WEST VIRGINIA
SECRETARY OF STATE
NATALIE E. TENNANT
ADMINISTRATIVE LAW DIVISION

Form #3

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SECRETARY OF STATE
STATE OF WEST VIRGINIA

NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE
AND
FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

AGENCY: WV Offices of the Insurance Commissioner TITLE NUMBER: 114

CITE AUTHORITY WV Code §§33-16H-4 and 33-2-10

AMENDMENT TO AN EXISTING RULE: YES_____ NO X

IF YES, SERIES NUMBER OF RULE BEING AMENDED: _____

TITLE OF RULE BEING AMENDED: _____

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: 96

TITLE OF RULE BEING PROPOSED: Health Plan Issuer Internal Grievance Procedure

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE MAKING REVIEW COMMITTEE FOR THEIR REVIEW.

Authorized Signature

Insurance Commissioner
Legislative Rule
Title 114, Series 96

HEALTH PLAN ISSUER INTERNAL GRIEVANCE PROCEDURE

TITLE 114, SERIES 96

BRIEF SUMMARY OF RULE

The purpose of this rule is to provide standards for the establishment and maintenance of procedures by health carriers to assure that covered persons have the opportunity for the appropriate resolution of grievances, as defined in this rule. Except as otherwise specified, this rule shall apply to all health carriers offering a health benefit plan. This rule is based upon the National Association of Insurance Commissioner's "Health Carrier Grievance Procedure Act" (Model 72), as amended in 2012.

QUESTIONNAIRE

(Please include a copy of this form with each filing of your rule: Notice of Public Hearing or Comment Period, Proposed Rule, and if needed, Emergency and Modified Rule.)

DATE: July 26, 2013

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: WV OFFICE OF THE INSURANCE COMMISSIONER
ATTN: Legal Division
1124 Smith Street
Post Office Box 50540
Charleston, West Virginia 25305-0540

LEGISLATIVE RULE TITLE: Health Plan Issuer Internal Grievance Procedure
Title 114, Series 96

1. **Authorizing statute(s) citation:**

   West Virginia Code §33-16H-4 and 33-2-10

2. a. **Date filed in State Register with Notice of Hearing or Public Comment Period:**

   June 19, 2013 (notice of public comment period).

   b. **What other notice, including advertising, did you give of the hearing?**

   N/A

   c. **Date of Public Hearing(s) *or* Public Comment Period ended:**

   Public comment period ended on July 19, 2013.

   d. **Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.**

   Attached __X__ **No comments received** _____

   e. **Date you filed in State Register the agency approved proposed Legislative Rule following public hearing: (be exact)**

   July 26, 2013

f. **Name, title, address and phone/fax/e-mail numbers of agency person(s) to receive all *written correspondence* regarding this rule: (Please type)**

Timothy R. Murphy, Associate Counsel
WV Offices of the Insurance Commissioner
P.O. Box 50540
Charleston, WV 25305
304-558-6279 Ext. 1210
304-558-1362 FAX
Timothy.Murphy@wvinsurance.gov

g. **IF DIFFERENT FROM ITEM 'f', please give Name, title, address and phone number(s) of agency person(s) who wrote and/or has responsibility for the contents of this rule: (Please type)**

N/A

3. **If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:**

N/A

a. **Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.**

b. **Date of hearing or comment period:**

c. **On what date did you file in the State Register the findings and determinations required together with the reasons therefor?**

d. **Attach findings and determinations and reasons:**

SPILMAN THOMAS & BATTLE, PLLC
ATTORNEYS AT LAW

(304) 720-4073
mpickens@spilmanlaw.com

July 19, 2013

Commissioner Michael Riley
Offices of the Insurance Commission
1124 Smith Street
Charleston, WV 25301

RE: Comments to Proposed Health Plan Issuer Internal Grievance Procedure Rule 114CSR96

Dear Commissioner Riley:

Thank you for the opportunity to file written comments on behalf of America's Health Insurance Plans ("AHIP") to the Insurance Commissioner's proposed Health Plan Issuer Internal Grievance Procedure rule. This rule, as well as the other rules currently proposed by the Insurance Commissioner relating to implementation of the Affordable Care Act and H.B. 2960 enacted during the 2013 regular legislative session, are complex and issuers are continuing to review them in light of the NAIC models.

