State of Wisconsin
1999 – 2000 LEGISLATURE

LIB-2313/P3
PJK:wlj:jf
v - - k -

PRELIMINARY DRAFT – NOT READY FOR INTRODUCTION

AN ACT to *renumber* 609.15 (1) (c), 609.15 (2) (c), 609.15 (2) (d) and 609.15 (2) *(e); to renumber and amend* 609.15 (1) (intro.), 609.15 (1) (a), 609.15 (1) (b), 609.15 (2) (intro.), 609.15 (2) (a) and 609.15 (2) (b); *to amend* 600.01 (2) (b) and 601.42 (4); and to create 601.31 (1) (Lp), 601.31 (1) (Lr), 632.83 and 632.835 of the statutes; **relating to:** requiring all insurers to establish internal grievance procedures, independent review of denials of coverage on the basis of medical necessity, granting rule-making authority and providing an exemption from emergency rule procedures.

Analysis by the Legislative Reference Bureau

NOTE: Except for a couple of technical changes, this analysis has not been changed from the "P2" version of the draft. The analysis will be finalized with the next version after all of the information for the draft has been received.

Under current law, every managed care plan is required to have an internal grievance procedure under which an enrollee may submit a written grievance and a grievance panel must investigate the grievance and, if appropriate, take corrective action. This bill requires every health benefit plan, including managed care plans, to have an independent review procedure for grievances related to denials of coverage for medical services, equipment, drugs or devices. To be eligible for

independent review, a denial must be based on medical necessity, and the value of the services, equipment, drug or device for which coverage was denied must be at least $500. An insured under a plan with an internal grievance procedure may be required to use the internal grievance procedure before requesting an independent review.

To request an independent review, an insured must pay $50, which is refunded to the insured if he or she prevails, in whole or in part, in the independent review. Any relevant evidence may be considered in an independent review, even if the evidence has not been considered at any time before. The decision at the conclusion of an independent review must be consistent with the terms of the health benefit plan and it must be in writing and served on both the insured who requested the review and the health benefit plan. The decision is binding on the insured and the health benefit plan and subject to judicial review.

Under the bill, an independent review may be conducted only by an independent review organization that has been certified by the commissioner of insurance (commissioner). A certified independent review organization must be recertified every two years to continue to conduct independent reviews. The commissioner may revoke, suspend or limit the certification of an independent review organization for various reasons specified in the bill.

The bill contains prohibitions aimed at avoiding conflicts of interest for independent review organizations, such as prohibiting an independent review organization from owning, controlling or being a subsidiary of a health benefit plan or an association of health benefit plans. The bill also provides independent review organizations, and clinical peer reviewers who conduct independent reviews on behalf of independent review organizations, with immunity from liability for decisions made in independent reviews.

Finally, the bill requires the commissioner to promulgate rules relating to such topics as the application procedures and standards for certification and recertification of independent review organizations, the procedures and processes that independent review organizations must use in independent reviews, standards for the practices and conduct of independent review organizations and additional standards related to conflicts of interest.

For further information see the state and ***local*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 600.01 (2) (b) of the statutes is amended to read:

600.01 (2) (b) Group or blanket insurance described in sub. (1) (b) 3. and 4. is not exempt from ss. 632.745 to 632.749, 632.83 or 632.835 or ch. 633 or 635.

SECTION 2. 601.31 (1) (Lp) of the statutes is created to read:

601.31 (1) (Lp) For certifying as an independent review organization under s. 632.835, $400.

SECTION 3. **601.31 (1)** (Lr) of the statutes is created to read:

601.31 (1) (Lr) For each biennial recertification as an independent review organization under s. 632.835, $100.

SECTION 4. 601.42 (4) of the statutes is amended to read:

601.42 (4) **REPLIES.** Any offker, manager or general agent of any insurer authorized to do or doing an insurance business in this state, any person controlling or having a contract under which the person has a right to control such an insurer, whether exclusively or otherwise, any person with executive authority over or in charge of any segment of such an insurer's affairs, any individual practice association or offker, director or manager of an individual practice association, any insurance agent or other person licensed under chs. 600 to 646, any provider of services under a continuing care contract, as defined in s. 647.01 (2), any independent review organization certified under s. 632.835 (4) or any health care provider, as defined in s. 655.001 (8), shall reply promptly in writing or in other designated form, to any written inquiry from the commissioner requesting a reply.

SECTION 5. 609.15 (1) (intro.) of the statutes is renumbered 609.15 and amended to read:

609.15 Grievance procedure. Each limited service health organization, preferred provider plan and managed care plan shall ~~do all of the following:~~ establish and use an internal grievance procedure as provided in s. 632.83.

SECTION 6. 609.15 (1) (a) of the statutes is renumbered 632.83 (2) (a) and amended to read:

632.83 (2) (a) Establish and use an internal grievance procedure that is approved by the commissioner and that complies with sub. ~~(2)~~ (3) for the resolution of ~~enrollees'~~ insureds' grievances with the ~~limited service health organization, preferred provider plan or managed care~~ health benefit plan.

SECTION 7. 609.15 (1) (b) of the statutes is renumbered 632.83 (2) (b) and amended to read:

632.83 (2) (b) Provide ~~enrollees~~ insureds with complete and understandable information describing the internal grievance procedure under par. (a).

SECTION 8. 609.15 (1) (c) of the statutes is renumbered 632.83 (2) (c).

SECTION 9. 609.15 (2) (intro.) of the statutes is renumbered 632.83 (3) (intro.) and amended to read:

632.83 (3) (intro.) The internal grievance procedure established under sub. ~~(1)~~ (2) (a) shall include all of the following elements:

SECTION 10. 609.15 (2) (a) of the statutes is renumbered 632.83 (3) (a) and amended to read:

632.83 (3) (a) The opportunity for an ~~enrollee~~ insured to submit a written grievance in any form.

SECTION 11. 609.15 (2) (b) of the statutes is renumbered 632.83 (3) (b) and amended to read:

632.83 (3) (b) Establishment of a grievance panel for the investigation of each grievance submitted under par. (a), consisting of at least one individual authorized to take corrective action on the grievance and at least one ~~enrollee~~ insured other than the grievant, if an ~~enrollee~~ insured is available to serve on the grievance panel.

SECTION 12. 609.15 (2) (c) of the statutes is renumbered 632.83 (3) (c).

SECTION 13. 609.15 (2) (d) of the statutes is renumbered 632.83 (3) (d).

SECTION 14. 609.15 (2) (e) of the statutes is renumbered 632.83 (3) (e).

SECTION 15. 632.83 of the statutes is created to read:

632.83 Internal grievance procedure. (1) In this section, "health benefit plan" has the meaning given in s. 632.745 (11).

(2) Each health benefit plan shall do all of the following:

SECTION 16. 632.835 of the statutes is created to read:

632.835 Independent review of ~~medical necessity~~ determinations. (1) In this section, "health benefit plan" has the meaning given in s. 632.745 (11).

(2) (a) Every health benefit plan shall establish an independent review procedure whereby an insured under the health benefit plan, or his or her authorized representative, may request and obtain an independent review of any decision made by or on behalf of the health benefit plan denying coverage for medical services or equipment or a drug or medical device if all of the following conditions apply:

1. Coverage was denied, in whole or in part, on the basis of the medical necessity of the services, equipment, drug or device.

2. The value of the services, equipment, drug or device for which coverage was denied exceeded or would exceed $500, as adjusted as provided in sub. (2m).

(b) An independent review under this section must be conducted by an independent review organization certified under sub. (4).

(c) An insured must exhaust the health benefit plan's internal grievance procedure before the insured may request an independent review under this section, unless the delay will result for the insured in serious injury or impairment or a life–threatening condition, as determined by the insured's treating health care provider.

(d) Whenever a health benefit plan denies coverage and the criteria under par. (a) ~~(b)~~ are satisfied, the health benefit plan shall advise the insured of the

insert 5-4
insert 5-8
insert 5-11
insert 5-19
adverse and experimental treatment
involved in the determination
an adverse determination or an experimental treatment determination is made

insured's right to obtain the independent review required under this section, how to request the review and the time within which the review must be requested.

(2m) Beginning in 2001, to reflect changes in the consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor, the commissioner shall at least annually adjust the ~~value of the services, equipment, drugs or devices for which coverage must be denied in order for an insured to be eligible for independent review under this section.~~ amounts specified in sub. (1) (a) 4. and

(3) (a) To request an independent review under this section, an insured or his or her authorized representative shall provide written notice of the request for independent review to the health benefit plan that ~~denied the coverage.~~ insert 6-10 The health benefit plan shall immediately notify the commissioner of the request&&% ~~commissioner shall appoint an independent review organization to conduct the review.~~ The insured or his or her authorized representative must pay a $50 fee to the independent review organization. If the insured prevails on the review, in whole or in part, the entire amount paid by the insured or his or her authorized representative shall be refunded by the health benefit plan to the insured or his or her authorized representative. For each independent review in which it is involved, a health benefit plan shall pay a fee to the independent review organization.

conducting the review

(b) An independent review under this section shall be based on the record of the proceedings, if any, in which the decision under review was made. An independent review organization, however, may accept for consideration any typed or printed, verifiable medical or scientific evidence that the independent review organization determines is relevant, regardless of whether the evidence has been submitted for consideration at any time previously. An independent review under this section may not include appearances by the insured or his or her authorized

representative, any person representing the health benefit plan or any witness on behalf of either the insured or the health benefit plan.

(c) A decision of an independent review organization must be consistent with the terms of the health benefit plan under which coverage was denied. A decision shall be in writing, signed on behalf of the independent review organization conducting the review and served by personal delivery or by mailing a copy to the insured or his or her authorized representative and to the health benefit plan. A decision of an independent review organization is binding on the insured and the health benefit plan. A rebuttable presumption that the decision was correct applies in any subsequent legal proceeding.

(4) (a) The commissioner shall certify independent review organizations. Only an independent review organization that has been certified by the commissioner may provide independent review services under this section. An organization certified under this paragraph must be recertified on a biennial basis to continue to provide independent review services under this section.

(b) An organization applying for certification or recertification as an independent review organization shall pay the applicable fee under s. 601.31 (1) (Lp) or (Lr). Every organization certified or recertified as an independent review organization shall file a report with the commissioner in accordance with rules promulgated under sub. (5) (d).

