall, consistent with section 72A.285, be provided the following:

(1) a complete summary of the review findings;

(2) qualifications of the reviewers, including any license, certification, or specialty designation; and

(3) the relationship between the enrollee's diagnosis and

the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision.

(f) In cases of appeal to reverse a determination not to certify for clinical reasons, the utilization review organization must, upon request of the attending ~~physician~~ health care professional, ensure that a physician of the utilization review organization's choice in the same or a similar general specialty as typically manages the medical condition, procedure, or treatment under discussion is reasonably available to review the case.

(g) If the initial determination is not reversed on appeal, the utilization review organization must include in its notification the right to submit the appeal to the external appeal process described in section 62Q.71 and the procedure for initiating the review process.

Subd. 4. ~~[NOTIFICATION TO CLAIMS ADMINISTRATOR.] If the utilization review organization and the claims administrator are separate entities, the utilization review organization must forward, electronically or in writing, a notification of certification or determination not to certify to the appropriate claims administrator for the health benefit plan.~~ [SECOND APPEAL OPTION.] (a) The utilization review organization may establish an appeal process that offers a second appeal if the determination not to certify is not reversed through the standard appeal. If the utilization review organization offers a second appeal, the process must meet the requirements of the internal appeal process described in section 62Q.68.

(b) If a utilization review organization offers a second appeal, an enrollee is not required to exhaust the second appeal process before submitting the determination not to certify to the external appeal process pursuant to section 62Q.71.

Subd. 5. [NOTIFICATION TO CLAIMS ADMINISTRATOR.] If the utilization review organization and the claims administrator are separate entities, the utilization review organization must notify, either electronically or in writing, the appropriate claims administrator for the health benefit plan of any

determination not to certify that is reversed on appeal.

Sec. 8. Minnesota Statutes 1998, section 62M.07, is amended to read:

62M.07 [PRIOR AUTHORIZATION OF SERVICES.]

(a) Utilization review organizations conducting prior authorization of services must have written standards that meet at a minimum the following requirements:

(1) written procedures and criteria used to determine whether care is appropriate, reasonable, or medically necessary;

(2) a system for providing prompt notification of its determinations to enrollees and providers and for notifying the provider, enrollee, or enrollee's designee of appeal procedures under clause (4);

(3) compliance with section ~~72A.201~~ 62M.05, subdivision ~~4a~~ 3, regarding time frames for approving and disapproving prior authorization requests;

(4) written procedures for appeals of denials of prior authorization which specify the responsibilities of the enrollee and provider, and which meet the requirements of ~~section~~ sections 62M.06 and 72A.285, regarding release of summary review findings; and

(5) procedures to ensure confidentiality of patient-specific information, consistent with applicable law.

(b) No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization of emergency confinement or emergency treatment. The enrollee or the enrollee's authorized representative may be required to notify the health plan company, claims administrator, or utilization review organization as soon after the beginning of the emergency confinement or emergency treatment as reasonably possible.

Sec. 9. Minnesota Statutes 1998, section 62M.08, is amended to read:

62M.08 [CONFIDENTIALITY.]

Subdivision 1. [WRITTEN PROCEDURES TO ENSURE CONFIDENTIALITY.] A utilization review organization must have

written procedures for ensuring that patient-specific information obtained during the process of utilization review will be:

(1) kept confidential in accordance with applicable federal and state laws;

(2) used solely for the purposes of utilization review, quality assurance, discharge planning, and case management; and

(3) shared only with those organizations or persons that have the authority to receive such information.

Subd. 2. [SUMMARY DATA.] Summary data is not subject to this section if it does not provide sufficient information to allow identification of individual patients.

Sec. 10. Minnesota Statutes 1998, section 62M.09, is amended to read:

62M.09 [STAFF AND PROGRAM QUALIFICATIONS.]

Subdivision 1. [STAFF CRITERIA.] A utilization review organization shall have utilization review staff who are properly trained, qualified, and supervised.

Subd. 2. [LICENSURE REQUIREMENT.] Nurses, physicians, and other licensed health professionals conducting reviews of medical services, and other clinical reviewers conducting specialized reviews in their area of specialty must be currently licensed or certified by an approved state licensing agency in the United States.

Subd. 3. [PHYSICIAN REVIEWER INVOLVEMENT.] A physician must review all cases in which the utilization review organization has concluded that a determination not to certify for clinical reasons is appropriate. The physician should be reasonably available by telephone to discuss the determination with the attending ~~physician~~ health care professional. This subdivision does not apply to outpatient mental health or substance abuse services governed by subdivision 3a.

Subd. 3a. [MENTAL HEALTH AND SUBSTANCE ABUSE REVIEWS.] A peer of the treating mental health or substance abuse provider or a physician must review requests for outpatient services in which the utilization review organization has concluded that a

determination not to certify a mental health or substance abuse service for clinical reasons is appropriate, provided that any final determination not to certify treatment is made by a psychiatrist certified by the American Board of Psychiatry and Neurology and appropriately licensed in the state in which the psychiatrist resides. Notwithstanding the notification requirements of section 62M.05, a utilization review organization that has made an initial decision to certify in accordance with the requirements of section 62M.05 may elect to provide notification of a determination to continue coverage through facsimile or mail.

Subd. 4. [DENTIST PLAN REVIEWS.] A dentist must review all cases in which the utilization review organization has concluded that a determination not to certify a dental service or procedure for clinical reasons is appropriate and an appeal has been made by the attending dentist, enrollee, or designee.

Subd. 4a. [CHIROPRACTIC REVIEW.] A chiropractor must review all cases in which the utilization review organization has concluded that a determination not to certify a chiropractic service or procedure for clinical reasons is appropriate and an appeal has been made by the attending chiropractor, enrollee, or designee.

