2011 DRAFTING REQUEST

Bill

Received: **10/31/2011**

Received By: **pkahler**

Wanted: **As time permits**

Companion to LRB:

For: **Jon Erpenbach (608) 266-6670**

By/Representing: **Kelly Becker**

May Contact:

Drafter: **pkahler**

Subject: **Insurance - health**

Addl. Drafters:

Extra Copies:

Submit via email: **YES**

Requester's email: **Sen.Erpenbach@legis.wisconsin.gov**

Carbon copy (CC:) to: **laura.rose@legis.wisconsin.gov**
Christian.Moran@legis.wisconsin.gov

Pre Topic:

No specific pre topic given

Topic:

External review process for health insurance

Instructions:

See attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	pkahler 11/18/2011	mduchek 12/09/2011		_____ _____			State
/P1			phenry 12/09/2011	_____ _____	lparisi 12/09/2011		State
/P2	pkahler 12/23/2011	mduchek 12/28/2011	jmurphy 01/03/2012	_____ _____	ggodwin 01/03/2012		State
/1	pkahler	mduchek	jmurphy	_____	sbasford	mbarman	

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
	01/11/2012	01/30/2012	01/30/2012	_____	01/30/2012	02/13/2012	

FE Sent For:

<END>

at intro
3/6

2011 DRAFTING REQUEST

Bill

Received: **10/31/2011**

Received By: **pkahler**

Wanted: **As time permits**

Companion to LRB:

For: **Jon Erpenbach (608) 266-6670**

By/Representing: **Kelly Becker**

May Contact:

Drafter: **pkahler**

Subject: **Insurance - health**

Addl. Drafters:

Extra Copies:

Submit via email: **YES**

Requester's email: **Sen.Erpenbach@legis.wisconsin.gov**

Carbon copy (CC:) to: **laura.rose@legis.wisconsin.gov**
Christian.Moran@legis.wisconsin.gov

Pre Topic:

No specific pre topic given

Topic:

External review process for health insurance

Instructions:

See attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	pkahler 11/18/2011	mduchek 12/09/2011		_____ _____			State
/P1			phenry 12/09/2011	_____ _____	lparisi 12/09/2011		State
/P2	pkahler 12/23/2011	mduchek 12/28/2011	jmurphy 01/03/2012	_____ _____	ggodwin 01/03/2012		State
/1	pkahler	mduchek	jmurphy	_____	sbasford		

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
	01/11/2012	01/30/2012	01/30/2012	_____	01/30/2012		

FE Sent For:

<END>

2011 DRAFTING REQUEST

Bill

Received: **10/31/2011**

Received By: **pkahler**

Wanted: **As time permits**

Companion to LRB:

For: **Jon Erpenbach (608) 266-6670**

By/Representing: **Kelly Becker**

May Contact:

Drafter: **pkahler**

Subject: **Insurance - health**

Addl. Drafters:

Extra Copies:

Submit via email: **YES**

Requester's email: **Sen.Erpenbach@legis.wisconsin.gov**

Carbon copy (CC:) to: **laura.rose@legis.wisconsin.gov**
Christian.Moran@legis.wisconsin.gov

Pre Topic:

No specific pre topic given

Topic:

External review process for health insurance

Instructions:

See attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	pkahler 11/18/2011	mduchek 12/09/2011		_____ _____			State
/P1			phenry 12/09/2011	_____ _____	lparisi 12/09/2011		State
/P2	pkahler 12/23/2011	mduchek 12/28/2011	jmurphy 01/03/2012	_____ _____	ggodwin 01/03/2012		

11/30/12 jm 1/30/12 jm+PH 1/30

FE Sent For:

<END>

2011 DRAFTING REQUEST

Bill

Received: **10/31/2011**

Received By: **pkahler**

Wanted: **As time permits**

Companion to LRB:

For: **Jon Erpenbach (608) 266-6670**

By/Representing: **Kelly Becker**

May Contact:

Drafter: **pkahler**

Subject: **Insurance - health**

Addl. Drafters:

Extra Copies:

Submit via email: **YES**

Requester's email: **Sen.Erpenbach@legis.wisconsin.gov**

Carbon copy (CC:) to: **laura.rose@legis.wisconsin.gov**

Pre Topic:

No specific pre topic given

Topic:

External review process for health insurance

Instructions:

See attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	pkahler 11/18/2011	mduchek 12/09/2011		_____ _____			State
/P1			phenry 12/09/2011	_____ _____	lparisi 12/09/2011		

FE Sent For:

/P2 MD 12/7/11 JM 12/29 kmm 1/3/11 <END>

2011 DRAFTING REQUEST

Bill

Received: **10/31/2011**

Received By: **pkahler**

Wanted: **As time permits**

Companion to LRB:

For: **Jon Erpenbach (608) 266-6670**

By/Representing: **Kelly Becker**

May Contact:

Drafter: **pkahler**

Subject: **Insurance - health**

Addl. Drafters:

Extra Copies:

Submit via email: **YES**

Requester's email: **Sen.Erpenbach@legis.wisconsin.gov**

Carbon copy (CC:) to: * Laura.Rose@legis.wisconsin.gov

Pre Topic:

No specific pre topic given

Topic:

External review process for health insurance

Instructions:

See attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	pkahler	12/9/11					
FE Sent For:		/P1		<END>			

10-31

let Kelly know what decisions need to be made as I go along

use 6-point deficient process (NAIC-similar)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

July 29, 2011

The Honorable Ted Nickel
Insurance Commissioner
P.O. Box 7873
Madison, WI 53707-7873

Re: State External Review Process Determination

Dear Commissioner Nickel:

This letter follows up on our discussions with your office regarding Wisconsin's external review laws. The Affordable Care Act ensures that all health care insurance consumers have access to strong external review processes under section 2719 of the Public Health Service Act (PHS Act).[1] In implementing this provision, the Departments of Health and Human Services (HHS), Labor, and the Treasury (the Departments) have focused on ensuring that State external review processes can be maintained to the extent possible.[2] Over the past year, we have actively worked with States to provide guidance and assist States seeking to amend their external review processes to meet federal requirements.

Through this process, the Departments have established two categories of State external review processes that will satisfy these statutory standards: 1) a State external review process that meets the 16 minimum consumer protections described in paragraph (c)(2) of the regulations as authorized under section 2719(b)(1) of the PHS Act (hereinafter referred to as "NAIC-parallel process"); or 2) a State external review process that meets the minimum standards established by the Secretary of Health and Human Services through guidance under section 2719(b)(2) (hereinafter referred to as "NAIC-similar process").[3]

We applaud your efforts and progress to date to provide a strong external review process. After reviewing the State of Wisconsin's external review process, the Center for Consumer Information and Insurance Oversight (CCIIO) has determined that it does not meet all of the standards of the NAIC-parallel process or the NAIC-similar process. In the attachment to this letter, CCIIO summarizes the components of Wisconsin's external review process that do not meet the components of an NAIC-parallel process or an NAIC-similar process.

[1] Section 2719 does not apply to grandfathered health plans. See interim final regulations regarding status of a group health plan or health insurance coverage as a grandfathered plan under section 1251 of the Affordable Care Act issued on June 17, 2010 (75 FR 34538), amended on November 17, 2010(75 FR 70114).

[2] Regulations implementing PHS Act section 2719 were published on July 23, 2010, at 75 FR 43330, and amended on June 24, 2011, at 76 FR 37208.