(c) The commissioner may examine, audit or accept an audit of the books and records of an independent review organization as provided for examination of licensees and permittees under s. 601.43 (1), (3), (4) and (5), to be conducted as provided in s. 601.44, and with costs to be paid as provided in s. 601.45.

(d) The commissioner may revoke, suspend or limit in whole or in part the certification of an independent review organization, or may refuse to recertify an independent review organization, if the commissioner finds that the independent review organization is unqualified or has violated an insurance statute or rule or a valid order of the commissioner under s. 601.41 **(4),** or if the independent review organization's methods or practices in the conduct of its business endanger, or its financial resources are inadequate to safeguard, the legitimate interests of consumers and the public. The commissioner may summarily suspend an independent review organization's certification under s. **227.51 (3).**

(e) The commissioner shall annually submit a report to the legislature under s. 13.172 (2) that specifies the number of independent reviews requested under this section in the preceding year, the insurers and health benefit plans involved in the independent reviews and the dispositions of the independent reviews.

(5) The commissioner shall promulgate rules. for the independent review required under this section. The rules shall include at least all of the following:

(a) The application procedures for certification and recertification as an independent review organization.

(b) The standards that the commissioner will use for certifying and recertifying organizations as independent review organizations. → insert 8-19

(c) Procedures and processes that independent review organizations must follow, including the times within which decisions must be rendered. The commissioner shall require a decision to be rendered more expeditiously if the services, equipment, drug or device for which coverage was denied relates to a serious injury or impairment or a life-threatening condition, as determined by the insured's treating health care provider.

adverse or experimental treatment determination relates

(d) What must be included in the report required under sub. (4) and the frequency with which the report must be filed with the commissioner.

(e) Standards for the practices and conduct of independent review organizations.

(f) Standards, in addition to those in sub. (6), addressing conflicts of interest by independent review organizations.

(g) Standards for contracts between insurers and independent review organizations.

(6) (a) An independent review organization may not be affiliated with any of the following:

1. A health benefit plan.

2. A national, state or local trade association of health benefit plans, or an affiliate of any such association.

3. A national, state or local trade association of health care providers, or an affiliate of any such association.

(b) An independent review organization appointed to conduct an independent review and a clinical peer reviewer assigned by an independent review organization to conduct an independent review may not have a material professional, familial or financial interest with any of the following:

1. The insurer that issued the health benefit plan that is the subject of the independent review.

2. Any officer, director or management employe of the insurer that issued the health benefit plan that is the subject of the independent review.

health care service or treatment

3. The health care provider that recommended or provided the ~~services, equipment, drug or device~~ that is the subject of the independent review, or the health care provider's medical group or independent practice association.

4. The facility at which the ~~services, equipment, drug or device~~ that is the subject of the independent review was or would be provided.

5. The developer or manufacturer of the principal procedure, equipment, drug or device that is the subject of the independent review.

6. The insured or his or her authorized representative.

(7) (a) A certified independent review organization and a clinical peer reviewer who conducts reviews on behalf of a certified independent review organization shall not be liable in damages to any person for any opinion rendered during or at the completion of an independent review under this section.

(b) A health benefit plan that is the subject of an independent review and the insurer that issued the health benefit plan shall not be liable in damages to any person for complying with any decision rendered by an independent review organization during or at the completion of an independent review under this section.

SECTION 17. Nonstatutory provisions.

(1) **RULES REGARDING INDEPENDENT REVIEW.** Using the procedure under section 227.24 of the statutes, the commissioner of insurance shall promulgate rules required under section 632.835 (5) of the statutes, as created by this act, for the period before the effective date of the permanent rules promulgated under section 632.835 (5) of the statutes, as created by this act, but not to exceed the period authorized under section 227.24 (1) (c) and (2) of the statutes. Notwithstanding section 227.24 (1) (a), (2) (b) and (3) of the statutes, the commissioner is not required

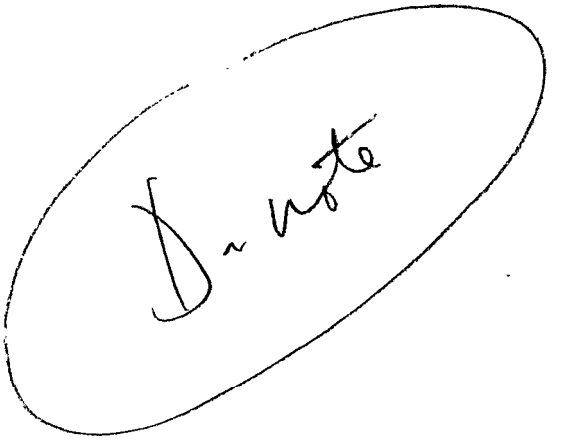
Why no line numbers?

to provide evidence that promulgating a rule under this subsection as an emergency rule is necessary for the preservation of the public peace, health, safety or welfare and is not required to provide a finding of emergency for a rule promulgated under this subsection.

SECTION 18. Effective date. This act takes effect on the first day of the 13th month beginning after publication, except as follows:

(1) The treatment of section 632.835 (5) of the statutes and SECTION 17 of this act take effect on the day after publication.

(END)



DRAFTER'S NOTE
FROMTHE
LEGISLATIVE REFERENCE BUREAU

LRB–2313/1dn
PJK:wlj:jf

1. Should the $500 triggering value for the services or treatment be the amount that the insured has to pay or the total value of the services or treatment? Note that, under the definition of adverse determination, a reduction in payment for services or a shortening of a hospital stay may be the triggering factor. If the $500 refers to the value of the services, a minor reduction in payment could be a triggering event as long as the value of the services exceeded $500. From the current language, it is not clear exactly *what* must exceed $500.

2. Do you want to specify how an independent review organization is chosen if a ~~health benefit plan~~ contracts with more than one?

3. Notice that, although OCI no longer appoints an independent review organization, I retained the requirement that a health benefit plan notify OCI when an independent review is requested. Okay? Since ~~a health benefit plan~~ must notify OCI if it does not renew a contract with an independent review organization, do you want ~~a health benefit plan~~ to inform OCI of the contracts that it enters into?

4. The experimental treatment definition in the Georgia law required the health care provider to be a physician. I retained this requirement. Is this what you want?

5. I revised the experimental treatment definition of the Georgia law quite extensively because so much of it seemed redundant and parts even seemed inconsistent. Let me know if I revised it too much. The definition refers to "proposed treatment". Would the treatment always be proposed? Is it possible that the treatment might already be provided but that payment is denied because the treatment is considered experimental?

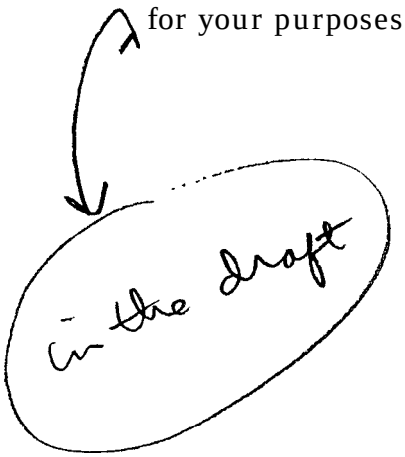
6. In s. 632.835 (1) (b) l., should the substantial probability of death within 2 years from the date of the independent review request apply only if the experimental treatment is withheld? Or should the substantial probability of death apply even with the treatment?

7. Because the definition of "experimental treatment determination" referred to *treating* health care provider, I added "treating" in front of other instances of "health care provider" in the draft. Okay?

8. Now that we have added as a triggering event a determination that a proposed treatment is experimental, might there be a problem with requiring a decision of an independent review organization to be consistent with the terms of the health benefit

plan? What if the terms were that treatment determined to be experimental is not a covered benefit? Section 632.835 (1) (b) 4. and the requirement that a decision be consistent with the terms of the policy would seem to result in no coverage for treatment determined to be experimental if the policy had such a provision. Is this what you want?

9. Please make sure that "insurer" and "health benefit plan" are used appropriately for your purposes.



Pamela J. Kahler
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INSERT 2–1

SECTION 4. 40.51 (8) of the statutes is amended to read:

40.51 (8) Every health care coverage plan offered by the state under sub. (6) shall comply with ss. **631.89, 631.90, 631.93 (2),** 632.72 **(2),** 632.746 (1) to (8) and (lo), 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to **(5),** 632.895 (5m) and (8) to (13) and 632.896.

History: 1981 c. 96; 1983 a. 27; 1985 a. 29; 1987 a. 27, 107, 356; 1987 a. 403 s. 256; 1989 a 31, 93, 121, 129, 182, 201, 336, 359; 1991 a. 39, 70, 113, 152, 269, 315, 1993 a. 450,481; 1995 a. 289; 1997 a. 27.1 2, 237, 252; s. 13.93 (2) (c).

SECTION . 40.51 (8m) of the statutes is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 632.746 (1) to (8) and (lo), 632.747, 632.748, 632.83, 632.835f632.85, 632.853, 632.855 and 632.895 (11) to (13).

NOTE: NOTE: Sob. **(8m)** is shown as affected by four acts of the 1997 legislature and as merged by the revisor under s. 13.93 (2) (c).NOTE:

History: 1981 c. 96; 1983 a. 27; 1985 a. 29; 1987 a. 27, 107, 356; 1987 a. 403 s. 256; 1989 a. 31, 93, 121, 129, 182, 201, 336, 359; 1991 a. 39, 70, 113, 152, 269, 315, 1993 a. 450,481; 1995 a. 289; 1997 a. 27. 55 2, 237, 252; s. 13.93 (2) (c).

SECTION . 111.91 (2) (r) of the statutes is created to read:

111.91 (2) (r) The requirements related to internal grievance procedures under s. 632.83 and independent review of certain health benefit plan determinations under s. 632.835.

(END OF INSERT 2-l)

INSERT 5–4

, except that "health benefit plan" includes the coverage specified in s. 632.745 (11) (b) 10

(ENDOFINSERT5-4)

INSERT 5–8

:

(a) "Adverse determination" means a determination by or on behalf of a health benefit plan to which all of the following apply:

ins. 5-8 cont'd

1. An admission, the availability of care, the continued stay or another health care service that is a covered benefit has been reviewed.