Subd. 5. [WRITTEN CLINICAL CRITERIA.] A utilization review organization's decisions must be supported by written clinical criteria and review procedures. Clinical criteria and review procedures must be established with appropriate involvement from actively practicing physicians. A utilization review organization must use written clinical criteria, as required, for determining the appropriateness of the certification request. The utilization review organization must have a procedure for ensuring, at a minimum, the annual evaluation and updating of the written criteria based on sound clinical principles.

Subd. 6. [PHYSICIAN CONSULTANTS.] A utilization review organization must use physician consultants in the appeal process described in section 62M.06, subdivision 3. The

physician consultants should include, as needed and available, specialists who are board-certified, or board-eligible and working towards certification, in a specialty board approved by the American Board of Medical Specialists or the American Board of Osteopathy.

Subd. 7. [TRAINING FOR PROGRAM STAFF.] A utilization review organization must have a formalized program of orientation and ongoing training of utilization review staff.

Subd. 8. [QUALITY ASSESSMENT PROGRAM.] A utilization review organization must have written documentation of an active quality assessment program.

Sec. 11. Minnesota Statutes 1998, section 62M.10, is amended to read:

62M.10 [ACCESSIBILITY AND ON-SITE REVIEW PROCEDURES.]

Subdivision 1. [TOLL-FREE NUMBER.] A utilization review organization must provide access to its review staff by a toll-free or collect call telephone line during normal business hours. A utilization review organization must also have an established procedure to receive timely callbacks from providers and must establish written procedures for receiving after-hour calls, **either** in person or by recording.

Subd. 2. [REVIEWS DURING NORMAL BUSINESS HOURS.] A utilization review organization must conduct its telephone reviews, on-site reviews, and hospital communications during ~~hospitals' and physicians'~~ reasonable and normal business hours, unless otherwise mutually agreed.

Subd. 3. [IDENTIFICATION OF ON-SITE REVIEW STAFF.] Each utilization review organization's staff must identify themselves by name and by the name of their organization and, for on-site reviews, must carry picture identification and the utilization review organization's company identification card. On-site reviews should, whenever possible, be scheduled at least one business day in advance with the appropriate hospital contact. If requested by a hospital or inpatient facility, utilization review organizations must ensure that their on-site review staff register with the appropriate contact person, if available,

prior to requesting any clinical information or assistance from hospital staff. The on-site review staff must wear appropriate hospital supplied identification tags while on the premises.

Subd. 4. [ON-SITE REVIEWS.] Utilization review organizations must agree, if requested, that the medical records remain available in designated areas during the on-site review and that reasonable hospital administrative procedures must be followed by on-site review staff so as to not disrupt hospital operations or patient care. Such procedures, however, must not limit the ability of the utilization review organizations to efficiently conduct the necessary review on behalf of the patient's health benefit plan.

Subd. 5. [ORAL REQUESTS FOR INFORMATION.] Utilization review organizations shall orally inform, upon request, designated hospital personnel or the attending ~~physician~~ health care professional of the utilization review requirements of the specific health benefit plan and the general type of criteria used by the review agent. Utilization review organizations should also orally inform, upon request, ~~hospitals, physicians, and other health care professionals~~ a provider of the operational procedures in order to facilitate the review process.

Subd. 6. [MUTUAL AGREEMENT.] Nothing in this section limits the ability of a utilization review organization and a provider to mutually agree in writing on how review should be conducted.

Subd. 7. [AVAILABILITY OF CRITERIA.] Upon request, a utilization review organization shall provide to an enrollee or to ~~an attending physician or~~ a provider the criteria used for a specific procedure to determine the necessity, appropriateness, and efficacy of that procedure and identify the database, professional treatment guideline, or other basis for the criteria.

Sec. 12. Minnesota Statutes 1998, section 62M.11, is amended to read:

62M.11 [COMPLAINTS TO COMMERCE OR HEALTH.]

Notwithstanding the provisions of sections 62M.01 to

62M.16, an enrollee may file a complaint regarding a determination not to certify directly to the commissioner responsible for regulating the utilization review organization.

Sec. 13. Minnesota Statutes 1998, section 62M.12, is amended to read:

62M.12 [PROHIBITION OF INAPPROPRIATE INCENTIVES.]

No individual who is performing utilization review may receive any financial incentive based on the number of denials of certifications made by such individual, provided that utilization review organizations may establish medically appropriate performance standards. This prohibition does not apply to financial incentives established between health ~~plans~~ plan companies and ~~their~~ providers.

Sec. 14. Minnesota Statutes 1998, section 62M.13, is amended to read:

62M.13 [SEVERABILITY.]

If any provisions of sections 62M.01 to 62M.16 are held invalid, illegal, or unenforceable for any reason and in any respect, the holding does not affect the validity of the remainder of sections 62M.01 to 62M.16.

Sec. 15. Minnesota Statutes 1998, section 62M.14, is amended to read:

62M.14 [EFFECT OF COMPLIANCE.]

Evidence of a utilization review organization's compliance or noncompliance with the provisions of sections 62M.01 to 62M.16 shall not be determinative in an action alleging that services denied were medically necessary and covered under the terms of the enrollee's health benefit plan.

Sec. 16. Minnesota Statutes 1998, section 62M.15, is amended to read:

62M.15 [APPLICABILITY OF OTHER CHAPTER REQUIREMENTS.]

The requirements of this chapter regarding the conduct of utilization review are in addition to any specific requirements contained in chapter 62A, 62C, 62D, 62Q, or 72A.

Sec. 17. Minnesota Statutes 1998, section 62M.16, is amended to read:

62M.16 [RULEMAKING.]