[3] HHS established these minimum standards in Technical Release 2011-02 on June 22, 2011, which can be found at: http://cciio.cms.gov/resources/files/appeals_srg_06222011.pdf . Beginning January 1, 2014, issuers of non-grandfathered health insurance plans and policies in a State with an external review process that does not satisfy the standards of the NAIC-parallel process will need to participate in a federally administered process.

We remain committed to working in partnership with your State to strengthen your external review process. Our goal is to ensure external reviews are conducted under State law, and we will provide whatever assistance we can to work with you and your State in the weeks ahead to meet that goal.

You may request that CCIIO re-evaluate your external review process. To do so, please send a letter to the attention of Ellen Kuhn, Director of the Appeals program in CCIIO at the Centers for Medicare & Medicaid Services (CMS) at externalappeals@cms.hhs.gov within 30 days of receipt of this determination letter. Please include the reason(s) why you believe that Wisconsin's external review process does meet the NAIC-parallel or NAIC-similar standards along with supporting documentation that you would like CCIIO to consider. CCIIO will re-evaluate Wisconsin's external review process and issue a redetermination within 30 days of receipt of your completed re-evaluation request.

If Wisconsin does not request a re-evaluation of the finding outlined in this letter, this finding is a final determination. We are aware that Wisconsin intends to put forth a "technical bill" that will be considered at the first floor session in September. If Wisconsin changes its external review process in the future, Wisconsin may request a new determination at any time.

Once a determination that Wisconsin's external review process does not meet federal minimum standards is final, all issuers of non-grandfathered health insurance plans and policies in Wisconsin's group and individual market will be subject to the Federally-administered external review process. These issuers may continue to follow the Wisconsin external review process during a transition period, but must make good faith efforts to come into compliance with federal law (e.g., inform HHS of Federal external review process elections, make appropriate modifications to consumer notices, etc.) and be fully participating in a Federally-administered external review process on January 1, 2012.

Please direct the health insurance issuers in your State to Technical Release 2011-02 as well as to the additional guidance on the CCIIO website ("Instructions for self-insured non-federal governmental health plans and health insurance issuers offering group and individual health coverage on how to elect a federal external review process") for more information on the Federally-administered external review process.[4]

As always, CCIIO welcomes questions from state regulators and remains available to provide technical assistance on proposed modifications to the external review processes. Please feel free to contact Veronica Morales at Veronica.Morales@cms.hhs.gov with any questions or concerns.

Sincerely,

Steve Larsen, Director
Center for Consumer Information and Insurance Oversight

cc: Julie Walsh

[4] Guidance is available at http://cciio.cms.gov/resources/files/hhs_srg_elections_06222011.pdf

Attachment – State of Wisconsin

Summary of Components – NAIC-Parallel Process

Please note that in addition to the summary below, the precise requirements of the NAIC-parallel process may be found at 45 CFR 147.136 and the exact paragraphs are noted in each bullet for your convenience.

The State of Wisconsin's external review process does not meet the required components of an NAIC-parallel process as follows:

- Under the NAIC-parallel process standard, if exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary if – (a) the issuer (or plan) waives the exhaustion requirement; (b) the issuer (or plan) is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process except those failures that are based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimants; or (c) the claimant simultaneously requests an expedited internal appeal and an expedited external review. (*See* 45 CFR 147.136 (c)(2)(iii)). Wisconsin does not have a provision that allows exhaustion of the internal appeals process in cases where the issuer fails to meet the internal appeals process requirements.
- Under the NAIC-parallel process standard, there cannot be any restriction on the minimum dollar amount of a claim in order for it to be eligible for external review. (*See* 45 CFR 147.136 (c)(2)(v)). Wisconsin requires claims be worth at least two hundred and fifty dollars to be eligible for external review.
- Under the NAIC-parallel process standard, the State process must provide that IROs will be assigned on a random basis or another method of assignment that assures the independence and impartiality of the assignment process (such as rotational assignment) by a State or independent entity, and in no event selected by the issuer, plan or the individual. (*See* 45 CFR 147.136 (c)(2)(vii)). Wisconsin allows the insured to select an IRO from a list provided to him/her in the denial notice.
- Under the NAIC-parallel process standard, the State process must provide for the maintenance of a list of approved IROs (only those that are accredited by a nationally recognized private accrediting organization) qualified to conduct the external review based on the nature of the health care service that is the subject of the review. (*See* 45 CFR 147.136 (c)(2)(viii)). Wisconsin has no provision requiring the use of accredited independent review organizations (IROs) to conduct external reviews.
- Under the NAIC-parallel process standard, claimants must be allowed to submit to the IRO additional information in writing that the IRO must consider when conducting the external review, and the claimant must be notified of the right to submit additional information to the IRO; the IRO must allow the claimant at least 5 business days to submit any additional information and any additional information submitted by the claimant must be forwarded to the issuer (or plan) within one business day of receipt by the IRO. (*See* 45 CFR 147.136 (c)(2)(x)). Wisconsin does have a provision governing the submission of additional evidence by claimants.

However, it does not include the specific requirements of the federal minimum standard.

- Under the NAIC-parallel process standard, for standard external review, the IRO must provide written notice to the issuer (or plan) and the claimant of its decision to uphold or reverse the adverse benefit determination within no more than 45 days after the receipt of the request for external review. (*See* 45 CFR 147.136 (c)(2)(xii)). Wisconsin's statutory structure for standard review refers to a series of business days between the date of referral for external review and the 30-day period for review and determination. A decision under the standard external review may fall within the 45-day period. However, the existing structure does not guarantee completion within the 45 days.
- Under the NAIC-parallel process standard, the State process must provide for an expedited external review in certain circumstances and, in such cases, provide notice of the decision as expeditiously as possible, but not later than 72 hours after receipt of the request for external review (and if notice of the IRO's decision is not in writing, the IRO must provide written confirmation of its decision within 48 hours after the date of the notice of the decision). (*See* 45 CFR 147.136 (c)(2)(xiii)). For urgent care claims on expedited external review, the IRO decision must be made 72 hours after the expiration of certain time limits that begin upon receipt of the request for external review, including 2 business days to request additional information and then 2 days after the insurer receives that request to submit the additional information.
- Under the NAIC-parallel process standard, issuers (or plans) must provide a description of the external review process in or attached to the summary plan descriptions, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to participants, beneficiaries, or enrollees, substantially similar to section 17 of the NAIC Uniform Model Act. (*See* 45 CFR 147.136 (c)(2)(xiv)). Wisconsin does not have a provision that requires issuers to provide notice of the right to external review in their summary plan descriptions and plan materials.
- Under the NAIC-parallel process standard, the State process must follow procedures for external reviews involving experimental or investigational treatment, substantially similar to section 10 of the NAIC Uniform Model Act. (*See* 45 CFR 147.136 (c)(2)(xvi)). Wisconsin does not have a provision that provides external review of claims involving experimental or investigational treatment determinations, except for the limited determination of whether the proposed treatment is experimental.

(6) The State of Wisconsin's external review process does not meet the required components of an NAIC-similar process as follows: 6 deficient areas

- Under the NAIC-similar process standard, if exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary if – (a) the internal appeal process timelines are not met; or (b) in an urgent care situation, the claimant files for an external review without having exhausted the internal appeal process. These requirements may not be articulated in a State's external review statute ~~but~~ but may be established in other areas of State law, rules, or procedures – for example, those that apply to internal appeals, claims payment practices, or other areas of State oversight. Wisconsin's exception to the requirement that the internal appeal process

must be exhausted before external review do not include the exception when the internal appeal process timelines are not met.