2. Based on the information provided, the health care service under subd. 1. does not meet the health benefit plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

3. The requested health care service or payment for the health care service under subd. 1. is denied, reduced or terminated.

4. The value of the denied, reduced or terminated health care service or payment exceeds $500.

(b) "Experimental treatment determination" means a determination by or on behalf of a health benefit plan that a proposed treatment is excluded as experimental under the terms of the health benefit plan, if all of the following criteria are met:

1. Either the insured has a terminal condition that, according to his or her **treating** health care provider, has a substantial probability of causing death within 2 years from the date of the request under sub. (3) (a) for independent review, or the insured's ability to regain or maintain maximum function, as determined by his or her treating health care provider, would be impaired by witholding the proposed treatment.

2. The insured's treating health care provider is a licensed physician qualified to practice in an area of medicine that is appropriate for the treatment of the insured's condition and recommends the proposed treatment.

3. The insured's treating health care provider certifies in writing all of the following:

ins 5 - 0 cont'd

a. That the insured has a condition for which standard treatment would not be medically indicated for the insured or for which there is no standard treatment available that would be as beneficial for the insured as the proposed treatment.

b. That scientifically valid studies using accepted protocols and published in peer reviewed literature demonstrate that the proposed treatment is likely to be more beneficial for the insured than available standard treatment.

4. The proposed treatment would be covered under the terms of the health benefit plan except for the determination that the treatment is experimental for the insured's condition.

5. The value of the proposed treatment exceeds $500.

(c) (end of ins. 5-8)

INSERT 5–11

an adverse determination or an experimental treatment determination made with respect to the insured.

(END OF INSERT 5–11)

INSERT 5–19

Every insurer issuing a health benefit plan shall contract with one or more independent review organizations certified under sub. (4) for the purpose of conducting independent reviews of adverse determinations and experimental treatment determinations made by or on behalf of the health benefit plan. The term of a contract with an independent review organization may not be less than 3 years. If an insurer fails to renew the contract of an independent review organization at the

ins 5-19 cont'd

end of the contract term, the insurer shall inform the commissioner that the contract has not been renewed and of the reasons for the nonrenewal.

(END OF INSERT 5-19)

INSERT 6–10

STET ↓

no ¶ made or on whose behalf ~~was~~ made the adverse or experimental treatment determination

(END OF INSERT 6-10)

INSERT 7–4

no ¶ the adverse or experimental treatment determination was made

(END OF INSERT 7-4)

INSERT 7-11

no ¶ An independent review organization must demonstrate to the satisfaction of the commissioner that it is unbiased, as defined by the commissioner by rule.

(END OF INSERT 7-11)

INSERT 8–19

no ¶ , including standards for determining whether an independent review organization is unbiased

(END OF INSERT S-19)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-23 13/1dn
PJK:wlj:jf

August 6, 1999

1. Should the $500 triggering value for the services or treatment be the amount that the insured has to pay or the total value of the services or treatment? Note that, under the definition of adverse determination, a reduction in payment for services or a shortening of a hospital stay may be the triggering factor. If the $500 refers to the value of the services, a minor reduction in payment could be a triggering event as long as the value of the services exceeded $500. From the current language, it is not clear exactly ***what*** must exceed $500.

2. Do you want to specify how an independent review organization is chosen if an insurer contracts with more than one?

3. Notice that, although OCI no longer appoints an independent review organization, I retained the requirement that a health benefit plan notify OCI when an independent review is requested. Okay? Since an insurer must notify OCI if it does not renew a contract with an independent review organization, do you want an insurer to inform OCI of the contracts that it enters into?

4. The experimental treatment definition in the Georgia law required the health care provider to be a physician. I retained this requirement. Is this what you want?

5. I revised the experimental treatment definition of the Georgia law quite extensively because so much of it seemed redundant and parts even seemed inconsistent. Let me know if I revised it too much. The definition refers to "proposed treatment". Would the treatment always be proposed? Is it possible that the treatment might already be provided but that payment is denied because the treatment is considered experimental?

6. In s. 632.835 (1) (b) l., should the substantial probability of death within 2 years from the date of the independent review request apply only if the experimental treatment is withheld? Or should the substantial probability of death apply even with the treatment?

7. Because the definition of "experimental treatment determination" referred to ***treating*** health care provider, I added "treating" in front of other instances of "health care provider" in the draft. Okay?

8. Now that we have added as a triggering event a determination that a proposed treatment is experimental, might there be a problem with requiring a decision of an independent review organization to be consistent with the terms of the health benefit

plan? What if the terms were that treatment determined to be experimental is not a covered benefit? Section 632.835 (1) (b) 4. and the requirement that a decision be consistent with the terms of the policy would seem to result in no coverage for treatment determined to be experimental if the policy had such a provision. Is this what you want?

9. Please make sure that "insurer" and "health benefit plan" are used appropriately in the draft for your purposes.

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Kahler, Pam

From: Lonergan, Sandra
Sent: Thursday, September 09, 1999 3:16 PM
To: Kahler, Pam
Subject: independent external review

--Original Message--
From: **Sweet, Richard**
Sent: **Thursday, September 02, 1999 10:19 AM**
To: **Lonergan, Sandra**
Subject:

IRO experimental.doc

Dick Sweet

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Page 6, line10—"(b)Experimental treatment determination" means a determination by or on behalf of a health benefit plan that a proposed treatment, with a value exceeding $500, is excluded as experimental under the terms of the health benefit plan."

Page 9, lines 12-"(c) A decision of an independent review organization regarding an adverse determination shall be consistent with the terms of the health benefit plan under which the adverse determination was made.

(d) A decision of an independent review organization regarding an experimental treatment determination shall be limited to a determination of whether the treatment is experimental. The determination is not reviewable by the independent review organization if the terms of the health benefit plan explicitly exclude coverage for the specific type of treatment sought. The independent review organization shall make a decision in favor of the insured if all of the following apply:

1. The insured has a terminal condition or the insured's ability to regain or maintain maximum function would be impaired by withholding the treatment.

2. The insured has a condition for which standard treatment would not be medically indicated for the insured or for which there is no standard treatment available that would be as beneficial for the insured as the proposed treatment.

3. Scientifically valid studies using accepted protocols and published in peer reviewed literature demonstrate that the proposed treatment is likely to be more beneficial for the insured than available standard treatment.

4. The proposed treatment would be covered under the terms of the health benefit plan except for the determination that the treatment is experimental for the insured's condition.

(e) A decision of an independent review organization shall be in writing, signed . . ."

time limits

decision → w/in 30 days (from having all info. needed)
or 72 hrs if union injx
(pll language)

→ from

hbp → opportunity from insured, 3 days to get injx iro

shorten
~~72~~ → 3 to 1 day
5 to 2 days (both)

FRO process does effective date

6 months stipulates that sufficient number of IRO's of certified FRO's to meet the demand of the market

(2), (2m), (3) delayed eff date

get rid of 2001 language for annual adjustment

~~last changes~~

GA law language re. qualif. panelists
p. 12

Kahler, Pam

From: Lonergan, Sandra
Sent: Friday, September 10, 1999 1051 AM
To: Kahler, Pam
cc: Sweet, Richard; Lonergan, Sandra
Subject: stuff

Hi Pam,

Here we go:

p. 6, line 8-9, replace current language with "4. The amount of the reduction or the value of the denied or terminated service exceeds $500, not including deductibles & co-payments."

p. 9, line 8, after the period insert "any new evidence shall also be submitted to the other party to the independent review."

p. 6, line 1 should read "An admission to a health care facility, the availability of care..."

p. 6, line 6 should read "3. Based on information provided, it has been determined by the insurer that the requested health care service..."

If we think of anything else we'll let you know!!!
Thanks Pam. You're great.

Sandy

Kahler. Pam

From: Lonergan, Sandra
Sent: Friday, September IO, 1999 11:34 AM
To: Kahler, Pam
cc: Sweet, Richard
Subject: MORE stuff

Hello again!

Gregg said let's go ahead with the Georgia language regarding qualifications of IRO panelists. Please add the appropriate language to require licensed, board certff'ied & clinical knowledge or experience (or whatever GA language says).

Does that make sense?

Thank you very much - you're the coolest!

Sandy

internal grievance → 6 months

listed subs → 6 mo. after

all else can be immediate

takes effect on day after pub except:

6 months: 609.15 (1)(intro.), (a), (b), (c)
(2)(intro.), (a), (b), (c), (d), (e)

632.83

6 mo. after ent: 632.835 (2), (3), (3m), (5)(6)

Sandy / Dick:

only basis for not experimental?

What about initial ap?

?
- requests on eff date?
- denials, etc. on eff date?
- internal review decisions made on eff. date?

When independent review begins, who can request it? (how long ago must an internal procedure have been done?

9-13-99

phone calls w/ Sandy & Dick Sweet:

require com. to submit rules to leg council in 6 mo.

allow a person who gets internal grievance decision 6 mo. or more after effective date (publication) to get indp. review

generally, allow individuals 4 mo. to request indp review (except for those above) after decision in internal grievance

make sure that immunity applies immediately

exp treatment requirements s/b exclusive ones - only situation for coverage

State af Wisconsin
1999 - 2000 **LEGISLATURE**

LRB-23 13/5 2
PJK:wlj:jf

rm is num

1999 BILL

D-note (Wed, 4 pm ltr)

regenerate

AN ACT ***to renumber*** 609.15 (1) (c), 669.15 (2) (c), 609.15 (2) (d) and 609.15 (2) (e); ***to renumber*** and amend 609.15 (1) (intro.), 609.15 (1) (a), 609.15 (1) (b), 609.15 (2) (intro.), 609.15 (2) (a) and 609.15 (2) (b); ***to amend*** 40.51 (8), 40.51 (8m), 600.01 (2) (b) and 601.42 (4); and ***to*** create 111.91 (2) (r), 601.31 (1) (Lp), 601.31 (1) (Lr), 632.83 and 632.835 of the statutes; **relating to:** requiring all insurers to establish internal grievance procedures, independent review of certain coverage determinations made by health benefit plans, granting rule-making authority and providing an exemption from emergency rule procedures.

Analysis by the Legislative Reference Bureau

NOTE: Except for a couple of technical changes, this analysis has not been changed from the **"P2"** version of the draft. The analysis will be finalized with the next version.