If it is determined that rules are reasonable and necessary to accomplish the purpose of sections 62M.01 to 62M.16, the rules must be adopted through a joint rulemaking process by both the department of commerce and the department of health.

Sec. 18. [62Q.66] [DEFINITIONS.]

Subdivision 1. [APPLICATION.] For purposes of sections 62Q.66 to 62Q.70, the terms defined in this section have the meanings given them.

Subd. 2. [COMPLAINT.] "Complaint" means any grievance against a health plan company, which is not the subject of litigation and which has been submitted by a complainant to a health plan company regarding the provision of health services including, but not limited to, the scope of coverage for health care services; retrospective denials or limitations of payment for services; eligibility issues; denials, cancellations, or nonrenewals of coverage; administrative operations; and the quality, timeliness, and appropriateness of health care services rendered. If the complaint is from an applicant, the complaint must relate to the application. If the complaint is from a former enrollee, the complaint must relate to services received during the period of time the individual was an enrollee. Any grievance requiring a medical determination in its resolution must be processed under the appeal procedure described in section 62M.06.

Subd. 3. [COMPLAINANT.] "Complainant" means an enrollee, applicant, or former enrollee, or anyone acting on behalf of an enrollee, applicant, or former enrollee who submits a complaint.

Sec. 19. [62Q.67] [COMPLAINT RESOLUTION.]

Subdivision 1. [ESTABLISHMENT.] Each health plan company must establish and maintain an internal complaint resolution process that meets the requirements of this section to provide for the resolution of a complaint initiated by a complainant.

Subd. 2. [PROCEDURES FOR FILING A COMPLAINT.] (a) A complainant may submit a complaint to a health plan company either by telephone or in writing. If a complaint is submitted

orally and the resolution of the complaint is partially or wholly adverse to the complainant, the health plan company must inform the complainant that the complaint may be submitted in writing and must promptly mail a complaint form to the complainant. The complaint form must include the following information:

(1) the telephone number of the office of health care consumer assistance, advocacy, and information, and the health plan company member services or other departments or persons equipped to advise complainants on complaint resolution;

(2) the address to which the form must be sent;

(3) a description of the health plan company's internal complaint procedure and the applicable time limits; and

(4) the toll-free telephone number of either the commissioner of health or commerce and notification that the complainant has the right to submit the complaint at any time to the appropriate commissioner for investigation.

(b) Upon receipt of a written complaint, the health plan company must notify the complainant within ten business days that the complaint was received, unless the complaint is resolved to the satisfaction of the complainant within the ten business days.

(c) At the complainant's request, a health plan company must provide a complainant with any assistance needed to file a written complaint.

(d) Each health plan company must provide, in the member handbook, subscriber contract, or certification of coverage, a clear and concise description of how to submit a complaint and a statement that, upon request, assistance in submitting a written complaint is available from the health plan company.

Subd. 3. [NOTIFICATION OF COMPLAINT DECISIONS.] (a) The health plan company must notify the complainant in writing of its decision and the reasons for it as soon as practical but in no case later than 30 days after receipt of a written complaint.

(b) If the decision is partially or wholly adverse to the complainant, the notification must advise the complainant of the

following:

(1) the right to appeal the decision through the health plan company's internal appeal process, either in writing or by hearing, and the procedure for initiating an appeal, including the applicable timelines; and

(2) the right to submit the complaint at any time to either the commissioner of health or commerce for investigation and the toll-free telephone number of the appropriate commissioner.

Sec. 20. [62Q.68] [APPEAL OF THE COMPLAINT DECISION.]

Subdivision 1. [ESTABLISHMENT.] (a) Each health plan company shall establish an internal appeal process for reviewing a health plan company's decision regarding a complaint filed in accordance with section 62Q.67. The appeal process must meet the requirements of this section.

(b) The person or persons with authority to resolve or recommend the resolution of the internal appeal must not be solely the same person or persons who made the complaint decision under section 62Q.67.

(c) The internal appeal process must permit the receipt of testimony, correspondence, explanations, or other information from the complainant, staff persons, administrators, providers, or other persons as deemed necessary by the person or persons investigating or presiding over the appeal.

Subd. 2. [PROCEDURES FOR FILING AN APPEAL.] If a complainant notifies the health plan company of the complainant's desire to appeal the health plan company's decision regarding the complaint through the internal appeal process, the health plan company must provide the complainant the option for the appeal to occur either in writing or by hearing.

Subd. 3. [NOTIFICATION OF APPEAL DECISIONS.] (a) Written notice of the appeal decision and all key findings must be given to the complainant within 30 days of the health plan company's receipt of the complainant's written notice of appeal.

(b) If the appeal decision is partially or wholly adverse to the complainant, the notice must advise the complainant of

the right to submit the appeal decision to the external review process described in section 62Q.71 and the procedure for initiating the review process.

(c) Upon the request of the complainant, the health plan company must provide the complainant with a complete summary of the appeal decision.

Sec. 21. [62Q.69] [NOTICE TO ENROLLEES.]

Each health plan company shall provide to enrollees a clear and concise description of their complaint resolution procedure and the procedure used for utilization review as defined under chapter 62M as part of the member handbook, subscriber contract, or certificate of coverage. The description must specifically inform enrollees:

(1) how to submit a complaint to the health plan company;

(2) if the health plan includes utilization review requirements, how to notify the utilization review organization in a timely manner and how to obtain certification for health care services;

(3) how to request an appeal either through the procedures described in sections 62Q.67 and 62Q.68 or through the procedures described in chapter 62M;

(4) of the right to file a complaint with either the commissioner of health or commerce at any time during the complaint and appeal process;

(5) the toll-free telephone number of the appropriate commissioner;

(6) the telephone number of the office of consumer assistance, advocacy, and information; and

(7) of the right to obtain an external appeal under section 62Q.71 and a description of when and how that right may be exercised.

