Stricken language would be deleted from and underlined language would be added to the law as it existed prior to this session of the General Assembly.

State of Arkansas
83rd General Assembly
Regular Session, 2001

A Bill

HOUSE BILL 2304

By: Representatives Bledsoe, Biggs, R. Smith

For An Act To Be Entitled

AN ACT TO ALLOW EXTERNAL REVIEWS OF ADVERSE DECISIONS OF HEALTH INSURANCE CLAIMS; AND FOR OTHER PURPOSES.

Subtitle

HEALTH CARRIER EXTERNAL REVIEW ACT.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Title and purpose.

(a) This act shall be known and cited as the "Health Carrier External Review Act."

(b) The purpose of this act is to provide standards for the establishment and maintenance of a process whereby an independent review organization shall review applicable adverse benefit determinations of a health benefit plan.

(c) This act does not require the coverage of any benefit or service not provided under the terms of a health benefit plan, nor does this act require reimbursement of any particular provider or class of providers for which coverage is not provided in a health benefit plan.

(d) Nothing in this act shall be construed to create any new private right or cause of action for or on behalf of any covered person.

SECTION 2. Definitions.

For purposes of this act:

(1) "Adverse benefit determination" means a health carrier's decision to deny, reduce, or terminate payment for a treatment, service, equipment,

supply, or drug claimed by a covered person because of an exclusion or limitation set out in the health benefit plan;

(2) “Commissioner” means the Insurance Commissioner for the State of Arkansas;

(3) "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

(4) "Facility" means an institution providing health care services or a health care setting, including but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings;

(5) "Final adverse benefit determination" means an adverse benefit determination involving a covered benefit that has been upheld by a health carrier at the completion of the health carrier’s internal review procedures;

(6)(A) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of a treatment, service, equipment, supply or drug.

(B) “Health benefit plan” shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, as defined by Arkansas Code 23-97-203, vision care or any other limited supplemental benefit or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code, and any coverage issued as supplemental to that coverage, any coverage issued as supplemental to liability insurance, workers’ compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group, blanket or individual basis;

(7) "Health care professional" means a physician or other health care practitioner licensed, accredited, or certified to perform specified health services consistent with state law;

(8) "Health care provider" or "provider" means a health care professional or a facility;

(9) "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of treatment, services, equipment supplies or drugs, including an accident and health insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a health benefit plan; and

(10) "Independent review organization" means an entity approved by the commissioner, after consultation with the Director of the Department of Health, that conducts independent external reviews of adverse benefit determinations specified in section 3.

SECTION 3. Applicability and Scope.

(a) Every health benefit plan shall provide covered persons an external review process by an independent review organization to examine the plan's adverse benefit determinations that meet the following criteria:

(1) The adverse benefit determination is based on the health plan's terms that:

(A) Reference "medical necessity", "medically necessary" or substantially equivalent terms; or

(B) Refer to "experimental," "investigational" or substantially equivalent terms as a coverage criteria.

(2) The adverse benefit determination is not based on:

(A) A specific plan exclusion other than the exclusions stated in subsection (a) of this section;

(B) A specific plan limitation of the number, amount or scope of services, treatments, equipment, drugs, or supplies;

(C) The plan's procedures for determining the covered person's access to a health care provider, including but not limited to any primary care gatekeeper, referral, or network access provision;

(D) An application of the plan's eligibility requirements;

(E) Fraud, abuse, or material misrepresentation;

(F) Illegality of services or the means or methods of administering them;

(G) Food and Drug Administration or other government agency determinations, reports or statements;

(H) Licensure, permit, or accreditation status of a health care provider; or

(I) Excess utilization practices or patterns of a provider;

(3) The adverse benefit determination is a final adverse benefit determination, except as may be established by the commissioner by rule or regulation; and

(4) The adverse benefit determination involves treatment, services, equipment, supplies, or drugs that would require the health benefit plan to incur five hundred dollars ($500) or more of expenditures.

(b) A health carrier may elect to establish the right of external review for health benefit plan decisions not otherwise subject to this act, in which case this act and regulations promulgated in conjunction with this act shall apply to any voluntary external review.

SECTION 4. External review standards.

(a) The commissioner, after consultation with the Director of the Department of Health, shall promulgate necessary rules and regulations to implement this act.

(b) The rules and regulations shall establish:

(1) The means by which health carriers shall notify covered persons of their right to external review;

(2) The time period in which a covered person shall file a request for external review with a health carrier;

(3) The circumstances in which a covered person may request a standard or an expedited external review, including when a health benefit plan’s internal review procedure may be by-passed;

(4) The evidence a covered person and a health carrier shall submit to and which shall be considered by the independent review organization conducting an external review;

(5) The following that an independent review organization and any medical reviewer shall consider in making a determination:

(A) Terms of the health benefit plan;

(B) Medical records of the covered person who has requested the review;

(C) Written arguments or documentation submitted by a

health carrier in support of its adverse benefit determination;

(D) Written arguments or documentation submitted by a covered person, a health care provider, or the commissioner in support of the argument opposing the adverse benefit determination; and

(E) Valid, relevant scientific evidence and clinical evidence, including peer-reviewed medical literature or findings and expert opinion; court order or ruling, including any declaratory judgment which was obtained by the health carrier in accordance with section 5;

(6) The time period in which the external review process shall reach a decision in a standard external review and in an expedited external review;

(7)(A) The credentials of independent review organizations, as determined by the commissioner after consultation with the Director of the Department of Health, and the medical reviewers utilized by independent review organizations in conducting external reviews.