AHIP offers the following comments at this time to the rule:

1) The proposed rule uses the term "issuer" rather than the term "health carrier" as used in the model. There is no objection to the use of that term in the rule; however there are instances where "health carrier" is also used in the rule and AHIP encourages consistency.

2) Section 3 of the proposed rule addresses maintenance of written records relating to grievances, but lacks the detail and certainty of the model's provisions relating to recordkeeping requirements. It is assumed that this detail will be provided by informational letter or other guidance if it is not included in the rule. It is important that such guidance be provided as to the types of requests and the specific data that must be included in the register so that issuers can meet the OIC's expectations. There is no objection to the maintenance period in the rule of 5 years or until the commissioner has adopted a final examination report. In addition, guidance should be provided as to the contents of the grievance report required to be submitted annually to the Commissioner under subsection 3.2 of the proposed rule so that issuers can meet the OIC's expectations.

3) In 4 subdivision 4.1.b. of the proposed rule, the words "refuses to rejects" are used. AHIP is sure this is a typo but suggests that the word "rejects" be used. In addition, 4.1.b.4.B. of the

proposed rule references a court's rejection of a grievance involving an adverse determination for immediate review. However, there is no other reference in section 4 of a court of competent jurisdiction reviewing a grievance.

4) Based upon the model language, the intent of 5.8.g.4. of the proposed rule is believed to be that if an issuer relied on an internal rule, guideline, etc., that it either provide the rule or guideline or state that a specific rule or guideline was relied upon and that the covered person may request the specific rule or guideline. This appears to be a drafting error, but AHIP suggests that the proposed rule reflect the model language on this point.

5) In subdivision 6.3.c., reference is made to "standard of review". It is believed that the intended wording should be "standard review" and AHIP suggests this correction.

AHIP again thanks the Insurance Commissioner for the opportunity to comment on this proposed rule.

Sincerely,

Mary Jane Pickens

MJP/sec

cc: Timothy Murphy, OIC
David Kennedy
Cindy Goff

SPILMAN THOMAS & BATTLE, PLLC
ATTORNEYS AT LAW

(304) 720-4073
mpickens@spilmanlaw.com

July 19, 2013

Commissioner Michael Riley
Offices of the Insurance Commission
1124 Smith Street
Charleston, WV 25301

RE: Comments to Proposed Health Plan Issuer Internal Grievance Procedure Rule 114CSR96

Dear Commissioner Riley:

Thank you for the opportunity to file written comments on behalf of the West Virginia HMO Association ("HMO Association") to the Insurance Commissioner's proposed Health Plan Issuer Internal Grievance Procedure rule. This rule, as well as the other rules currently proposed by the Insurance Commissioner relating to implementation of the Affordable Care Act and H.B. 2960 enacted during the 2013 regular legislative session, are complex and issuers are continuing to review them in light of the NAIC models.

The HMO Association offers the following comments at this time to the rule:

1) The proposed rule uses the term "issuer" rather than the term "health carrier" as used in the model. There is no objection to the use of that term in the rule; however there are instances where "health carrier" is also used in the rule and the HMO Association encourages consistency.

2) In 4 subdivision 4.1.b. of the proposed rule, the words "refuses to rejects" are used. The HMO Association is sure this is a typo but suggests that the word "rejects" be used. In addition, 4.1.b.4.B. of the proposed rule references a court's rejection of a grievance involving an adverse determination for immediate review. However, there is no other reference in section 4 to a court of competent jurisdiction reviewing a grievance. The HMO Association submits that reference to a court in 4.1.b.4.B. is inappropriate and should be removed.

3) The HMO Association expresses concern with the requirement in 5.3.a. that the clinical peer or peers designated by the issuer to review an adverse determination involving utilization review must be of the same or similar specialty as would typically manage the case being reviewed. The HMO may not have access to an abundance of specialists as medical directors and may have difficulty complying with this requirement. All HMOs use utilization guidelines and it is

submitted that a physician need not be of the same or similar specialty in order to be qualified to conduct this type of review.

The HMO Association again thanks the Insurance Commissioner for the opportunity to comment on this proposed rule.