Sec. 22. [62Q.70] [RECORDKEEPING; REPORTING.]

Subdivision 1. [RECORDKEEPING.] Each health plan company shall maintain records of all enrollee complaints and their resolutions. These records shall be retained for five years and shall be made available to the appropriate commissioner upon

request.

Subd. 2. [REPORTING.] Each health plan company shall submit to the appropriate commissioner, as part of the company's annual filing, data on the number and type of complaints that are not resolved within 30 days. A health plan company shall also make this information available to the public upon request.

Sec. 23. [62Q.71] [EXTERNAL APPEAL OF ADVERSE DETERMINATIONS.]

Subdivision 1. [DEFINITIONS.] (a) For purposes of this section, the term defined in this subdivision has the meaning given it.

(b) Adverse determination means a complaint relating to a health care service or claim that has been appealed in accordance with section 62Q.68 and the appeal decision was partially or wholly adverse to the complainant; or any determination not to certify made by a utilization review organization as defined under section 62M.02, subdivision 21, that has been appealed in accordance with section 62M.06 but was not overturned upon appeal. An adverse determination does not include complaints relating to fraudulent marketing practices or agent misrepresentation.

Subd. 2. [RIGHT TO EXTERNAL APPEAL.] (a) Any enrollee or anyone acting on behalf of an enrollee who has received an adverse determination may obtain an external appeal by filing a written request for an external appeal of the adverse determination with the commissioner.

(b) If an enrollee requests an external appeal, the health plan company must participate.

Subd. 3. [REGULATORY AUTHORITY.] Upon receiving a request for an external appeal the commissioner shall determine whether the request involves the commissioner's regulatory authority described under chapters 45, 60A, 62A, 62C, 62D, 62Q, 72A, or 144. All requests that do not involve a regulatory issue shall be sent to a joint interagency for an external appeal.

Subd. 4. [JOINT INTERAGENCY PROCESS.] (a) The commissioners of health and commerce shall establish a joint

interagency external appeal process. This process shall be separate from the regulatory functions within the department of health or commerce and shall provide an external appeal of all adverse determinations that do not involve the regulatory authority of the commissioners.

(b) Upon receiving a request for external appeal, the joint interagency must provide immediate notice of the appeal to the enrollee and to the health plan company. Within ten business days of receiving notice of the appeal the health plan company and the enrollee must provide the joint interagency with any information that they wish the joint interagency to consider. Each party shall be provided an opportunity to present its version of the facts and arguments. An enrollee may be assisted or represented by a person of the enrollee's choice.

(c) As part of the joint interagency external appeal process, an independent medical opinion may be sought or a medical review panel may be established to provide additional technical expertise.

(d) The joint interagency shall make a recommendation to the appropriate commissioner as soon as practical but in no case later than 30 days.

(e) The appropriate commissioner must send written notice of the final decision to the enrollee and the health plan company within ten days after the commissioner has received the joint interagency's recommendation.

Subd. 5. [EFFECTS OF EXTERNAL APPEAL.] A decision rendered under this section shall be binding on both the enrollee and the health plan company. Either party may seek judicial review of the decision on the grounds that the decision was arbitrary and capricious or involved an abuse of discretion.

Subd. 6. [IMMUNITY FROM CIVIL LIABILITY.] A person who participates in an external appeal by investigating, reviewing materials, providing technical expertise, or rendering a decision shall not be civilly liable for any action that is taken in good faith, that is within the scope of the person's duties, and that does not constitute willful or reckless

misconduct.

Subd. 7. [ATTORNEY FEES.] The commissioner may award attorney fees to the enrollee if the commissioner determines such an award is warranted.

Subd. 8. [DATA PRIVACY.] Any medical record provided to the commissioner or to the joint interagency for purposes on an external appeal shall remain confidential and shall be used only for the purpose of rendering a decision under this section.

Subd. 9. [DATA REPORTING.] The commissioners shall make available to the public, upon request, summary data on the decisions rendered under this section including the number of appeals heard and decided and the final outcomes.

Sec. 24. Minnesota Statutes 1996, section 72A.201, subdivision 4, is amended to read:

Subd. 4. [STANDARDS FOR CLAIM FILING AND HANDLING.] The following acts by an insurer, an adjuster, a self-insured, or a self-insurance administrator constitute unfair settlement practices:

(1) except for claims made under a health insurance policy, after receiving notification of claim from an insured or a claimant, failing to acknowledge receipt of the notification of the claim within ten business days, and failing to promptly provide all necessary claim forms and instructions to process the claim, unless the claim is settled within ten business days. The acknowledgment must include the telephone number of the company representative who can assist the insured or the claimant in providing information and assistance that is reasonable so that the insured or claimant can comply with the policy conditions and the insurer's reasonable requirements. If an acknowledgment is made by means other than writing, an appropriate notation of the acknowledgment must be made in the claim file of the insurer and dated. An appropriate notation must include at least the following information where the acknowledgment is by telephone or oral contact:

(i) the telephone number called, if any;

(ii) the name of the person making the telephone call or

oral contact;

(iii) the name of the person who actually received the telephone call or oral contact;

(iv) the time of the telephone call or oral contact; and

(v) the date of the telephone call or oral contact;

(2) failing to reply, within ten business days of receipt, to all other communications about a claim from an insured or a claimant that reasonably indicate a response is requested or needed;

(3) unless provided otherwise by law or in the policy, failing to complete its investigation and inform the insured or claimant of acceptance or denial of a claim within 30 business days after receipt of notification of claim unless the investigation cannot be reasonably completed within that time. In the event that the investigation cannot reasonably be completed within that time, the insurer shall notify the insured or claimant within the time period of the reasons why the investigation is not complete and the expected date the investigation will be complete. ~~For claims made under a health policy the notification of claim must be in writing~~ Claims made under a health policy must be processed in accordance with sections 62Q.66 to 62Q.71;