- Under the NAIC-similar process standard, there cannot be any restriction on the minimum dollar amount of a claim in order to be eligible for external review. Wisconsin requires claims be at least two hundred fifty dollars to be eligible for external review.

- Under the NAIC-similar process standard, the State process must provide for the IRO to be assigned impartially. The claimant and issuer (or plan) should have no discretion as to the IRO that is chosen. In Wisconsin, the IRO is selected by the insured from a list of certified IROs provided in the notice to the insured.

- Under the NAIC-similar process standard, for standard external reviews (those not involving urgent care), the IRO must inform the issuer and the claimant, in writing, of its decision within 60 days from receipt of the request for external review. Wisconsin's statutory structure for standard review refers to a series of business days between the date of referral for external review and the 30-day period for review and determination. A decision under the standard external review may fall within the 60-day period. However, the existing structure does not guarantee completion within the 60 days.

- Under the NAIC-similar process standard, the process must provide for expedited external review of urgent care claims. In such cases, the IRO must inform the issuer and the claimant of an urgent care decision within four business days or less (depending on medical exigencies of the case) from receipt of the request for review. If the IRO's decision was given orally, the IRO must provide written notice of its decision within 48 hours of the oral notification. In Wisconsin's provision for urgent care claims on expedited external review, the IRO decision must be made 72 hours after the expiration of certain time limits that begin upon receipt of the request for external review, including 2 business days to request additional information and then 2 days after the insurer receives that request to submit the additional information.

- Under the NAIC-similar process standard, the process must provide for external review of adverse benefit determinations (and final internal adverse benefit determinations) involving experimental or investigational treatments or services and must have at least all of the protections that are available for external reviews based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. Wisconsin does not have a provision that provides external review of claims involving experimental or investigational treatment determinations, except for the limited determination of whether the proposed treatment is experimental.

State of Wisconsin
2011 - 2012 LEGISLATURE

LRB-3368/P1
PJK:...
fred

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** external review process of health benefit plan decisions.

Analysis by the Legislative Reference Bureau

This is a preliminary draft. An analysis will be provided in a subsequent version of this draft.

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

SECTION 1. 632.835 (1) (a) 4. of the statutes is repealed.

SECTION 2. 632.835 (1) (b) 2. of the statutes is amended to read:

632.835 **(1)** (b) 2. Based on the information provided, the treatment under subd. 1. is determined to be experimental or investigational under the terms of the health benefit plan.

History: 1999 a. 155; 2001 a. 65; 2009 a. 28, 276.

SECTION 3. 632.835 (1) (b) 4. of the statutes is repealed.

SECTION 4. 632.835 (2) (b) of the statutes is amended to read:

632.835 **(2)** (b) If a coverage denial determination is made, the insurer involved in the determination shall provide notice to 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. The notice shall include a current listing of independent review organizations certified under sub. (4). An independent review under this section may be conducted only by an independent review organization certified under sub. (4) and selected by the ~~insured~~ commissioner under sub. (3) (a).

History: 1999 a. 155; 2001 a. 65; 2009 a. 28, 276.

SECTION 5. 632.835 (2) (d) 2. of the statutes is amended to read:

632.835 **(2)** (d) 2. ~~Along with the notice to the insurer of the request for~~ After receiving notice of the independent review organization selected by the commissioner under sub. (3) (a), the insured submits to the independent review organization ~~selected by the insured~~ a request to bypass the internal grievance procedure under s. 632.83 and the independent review organization determines that the health condition of the insured is such that requiring the insured to use the internal grievance procedure before proceeding to independent review would jeopardize the life or health of the insured or the insured's ability to regain maximum function.

History: 1999 a. 155; 2001 a. 65; 2009 a. 28, 276.

****NOTE: This could operate differently, depending on how you want the notices to be given. (See the NOTE after s. 632.835 (3) (a).)

SECTION 6. 632.835 (2) (d) 3. of the statutes is created to read:

632.835 **(2)** (d) 3. The insurer or another entity other than the insured does not meet all of the timeline requirements, if any, under the internal grievance procedure under s. 632.83.

SECTION 7. 632.835 (3) (a) of the statutes is amended to read:

632.835 **(3)** (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~~, and of the independent review organization selected,~~ to the commissioner and to the insurer that made or on whose behalf was made the coverage denial determination. The ~~insurer shall immediately notify the~~ commissioner ~~and the~~ immediately shall, on a random basis, select an independent review organization ~~selected by the insured of the request for independent review~~ certified under sub. (4) to conduct the independent review based on the subject of the review and other circumstances, including any conflict of interest concerns, and shall notify the independent review organization, the insured, or his or her authorized representative, and the insurer of the independent review organization selected. For each independent review in which it is involved, an insurer shall pay a fee to the independent review organization.

History: 1999 a. 155; 2001 a. 65; 2009 a. 28, 276.

****NOTE: This is one possibility for how the process would work with the commissioner selecting the IRO. You could also have the insured notify the commissioner of the request for independent review; the commissioner could then select the IRO and notify the insured, who could then notify the insurer. Either the commissioner or the insurer could notify the IRO.

SECTION 8. 632.835 (3) (f) 1. of the statutes is renumbered 632.835 (3) (f) 1. a. and amended to read:

632.835 **(3)** (f) 1. a. If the independent review is not terminated under par. (e), 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 insurer.

2. a. Except as provided in subd. 2. b., a decision of an independent review organization is binding on the insured and the insurer.

History: 1999 a. 155; 2001 a. 65; 2009 a. 28, 276.

SECTION 9. 632.835 (3) (f) 1. b. of the statutes is created to read:

632.835 **(3)** (f) 1. b. Notwithstanding subd. 1. a., in no case may the written decision under subd. 1. a. be served or mailed to the insured, or his or her authorized representative, or to the insurer more than 60 calendar days after the insured or his or her authorized representative provided notice of the request for independent review under par. (a).

SECTION 10. 632.835 (3) (f) 2. of the statutes is renumbered 632.835 (3) (f) 2. b.

SECTION 11. 632.835 (3) (g) of the statutes is repealed and recreated to read:

632.835 **(3)** (g) 1. If the independent review organization determines that the health condition of the insured is such that following the procedure outlined in pars. (b) to (f) would jeopardize the life or health of the insured or the insured's ability to regain maximum function, the independent review organization shall follow an expedited process and notify the insured, or his or her authorized representative, and the insurer of its decision no more than 4 business days after receiving the notice of the request for independent review under par. (a).

****NOTE: It's not clear when the "4 business days" begins running. Is it when the commissioner receives the notice of the request for independent review, or is it when the IRO receives notice that it has been selected? It depends on the notice timeline that applies in the procedure.

2. If the notice of its decision under subd. 1. is not in writing, the independent review organization shall provide written confirmation of its decision within 48 hours after the date of the notice of the decision under subd. 1.

SECTION 12. 632.835 (3m) (b) (intro.) of the statutes is amended to read:

632.835 **(3m)** (b) (intro.) ~~A~~ With respect to 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,~~ 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:

History: 1999 a. 155; 2001 a. 65; 2009 a. 28, 276.