Under current law, every managed care plan is required to have an internal grievance procedure under which an enrollee may submit a written grievance and a grievance panel must investigate the grievance and, if appropriate, take corrective action. This bill requires every health benefit plan, including managed care plans, to have an independent review procedure for grievances related to denials of

coverage for medical services, equipment, drugs or devices. To be eligible for independent review, a denial must be based on medical necessity, and the value of the services, equipment, drug or device for which coverage was denied must be at least $500. An insured under a-plan with an internal grievance procedure may be required to use the internal grievance procedure before requesting an independent review.

To request an independent review, an insured must pay $50, which is refunded to the insured if he or she prevails, in whole or in part, in the independent review. Any relevant evidence may be considered in an independent review, even if the evidence has not been considered at any time before. The decision at the conclusion of an independent review must be consistent with the terms of the health benefit plan and it must be in writing and served on both the insured who requested the review and the health benefit plan. The decision is binding on the insured and the health benefit plan and subject to judicial review.

Under the bill, an independent review may be conducted only by an independent review organization that has been certified by the commissioner of insurance (commissioner). A certified independent review organization must be recertified every two years to continue to conduct independent reviews. The commissioner may revoke, suspend or limit the certification of an independent review organization for various reasons specified in the bill.

The bill contains prohibitions aimed at avoiding conflicts of interest for independent review organizations, such as prohibiting an independent review organization from owning, controlling or being a subsidiary of a health benefit plan or an association of health benefit plans. The bill also provides independent review organizations, and clinical peer reviewers who conduct independent reviews on behalf of independent review organizations, with immunity from liability for decisions made in independent reviews.

Finally, the bill requires the commissioner to promulgate rules relating to such topics as the application procedures and standards for certification and recertification of independent review organizations, the procedures and processes that independent review organizations must use in independent reviews, standards for the practices and conduct of independent review organizations and additional standards related to conflicts of interest.

For further information see the state and *local* fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 40.51 (8) of the statutes is amended to read:

40.51 (8) Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 632.72 (2), 632.746 (1) to (8) and (10),

632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to (5), 632.895 (5m) and (8) to (13) and 632.896.

SECTION 2. **40.51 (8m)** of the statutes is amended to read:

40.51 (8m) Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 632.746 (1) to (8) and (10), 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855 and 632.895 (11) to (13).

SECTION 3. **111.91 (2) (r)** of the statutes is created to read:

111.91 (2) (r) The requirements related to internal grievance procedures under s. 632.83 and independent review of certain health benefit plan determinations under s. 632.835.

SECTION 4. **600.01 (2)** (b) of the statutes is amended to read:

600.01 (2) (b) Group or blanket insurance described in sub. (1) (b) 3. and 4. is not exempt from ss. 632.745 to **632.749**, 632.83 or 632.835 or ch. 633 or 635.

SECTION 5. **601.31 (1)** (Lp) of the statutes is created to read:

601.310) (Lp) For certifying as an independent review organization under s. 632.835, $400.

SECTION 6. 601.31 (1) (Lr) of the statutes is created to read:.

601.31 (1) (Lr) For each biennial recertification as an independent review organization under s. 632.835, $100.

SECTION 7. 601.42 (4) of the statutes is amended to read:

601.42 (4) **REPLIES.** Any officer, manager or general agent of any insurer authorized to do or doing an insurance business in this state, any person controlling or having a contract under which the person has a right to control such an insurer, whether exclusively or otherwise, any person with executive authority over or in charge of any segment of such' an insurer's affairs, any individual practice

association or officer, director or manager of an individual practice association, any insurance agent or other person licensed under chs. 600 to 646, any provider of services under a continuing care contract, as defined in s. 647.01 (2), any indenendent review organization certified under s. 632.835 (4) or any health care provider, as defined in s. 655.001 (8), shall reply promptly in writing or in other designated form, to any written inquiry from the commissioner requesting a reply.

SECTION 8. 609.15 **(1)** (intro.) of the statutes is renumbered 609.15 and amended to read:

609.15 Grievance procedure. Each limited service health organization, preferred provider plan and managed care plan shall ~~do all of the following:~~ establish and use an internal grievance procedure as provided in 32 .83.

SECTION 9. 609.15 (1) (a) of the statutes is renumbered 632.83 (2) (a) and amended to read:

632.83 **(2)** (a) Establish and use an internal grievance procedure that is approved by the commissioner and that complies with sub. ~~(2)~~ (3) for the resolution of ~~enrollees'~~ insureds' grievances with the ~~limited service health organization, preferred provider plan or managed care~~ health benefit plan.

SECTION 10. 609.15 (1) (b) of the statutes is renumbered 632.83 (2) (b) and amended to read:

632.83 (2) (b) Provide ~~enrollees~~ insure& with complete and understandable information describing the internal grievance procedure under par. (a).

SECTION 11. 609.15 (1) (c) of the statutes is renumbered 632.83 (2) (c).

SECTION 12. 609.15 (2) (intro.) of the statutes is renumbered 632.83 (3) (intro.) and amended to read:

632.83 (3) (intro.) The internal grievance procedure established under sub. ~~(1)~~ (2) (a) shall include all of the following elements:

SECTION 13. 609.15 (2) (a) of the statutes is renumbered 632.83 (3) (a) and amended to read:

632.83 (3) (a) The opportunity for an ~~enrollee~~ insured to submit a written grievance in any form.

SECTION 14. 609.15 (2) (b) of the statutes is renumbered 632.83 (3) (b) and amended to read:

632.83 (3) (b) Establishment of a grievance panel for the investigation of each grievance submitted under par. (a), consisting of at least one individual authorized to take corrective action on the grievance and at least one ~~enrollee~~ insured other than the grievant, if an ~~enrollee~~ insured is available to serve on the grievance panel.

SECTION 15. 609.15 (2) (c) of the statutes is renumbered 632.83 (3) (c).

SECTION 16. 609.15 (2) (d) of the statutes is renumbered 632.83 (3) (d).

SECTION 17. 609.15 (2) (e) of the statutes is renumbered 632.83 (3) (e).

SECTION 18. 632.83 of the statutes is created to read:

632.83 Internal grievance procedure. (1) In this section, "health benefit plan" has the meaning given in s. 632.745 (11), except that "health benefit plan" includes the coverage specified in s. 632.745 (11) (b) 10.

(2) Each health benefit plan shall do all of the following:

SECTION 19. 632.835 of the statutes is created to read:

632.835 Independent review of adverse and experimental treatment determinations. (1) In this section: → (CS) DEFINITIONS.

(a) "Adverse determination" means a determination by or on behalf of a health benefit plan to which all of the following apply:

to a health care facility

1. An admission, the availability of care, the continued stay or another health care service that is a covered benefit has been reviewed.

2. Based on the information provided, the health care service under subd. 1. does not meet the health benefit plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

3. The requested health care service or payment for the health care service under subd. 1. is denied, reduced or terminated.

4. The value of the denied, reduced or terminated health care service or payment exceeds $500.

Insert 6-9

(b) ~~"Experimental treatment determination" means a determination by or on behalf of a health benefit plan that a proposed treatment is excluded as experimental under the terms of the health benefit plan.~~ "Experimental treatment determination" means a determination by or on behalf of a health benefit plan that a proposed treatment is excluded as experimental under the terms of the health benefit plan, if all of the following criteria are met:

1. Either the insured has a terminal condition that, according to his or her treating health care provider, has a substantial probability of causing death within 2 years from the date of the request under sub. (3) (a) for independent review, or the insured's ability to regain or maintain maximum function, as determined by his or her treating health care provider, would be impaired by withholding the proposed treatment.

2. The insured's treating health care provider is a licensed physician qualified to practice in an area of medicine that is appropriate for the treatment of the insured's condition and recommends the proposed treatment.

3. The insured's treating health care provider certifies in writing all of the following:

a. That the insured has a condition for which standard treatment would not be medically indicated for the insured or for which there is no standard treatment available that would be as beneficial for the insured as the proposed treatment.

b. That scientifically valid studies using accepted protocols and published in peer reviewed literature demonstrate that the proposed treatment is likely to be more beneficial for the insured than available standard treatment.

4. The proposed treatment would be covered under the terms of the health benefit plan except for the determination that the treatment is experimental for the insured's condition.

5. The value of the proposed treatment exceeds $500.

(c) "Health benefit plan" has the meaning given in s. 632.745 (11), except that "health benefit plan" includes the coverage specified in s. 632.745 (11) (b) 10.

(2) (a) Every health benefit plan shall establish an independent review procedure whereby an insured under the health benefit plan, or his or her authorized representative, may request and obtain an independent review of an adverse determination or an experimental treatment determination made with respect to the insured.

(b) An independent review under this section ~~must~~ may be conducted only by an independent review organization certified under sub. (4). Every insurer issuing a health benefit plan shall contract with one or more independent review organizations certified under sub. (4) for the purpose of conducting independent reviews of adverse determinations and experimental treatment determinations made by or on behalf of the health benefit plan. The term of a contract with an independent review organization may not be less than 2 years. If an insurer fails to renew the contract of an independent review organization at the end of the contract

CS → REVIEW REQUIREMENTS. WHO MAY CONDUCT.

term, the insurer shall inform the commissioner that the contract has not been renewed and of the reasons for the nonrenewal.

(c) An insured must exhaust the health benefit plan's internal grievance procedure before the insured may request an independent review under this section, unless the delay will result for the insured in serious injury or impairment or a life-threatening condition, as determined by the insured's treating health care provider. Insert 8-7

(d) Whenever an adverse determination or an experimental treatment determination is made, the health benefit plan involved in the determination shall advise the insured of the insured's right to obtain the independent review required under this section, how to request the review and the time within which the review must be requested.

(c) Beginning in 2001, to reflect changes in the consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor, the commissioner shall at least annually adjust the amounts specified in sub. (1) (a) 4. and (b) 4.

(3) (a) To request an independent review under this section, an insured or his or her authorized representative shall provide timely written notice of the request for independent review to the health benefit plan that made or on whose behalf was made the adverse or experimental treatment determination. The health benefit plan shall immediately notify the commissioner of the request. Insert 8-21 The insured or his or her authorized representative must pay a $50 fee to the independent review organization conducting the review. If the insured prevails on the review, in whole or in part, the entire amount paid by the insured or his or her authorized representative shall be refunded by the health benefit plan to the insured or his or

Insert 11-19 → Move to page 11

Move to p. 11

(CS) PROCEDURE.

her authorized representative. For each independent review in which it is involved, a health benefit plan shall pay a fee to the independent review organization.