Sincerely,

Mary Jane Pickens

MJP/sec

cc: Timothy Murphy, OIC
Bob Kota
Colleen Cohan
Jeff Folks
John Fleig
John Muraca
Pamela Perry
Phil Wright
Tadd Haynes
Todd White

Sarah Young

From: Timothy Murphy
Sent: Friday, July 19, 2013 4:25 PM
To: Sarah Young (Sarah.Young@wvinsurance.gov); Joy Zirkle (Joy.Zirkle@wvinsurance.gov)
Subject: FW: Comments to Proposed Rules 114-95, 114-96 and 114-97
Attachments: UR.Internal Appeals.External Review Comments 7.19.13.docx

Timothy R. Murphy
Associate Counsel
WV Offices of the Insurance Commissioner
PO Box 50540
Charleston WV 25305-0540

304-558-6279 ext. 1210
fax 304-558-1362

From: Wade, Susan L [mailto:susan.wade-miller@highmark.com]
Sent: Friday, July 19, 2013 3:34 PM
To: Timothy Murphy
Subject: Comments to Proposed Rules 114-95, 114-96 and 114-97

Mr. Murphy,

Thank you for the opportunity to comment on the above referenced proposed rules. Please find our comments attached.

Thank you.

Susan Wade | Highmark West Virginia
V: 304-424-9838 | F: 304-424-9875 | Email: susan.wade-miller@highmark.com

07.19.2013
NOT INTENDED FOR GENERAL DISTRIBUTION

Comments to Proposed Rules:
§114-95 Utilization Review and Benefit Determination
§114-96 Internal Grievance Procedure
§114-97 Standard External Review Procedures
Authority: WV Code §33-16H

General Comments – "Adverse Determination"		
Section	Subsection	Comment
§114-95-2.1 §114-96-2.1		Proposed Rule: "'Adverse determination' means a determination by an issuer or its designee utilization review organization that, based upon the information provided, a request for a benefit under the health issuer's health benefit plan upon application of any utilization review technique does not meet the health issuer's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced or terminated." WVOIC Proposed Rule §114-95-2.1. "'Final adverse determination' – an adverse determination that has been upheld by the issuer at the completion of the internal grievance procedures or an adverse determination with respect to which the internal grievance procedures have been deemed exhausted." WVOIC Proposed Rule §114-96-2.1 WV Code §33-16H-1 This section defines "adverse determination" as "a determination by a health carrier or its designee utilization review organization that an admission, availability of care, continued stay or other healthcare service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated". DOL defines "adverse benefit determination" as a denial (or partial denial) of a benefit, a reduction or termination of a benefit, and a decision based on a claimant's eligibility for coverage under a plan or policy. 29 CFR § 2560.503-1(m)(4). The amended interim final rule issued on June 22, 2011 broadens the definition of "adverse benefit determination" to include rescissions of coverage. The state process does not appear to include rescissions of coverage within the scope of external review. Please clarify.
§114-95 Utilization Review and Benefit Determination		
§114-95-8	8.1.a	Section 8.1.a seems to have conflicting language relating to timeframes for notifying covered persons that additional information is necessary with respect to urgent care and concurrent review urgent care requests. The section lists both forty-eight (48) hours and twenty-four (24) hours. The current standard is 48. Please clarify.

§114-95-11	11.3	Section 11.3 requires issuers to include a toll-free telephone number for utilization review and benefit decisions. Currently, a "Member Services" number is listed which can be utilized for any information including information relating to all types of appeals. Please confirm that no additional numbers would be required.
§114-96 Internal Grievance Procedure		
§114-96-4	4.1.b	"If an independent review organization refuses to rejects the grievance involving an adverse determination for immediate review on the basis that the health carrier met the requirements of the exception provided in subdivision a of this rule, the covered person has the right to resubmit and pursue a review of the grievance under this rule." Should this read "refuses [or] rejects"? Does the reference to "subdivision a" mean "subdivision 4.1.a"?
	4.1.b.4.B	"In this case, within a reasonable time, after the independent reviewer or the court rejects the grievance involving an adverse determination for immediate review, but not exceeding then (10) days, the health carrier shall provide to the covered person or, if applicable, the covered person's authorized representative notice of the opportunity to resubmit and, as appropriate, pursue a review of the grievance under this rule."
§114-96-5	4.b	"The health carrier shall make the provisions of subdivision a of this subsection known to the covered person or, if applicable, the covered person's representative within three working days after the date of receipt of the grievance." Does this mean issuers have no more than three days from receipt of the grievance to send out a letter notifying the member/member representative of all the information that's listed under 5.4.a?
§114-97 Standard External Review Procedures		
§114-97-3.1		"If he or she has a medical condition where the time-frame for expedited review of a grievance under the issuer's internal grievance process, would seriously jeopardize his or her life, health or ability to regain maximum function, he or she may file with the commissioner, simultaneously with a request for expedited review under the issuer's internal grievance process, a request for expedited external review to be conducted pursuant to section 7 or, in cases involving denials based on the issuer's determination that the treatment or service is experimental or investigational where the covered person's treating physician certifies in writing that the recommended or requested service or treatment would be significantly less effective if not promptly initiated, pursuant to section 8 of this rule"; and 3.I.f.I. "If the covered person has a medical condition where the time-frame for completion of a standard external review pursuant to section 6 of this rule would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person may file a request for an expedited external review pursuant to section 7 of this rule." Will the notice included in the member benefit book meet these requirements?
§114-97-13		External Review Reporting Requirements Section 114.97-13.1.d requires IROs to retain written records for at least three (3) years. Current federal guidance and business practice requires IROs to retain records for at least six (6) years.