****NOTE: I do not know if the way in which s. 632.835 (3m) (b) is amended is sufficient. The summary stated that the process "must have at least all of the protections that are available for external reviews [of adverse determinations]." Our statutes do not explicitly provide for any "protections" for any of the types of external review. OCI is required to promulgate rules under s. 632.835 (5) (a) 3.v

SECTION 13. 632.835 (5) (c) of the statutes is repealed.

(END)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-3368/P1dn
PJK:...
med

Date

Insert D-N1

Insert D-N2

This is a rough first draft that attempts to address each of the six areas of our independent (external) review process that are not in compliance with the NAIC-similar process standard. In this draft, in compliance with that standard, the commissioner, rather than the insured, selects the independent review organization (IRO). This change in our procedure may affect the required timelines. For example, under current law, the insured selects an IRO and notifies the insurer both of the request for independent review (IR) and of the IRO selected. The insurer then notifies the commissioner. In this draft, the insured notifies the commissioner and the insurer of the request for IR, the commmissioner then selects an IRO and notifies the insured, the insurer, and the IRO. (There are, of course, other possibilities.) The timelines within which the IRO must make decisions generally run in relation to the notice of the request for review. Is that the notice from the insured to the commissioner or the notice from the commissioner to the IRO? Under the bill as it is currently drafted, the decision in the normal IR must be served or mailed no more than 60 days after notice was given to the commissioner by the insured; the decision in the expedited IR, however, must be provided within four business days after the IRO received notice of the IR from the commissioner.

Another possible problem area is the procedure used for review of experimental determinations. Under the NAIC-similar process standard, experimental determinations must be reviewed with "all of the protections" of adverse determination reviews. The statutes, however, do not specify procedures for any of the types of IR.

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266-2682
E-mail: pam.kahler@legis.wisconsin.gov

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-3368/P1dn insert
PJK:.....

INSERTS

Insert D-N1: and has five business days from the date of receiving notice of the request for IR from the insured to submit copies of various types of information to the IRO

Insert D-N2: Is it still reasonable to require the insurer to submit information to the IRO within five days of receiving notice of the request for IR since the commissioner must first select an IRO after receiving the notice of the request at the same time as the insurer? → , or should the five-day timeline start when the insurer receives notice of which IRO is selected

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-3368/P1dn
PJK:med:ph

December 9, 2011

This is a rough first draft that attempts to address each of the six areas of our independent (external) review process that are not in compliance with the NAIC-similar process standard. In this draft, in compliance with that standard, the commissioner, rather than the insured, selects the independent review organization (IRO). This change in our procedure may affect the required timelines. For example, under current law, the insured selects an IRO and notifies the insurer both of the request for independent review (IR) and of the IRO selected. The insurer then notifies the commissioner and has five business days from the date of receiving notice of the request for IR from the insured to submit copies of various types of information to the IRO. In this draft, the insured notifies the commissioner and the insurer of the request for IR, the commissioner then selects an IRO and notifies the insured, the insurer, and the IRO. (There are, of course, other possibilities.) Is it still reasonable to require the insurer to submit information to the IRO within five days of receiving notice of the request for IR since the commissioner must first select an IRO after receiving the notice of the request at the same time as the insurer, or should the five-day timeline start when the insurer receives notice of which IRO is selected? The timelines within which the IRO must make decisions generally run in relation to the notice of the request for review. Is that the notice from the insured to the commissioner or the notice from the commissioner to the IRO? Under the bill as it is currently drafted, the decision in the normal IR must be served or mailed no more than 60 days after notice was given to the commissioner by the insured; the decision in the expedited IR, however, must be provided within four business days after the IRO received notice of the IR from the commissioner.

Another possible problem area is the procedure used for review of experimental determinations. Under the NAIC-similar process standard, experimental determinations must be reviewed with "all of the protections" of adverse determination reviews. The statutes, however, do not specify procedures for any of the types of IR.

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266-2682
E-mail: pam.kahler@legis.wisconsin.gov

Kahler, Pam

From: Rose, Laura
Sent: Wednesday, December 21, 2011 4:31 PM
To: Kahler, Pam
Cc: Moran, Christian; Becker, Kelly
Subject: FW: Draft review: LRB 11-3368/P1 Topic: External review process for health insurance
Attachments: LRB-3368_P1; LRB-3368_P1 Drafters_Note

Hi Pam,

I sat down with Kelly Becker from Senator Erpenbach's office yesterday to talk about LRB:3368/P1. We went over the drafter's note and your questions.

SECTION 5 seems to work fine; I would keep it as is. Also, SECTION 7 should be kept as is. It seems that this process is more streamlined than the alternative suggested in the note to that section.

With regard to the note after SECTION 11: I checked some other states that have the appropriate IR process and they seem to indicate that the 4 business days begins running when the IRO receives notice that it has been selected.

Finally, with regard to the note after SECTION 12: I think the statute relating to external reviews of experimental treatment determinations should be amended to explicitly provide for the protections available for external reviews of adverse determinations.

If you could draft a /P2 of this, that would be great. Kelly is on maternity leave as of today, and she has asked Christian Moran of Rep. Richards' office to be involved during her absence, which is why I copied him on this email. Please let me know if you have any questions or want to discuss this.

Thanks Pam, happy holidays!

Laura

Laura D. Rose, Deputy Director

Wisconsin Legislative Council

One East Main Street, Suite 401

PO Box 2536

Madison, WI 53701-2536

tel: 608.266.9791

fax: 608.266.3830

laura.rose@legis.wisconsin.gov

should "5 business" days begin to run when insurer receives notice of IRO selected?

From: LRB.Legal
Sent: Friday, December 09, 2011 1:42 PM
To: Rose, Laura
Subject: Draft review: LRB 11-3368/P1 Topic: External review process for health insurance

Draft Requester: Jon Erpenbach

Following is the PDF version of draft LRB 11-3368/P1 and drafter's note.

State of Wisconsin
2011 - 2012 LEGISLATURE

LRB-3368/P2
PJK:med:ph

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

AN ACT ***to repeal*** 632.835 (1) (a) 4., 632.835 (1) (b) 4. and 632.835 (5) (c); ***to renumber*** 632.835 (3) (f) 2.; ***to renumber and amend*** 632.835 (3) (f) 1.; ***to amend*** 632.835 (1) (b) 2., 632.835 (2) (b), 632.835 (2) (d) 2., 632.835 (3) (a) and 632.835 (3m) (b) (intro.); ***to repeal and recreate*** 632.835 (3) (g); and ***to create*** 632.835 (2) (d) 3. and 632.835 (3) (f) 1. b. of the statutes; **relating to:** external review process of health benefit plan decisions.

Analysis by the Legislative Reference Bureau

This is a preliminary draft. An analysis will be provided in a subsequent version of this draft.

For further information see the ***state*** 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. 632.835 (1) (a) 4. of the statutes is repealed.

SECTION 2. 632.835 (1) (b) 2. of the statutes is amended to read:

632.835 **(1)** (b) 2. Based on the information provided, the treatment under subd. 1. is determined to be experimental or investigational under the terms of the health benefit plan.

SECTION 3. 632.835 (1) (b) 4. of the statutes is repealed.