(B) At a minimum, a medical reviewer shall be a health care professional who:

(i) Is licensed in one (1) or more states;

(ii) Typically treats the condition, makes the diagnosis, or provides the type of treatment under review;

(iii) Has no conflict of interest with respect to either the covered person, the treating provider, or the health carrier; and

(iv) Has no direct or indirect pecuniary interest in the outcome of the review;

(8) The statistics and reports concerning the external review process required of health carriers and independent review organizations; and

(9) The regulations shall specify that an independent review organization and any court reviewing either an adverse benefit determination, a final adverse benefit determination, or the decision or action of an independent review organization shall give primary weight and substantial deference to the terms of the applicable health benefit plan, including but not limited to the health benefit plan’s standards for determining coverage, its standards or definitions of relevant scientific evidence, and its definitions of “medical necessity,” “medically necessary,” “investigational,” “experimental,” or substantially equivalent terms.

SECTION 5. Binding nature of external review decision.

(a) An independent review organization's external review decision is binding on the health carrier.

(b)(1) The health carrier shall be entitled to seek a declaratory judgment from a court of competent jurisdiction that the independent review organization's decision does not bind the carrier in any future similar cases if a health carrier believes that an independent review organization's external review decision is:

(A) Contrary to the provisions of the health benefit plan;

(B) Contrary to provisions of the act, regulations of the commissioner, or contrary to or conflicting with any other laws or regulations; or

(C) Violates or ignores the independent review organization's procedures.

(2) An independent review organization shall be required, in all future cases, to give deference to any declaratory judgment ruling obtained by a health carrier under this section.

(c)(1) If a health carrier believes that an independent review organization's external review decision conflicts with a prior independent review organization decision, whether of the same or of a different independent review organization, the health carrier shall be entitled to seek a declaratory judgment from a court of competent jurisdiction to determine how to proceed in any future case.

(2) An independent review organization shall be required, in all similar future cases, to give deference to any declaratory judgment ruling obtained by a health carrier under this section.

(d) Declaratory judgment actions under subdivisions (b)(1) or (b)(2) shall be heard by the court on an expedited basis so as to provide timely direction to the health carrier for administration of the health benefit plan and shall be tried to the court, rather than to a jury.

(e)(1) In any declaratory judgment action pursuant to this section, the health carrier may name as defendants either the independent review organizations or the commissioner, or each of them.

(2) In any action, the independent review organization or the commissioner may, but shall not be obligated to defend the action, in their discretion.

(f)(1) The court in any declaratory judgment action pursuant to this section shall act on the declaratory judgment complaint as quickly as possible and in accordance with the exigencies of the circumstances, but in any event not later than ninety (90) calendar days after the filing of the complaint.

(2) In any case in which the health carrier represents to the court that a fast decision is needed in order to enable the health carrier to respond appropriately to any benefits claim or request for coverage then pending under the health carrier's health benefits plans, the court, upon the health carrier's request, shall grant an emergency hearing, and shall issue its declaratory judgment on an expedited basis, and within the time as shall permit the health carrier to take timely action with respect to the pending benefits claim or request for coverage.

(g)(1) An independent review organization's external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or state law.

(2) However, if an adverse benefit determination of a health carrier has been upheld by an independent review organization, no court judgment or order shall overturn the adverse benefit determination on the grounds of any procedural error or omission of the independent review organization or of a medical reviewer.

(h) A covered person shall not file a subsequent request for external review involving the same adverse benefit determination or final adverse benefit determination for which the covered person has already received an independent review organization's external review decision pursuant to this act, or to which any court has made a declaratory judgment, ruling or other judicial decision, addressing the covered person's case.

SECTION 6. Hold harmless for independent review organizations and health carriers.

(a) No independent review organization or medical reviewer working on behalf of an independent review organization shall be liable in damages to any person for any opinions rendered during or upon completion of an external review conducted pursuant to this act, unless the opinion was rendered in bad faith or involved gross negligence.

(b) No health carrier shall be held liable for any negligence,

improper conduct, procedural errors, judgments, opinions or omissions of an independent review organization or medical reviewer working on behalf of an independent review organization.

SECTION 7. Cost and filing fees.

(a) The health carrier against which a request for an external review is filed shall pay the reasonable cost of the independent review organization for conducting the external review.

(b)(1) The commissioner shall establish by rule and regulation a filing fee to cover part of the costs of an external review to be paid by a covered person at the time the covered person requests an external review.

(2) The fee shall be at least fifteen dollars ($15.00) but not more than fifty dollars ($50.00).

(3) The commissioner may by regulation establish grounds for waiver of the filing fee if a covered person is indigent or otherwise lacks financial means to pay the filing fee.

(4) The filing fee shall be refunded if the external review results in a decision overturning the adverse benefit determination in whole or in part.

SECTION 8. Conflict with federal law.

(a) The commissioner may waive as to health carriers any provision of this act that creates any conflict with similar federal laws or regulations, or which, due to the enactment of any similar federal laws or regulations, creates an undue burden or increased financial or operational demands upon a health carrier in order to comply with both this act and similar federal laws and regulations.

(b) If a health carrier believes that any provision of this act or regulations conflict with federal laws or create an inconsistency for purposes of the health carrier’s compliance with this act and any similar provisions of federal law or regulations, then the health carrier shall be entitled to appeal under the Arkansas Administrative Procedure Act, the commissioner’s decision not to grant a waiver.

(c)(1) In any appeal pursuant to this section, the health carrier shall name the commissioner as defendant.

(2) In any action, the commissioner may defend the action.

SECTION 9. Effective Date.

This act shall become effective on July 1, 2002.