(4) where evidence of suspected fraud is present, the requirement to disclose their reasons for failure to complete the investigation within the time period set forth in clause (3) need not be specific. The insurer must make this evidence available to the department of commerce if requested;

(5) failing to notify an insured who has made a notification of claim of all available benefits or coverages which the insured may be eligible to receive under the terms of a policy and of the documentation which the insured must supply in order to ascertain eligibility;

(6) unless otherwise provided by law or in the policy, requiring an insured to give written notice of loss or proof of loss within a specified time, and thereafter seeking to relieve the insurer of its obligations if the time limit is not complied

with, unless the failure to comply with the time limit prejudices the insurer's rights and then only if the insurer gave prior notice to the insured of the potential prejudice;

(7) advising an insured or a claimant not to obtain the services of an attorney or an adjuster, or representing that payment will be delayed if an attorney or an adjuster is retained by the insured or the claimant;

(8) failing to advise in writing an insured or claimant who has filed a notification of claim known to be unresolved, and who has not retained an attorney, of the expiration of a statute of limitations at least 60 days prior to that expiration. For the purposes of this clause, any claim on which the insurer has received no communication from the insured or claimant for a period of two years preceding the expiration of the applicable statute of limitations shall not be considered to be known to be unresolved and notice need not be sent pursuant to this clause;

(9) demanding information which would not affect the settlement of the claim;

(10) unless expressly permitted by law or the policy, refusing to settle a claim of an insured on the basis that the responsibility should be assumed by others;

(11) failing, within 60 business days after receipt of a properly executed proof of loss, to advise the insured of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition, or exclusion unless reference to the provision, condition, or exclusion is included in the denial. The denial must be given to the insured in writing with a copy filed in the claim file;

(12) denying or reducing a claim on the basis of an application which was altered or falsified by the agent or insurer without the knowledge of the insured;

(13) failing to notify the insured of the existence of the additional living expense coverage when an insured under a homeowners policy sustains a loss by reason of a covered occurrence and the damage to the dwelling is such that it is not

habitable;

(14) failing to inform an insured or a claimant that the insurer will pay for an estimate of repair if the insurer requested the estimate and the insured or claimant had previously submitted two estimates of repair.

Sec. 25. Minnesota Statutes 1998, section 72A.201, subdivision 4a, is amended to read:

Subd. 4a. [STANDARDS FOR PREAUTHORIZATION APPROVAL.] If a policy of accident and sickness insurance or a subscriber contract requires preauthorization approval for any nonemergency services or benefits, the decision to approve or disapprove the requested services or benefits must be ~~communicated to the insured or the insured's health care provider within ten business days of the preauthorization request provided that all information reasonably necessary to make a decision on the request has been made available to the insurer~~ processed in accordance with section 62M.07.

Sec. 26. [APPROPRIATION.]

$..... is appropriated from the state government special revenue fund to the commissioners of health and commerce for the biennium ending June 30, 2001, for the purpose of establishing and operating the joint interagency described in Minnesota Statutes, section 62Q.71.

Sec. 27. [REPEALER.]

Minnesota Statutes 1998, sections 62D.11, subdivisions 1b and 2; 62Q.105; 62Q.11; and 62Q.30, are repealed.

Minnesota Rules, parts 4685.0100, subparts 4 and 4a; and 4685.1700, are repealed.