SECTION 4. 632.835 (2) (b) of the statutes is amended to read:

632.835 **(2)** (b) If a coverage denial determination is made, the insurer involved in the determination shall provide notice to 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. The notice shall include a current listing of independent review organizations certified under sub. (4). An independent review under this section may be conducted only by an independent review organization certified under sub. (4) and selected by the ~~insured~~ commissioner under sub. (3) (a).

SECTION 5. 632.835 (2) (d) 2. of the statutes is amended to read:

632.835 **(2)** (d) 2. ~~Along with the notice to the insurer of the request for~~ After receiving notice of the independent review organization selected by the commissioner under sub. (3) (a), the insured submits to the independent review organization ~~selected by the insured~~ a request to bypass the internal grievance procedure under s. 632.83 and the independent review organization determines that the health condition of the insured is such that requiring the insured to use the internal grievance procedure before proceeding to independent review would jeopardize the life or health of the insured or the insured's ability to regain maximum function.

****NOTE: This could operate differently, depending on how you want the notices to be given. (See the NOTE after s. 632.835 (3) (a).)

SECTION 6. 632.835 (2) (d) 3. of the statutes is created to read:

632.835 **(2)** (d) 3. The insurer or another entity other than the insured does not meet all of the timeline requirements, if any, under the internal grievance procedure under s. 632.83.

SECTION 7. 632.835 (3) (a) of the statutes is amended to read:

632.835 **(3)** (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~~, and of the independent review organization selected~~, to the commissioner and to the insurer that made or on whose behalf was made the coverage denial determination. The ~~insurer shall immediately notify the~~ commissioner ~~and the~~ immediately shall, on a random basis, select an independent review organization ~~selected by the insured of the request for independent review~~ certified under sub. (4) to conduct the independent review based on the subject of the review and other circumstances, including any conflict of interest concerns, and shall notify the independent review organization, the insured or his or her authorized representative, and the insurer of the independent review organization selected. For each independent review in which it is involved, an insurer shall pay a fee to the independent review organization.

****NOTE: This is one possibility for how the process would work with the commissioner selecting the IRO. You could also have the insured notify the commissioner of the request for independent review; the commissioner could then select the IRO and notify the insured, who could then notify the insurer. Either the commissioner or the insurer could notify the IRO.

SECTION 8. 632.835 (3) (f) 1. of the statutes is renumbered 632.835 (3) (f) 1. a. and amended to read:

632.835 **(3)** (f) 1. a. If the independent review is not terminated under par. (e), the independent review organization shall, within 30 business days after the

Insert 3-18

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 insurer.

2. a. Except as provided in subd. 2. b., a decision of an independent review organization is binding on the insured and the insurer.

SECTION 9. 632.835 (3) (f) 1. b. of the statutes is created to read:

632.835 **(3)** (f) 1. b. Notwithstanding subd. 1. a., in no case may the written decision under subd. 1. a. be served or mailed to the insured, or his or her authorized representative, or to the insurer more than 60 calendar days after the insured or his or her authorized representative provided notice of the request for independent review under par. (a).

SECTION 10. 632.835 (3) (f) 2. of the statutes is renumbered 632.835 (3) (f) 2. b.

SECTION 11. 632.835 (3) (g) of the statutes is repealed and recreated to read:

632.835 **(3)** (g) 1. If the independent review organization determines that the health condition of the insured is such that following the procedure outlined in pars. (b) to (f) would jeopardize the life or health of the insured or the insured's ability to regain maximum function, the independent review organization shall follow an expedited process and notify the insured, or his or her authorized representative, and the insurer of its decision no more than 4 business days after receiving the notice of the request for independent review under par. (a).

****NOTE: It's not clear when the "4 business days" begins running. Is it when the commissioner receives the notice of the request for independent review, or is it when the

its selection

(c) par. (g) 1. and par.

the timelines specified in

from the commissioner

independent reviews

IRO receives notice that it has been selected? It depends on the notice timeline that applies in the procedure.

2. If the notice of its decision under subd. 1. is not in writing, the independent review organization shall provide written confirmation of its decision within 48 hours after the date of the notice of the decision under subd. 1.

SECTION 12. 632.835 (3m) (b) (intro.) of the statutes is amended to read:

632.835 **(3m)** (b) (intro.) ~~A~~ With respect to 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~~, 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:

****NOTE: I do not know if the way in which s. 632.835 (3m) (b) is amended is sufficient. The summary stated that the process "must have at least all of the protections that are available for external reviews [of adverse determinations]." Our statutes do not explicitly provide for any "protections" for any of the types of external review. OCI is required to promulgate rules under s. 632.835 (5) (a) 3.

SECTION 13. 632.835 (5) (c) of the statutes is repealed.

(END)

Insert 5-11

2011-2012 DRAFTING INSERT
FROM THE
LEGISLATIVE REFERENCE BUREAU

INSERT 3-18

SECTION 1. 632.835 (3) (b) (intro.) of the statutes is amended to read:

632.835 **(3)** (b) (intro.) Within 5 business days after receiving written notice of a request for independent review under par. (a), the insurer shall submit to the independent review organization copies of all of the following:

History: 1999 a. 155; 2001 a. 65; 2009 a. 28, 276.

****NOTE: I have not amended this provision in this draft. However, would you like to amend it to start the 5 business days running when the insurer receives notice of which independent review organization has been selected?

SECTION 2. 632.835 (3) (dm) of the statutes is created to read:

632.835 **(3)** (dm) An independent review of an experimental treatment determination shall provide for all of the same protections that apply in an independent review of an adverse determination.

(END OF INSERT 3-18)

INSERT 5-11

SECTION 3. Initial applicability.

(1) This act first applies to independent reviews that are requested on the effective date of this subsection.

****NOTE: Should the effective date be delayed to give the commissioner and insurers time to make any adjustments that are needed to comply with these changes?

(END OF INSERT 5-11)

Kahler, Pam

From: Moran, Christian
Sent: Tuesday, January 03, 2012 10:19 AM
To: Rose, Laura; Kahler, Pam
Cc: Knutson, Tryg
Subject: RE: Draft review: LRB 11-3368/P1 Topic: External review process for health insurance

Hi Laura and Pam,

Thought you'd be interested in this piece that ran in today's Wisconsin Health News. This news seems to bolster the case for moving ahead with the bill below.

Are you free sometime this week to discuss LRB-3368? I really need to get up to speed on this bill. My schedule is pretty flexible.

I'm copying Tryg from Sen. Erpenbach's office, because he's handling health care while Kelly is on leave.

Thanks, and happy new year.

Christian

-
-
-

Feds: State no longer compliant with external review process

Starting March 1, 2012, non-grandfathered Wisconsin health plans must be full participants in a federally-administered external review process, the Centers for Medicare and Medicaid Services told Insurance Commissioner Ted Nickel late last month.

On December 1, Governor Scott Walker ordered Nickel to repeal an emergency rule that brought the state into compliance with the federal health reform requirements. Walker said he was worried the rule might impact the upcoming U.S. Supreme Court case.

"Due to the imminent repeal of the emergency rule, Wisconsin's external review process will not meet all of the standards of the NAIC-parallel process or the NAIC-similar process," said Center for Consumer Information and Insurance Oversight deputy director Timothy Hill in a letter to Nickel.