Insurance Commissioner
Title 114, Series 96

ATTACHMENT TO QUESTION 2(d):

The Insurance Commissioner ("OIC") received multiple comments from the WV HMO Association, America's Health Insurance Plans ("AHIP") and Highmark of West Virginia. These comments are addressed below.

1) The HMO Association and AHIP both state that the proposed rule uses the term "issuer" as defined in subsection 2.20, rather than the term "health carrier" as used in the model. They have no objection to the use of "issuer" but note that "health carrier" is also used in the rule. OIC will amend the rule to change "health carrier" to "issuer."

2) AHIP comments that section 3 of the proposed rule addresses maintenance of written records relating to grievances, but lacks the detail and certainty of the model's provisions relating to recordkeeping requirements.

As explained in the rule, this detail will be provided by future guidance such as an informational letter in which the types of requests and the specific data that must be included in the register will be set forth; the form and contents of the annual grievance report will also be the subject of such a guidance. The Commissioner will amend the proposed rule to clarify these points.

> ***§114-96-3. Grievance Reporting and Recordkeeping Requirements.***
>
> *3.1. An issuer shall maintain written records to document all grievances received, including the notices and claims associated with the grievances.*
>
> *3.1.a. The records of all grievances initiated in each calendar year shall be arranged in a separate register, the contents and form of which shall be prescribed by the Commissioner.*
>
> *3.1.b. The records shall be retained for the longer of five (5) years or until the Commissioner has adopted a final report of an examination that contains a review of the register for that calendar year.*
>
> *3.1.c. The issuer shall make the records available for examination by the Commissioner and such other persons designated by the Commissioner.*
>
> *3.2. An issuer shall annually submit to the Commissioner, at such times and in a format prescribed by the Commissioner, a report containing a compilation and analysis of the grievances filed, their disposition and their underlying causes.*

3) The HMO Association and AHIP note that subdivision 4.1.b. of the proposed rule uses the words "refuses to rejects" rather than only "rejects" as used in the model and suggests that the model be followed. The Commissioner agrees and will make the following amendment:

4.1.b. If an independent review organization rejects the grievance involving an adverse determination for immediate review on the basis that the issuer met the requirements of the exception provided in subdivision a of this rule, the covered person has the right to resubmit and pursue a review of the grievance under this rule.

These same commenters also note that (former) 4.1.b.4.B of the proposed rule (now renumbered as 4.1.b.1) refers to a court's rejection of a grievance involving an adverse determination for immediate review despite there being no other reference in section 4 to a court reviewing a grievance. The Commissioner will amend that paragraph as follows:

4.1.b.1. In this case, within a reasonable time but not exceeding ten (10) days after the independent review organization rejects the grievance involving an adverse determination for immediate review, the issuer shall provide to the covered person notice of the opportunity to resubmit and, as appropriate, pursue a review of the grievance under this rule.

4) The HMO Association expresses concern with the requirement in 5.3.a that the clinical peer(s) designated by the issuer to review an adverse determination involving utilization review must be "of the same or similar specialty as would typically manage the case being reviewed." The Association contends that an HMO may not have access to an abundance of specialists as medical directors and may have difficulty complying with this requirement and, further, inasmuch as all HMOs use utilization guidelines, the Association submits that a physician need not be "of the same or similar specialty" in order to be qualified to conduct this type of review. The Commissioner notes that the model language mirrored in the proposed rule goes beyond the federal department of labor regulations upon which the model was based and the model "is more stringent than the DOL final rule" in this regard. The DOL rule only requires that reviewer of adverse determinations based on medical judgment "to consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment". The Commissioner agrees that the DOL rule is sufficient to assure adequate review and, accordingly, amends the rule to read as follows:

5.3.a. In the case of a review of an adverse determination involving utilization review, the issuer shall designate a review panel of health care professionals, none of whom shall have been involved in the initial adverse determination.