Appendix B

Complaint Process Work Group

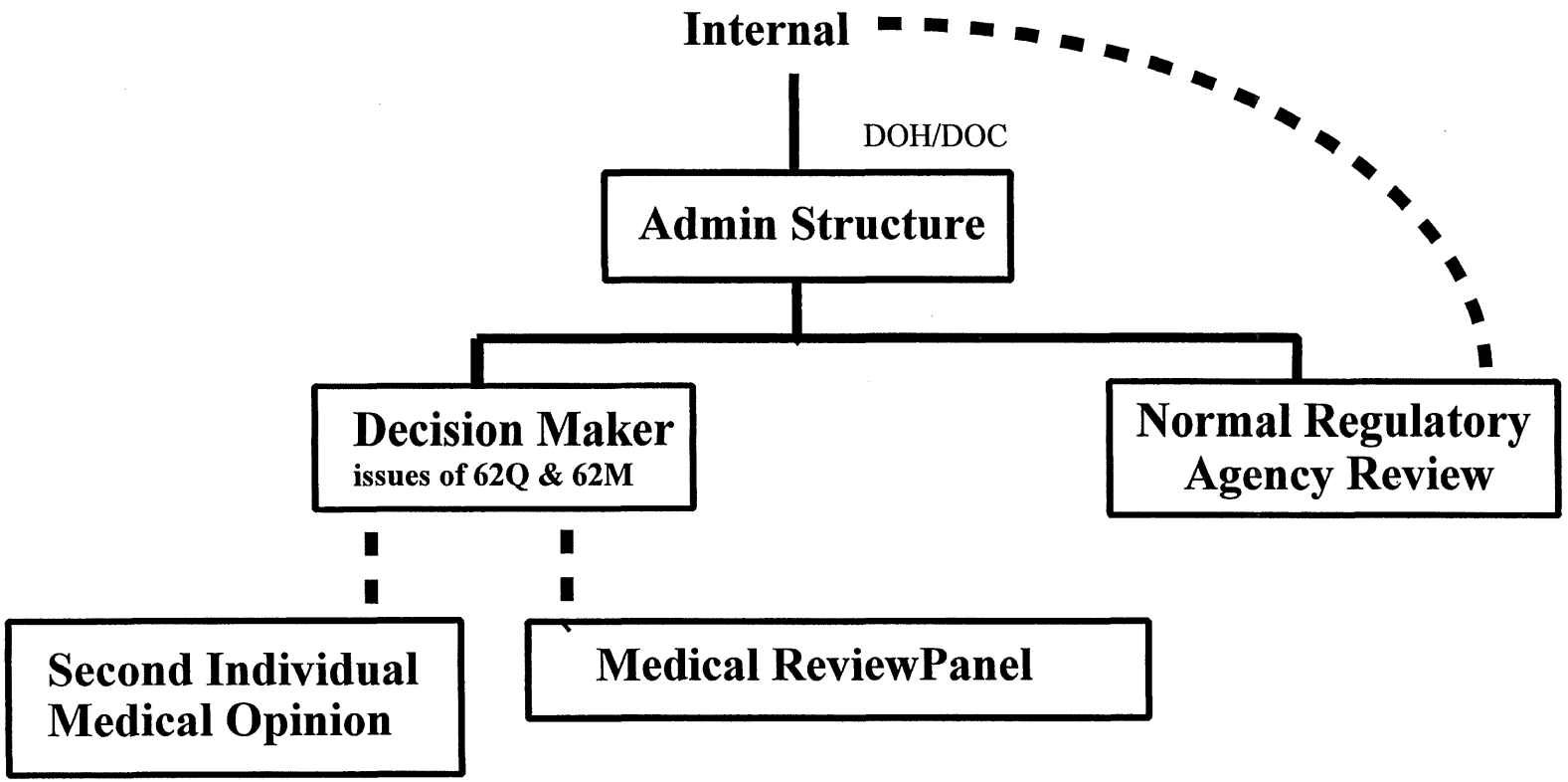
Members *
Tom Brick, MN Council on Disability
Sandy Burge, Department of Human Services
Bill Conley, Mental Health Association
Tom Ehlichmann, Minnesota Hospital and Healthcare Partnership
Mary Jo George, MS Society
Phil Griffin, PreferredOne
John Gross, Department of Commerce
Roger Hopke, 3M
Karen Jacobson, Medica
Cindy Johnson, Consumer Advisory Board
Tim Jorissen, Department of Employee Relations
Maureen O'Connell, Legal Services Advocacy Project
Roberta Opheim, Ombudsman for Mental Health and Retardation
Kent Peterson, Department of Health
Mary Prentieks, Blue Cross Blue Shield of MN
Jeff Reed, HealthPartners
Michael Scandrett, Minnesota Council of Health Plans
Joyce Shellhart-Warner, Consumer Advisory Board
Mark Skubic, HealthSystem Minnesota
Christeen Stone, American Association of Retired Persons
Sue Stout, Minnesota Nurses Association
Rebecca Thoman, MN Physician - Patient Alliance
Charles Wikelius, Attorney General's Office
Roger Williams, MN Office of Dispute Resolution, Facilitator
Sharon Zoesch, Ombudsman for Older Minnesotans

Alternates
Karen Brooks, HealthParnters
Mary Ann Fena, Department of Health
Carolyn Jones, MN Chamber of Commerce
Kathyrn Kmit, MN Council of Health Plans
Rich Korman, Minnesota Hospital & Healthcare Partnership
Nancy Link, MN Department of Commerce
Karen Peed, Department of Human Services

Legislative Staff
Katie Cavanor, Senate Counsel
Elisabeth Loehrke, House Research

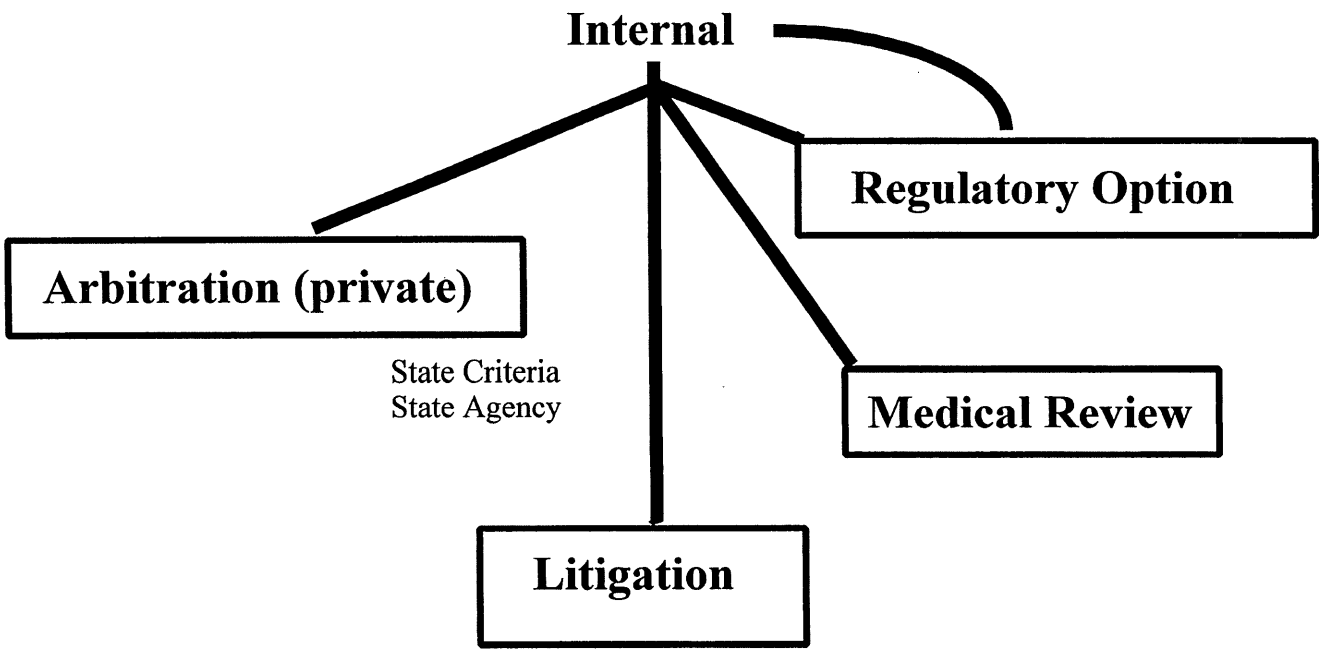
*Rochelle Rubin and her alternate, Jennifer Breitinger, participated in the work group until the Insurance Federation of Minnesota withdrew from the group on October 26, 1998. (See Appendix E, Letter from the Insurance Federation of Minnesota, dated November 3, 1998.)