Read the letter

Christian T. Moran
Office of Representative Jon Richards
State Capitol, 118 North
Madison, WI 53708
608-266-0650

From: Rose, Laura
Sent: Wednesday, December 21, 2011 4:31 PM
To: Kahler, Pam
Cc: Moran, Christian; Becker, Kelly
Subject: FW: Draft review: LRB 11-3368/P1 Topic: External review process for health insurance

Hi Pam,

I sat down with Kelly Becker from Senator Erpenbach's office yesterday to talk about LRB:3368/P1. We went over the drafter's note and your questions.

SECTION 5 seems to work fine; I would keep it as is. Also, SECTION 7 should be kept as is. It seems that this process is more streamlined than the alternative suggested in the note to that section.

With regard to the note after SECTION 11: I checked some other states that have the appropriate IR process and they seem to indicate that the 4 business days begins running when the IRO receives notice that it has been selected.

Finally, with regard to the note after SECTION 12: I think the statute relating to external reviews of experimental treatment determinations should be amended to explicitly provide for the protections available for external reviews of adverse determinations.

If you could draft a /P2 of this, that would be great. Kelly is on maternity leave as of today, and she has asked Christian Moran of Rep. Richards' office to be involved during her absence, which is why I copied him on this email. Please let me know if you have any questions or want to discuss this.

Thanks Pam, happy holidays!

Laura

Laura D. Rose, Deputy Director

Wisconsin Legislative Council

One East Main Street, Suite 401

PO Box 2536

Madison, WI 53701-2536

tel: 608.266.9791

fax: 608.266.3830

laura.rose@legis.wisconsin.gov

From: LRB.Legal
Sent: Friday, December 09, 2011 1:42 PM
To: Rose, Laura
Subject: Draft review: LRB 11-3368/P1 Topic: External review process for health insurance

Draft Requester: Jon Erpenbach

Following is the PDF version of draft LRB 11-3368/P1 and drafter's note.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

200 Independence Avenue SW
Washington, DC 20201

December 21, 2011

Honorable Ted Nickel
Insurance Commissioner
P.O. Box 7873
Madison, WI 53707-7873

Re: State External Review Process Redetermination

Dear Commissioner Nickel:

This letter follows up on our discussion with your office regarding Wisconsin's external reviews laws on December 5, 2011. The Affordable Care Act ensures that health care insurance consumers have access to strong external review processes under section 2719 of the Public Health Service Act (PHS Act).[1] In implementing this provision, the Departments of Health and Human Services (HHS), Labor, and the Treasury (the Departments) have focused on ensuring that State external review processes can be maintained to the extent possible.[2] Over the past year, we have actively worked with States to provide guidance and assist States seeking to amend their external review processes to meet federal standards.

Through this process, the Departments have established two categories of State external review processes that will satisfy these statutory standards: 1) a State external review process that meets the 16 minimum consumer protections described in paragraph (c)(2) of the regulations as authorized under section 2719(b)(1) of the PHS Act (hereinafter referred to as "NAIC-parallel process"); or 2) a State external review process that meets the minimum standards established by the Secretary of Health and Human Services through guidance under section 2719(b)(2) (hereinafter referred to as "NAIC-similar process").[3]

It has come to our attention that on December 1, 2011, Governor Walker endorsed and consented to the repeal of Emergency Rule 1117 that had brought Wisconsin's external review provisions into compliance with the NAIC-parallel process. It is our understanding from discussions with your office that as soon as the Insurance Commissioner has the ability to repeal the emergency rule, the Department of Insurance will act as directed by the Governor. In our October 4, 2011, re-determination letter, we noted that "Wisconsin may not reduce the consumer protections in their external review process below the levels that apply as articulated in the Emergency Rule." Consequently, the Center for Consumer Information and Insurance Oversight (CCIIO) has determined that due to the imminent repeal of the Emergency Rule, Wisconsin's external review process will not meet all of the standards of the NAIC-parallel process or the NAIC-similar process.

---

[1] Section 2719 does not apply to grandfathered health plans. See interim final regulations regarding status of a group health plan or health insurance coverage as a grandfathered plan under section 1251 of the Affordable Care Act issued on June 17, 2010 (75 FR 34538), amended on November 17, 2010.(75 FR 70114).

[2] Regulations implementing PHS Act section 2719 were published on July 23, 2010, at 75 FR 43330, and amended on June 24, 2011, at 76 FR 37208 (corrected on July 26, 2011, at 76 FR 44491).

[3] HHS established these minimum standards in Technical Release 2011-02 on June 22, 2011, which can be found at: http://cciio.cms.gov/resources/files/appeals_srg_06222011.pdf. Beginning January 1, 2014, issuers of non-grandfathered health insurance plans and policies in a State with an external review process that does not satisfy the standards of the NAIC-parallel process will need to participate in a federally administered process.

All issuers of non-grandfathered health insurance plans and policies in Wisconsin's group and individual market will be subject to the Federally-administered external review process. These issuers may continue to follow Wisconsin's external review process during a transition period, but must make good faith efforts to come into compliance with federal law (e.g., inform HHS of Federal external review process elections, make appropriate modifications to consumer notices, etc.) and be fully participating in a Federally-administered external review process on March 1, 2012. Please direct the health insurance issuers in your state to Technical Release 2011-02 as well as to the additional guidance on the CCIIO website ("Instructions for self-insured non-federal governmental health plans and health insurance issuers offering group and individual health coverage on how to elect a federal external review process") for more information on the Federally-administered external review process.[4] CCIIO will also send issuers in your state a letter outlining their responsibility to participate in a federally-administered process and instructing them on how to make an election by March 1, 2012.

We remain committed to working in partnership with your State to strengthen your external review process. Our goal is to ensure external reviews are conducted under State law, and we will provide whatever assistance we can to work with you and your State in the future to meet that goal.

In our July 29, 2011, initial determination letter, we attached a summary of the components of Wisconsin's external review process that did not meet the components of an NAIC-parallel process or an NAIC-similar process. Since the repeal of the Emergency Rule places Wisconsin law into the same posture as it was on July 29, 2011, we refer you to that attachment for further information on the components of Wisconsin's external review process.

This finding is a final determination. If Wisconsin changes its external review process in the future, Wisconsin may request a new determination at any time by sending a letter to the attention of Ellen Kuhn, Director of the Appeals program in CCIIO at the Centers for Medicare & Medicaid Services (CMS) at externalappeals@cms.hhs.gov. Please include the reason(s) why you believe that Wisconsin's external review process does meet the NAIC-parallel or NAIC-similar standards along with supporting documentation that you would like CCIIO to consider. CCIIO will re-evaluate Wisconsin's external review process and issue a redetermination within 30 days of receipt of your completed re-evaluation request.

As always, CCIIO welcomes questions from state regulators and remains available to provide technical assistance on proposed modifications to the external review processes. Please feel free to contact Veronica Morales at veronica.morales@cms.hhs.gov with any questions or concerns.

Sincerely,

Timothy Hill
Deputy Director
Center for Consumer Information and Insurance Oversight

cc: Julie Walsh

[4] Guidance is available at http://cciio.cms.gov/resources/files/hhs_srg_elections_06222011.pdf

Kahler, Pam

From: Moran, Christian
Sent: Friday, January 06, 2012 1:44 PM
To: Kahler, Pam; Rose, Laura; Knutson, Tryg
Subject: FW: Draft review: LRB 11-3368/P2 Topic: External review process for health insurance
Attachments: 11-3368P2.pdf; Wisconsin.pdf

Here are comments on the draft from ABC for Health.