(b) An independent review under this section shall be based on the record of the proceedings, if any, in which the decision under review was made. An independent review organization, however, may accept for consideration any typed or printed, verifiable medical or scientific evidence that the independent review organization determines is relevant, regardless of whether the evidence has been submitted for consideration at any time previously. An independent review under this section may not include appearances by the insured or his or her authorized representative, any person representing the health benefit plan or any witness on behalf of either the insured or the health benefit plan.

(c) A decision of an independent review organization must be consistent with the terms of the health benefit plan under which the adverse or experimental treatment determination was made. A decision shall be in writing, signed on behalf of the independent review organization ~~conducting the review~~ and served by personal delivery or by mailing a copy to the insured or his or her authorized representative and to the health benefit plan. A decision of an independent review organization is binding on the insured and the health benefit plan.

(4) (a) The commissioner shall certify independent review organizations. An independent review organization ~~must demonstrate to the satisfaction of the~~ commissioner that it is unbiased, as defined by the commissioner by rule. Only an independent review organization that has been certified by the commissioner may provide independent review services under this section. An organization certified under this paragraph must be recertified on a biennial basis to continue to provide independent review services under this section.

insert 9-2

insert 9-14

insert 9-18

(c) CERTIFICATION OF INDEPENDENT REVIEW ORGANIZATIONS.

(b) An organization applying for certification or recertification as an independent review organization shall pay the applicable fee under s. 601.31 (1) (Lp) or (Lr). Every organization certified or recertified as an independent review organization shall file a report with the commissioner in accordance with rules promulgated under sub. (5) (4).

(c) The commissioner may examine, audit or accept an audit of the books and records of an independent review organization as provided for examination of licensees and permittees under s. 601.43 (l), (3), (4) and (5), to be conducted as provided in s. 601.44, and with costs to be paid as provided in s. 601.45.

(d) The commissioner may revoke, suspend or limit in whole or in part the certification of an independent review organization, or may refuse to recertify an independent review organization, if the commissioner finds that the independent review organization is unqualified or has violated an insurance statute or rule or a valid order of the commissioner under s. 601.41 (4), or if the independent review organization's methods or practices in the conduct of its business endanger, or its financial resources are inadequate to safeguard, the legitimate interests of consumers and the public. The commissioner may summarily suspend an independent review organization's certification under s. 227.51 (3).

(4) The commissioner shall annually submit a report to the legislature under s. 13.172 (2) that specifies the number of independent reviews requested under this section in the preceding year, the insurers and health benefit plans involved in the independent reviews and the dispositions of the independent reviews.

(5) The commissioner shall promulgate rules for the independent review required under this section. The rules shall include at least all of the following:

RULES; REPORT; ADJUSTMENTS.

1. (a) The application procedures for certification and recertification as an independent review organization.

2. (b) The standards that the commissioner will use for certifying and recertifying organizations as independent review organizations, including standards for determining whether an independent review organization is unbiased.

3. (c) Procedures and processes that independent review organizations must follow, including the times within which decisions must be rendered. The commissioner shall require a decision to be rendered more expeditiously if the adverse or experimental treatment determination relates to a serious injury or impairment or a life-threatening condition, as determined by the insured's treating health care provider.

4. (d) What must be included in the report required under sub. (4) and the frequency with which the report must be filed with the commissioner.

5. (e) Standards for the practices and conduct of independent review organizations.

6. (f) Standards, in addition to those in sub. (6), addressing conflicts of interest by independent review organizations.

7. (g) Standards for contracts between insurers and independent review organizations.

(6) (a) An independent review organization may not be affiliated with any of the following:

1. A health benefit plan.

2. A national, state or local trade association of health benefit plans, or an affiliate of any such association.

(CS) CONFLICT OF INTEREST STANDARDS.

in addition to those in sub. (3)

insert 11-19a from p. 10

insert 11-19b from p. 8

3. A national, state or local trade association. of health care providers, or an affiliate of any such association.

(b) An independent review organization appointed to conduct an independent review and a clinical peer reviewer assigned by an independent review organization to conduct an independent review may not have a material professional, familial or financial interest with any of the following:

1. The insurer that issued the health benefit plan that is the subject of the independent review.

2. Any officer, director or management employe of the insurer that issued the health benefit plan that is the subject of the independent review.

3. The health care provider that recommended or provided the health care service or treatment that is the subject of the independent review, or the health care provider's medical group or independent practice association.

4. The facility at which the health care service or treatment that is the subject of the independent review was or would be provided.

5. The developer or manufacturer of the principal procedure, equipment, drug or device that is the subject of the independent review.

6. The insured or his or her authorized representative.

(7)(a) A certified independent review organization and a clinical peer reviewer who conducts reviews on behalf of a certified independent review organization shall not be liable in damages to any person for any opinion rendered during or at the completion of an independent review under this section.

(b) A health benefit plan that is the subject of an independent review and the insurer that issued the health benefit plan shall not be liable in damages to any person for complying with any decision rendered by a certified independent review

Insert 12-18

(c) IMMUNITY.

organization during or at the completion of an independent review ~~of this section~~.

SECTION 20. Nonstatutory provisions.

(1) **RULES REGARDING INDEPENDENT REVIEW.** Using the procedure under Section 227.24 of the statutes, the commissioner/f insurance shall promulgate rules required under section 632.835 (5) (a) of the statutes, as created by this act, for the period before the effective date of the permanent rules promulgated under section 632.835 (5) (a) of the statutes, as created by this act, but not to exceed the period authorized under section 227.24 (1) (c) and (2) of the statutes. Notwithstanding section 227.24 (1) (a), (2) (b) and (3) of the statutes, the commissioner is not required to provide evidence that promulgating a rule under this ~~subsection~~ new paragraph as an emergency rule is necessary for the preservation of the public peace, health, safety or welfare and is not required to provide a finding of emergency for a rule promulgated under this ~~subsection~~ paragraph.

SECTION 21. Effective date. This act takes effect *on* the ~~first~~ day ~~after~~ ~~publication~~ after publication, except as follows:

(1) The treatment of section 632.835 (5) of the statutes and SECTION 20 of this act take effect on the day after publication.

(END)

insert 13-2

insert 13-4

insert 13-18

D-note

INSERT 6–9

3. Based on the information provided, the health benefit plan reduced, denied or terminated the health care service under subd. 1. or payment for the health care service under subd. 1.

4. Subject to sub. (5) (b), the amount of the reduction or the value of the denied or terminated service or payment exceeds $500, excluding deductibles and copayments.

(b) "Experimental treatment determination" means a determination by or on behalf of a health benefit plan to which all of the following apply:

1. A proposed treatment has been reviewed.

2. Based on the information provided, the treatment under subd. 1. is determined to be experimental under the terms of the health benefit plan.

3. Based on the information provided, the health benefit plan denied the treatment under subd. 1. or payment for the treatment under subd. 1.

4. Subject to sub. (5) (b), the value of the denied treatment or payment exceeds $500, excluding deductibles and copayments.

(END OF INSERT 6-9)

INSERT8-7

Except as provided in sub. (5) (b), an insured must request an independent review as provided in sub. (3) (a) within 4 months after the insured receives notice of the disposition of his or her grievance under s. 632.83 (3) (d).

(END OF INSERT S-7)

INSERT 8–21

for independent review and the insured of the name and address of the independent review organization that will be conducting the review

(END OF INSERT S-21)

INSERT S-2

(b) Within 3 business days after receiving written notice of the request for independent review under par. (a), the health benefit plan shall submit to the independent review organization copies of all of the following:

1. Any information submitted to the health benefit plan by the insured in support of the insured's position in the internal grievance under s. 632.83.

2. A copy of the contract provisions or evidence of coverage of the health benefit plan.

3. Any other relevant documents or information used by the health benefit plan in the internal grievance determination under s. 632.83.

(c) Within 5 business days after receiving the information under par. (b), the independent review organization shall request any additional information that it requires for the review from the insured or the health benefit plan. Within 5 business days after receiving a request for additional information, the insured or health benefit plan shall submit the information or an explanation of why the information is not being submitted.

(d) In addition to the information under pars. (b) and (c), the independent review organization may accept for consideration any typed or printed, verifiable medical or scientific evidence that the independent review organization determines is relevant, regardless of whether the evidence has been submitted for consideration at any time previously. The health benefit plan and the insured shall submit to the

other party to the independent review any information submitted to the independent review organization under pars. (b) to (d).

(END OF INSERT 9–2)

INSERT s-14

(f) The independent review organization shall, within 30 business days after the expiration of all time limits that apply in the matter, make a decision on the basis of the documents and information submitted under this subsection. The

(END OF INSERT 9-14)

INSERT 9–18

(g) If, in the judgment of the insured's treating health care provider, the adverse or experimental treatment determination relates to a serious injury or impairment or a life-threatening condition, the procedure outlined in pars. (b) to (f) shall be followed with the following differences:

1. The health benefit plan shall submit the information under par. (b) within one day after receiving the notice of the request for independent review under par. (a).

2. The independent review organization shall request any additional information under par. (c) within 2 business days after receiving the information under par. (b).

3. The insured or health benefit plan shall, within 2 days after receiving a request under par. (c), submit any information requested or an explanation of why the information is not being submitted.

4. The independent review organization shall make its decision under par. (f) within 72 hours after the expiration of the time limits under this paragraph that apply in the matter.

(3m) **STANDARDS FOR DECISIONS.** (a) A decision of an independent review organization regarding an adverse determination must be consistent with the terms of the health benefit plan under which the adverse determination was made.

(b) A decision of an independent review organization regarding an experimental treatment determination is limited to a determination of whether the proposed treatment is experimental. The independent review organization shall determine that the treatment is not experimental and find in favor of the insured only if the independent review organization finds all of the following:

1. The insured has a terminal condition, or the insured's ability to regain or maintain maximum function would be impaired by withholding the proposed treatment.

2. The insured has a condition for which standard treatment would not be medically indicated for the insured or for which there is no standard treatment available that would be as beneficial for the insured as the proposed treatment.

3. Scientifically valid studies using accepted protocols and published in peer reviewed literature demonstrate that the proposed treatment is likely to be more beneficial for the insured than available standard treatment.