Appendix C



Model One from 10/26/98 Meeting

Appendix D



Model Two - from 10/26/98 Meeting

Appendix E

INSURANCE FEDERATION OF MINNESOTA

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Phone (612) 292-1099 ⋄ Fax (612) 228-7369

November 3, 1998

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121 East Seventh Place
P.O. Box 64975
St. Paul, Minnesota 55164

RE: Complaint Process Work Group

Dear Commissioner Gruenes and Commissioner Barry:

On behalf of the Insurance Federation of Minnesota, we submit this letter for your consideration and ask that it be made a part of the report and recommendations that you will submit to the legislature in accordance with the statutory mandate. We wish to be on record with our objection to the process and substance of the Complaint Process Work Group meetings and, by this letter, we formally resign and withdraw from that group. We feel strongly that the direction of the group is **not** in the interest of buyers of insurance products from our members and likewise is **not** warranted as applied to these insurance carriers.

The Insurance Federation of Minnesota has just formally adopted a position to evaluate all legislative and regulatory medical insurance proposals according to a set of important principals: whether the proposals promote **competition, choice and affordability** with respect to medical insurance for Minnesota health care consumers. Our goal is to promote competition and expanded choices in the medical insurance marketplace for the benefit of consumers.

Measured against the principals described above, the revisions to Minnesota Statutes, Chapter 62Q, that the group has discussed or proposed to date, do not accomplish the desired goals. We formally oppose the proposals which would impose new and different processes for internal and/or external complaint or appeals procedures. It has been acknowledged publicly that few if any of the problems with the payment of claims or provision of care according to the insurance policy provisions have resulted from actions or decisions of indemnity carriers as they currently operate. Generally, complaints or grievances have been dealt with satisfactorily through the existing internal company processes and with access to the Department of Commerce and, ultimately, to litigation if necessary. Consequently, we object to a reworking of the current process which is, by all accounts, satisfactorily serving its intended purpose. Although uniformity may be a

generally laudable goal, we feel strongly that in this case, uniformity for its own sake is unwise and unwarranted. Different types of "insurers", whether they be HMOs, ERISA plans or indemnity carriers, are treated differently in numerous ways for necessary and legitimate reasons. Different types of insurers should be dealt with differently for this purpose as well.

We remain committed to serving policyholders in a fair, timely and satisfactory manner. We believe that is best accomplished through the process currently in place under Minnesota Statutes, Chapter 72A and the processes created by the carriers to serve their policyholders.

Sincerely,

Robert D. Johnson
Executive Vice President
Insurance Federation of Minnesota

Rochelle Rubin
Government Affairs Counsel
Insurance Federation of Minnesota

CC: John Gross, MN Department of Commerce
Mr. Kent Peterson, MN Department of Health
Roger Williams, MN Bureau of Mediation Services
Complaint Process Advisory Group Members

Appendix F

MINNESOTA CHAMBER
of Commerce
THE VOICE OF BUSINESS.

December 29, 1998

Commissioner David B. Gruenes
Minnesota Department of Commerce
133 East Seventh Street
St. Paul, MN 55101

Commissioner Anne M. Barry
Minnesota Department of Health
121 East Seventh Place
PO Box 64975
St. Paul, MN 55164

Dear Commissioner Gruenes and Commissioner Barry:

On behalf of the Minnesota Chamber of Commerce I submit this letter for your consideration and ask that it be made part of the report and recommendations that you will submit to the legislature in accordance with Laws of Minnesota 1997, chapter 237, section 20.

As the primary purchaser of health care, employers desire a system in which their employees have timely access to the services they have contracted for and a fair resolution of disputes when they arise. The following principles guide what we believe is a fair and reasonable complaint resolution process. This process:

- must not increase the disparity of costs between regulated and self-insured plans.
- must discourage frivolous disputes.
- should improve on the existing system by making it simpler and more consumer friendly before creating new systems.
- must lead to timely, efficient and fair resolution of disputes.
- should be funded through the general fund.

Unfortunately, the recommendations put forward in this report fail to meet the first three principles. As a result, had the Minnesota Chamber been given the opportunity to vote on these recommendations and the coinciding legislation, we would have voted against them.

Improvements in consumer protections must be accomplished without increasing health care premiums, reducing the number of people who have health care coverage or the creation of new bureaucracies that will harm quality care. We look forward to working with you in the future to create a system that meets this criteria.

Sincerely,

Carolyn B. Jones
Manager, Small Business Policy

INSURANCE FEDERATION OF MINNESOTA

750 Norwest Center Tower ◆ 55 Fifth Street East ◆ Saint Paul, Minnesota 55101
Phone (612) 292-1099 ◆ Fax (612) 228-7369

December 29, 1998

Commissioner David B. Gruenes
Minnesota Department of Commerce
133 East Seventh Street
St. Paul, Minnesota 55101

Commissioner Anne M. Barry
Minnesota Department of Health
85 East Seventh Place
St. Paul, Minnesota 55101

RE: Complaint Process Work Group Report and Recommendations

Dear Commissioners Gruenes and Barry:

On behalf of the Insurance Federation of Minnesota, we write to express our extreme disappointment at the draft report and proposed legislation presented by the staff of the Commerce and Health Departments regarding complaint processes. Although the Federation formally withdrew from this working group by letter dated November 3, 1998, we must be on record in response to the ill-advised report and legislative recommendations issued by the Departments' staff.