5.3.b. If a panel designated pursuant to subdivision a of this subsection does not include a clinical peer, then the issuer shall ensure that a clinical peer is available for consultation to the panel and the panel shall consult with such clinical peer.

5.3.c. In conducting a review under this section, the reviewer or reviewers shall take into consideration all comments, documents, records and other information regarding the request for services submitted by the covered person, without regard to whether the information was submitted or considered in making the initial adverse determination.

5) Highmark asks whether subsection 5.4.b -- "The health carrier shall make the provisions of subdivision a of this subsection known to the covered person or, if applicable, the covered person's representative within three working days after the date of receipt of the grievance" -- means that an issuer has 3 days from its receipt of the grievance to send out *a letter* notifying the covered person of all the information listed under 5.4.a.

The Commissioner notes that this subdivision mirrors the model language; however, the model also includes this drafting note to the subdivision:

> Drafting Note: States that have adopted the NAIC Utilization Review and Benefit Determination Model Act may want to consider whether to include the requirements of Paragraph (2) because of the notice requirements contained in that model act.

OIC has proposed a rule based on the NAIC Utilization Review and Benefit Determination Model Act (W. Va. Code St. R. §114-95); both the model #75 and the OIC proposed rule 114-95 contain extensive notice requirements. *See* sections 7 and 8 of the proposed rule 114-95. In light of these requirements, the Commissioner believes that the additional requirement in 5.4.b is unnecessary and, accordingly, will amend the proposed rule to delete that subdivision and renumber the remainder of the subsection accordingly.

6) AHIP comments that based upon the model language, the intent of 5.8.g.4 of the proposed rule is believed to be that if an issuer relied on an internal rule, guideline, etc., then it must either (i) provide the rule or guideline *or* (ii) state that a specific rule or guideline was relied upon *and* that the covered person may request the specific rule or guideline. The OIC agrees that a drafting error was made and corrects this paragraph to read as follows:

5.8.g.4. If the issuer relied upon an internal rule, guideline, protocol or other similar criterion to make the final adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the final adverse determination and that a copy of same will be provided free of charge to the covered person upon request;

7) AHIP comments that subdivision 6.3.C refers to a "standard of review" and suggests that the intended wording should be "standard review". The Commissioner OIC agrees and makes the change to subdivision 6.3.c to read as follows:

6.3.c. The health carrier shall provide the covered person with the name, address and telephone number of a person designated to coordinate the standard review on behalf of the health carrier.

Insurance Commissioner
Legislative Rule
Title 114, Series 96

HEALTH PLAN ISSUER INTERNAL GRIEVANCE PROCEDURE

TITLE 114, SERIES 96

STATEMENT OF CIRCUMSTANCES

WV Code 33-16H-4(a)(2), enacted in 2013 (H.B. 2960), requires the Insurance Commissioner to "propose legislative rules for approval by the Legislature …, including but not limited to rules to: … (2) Establish requirements for all issuers with regard to utilization review and for internal grievance procedures and external review of adverse determinations, which rules shall be based on the corresponding model acts adopted by the National Association of Insurance Commissioners …"

PPACA 1001 (PHSA 2719(b)) mandates that most "adverse determinations" in group health plans - no coverage, rescission of coverage, etc. - must be subject to external review by an independent review organization. A state can avoid federal preemption if it has in place a process that meets the minimum standards established by NAIC model act #76 "Health Carrier External Review"; however, HHS has determined that WV does not meet the minimum requirements and thus group plans are currently subject to the federal process in 45 CFR 147.136(d). HB2960 and this implementing rule are intended to enable WV to regain regulatory oversight of the ER process, and a proposed external review is being proposed by OIC. NAIC recommends that states adopting the external review model also enact the models for utilization review (how coverage decisions are reached by issuers) and the internal grievance model (how issuers internally resolve policyholder appeals of adverse determinations).