4. The proposed treatment is not specifically excluded under the terms of the health benefit plan and would be covered except for the determination that the treatment is experimental for the insured's condition.

(END OF INSERT 9–18)

INSERT 12–18

(6m) QUALIFICATIONS OF CLINICAL PEER REVIEWERS. A clinical peer reviewer who conducts a review on behalf of a certified independent review organization must satisfy all of the following requirements:

(a) Be a health care provider who is expert in treating the medical condition that is the subject of the review and who is knowledgeable about the treatment that is the subject of the review through actual clinical experience.

(b) Hold a credential, as defined in s. 440.01 (2) (a), that is not limited or restricted; or hold a license, certificate, registration or permit that authorizes or qualifies the health care provider to perform acts #&M&substantially the same as those acts authorized by a credential, as defined in s. 440.01 (2) (a), that was issued by a governmental authority in a jurisdiction outside this state and that is not limited or restricted.

(c) If a physician, hold a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the review.

(d) Have no history of disciplinary sanctions, including loss of staff privileges, taken or pending by the medical examining board or another regulatory body or by any hospital or government.

(END OF INSERT 12–18)

INSERT 13–2

(8) NOTICE OF SUFFICIENT INDEPENDENT REVIEW ORGANIZATIONS. The commissioner shall make a determination that a sufficient number of independent review organizations have been certified under sub. (4) to effectively provide the independent reviews required under this section and shall publish a notice in the Wisconsin Administrative Register that states a date that is 6 months after the commissioner makes that determination. The date stated in the notice shall be the date on which the independent review procedure under this section begins operating.

(9) **APPLICABILITY.** The independent review required under this section shall be available to an insured who receives notice of the disposition of his or her grievance under s. 632.83 (3) (d) on or after the first day of the 7th month beginning after the effective date of this paragraph/Subsection.... [revisor inserts date]. Notwithstanding sub. (2) (c), an insured who receives notice of the disposition of his or her grievance under s. 632.83 (3) (d) on or after the first day of the 7th month beginning after the effective date of this paragraph/Subsection.... [revisor inserts date], but before the date stated in the notice published by the commissioner ~~under this paragraph~~ in the Wisconsin Administrative Register under sub. (8) . . . . [revisor inserts date], must request an independent review no later than 4 months after the date stated in the notice published by the

commissioner of insurance in the Wisconsin Administrative Register under sub. (8) .... [revisor inserts date].

(END OF INSERT 13-2)

INSERT 13–4

(a) The commissioner of insurance shall submit in proposed form the rules required under section 632.835 (5) (a) of the statutes, as created by this act, to the legislative council staff under section 227.15 (1) of the statutes no later than the first day of the 7th month beginning after the effective date of this paragraph.

(b)

(END OF INSERT 13–4)

INSERT 13–18

(1) The treatment of sections 609.15 (1) (intro.), (a), (b) and (c) and (2) (intro.), (a), (b), (c), (d) and (e) and 632.83 of the statutes takes effect on the first day of the 7th month beginning after publication.

(2) The treatment of section 632.835 (2), (3), (3m) and (5) (b) of the statutes and (c) takes effect on the date stated in the notice published by the commissioner of insurance in the Wisconsin Administrative Register under section 632.835 (8) of the statutes, as created by this act.

(END OF INSERT 13-18)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-23 13/2dn
PJK:wlj:jf

September 14, 1999

As we discussed, I will begin updating the analysis before hearing back from you on this version of the draft.

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266-2682
E-mail: Pam.Kahler@legis.state.wi.us

State of Wisconsin
1999 - 2000 LEGISLATURE

LRB-23 13/~~1~~ 3
PJK:wlj:jf

r m is now

1999 BILL

SDOM (Friday 9-17 (just analysis) Regen

AN ACT ~~*to renumber*~~ 609.15 (1) (c), 609.15 (2) (c), 609.15 (2) (d) and 609.15 (2) (e); ***to renumber and amend*** 609.15 (1) (intro.), 609.15 (1) (a), 609.15 (1) (b), 609.15 (2) (intro.), 609.15 (2) (a) and 609.15 (2) (b); ***to amend*** 40.51 (8), 40.51 (8m), 600.01 (2) (b) and 601.42 (4); and ***to create*** 111.91 (2) (r), 601.31 (1) (Lp), 601.31 (1) (Lr), 632.83 and 632.835 of the statutes; **relating to:** requiring all insurers to establish internal grievance procedures, independent review of certain coverage determinations made by health benefit plans, granting rule-making authority and providing an exemption from emergency rule procedures.

Analysis by the Legislative Reference Bureau

~~NOTE: Except for a couple of technical changes, this analysis has not been changed from the "P2" version of the draft. The analysis will be finalized with the next version.~~

Under current law, every managed care plan is required to have an internal grievance procedure under which an enrollee may submit a written grievance and a grievance panel must investigate the grievance and, if appropriate, take corrective action. This bill requires every health benefit plan, including managed care plans, to have an independent review procedure for grievances related to denials of

coverage for -medical- services, equipment, drugs or devices. To be eligible for independent review, a denial must be based on medical necessity, and the value of the services, equipment, drug or device for which coverage was denied must be at least $500. An insured under a plan with an internal grievance procedure may be required to use the internal grievance procedure before requesting an independent review.

To request an independent review, an insured must pay $50, which is refunded to the insured if he or she prevails, in whole or in part, in the independent review. Any relevant evidence may be considered in an independent review, even if the evidence has not been considered at any time before. The decision at the conclusion of an independent review must be consistent with the terms of the health benefit plan and it must be in writing and served on both the insured who requested the review and the health benefit plan. The decision is binding on the insured and the health benefit plan and subject to judicial review.

Under the bill, an independent review may be conducted only by an independent review organization that has been certified by the commissioner of insurance (commissioner). A certified independent review organization must be recertified every two years to continue to conduct independent reviews. The commissioner may revoke, suspend or limit the certification of an independent review organization for various reasons specified in the bill.

The bill contains prohibitions aimed at avoiding conflicts of interest for independent review organizations, such as prohibiting an independent review organization from owning, controlling or being a subsidiary of a health benefit plan or an association of health benefit plans. The bill also provides independent review organizations, and clinical peer reviewers who conduct independent reviews on behalf of independent review organizations, with immunity from liability for decisions made in independent reviews.

Finally, the bill requires the commissioner to promulgate rules relating to such topics as the application procedures and standards for certification and recertification of independent review organizations, the procedures and processes that independent review organizations must use in independent reviews, standards for the practices and conduct of independent review organizations and additional standards related to conflicts of interest.

For further information see the state ***and local*** fiscal estimate, which will be printed as an appendix to this bill.

Insert 1A

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 40.51 (8) of the statutes is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. **(6)** shall comply with ss. **631.89, 631.90, 631.93(2),** 632.72 **(2),** 632.746 **(1)** to **(8)** and **(10),**

632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855, 632.87 (3) to (5), 632.895 (5m) and (8) to (13) and 632.896.

SECTION 2. 40.51 (8m) of the statutes is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 632.746 (1) to (8) and (10), 632.747, 632.748, 632.83, 632.835, 632.85, 632.853, 632.855 and 632.895 (11) to (13).

SECTION 3. 111.91 (2) (r) of the statutes is created to read:

111.91 (2) (r) The requirements related to internal grievance procedures under s. 632.83 and independent review of certain health benefit plan determinations under s. 632.835.

SECTION 4. 600.01 (2) (b) of the statutes is amended to read:

600.01 (2) (b) Group or blanket insurance described in sub. (1) (b) 3. and 4. is not exempt from ss. 632.745 to 632.749, 632.83 or 632.835 or ch. 633 or 635.

SECTION 5. 601.31 (1) (Lp) of the statutes is created to read:

601.31 (1) (Lp) For certifying as an independent review organization under s. 632.835, $400.

SECTION 6. 601.31 (1) (Lr) of the statutes is created to read:

601.31 **(1)** (Lr) For each biennial recertification as an independent review organization under s. 632.835, $100.

SECTION 7. 601.42 (4) of the statutes is amended to read:

601.42 (4) **REPLIES.** Any officer, manager or general agent of any insurer authorized to do or doing an insurance business in this state, any person controlling or having a contract under which the person has a right to control such an insurer, whether exclusively or otherwise, any person with executive authority over or in charge of any segment of such an insurer's affairs, any individual practice

association or officer, director or manager of an individual practice association, any insurance agent or other person licensed under chs. 600 to 646, any provider of services under a continuing care contract, as defined in s. 647.01 (2), any independent review organization certified under s. 632.835 (4) or any health care provider, as defined in s. 655.001 (8), shall reply promptly in writing or in other designated form, to any written inquiry from the commissioner requesting a reply.

SECTION 8. 609.15 (1) (intro.) of the statutes is renumbered 609.15 and amended to read:

609.15 Grievance procedure. Each limited service health organization, preferred provider plan and managed care plan shall ~~do all of the following:~~ establish and use an internal grievance procedure as provided in s. 632.83.

SECTION 9. 609.15 (1) (a) of the statutes is renumbered 632.83 (2) (a) and amended to read:

632.83 (2) (a) Establish and use an internal grievance procedure that is approved by the commissioner and that complies with sub. ~~(2)~~ (3) for the resolution of ~~enrollees'~~ insureds' grievances with the ~~limited service health organization, preferred provider plan or managed care~~ health benefit plan.

SECTION 10. 609.15 (1) (b) of the statutes is renumbered 632.83 (2) (b) and amended to read:

632.83 (2) (b) Provide ~~enrollees~~ insure& with complete and understandable information describing the internal grievance procedure under par. (a).

SECTION 11. 609.15 (1) (c) of the statutes is renumbered 632.83 (2) (c).

SECTION 12. 609.15 (2) (intro.) of the statutes is renumbered 632.83 (3) (intro.) and amended to read:

632.83 (3) (intro.) The internal grievance procedure established under sub. ~~(1)~~ (2) (a) shall include all of the following elements:

SECTION 13. 609.15 (2) (a) of the statutes is renumbered 632.83 (3) (a) and amended to read:

632.83 (3) (a) The opportunity for an ~~enrollee~~ insured to submit a written grievance in any form.