As acknowledged in the report, this working group was unable to arrive at consensus on virtually any of the issues concerned despite on-going lengthy meetings and intense discussion. Further, staff stated to participants as recently as last month that because of the inability to agree, there would be no legislative recommendations issued by the Departments on behalf of the group. Yet Commerce and Health Department staff saw fit to issue a report with specific and comprehensive legislative proposals for a major overhaul of numerous chapters of Minnesota statutes, NONE OF WHICH IS SUPPORTED BY THE WORKING GROUP.

Additionally, we wish to note that, as in the past, the materials were sent to us with virtually no time to review and comment in a meaningful way. We received the draft report and proposed legislation on Monday, December 28th with instructions to submit comments by Wednesday, December 30th (a week during which many are typically out of the office). As a membership organization, it is impossible for us to get input from our members on the proposal in such a short timeframe, particularly during the Holiday season, and it is outrageous to be required to comment in two days' time.

We respectfully submit our opposition to this report, the accompanying proposal, and the entire process. **We ask you to consider issuing NO report given the circumstances.** Thank you.

Sincerely,

Robert D. Johnson
Executive Vice President
Insurance Federation of Minnesota

Rochelle Rubin
Government Affairs Counsel
Insurance Federation of Minnesota

MINNESOTA COUNCIL of HEALTH PLANS

COURT INTERNATIONAL BUILDING
2550 UNIVERSITY AVENUE WEST
SUITE 255 SOUTH
ST. PAUL, MINNESOTA 55114
651-603-2696 FAX 651-647-0071
www.mnhealthplans.org

December 30, 1998

Mr. David Giese
Minnesota Department of Health
121 East Seventh Place
St. Paul, MN 55155

Mr. John Gross
Minnesota Department of Commerce
133 East Seventh Place
St. Paul, MN 55155

RE: Final Report to the Legislature on Recommendations on Developing a Complaint Resolution Process for Health Plan Enrollees

CC: Commissioner Anne Barry, Minnesota Department of Health
Commissioner David Gruenes, Minnesota Department of Commerce

Dear Mr. Giese and Mr. Gross:

Members of the council and other interested parties began meeting over two years ago with the staff from the Departments of Health and Commerce to address problematic language in statute relating to complaint processes and alternative dispute resolution for health plans. After an enormous amount of time and energy spent in good faith trying to resolve this issue, I am writing to express my disappointment with the outcome and the final report. Ultimately, no consensus was reached on key issues. Your report should make it clear that the recommendations in the report reflect agency staff positions rather than being based on the work group's decisions or consensus.

Despite multiple requests by the council and its representatives to take a broader view, the work group was never able to focus on what impact the proposed changes would have on the entire health care insurance system or on the affordability of health coverage. Based on anecdote, the focus was on how to create a new system to address a small number of exceptional individual cases rather than improve the existing system. Many of the anecdotes shared during this process to justify changes were revealed to be cases that are either exempt from state regulation, or would not have had a different outcome under any of the new approaches discussed by the work group.

The report fails to acknowledge how well the health care system is working already, including high consumer satisfaction rates and small numbers of complaints, which justify using a scalpel instead of an ax. For example:

- Data collected by the Minnesota Health Data Institute in 1996 showed that 94 percent of Minnesotans are satisfied with their health plan. MHDI also found higher levels of satisfaction with HMO-type plans compared to traditional health insurance.

- Minnesota consumers file very few complaints against their health plans. Over the past several years, less than one-third of one percent of consumers file complaints. Of these complaints, only about 3.5 percent result in a formal appeal and fewer than one percent end up in lawsuits or other forms of legal action.

- The Department of Health's records show that the number of complaints has decreased significantly over the past several years. Both the total number of complaints and the complaints relating to quality of care or access to services have declined steadily since the 1980s.

The council agrees that the more informed consumers are, the more likely they are to make better choices and to know how to resolve any problems that may arise. The council recommends that state efforts should concentrate on informing, empowering and assisting consumers rather than creating costly and burdensome new regulatory systems that ultimately will not apply to most consumers anyway due to federal exemptions.

The council uses the following principles to guide us in assessing any proposed new laws:

- Any new changes to the system should not target small employers and individual policyholders for additional cost increases as a result of additional state regulations that do not apply to larger self-insured employers. We should not increase the inequities between the fully-insured and self-insured markets.

- There is a perception that the current state-mandated appeals and complaint system is complex and hard to navigate for consumers. Any changes should make the system simpler, more uniform, and easier to understand, rather than making it more complicated.

- The appeals process should lead to a fair and efficient resolution of disputes. No one benefits from long, drawn out processes with no clear end in sight.

The agency staff's recommendations in the report do not pass muster based on these principles.

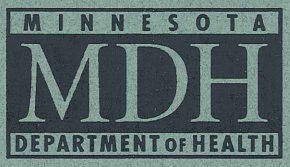
The council has also attached a document with specific comments and corrections to the text of the report and the proposed legislation. However, due to the short turnaround time for comments and the unavailability of several council members because of the holidays, the council reserves the right to make further comments in the future.

We respectfully ask that you include this cover letter with the final report.

Sincerely,

Michael Scandrett/kk

Michael Scandrett
Executive Director



Managed Care Systems Section
December 1998

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