From: Brynne McBride [mailto:bmcbride@safetyweb.org]
Sent: Wednesday, January 04, 2012 6:11 PM
To: Bobby Peterson; Moran, Christian
Subject: RE: Draft review: LRB 11-3368/P2 Topic: External review process for health insurance

Hi, Christian –
I gave the draft bill a quick look. I have here a summary and then questions on what still might be missing. I attached the memo from the Feds that we saw back in early October, to help fill in some of the gaps.

What's Included: Overall, the bill is a very simple edit to the independent review statute that accomplishes the following items:

1. It eliminates language that puts a dollar amount on the adverse determination definition
2. It specifies that independent review organizations are to be selected by the Commissioner, on a random basis
3. It adds an exemption to the internal grievance if the insurer or other agency misses timelines
4. It adds language that says review of experimental treatment has the same protections as the review of adverse determinations
5. It adds a timeline "cap" of 60 days after a request for an independent review has been made after which no decision may be mailed
6. It adds clear language on expedited independent review with the notice of decision within 4 business days (with written confirmation within 48 hours after a notice date)
7. It deletes language on experimental treatment ("IRO must determine treatment is not experimental") is deleted
8. It deletes the annual adjustment being made by the commissioner on denied treatment costs using the consumer price index

The drafter asked a question: When should the "5 business days for an insurer to provide documents to the independent review organization start?"
The statute currently says "after written notice of request for the independent review." The new policy can be "upon notice from the commissioner of its selection." This would be consistent with the new language added to 632.835(3)(g)1.

What's Missing: I took a VERY quick look at the original OCIIO (now CCIIO) memo that stated where Wisconsin wasn't in compliance with a "NAIC-parallel process." I would make the following recommendations:

1. Be more clear in the draft legislation on "a provision that allows exhaustion of the internal appeals process in cases where the issuer fails to meet the internal appeals process requirement"
2. I think section 632.835(4) is pretty weak in explaining what it takes for an IRO to be "certified." The OCIIO memo asks for IROs to be "accredited and qualified." First, I would be more clear that the IRO is "accredited." The original statute and the new language refer to the certification process and 632.835(3)(a) that says that the commissioner will select an IRO that is "certified

under sub. 4 to conduct the independent review based on the subject of the review and other circumstances." I don't know if the quick definition of certification referenced in sub 4 (being "unbiased and paying fees on time) meet OCIIO's "accredited" standard.

3. Be more clear that the IRO is "qualified." One of the things that Commissioner Sean Dilweg did in the regulations was ensure the Independent Review Organizations have capacity to conduct both medical and legal review. The existing statute includes language on having "physicians" that understand the diagnosis at issue, but there is absolutely no language on having someone at the IRO be able to understand the contracts or insurance plan documents that control the relationship between the issuer and insured. This bill may be the best place to clarify legal review as a quality IROs must possess. The inserted language in 632.835 (3)(a) speaks to the IRO being certified based on the "subject of the review"- medical and legal expertise can be clarified here.
4. New language is needed on insured being able to submit additional evidence to independent review organizations that includes the new "federal minimum standard" language-Wisconsin's statue stops short of having the federal minimum language.
5. New language is needed that requires issuers to provide notice of the right to external review in summary plan descriptions and plan materials-I am not seeing this in the state statute or in the draft legislation.

Question: the federal rule says that a state *OR* independent entity can select the independent review organization. In the draft legislation, it specifies that the commissioner of insurance will select the IRO. Do we see a problem in having OCI make this selection?

Thanks,
Brynne

meeting on 1-10
Laura Rose, Christian Moran, Trygg Knutson, me

limit application? shouldn't be necessary
* but could apply to issued or renewed

initial app:
· independent reviews requested under policies that are issued or renewed on eff date?

---

add:

* ~~flow~~ limit to 2 business days (working days) but no more than ↑

* give insurer 5 days from IRO selection to submit info to IRO

* delay 30 days – whole bill

* initial app → issued or renew

State of Wisconsin
2011 - 2012 LEGISLATURE

LRB-3368/P1
PJK:med:jm

PRELIMINARY DRAFT - NOT READY FOR INTRODUCTION

AN ACT ***to repeal*** 632.835 (1) (a) 4., 632.835 (1) (b) 4. and 632.835 (5) (c); ***to renumber*** 632.835 (3) (f) 2.; ***to renumber and amend*** 632.835 (3) (f) 1.; ***to amend*** 632.835 (1) (b) 2., 632.835 (2) (b), 632.835 (2) (d) 2., 632.835 (3) (a), 632.835 (3) (b) (intro.) and 632.835 (3m) (b) (intro.); ***to repeal and recreate*** 632.835 (3) (g); and ***to create*** 632.835 (2) (d) 3., 632.835 (3) (dm) and 632.835 (3) (f) 1. b. of the statutes; **relating to:** external review process of health benefit plan decisions.

Analysis by the Legislative Reference Bureau

This is a preliminary draft. An analysis will be provided in a subsequent version of this draft.

For further information see the ***state*** 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. 632.835 (1) (a) 4. of the statutes is repealed.

SECTION 2. 632.835 (1) (b) 2. of the statutes is amended to read:

632.835 **(1)** (b) 2. Based on the information provided, the treatment under subd. 1. is determined to be experimental or investigational under the terms of the health benefit plan.

SECTION 3. 632.835 (1) (b) 4. of the statutes is repealed.

SECTION 4. 632.835 (2) (b) of the statutes is amended to read:

632.835 **(2)** (b) If a coverage denial determination is made, the insurer involved in the determination shall provide notice to 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. The notice shall include a current listing of independent review organizations certified under sub. (4). An independent review under this section may be conducted only by an independent review organization certified under sub. (4) and selected by the ~~insured~~ commissioner under sub. (3) (a).

SECTION 5. 632.835 (2) (d) 2. of the statutes is amended to read:

632.835 **(2)** (d) 2. ~~Along with the notice to the insurer of the request for~~ After receiving notice of the independent review organization selected by the commissioner under sub. (3) (a), the insured submits to the independent review organization ~~selected by the insured~~ a request to bypass the internal grievance procedure under s. 632.83 and the independent review organization determines that the health condition of the insured is such that requiring the insured to use the internal grievance procedure before proceeding to independent review would jeopardize the life or health of the insured or the insured's ability to regain maximum function.

SECTION 6. 632.835 (2) (d) 3. of the statutes is created to read:

632.835 **(2)** (d) 3. The insurer or another entity other than the insured does not meet all of the timeline requirements, if any, under the internal grievance procedure under s. 632.83.

SECTION 7. 632.835 (3) (a) of the statutes is amended to read:

632.835 **(3)** (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~~, and of the independent review organization selected,~~ to the commissioner and to the insurer that made or on whose behalf was made the coverage denial determination. ~~The insurer shall immediately notify~~ the commissioner ~~and the~~ immediately shall, on a random basis, select an independent review organization ~~selected by the insured of the request for independent review~~ certified under sub. (4) to conduct the independent review based on the subject of the review and other circumstances, including any conflict of interest concerns, and shall notify the independent review organization, the insured or his or her authorized representative, and the insurer of the independent review organization selected. For each independent review in which it is involved, an insurer shall pay a fee to the independent review organization.