SECTION 14. 609.15 (2) (b) of the statutes is renumbered 632.83 (3) (b) and amended to read:

632.83 (3) (b) Establishment of a grievance panel for the investigation of each grievance submitted under par. (a), consisting of at least one individual authorized to take corrective action on the grievance and at least one ~~enrollee~~ insured other than the grievant, if an ~~enrollee~~ insured is available to serve on the grievance panel.

SECTION 15. 609.15 (2) (c) of the statutes is renumbered 632.83 (3) (c).

SECTION 16. 609.15 (2) (d) of the statutes is renumbered 632.83 (3) (d).

SECTION 17. 609.15 (2) (e) of the statutes is renumbered 632.83 (3) (e).

SECTION 18. 632.83 of the statutes is created to read:

632.63 Internal grievance procedure. (1) In this section, "health benefit plan" has the meaning given in s. 632.745 (11), except that "health benefit plan" includes the coverage specified in s. 632.745 (11) (b) 10.

(2) Each health benefit plan shall do all of the following:

SECTION 19. 632.835 of the statutes is created to read:

632.635 Independent review of adverse and experimental treatment determinations. (1) DEFINITIONS. In this section:

(a) "Adverse determination" means a determination by or on behalf of a health benefit plan to which all of the following apply:

1. An admission to a health care facility, the availability of care, the continued stay or another health care service that is a covered benefit has been reviewed.

2. Based on the information provided, the health care service under subd. 1. does not meet the health benefit plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness.

3. Based on the information provided, the health benefit plan reduced, denied or terminated the health care service under subd. 1. or payment for the health care service under subd. 1.

4. Subject to sub. (5) (c), the amount of the reduction or the value of the denied or terminated service or payment exceeds $500, excluding deductibles and copayments.

(b) "Experimental treatment determination" means a determination by or on behalf of a health benefit plan to which all of the following apply:

1. A proposed treatment has been reviewed.

2. Based on the information provided, the treatment under subd. 1. is determined to be experimental under the terms of the health benefit plan.

3. Based on the information provided, the health benefit plan denied the treatment under subd. 1. or payment for the treatment under subd. 1.

4. Subject to sub. (5) (c), the value of the denied treatment or payment exceeds $500, excluding deductibles and copayments.

(c) "Health benefit plan" has the meaning given in s. 632.745 (11), except that "health benefit plan" includes the coverage specified in s. 632.745 (11) (b) 10.

(2) **REVIEW REQUIREMENTS; WHO MAY CONDUCT.** (a) Every health benefit plan shall establish an independent review procedure whereby an insured under the health benefit plan, or his or her authorized representative, may request and obtain

an independent review of an adverse determination or an experimental treatment determination made with respect to the insured.

(b) An independent review under this section may be conducted only by an independent review organization certified under sub. (4). Every insurer issuing a health benefit plan shall contract with one or more independent review organizations certified under sub. **(4)** for the purpose of conducting independent reviews of adverse determinations and experimental treatment determinations made by or on behalf of the health benefit plan. The term of a contract with an independent review organization may not be less than 2 years. If an insurer fails to renew the contract of an independent review organization at the end of the contract term, the insurer shall inform the commissioner that the contract has not been renewed and of the reasons for the nonrenewal.

(c) An insured must exhaust the health benefit plan's internal grievance procedure before the insured may request an independent review under this section, unless the delay will result for the insured in serious injury or impairment or a life-threatening condition, as determined by the insured's treating health care provider. Except as provided in sub. (9), an insured must request an independent review as provided in sub. (3) (a) within 4 months after the insured receives notice of the disposition of his or her grievance under s. 632.83 (3) (d).

(d) Whenever an adverse determination or an experimental treatment determination is made, the health benefit plan involved in the determination shall advise the insured of the insured's right to obtain the independent review required under this section, how to request the review and the time within which the review must be requested.

(3) PROCEDURE. (a) To request an independent review, an insured or his or her authorized representative shall provide timely written notice of the request for independent review to the health benefit plan that made or on whose behalf was made the adverse or experimental treatment determination. The health benefit plan shall immediately notify the commissioner of the request for independent review and notify the insured of the name and address of the independent review organization that will be conducting the review. . The insured or his or her authorized representative must pay a $50 fee to the independent review organization. If the insured prevails on the review, in whole or in part, the entire amount paid by the insured or his or her authorized representative shall be refunded by the health benefit plan to the insured or his or her authorized representative. For each independent review in which it is involved, a health benefit plan shall pay a fee to the independent review organization.

(b) Within 3 business days after receiving written notice of a request for independent review under par. (a), the health benefit plan shall submit to the independent review organization copies of all of the following:

1. Any information submitted to the health benefit plan by the insured in support of the insured's position in the internal grievance under s. 632.83.

2. The contract provisions or evidence of coverage of the health benefit plan.

3. Any other relevant documents or information used by the health benefit plan in the internal grievance determination under s. 632.83.

(c) Within 5 business days after receiving the information under par. (b), the independent review organization shall request any additional information that it requires for the review from the insured or the health benefit plan. Within 5 business days after receiving a request for additional information, the insured or health

benefit plan shall submit the information or an explanation of why the information is not being submitted.

(d) In addition to the information under pars. (b) and (c), the independent review organization may accept for consideration any typed or printed, verifiable medical or scientific evidence that the independent review organization determines is relevant, regardless of whether the evidence has been submitted for consideration at any time previously. The health benefit plan and the insured shall submit to the other party to the independent review any information submitted to the independent review organization under pars. (b) to (d).

(e) An independent review under this section may not include appearances by the insured or his or her authorized representative, any person representing the health benefit plan or any witness on behalfofeither the insured or the health benefit plan.

(f) The independent review organization shall, within 30 business days after the expiration of all time limits that apply in the matter, make a decision on the basis of the documents and information submitted under this subsection. The decision shall be in writing, signed on behalf of the independent review organization and served by personal delivery or by mailing a copy to the insured or his or her authorized representative and to the health benefit plan. A decision of an independent review organization is binding on the insured and the health benefit plan.

(g) If, in thejudgment of the insured's treating health care provider, the adverse or experimental treatment determination relates to a serious injury or impairment or a life-threatening condition, the procedure outlined in pars. (b) to (f) shall be followed with the following differences:

1. The health benefit plan shall submit the information under par. (b) within one day after receiving the notice of the request for independent review under par. (a).

2. The independent review organization shall request any additional information under par. (c) within 2 business days after receiving the information under par. (b).

3. The insured or health benefit plan shall, within 2 days after receiving a request under par. (c), submit any information requested or an explanation of why the information is not being submitted.

4. The independent review organization shall make its decision under par. (f) within 72 hours after the expiration of the time limits under this paragraph that apply in the matter.

(3m) STANDARDS FOR DECISIONS. (a) A decision of an independent review organization regarding an adverse determination must be consistent with the terms of the health benefit plan under which the adverse determination was made.

(b) A decision of an independent review organization regarding an experimental treatment determination is limited to a determination of whether the proposed treatment is experimental. The independent review organization shall determine that the treatment is not experimental and find in favor of the insured only if the independent review organization finds all of the following:

1. The insured has a terminal condition, or the insured's ability to regain or maintain maximum' function would be impaired by withholding the proposed treatment.

2. The insured has a condition for which standard treatment would not be medically indicated for the insured or for which there is no standard treatment available that would be as beneficial for the insured as the proposed treatment.

3. Scientifically valid studies using accepted protocols and published in peer reviewed literature demonstrate that the proposed treatment is likely to be more beneficial for the insured than available standard treatment.

4. The proposed treatment is not specifically excluded under the terms of the health benefit plan and would be covered except for the determination that the treatment is experimental for the insured's condition.

(4) CERTIFICATION OF INDEPENDENT REVIEW ORGANIZATIONS. (a) The commissioner shall certify independent review organizations. An independent review organization must demonstrate to the satisfaction of the commissioner that it is unbiased, as defined by the commissioner by rule. An organization certified under this paragraph must be recertified on a biennial basis to continue to provide independent review services under this section.

(b) An organization applying for certification or recertification as an independent review organization shall pay the applicable fee under s. 601.31 (1) (Lp) or (Lr). Every organization certified or recertified as an independent review organization shall file a report with the commissioner in accordance with rules promulgated under sub. (5) (a) 4.

(c) The commissioner may examine, audit or accept an audit of the books and records of an independent review organization as provided for examination of licensees and permittees under s. 601.43 (l), (3), (4) and (5), to be conducted as provided in s. 601.44, and with costs to be paid as provided in s. 601.45.

(d) The commissioner may revoke, suspend or limit in whole or in part the certification of an independent review organization, or may refuse to recertify an independent review organization, if the commissioner finds that the independent review organization is unqualified or has violated an insurance statute or rule or a valid order of the commissioner under s. 601.41 (4), or if the independent review organization's methods or practices in the conduct of its business endanger, or its financial resources are inadequate to safeguard, the legitimate interests of consumers and the public. The commissioner may summarily suspend an independent review organization's certification under s. 227.51 (3).

(5) RULES; REPORT, ADJUSTMENTS. (a) The commissioner shall promulgate rules for the independent review required under this section. The rules shall include at least all of the following:

1. The application procedures for certification and recertification as an independent review organization.

2. The standards that the commissioner will use for certifying and recertifying organizations as independent review organizations, including standards for determining whether an independent review organization is unbiased.

3. Procedures and processes, in addition to those in sub. (3), that independent review organizations must follow.

4. What must be included in the report required under sub. **(4)** and the frequency with which the report must be filed with the commissioner.

5. Standards for the practices and conduct of independent review organizations.

6. Standards, in addition to those in sub. (6), addressing conflicts of interest by independent review organizations.

7. Standards for contracts between insurers and independent review organizations.

(b) The commissioner shall annually submit a report to the legislature under s. 13.172 (2) that specifies the number of independent reviews requested under this section in the preceding year, the insurers and health benefit plans involved in the independent reviews and the dispositions of the independent reviews.

(c) To reflect changes in the consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor, the commissioner shall at least annually adjust the amounts specified in sub. (1) (a) 4. and (b) 4.

(6) **CONFLICT OF INTEREST STANDARDS.** (a) An independent review organization may not be affiliated with any of the following:

1. A health benefit plan.

2. A national, state or local trade association of health benefit plans, or an affiliate of any such association.

3. A national, state or local trade association of health care providers, or an affiliate of any such association.

(b) An independent review organization appointed to conduct an independent review and a clinical peer reviewer assigned by an independent review organization to conduct an independent review may not have a material professional, familial or financial interest with any of the following:

1. The insurer that issued the health benefit plan that is the subject of the independent review.

2. Any officer, director or management employe of the insurer that issued the health benefit plan that is the subject of the independent review.

3. The health care provider that recommended or provided the health care service or treatment that is the subject of the independent review, or the health care provider's medical group or independent practice association.

4. The facility at which the health care service or treatment that is the subject of the independent review was or would be provided.

5. The developer or manufacturer of the principal procedure, equipment, drug or device that is the subject of the independent review.

6. The insured or his or her authorized representative.

(6m) QUALIFICATIONS OF CLINICAL PEER REVIEWERS. A clinical peer reviewer who conducts a review on behalf of a certified independent review organization must satisfy all of the following requirements:

(a) Be a health care provider who is expert in treating the medical condition that is the subject of the review and who is knowledgeable about the treatment that is the subject of the review through actual clinical experience.

(b) Hold a credential, as defined in s. 440.01 (2) (a), that is not limited or restricted; or hold a license, certificate, registration or permit that authorizes or qualifies the health care provider to perform acts substantially the same as those acts authorized by a credential, as defined in s. 440.01 (2) (a), that was issued by a governmental authority in a jurisdiction outside this state and that is not limited or restricted.

(c) If a physician, hold a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the review.

(d) Have no history of disciplinary sanctions, including loss of staff privileges, taken *or* pending by the medical examining board or another regulatory body or by any hospital or government.

(7) **IMMUNITY.** (a) A certified independent review organization and a clinical peer reviewer who conducts reviews on behalf of a certified independent review organization shall not be liable in damages to any person for any opinion rendered during or at the completion of an independent review.

(b) A health benefit plan that is the subject of an independent review and the insurer that issued the health benefit plan shall not be liable in damages to any person for complying with any decision rendered by a certified independent review organization during or at the completion of an independent review.

(8) NOTICE OF SUFFICIENT INDEPENDENT REVIEW ORGANIZATIONS. The commissioner shall make a determination that a sufficient number of independent review organizations have been certified under sub. (4) to effectively provide the independent reviews required under this section and shall publish a notice in the Wisconsin Administrative Register that states a date that is 6 months after the commissioner makes that determination. The date stated in the notice shall be the date on which the independent review procedure under this section begins operating.

(9) **APPLICABILITY.** The independent review required under this section shall be available to an insured who receives notice of the disposition of his or her grievance under s. 632.83 (3) (d) on or after the first day of the 7th month beginning after the effective date of this subsection . . . . [revisor inserts date]. Notwithstanding sub. (2) (c), an insured who receives notice of the disposition of his or her grievance under s. 632.83 (3) (d) on or after the first day of the 7th month beginning after the effective date of this subsection . . . . [revisor inserts date], but before the date stated in the notice published by the commissioner in the Wisconsin Administrative Register under sub. (8) . . . . [revisor inserts date], must request an independent review no later

than 4 months after the date stated in the notice published by the commissioner in the Wisconsin Administrative Register under sub. (8) . . . . [revisor inserts date].

SECTION 20. Nonstatutory provisions.

(1) **RULES REGARDING INDEPENDENT REVIEW.**

(a) The commissioner of insurance shall submit in proposed form the rules required under section 632.835 (5) (a) of the statutes, as created by this act, to the legislative council staff under section 227.15 (1) of the statutes no later than the first day of the 7th month beginning after the effective date of this paragraph.

(b) Using the procedure under section 227.24 of the statutes, the commissioner of insurance shall promulgate rules required under section 632.835 (5) (a) of the statutes, as created by this act, for the period before the effective date of the permanent rules promulgated under section 632.835 (5) (a) of the statutes, as created by this act, but not to exceed the period authorized under section 227.24 (1) (c) and (2) of the statutes. Notwithstanding section 227.24 (1) (a), (2) (b) and (3) of the statutes, the commissioner is not required to provide evidence that promulgating a rule under this paragraph as an emergency rule is necessary for the preservation of the public peace, health, safety or welfare and is not required to provide a finding of emergency for a rule promulgated under this paragraph.

SECTION 21. Effective dates. This act takes effect on the day after publication, except as follows:

(1) The treatment of sections 609.15 (1) (intro.), (a), (b) and (c) and (2) (intro.), (a), (b), (c), (d) and (e) and 632.83 of the statutes takes effect on the first day of the 7th month beginning after publication.

(2) The treatment of section 632.835 (2), (3), (3m) and (5) (b) and (c) of the statutes takes effect on the date stated in the notice published by the commissioner

of insurance in the Wisconsin Administrative Register under section 632.835 (8) of the statutes, as created by this act.

(END)

INSERT A (Analysis for 13)

Under current law, every managed care plan is required to have an internal grievance procedure under which an enrollee may submit a written grievance and a grievance panel must investigate the grievance and, if appropriate, take corrective action. This bill requires every health benefit plan to have such an internal grievance procedure. In addition, the bill requires every health benefit plan, including managed care plans and plans covering state and municipal employes, to have an independent review procedure for review of certain decisions under the health benefit plan's internal grievance procedure that are adverse to insureds. The decision must relate to the plan's denial of treatment or payment for treatment that the plan determined was experimental or to the plan's denial, reduction or termination of a health care service or payment for a health care service, including admission to or continued stay in a health care facility, on the basis that the health care service did not meet the plan's requirements for medical necessity or appropriateness, health care setting or level of care or effectiveness. In order to be eligible for independent review, the amount of the reduction or the value of the denied or terminated service must be at least $500, which may be increased or decreased by the commissioner of insurance (commissioner) based on changes in the consumer price index. Generally, an insured must request independent review within four months after receiving notice of the adverse decision on his or her grievance under the internal grievance procedure.

Under the bill, an independent review may be conducted only by an independent review organization that has been certified by the commissioner. A certified independent review organization must be recertified every two years to continue to conduct independent reviews. The commissioner may revoke, suspend or limit the certification of an independent review organization for various reasons specified in the bill. Clinical peer reviewers, who conduct the reviews on behalf of independent review organizations, must be health care providers who satisfy specified criteria, including having expertise through actual clinical experience in treating the condition that is the subject of the review. Every insurer that issues a health benefit plan must contract with one or more certified independent review organizations for the purpose of conducting the independent reviews in which the plan is involved. A contract must be at least two years long, and an insurer must inform the commissioner if such a contract is not renewed and of the reasons for the nonrenewal.

To request an independent review, an insured must provide written notice of the request to the health benefit plan, which must inform the commissioner of the request and inform the insured of the name and address of the independent review organization that will be conducting the independent review. The insured must pay $50 to the independent review organization, which is refunded to the insured if he or she prevails, in whole or in part, in the independent review. In addition, the plan must pay a fee to the independent review organization for each review.

Within three days after receiving the notice from the insured, the health benefit plan must send to the independent review organization all of the information that

it used in making the determination in the internal grievance procedure. No later than five days after receiving that information, the independent review organization may request more information from either or both parties, who have five more days in which to supply the requested information. The independent review organization may consider, however, any other relevant information, and any information that a party provides to the independent review organization must also be provided to the other party. Within 30 days after the expiration of all relevant time limits in the matter, the independent review organization must make a determination on the basis of the written information submitted by the parties. If an expedited review is required because of the enrollee's medical condition, all specified time limits are shortened, and the independent review organization must make a determination within 72 hours after the expiration of all relevant time limits in the matter. The bill specifies certain review standards for independent review organizations, including under what circumstances treatment that was considered experimental by the health benefit plan must be covered. The decision at the conclusion of an independent review, which is binding on the insured and the health benefit plan, must be in writing and served on both parties.

The bill contains prohibitions aimed at avoiding conflicts of interest for independent review organizations, such as prohibiting an independent review organization from owning, controlling or being a subsidiary of a health benefit plan or an association of health benefit plans. The bill also provides independent review organizations and clinical peer reviewers with immunity from liability for decisions made in independent reviews.

The bill requires the commissioner to promulgate rules relating to such topics as the application procedures and standards for certification and recertification of independent review organizations, additional procedures and processes that independent review organizations must use in independent reviews, standards for the practices and conduct of independent review organizations and additional standards related to conflicts of interest.

Finally, the bill requires the commissioner to determine when a sufficient number of independent review organizations have been certified to effectively provide the independent reviews required under the bill. When the commissioner makes that determination, the commissioner must publish a notice in the Wisconsin Administrative Register that specifies a date that is six months after the determination is made. That date is the date on which the independent review procedure must begin operating.

For further information ***see*** the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

SUBMITTAL .FORM

LEGISLATIVE REFERENCE BUREAU
Legal Section Telephone: 266-3561
5th Floor, 100 N. Hamilton Street

The attached draft is submitted for your inspection. Please check each part carefully, proofread each word, and **sign** on the appropriate line(s) below.

Date: 09/20/1999

To: Representative Underheim

Relating to LRB drafting number: LRB-23 13

Topic
Require independent review for grievances by insureds regarding medical necessity determinations

Subject(s)
Insurance - health

1. **JACKET** the draft for introduction _____

   in the **Senate** or the **Assembly** X (check only one). Only the requester under whose name the drafting request is entered in the LRB's drafting records may authorize the draft to be submitted. Please allow one day for the preparation of the required copies.

2. **REDRAFT.** See the changes indicated or attached _____

   A revised draft will be submitted for your approval with changes incorporated.

3. Obtain **FISCAL ESTIMATE NOW,** prior to introduction _____

   If the analysis indicates that a fiscal estimate is required because the proposal makes an appropriation or increases or decreases existing appropriations or state or general local government fiscal liability or revenues, you have the option to request the fiscal estimate prior to introduction. If you choose to introduce the proposal without the fiscal estimate, the fiscal estimate will be requested automatically upon introduction. It takes about 10 days to obtain a fiscal estimate. Requesting the fiscal estimate prior to introduction retains your flexibility for possible redrafting of the proposal.

If you have any questions regarding the above procedures, please call 266-3561. If you have any questions relating to the attached draft, please feel free to call me.

Pamela J. Kahler, Senior Legislative Attorney
Telephone: (608) 266-2682