SECTION 8. 632.835 (3) (b) (intro.) of the statutes is amended to read:

632.835 **(3)** (b) (intro.) Within 5 business days after receiving ~~written~~ notice of ~~a request for~~ the independent review organization selected under par. (a), the insurer shall submit to the independent review organization copies of all of the following:

****NOTE: I have not amended this provision in this draft. However, would you like to amend it to start the 5 business days running when the insurer receives notice of which independent review organization has been selected?

SECTION 9. 632.835 (3) (dm) of the statutes is created to read:

632.835 **(3)** (dm) An independent review of an experimental treatment determination shall provide for all of the same protections that apply in an independent review of an adverse determination.

SECTION 10. 632.835 (3) (f) 1. of the statutes is renumbered 632.835 (3) (f) 1. a. and amended to read:

632.835 **(3)** (f) 1. a. If the independent review is not terminated under par. (e), 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 insurer.

2. a. Except as provided in subd. 2. b., a decision of an independent review organization is binding on the insured and the insurer.

SECTION 11. 632.835 (3) (f) 1. b. of the statutes is created to read:

632.835 **(3)** (f) 1. b. Notwithstanding the timelines specified in subd. 1. a. and pars. (b) and (c), in no case may the written decision under subd. 1. a. be served or mailed to the insured, or his or her authorized representative, or to the insurer more than 60 calendar days after the insured or his or her authorized representative provided notice of the request for independent review under par. (a). Insert 4-20

SECTION 12. 632.835 (3) (f) 2. of the statutes is renumbered 632.835 (3) (f) 2. b.

SECTION 13. 632.835 (3) (g) of the statutes is repealed and recreated to read:

632.835 **(3)** (g) 1. If the independent review organization determines that the health condition of the insured is such that following the procedure outlined in pars.

(b) to (f) would jeopardize the life or health of the insured or the insured's ability to regain maximum function, the independent review organization shall follow an expedited independent review process and notify the insured, or his or her authorized representative, and the insurer of its decision no more than 4 business days after receiving notice from the commissioner of its selection under par. (a).

2. If the notice of its decision under subd. 1. is not in writing, the independent review organization shall provide written confirmation of its decision within 48 hours after the date of the notice of the decision under subd. 1.

SECTION 14. 632.835 (3m) (b) (intro.) of the statutes is amended to read:

632.835 **(3m)** (b) (intro.) ~~A~~ With respect to 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,~~ 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:

SECTION 15. 632.835 (5) (c) of the statutes is repealed.

SECTION 16. Initial applicability.

(1) This act first applies to independent reviews that are requested on the effective date of this ~~subsection~~ paragraph

Insert 5-18

****NOTE: Should the effective date be delayed to give the commissioner and insurers time to make any adjustments that are needed to comply with these changes?

(END)

Insert 5-20

INSERT A

Under current law, a health insurer must have an internal grievance procedure and an independent review procedure whereby an insured person may appeal certain types of coverage denials to an independent review organization. This bill makes the following changes to the independent review process that health insurers must provide:

1. Under current law, with some exceptions, an insured must exhaust the internal grievance procedure before the insured may request an independent review of a coverage denial. The bill adds as another exception to that requirement that the insurer or another entity other than the insured did not meet all of the timelines required under the internal grievance procedure.

2. Under current law, access to the independent review process must be provided for a reduction, denial, or termination of treatment or payment for treatment related to the admission to a facility, the availability of care, or the continued stay in a facility (adverse determination) if the amount of the reduction or the cost of the denied or terminated treatment exceeds $250. Also under current law, access to the independent review process must be provided for a denial of treatment on the basis that the treament is experimental (experimental treatment determination) if the cost of the denied treatment exceeds $250. The bill removes the minimum dollar amount for both adverse determinations and experimental treatment determinations.

3. Under current law, the insured selects an independent review organization and notifies the insurer both that he or she is requesting an independent review and which independent review organization he or she has selected to conduct the review. Under the bill, the insured notifies both the insurer and the commissioner of insurance (commissioner) that he or she is requesting an independent review and the commissioner then, within two business days, randomly selects the independent review organization that will conduct the review.

4. Current law provides a timeline within which an insurer must submit information to the independent review organization and the independent review organization must make a decision. The bill generally does not change the timeline, but specifies that in no case may the independent review organization send its written decision to the insured and insurer more than 60 days after it was notified of its selection by the commissioner.

5. Current law provides an expedited timeline for independent reviews when the independent review organization determines that, due to the insured's health condition, following the usual timeline would jeopardize the insured's life or health (urgent matters). The bill eliminates the expedited timeline and provides, simply, that in urgent matters the independent review organization must notify the insured and insurer of its decision no more than four business days after it was notified of its selection by the commissioner. Additionally, if notification to the insured and insurer of its decision is not in writing, the independent review organization must send written confirmation of its decision within 48 hours after providing the initial notice of its decision.

Ins A cont'd

6. Finally, current law provides that a decision regarding an experimental treatment determination is limited to a determination of whether the proposed treatment is experimental and specifies what an independent review organization must find to determine that a treatment is not experimental and to find in favor of the insured. The bill does not change what an independent review organization must find to find in favor of the insured, but removes the restriction that an experimental treatment determination is limited to a determination of whether the proposed treatment is experimental and requires that an independent review of an experimental treatment determination must provide for all the same protections that apply in an independent review of an adverse determination.

(END OF INSERT A)

INSERT 3-9

w/ 4 No more than 2 business days after receiving the notice of the request for independent review.

(END OF INSERT 3-9)

INSERT 4-20

w/ 4 organization received notice from the commissioner of its selection

(END OF INSERT 4-20)

INSERT 5-18

w/ 4 by insureds under all of the following: ← auto ref A

4 (a) Except as provided in paragraph (b), health benefit plans that are newly issued or renewed

(END OF INSERT 5-18)

INSERT 5-20

← auto ref A

(b) Health benefit plans covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are newly issued or renewed on the earlier of the following:

lns 5-20 contd

1 #. The day on which the collective bargaining agreement expires.

2 #. The day on which the collective bargaining agreement is extended, modified,

3 or renewed.

4 **SECTION 1. Effective date.**

5 (1) This act takes effect on the first day of the 2nd month beginning after

6 publication.

(END OF INSERT 5-20)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-3368/1dn
PJK:...:...
med

Dave

Please note that, in addition to the changes we discussed, I changed the maximum time for the independent review organization to make its decision in a routine case from 60 days after the insured provided notice of its request for independent review to 60 days after the independent review organization was notified of its selection. (See proposed s. 632.835 (3) (f) 1. b.) That timeline seemed more consistent with the others in the bill. Let me know, however, if you want it changed back.

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266-2682
E-mail: pam.kahler@legis.wisconsin.gov

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-3368/1dn
PJK:med:jm

January 30, 2012

Please note that, in addition to the changes we discussed, I changed the maximum time for the independent review organization to make its decision in a routine case from 60 days after the insured provided notice of its request for independent review to 60 days after the independent review organization was notified of its selection. (See proposed s. 632.835 (3) (f) 1. b.) That timeline seemed more consistent with the others in the bill. Let me know, however, if you want it changed back.

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266-2682
E-mail: pam.kahler@legis.wisconsin.gov

Barman, Mike

From: Knutson, Tryg
Sent: Monday, February 13, 2012 12:40 PM
To: LRB.Legal
Subject: Draft Review: LRB 11-3368/1 Topic: External review process for health insurance

Please Jacket LRB 11-3368/1 for the SENATE.