APPENDIX B

FISCAL NOTE FOR PROPOSED RULES

Rule Title: Health Plan Issuer Internal Grievance Procedure (Title 114, Series 96)

Type of Rule: __X__ Legislative _____Interpretive ___Procedural

Agency: WV Offices of the Insurance Commissioner

Address: Post Office Box 50540

1124 Smith Street, Albert T. Summers Building

Charleston, West Virginia 25305-0540

Phone Number: (304) 558-0401 Email: Timothy.Murphy@wvinsurance.gov

Fiscal Note Summary

Summarize in a clear and concise manner what impact this measure will have on costs and revenues of state government.

This new rule will entail some additional regulatory costs in order to monitor compliance. Currently only HMOs are subject to utilization review (114 CSR 51) and internal grievance (WVC 33-25C-5; 114 CFR 46.5) requirements; the proposed rule will expand such requirements and extend them to all issuers. OIC will have to include the new requirements in all future examinations. The proposed rule will have no impact on revenues of state government.

Fiscal Note Detail

Show over-all effect in Item 1 and 2 and, in Item 3, give an explanation of Breakdown by fiscal year, including long-range effect.

FISCAL YEAR			
Effect of Proposal	Current Increase/Decrease (use "-")	Next Increase/Decrease (use "-")	Fiscal Year (Upon Full Implementation)
1. Estimated Total Cost	N/A	N/A	N/A
Personal Services	"1/3 FTE"	"1/3 FTE"	"1/3 FTE"
Current Expenses	N/A	N/A	N/A
Repairs & Alterations	N/A	N/A	N/A
Assets	N/A	N/A	N/A
Equipment	N/A	N/A	N/A
Other	N/A	N/A	N/A
2. Estimated Total Revenues	N/A	N/A	N/A

3. **Explanation of above estimates (including long-range effect):**
Please include any increase or decrease in fees in your estimated total revenues.

Recent federal health care reforms (PPACA) include mandatory external review by independent review organizations (IROs) of adverse determinations relative to coverage under health insurance policies. Such external reviews may proceed under state processes that meet certain minimum consumer protections; WV does not currently have a compliant process in place but is proposing a rule to bring it into compliance (114 CSR 97, based on an NAIC model act). The National Association of Insurance Commissioners recommends that states that are adopting the external review model also adopt 2 related model acts that involve how insurers make coverage decisions (utilization review, proposed rule 95) and how such decisions are disputed by enrollees through an internal process (internal grievances, proposed rule 96). Taken together, these models will add to OIC's regulatory duties that are estimated to require the equivalent of a single FTE. For instance, market conduct examiners will have to review compliance by *all* issuers with the new expanded requirements; the new external review scheme will entail approval of and assignment of IROs for the new external review scheme; OIC's consumer services division will have to review grievance reports for the entire regulated market rather than for HMOs only. The fiscal note for each of these new proposed rules includes an estimate of one-third FTE.

MEMORANDUM

Please identify any areas of vagueness, technical defects, reasons the proposed rule **would not** have a fiscal impact, and/or any special issues **not** captured elsewhere on this form.

n/a

Date: June 19, 2013

Signature of Agency Head or Authorized Representative

Timothy Murphy, Associate Counsel
WV Offices of the Insurance Commissioner
P. O. Box 50540
Charleston WV 25305-0540
Timothy.Murphy@wvinsurance.gov

TITLE 114
INSURANCE COMMISSIONER
LEGISLATIVE RULE

SERIES 96
HEALTH PLAN ISSUER INTERNAL GRIEVANCE PROCEDURE

Section.

TITLE 114
INSURANCE COMMISSIONER
LEGISLATIVE RULE

SERIES 96
HEALTH PLAN ISSUER INTERNAL GRIEVANCE PROCEDURE

§114-96-1. General.

1.1. Scope. – The purpose of this rule is to provide standards for the establishment and maintenance of procedures by issuers to assure that covered persons have the opportunity for the appropriate resolution of grievances. This rule is based upon the National Association of Insurance Commissioners' "Health Carrier Grievance Procedure Act" (Model #72), as amended in 2012. To the extent feasible, this rule should be construed consistently with related state and federal laws, but to the extent any provision conflicts with a provision of other related rules in this title (including, but not limited to, series 43, 46, 50, 51 and 53 of this title), the provisions of this rule shall control and take precedence.

1.2. Authority. – W. Va. Code §33-2-10 & 33-16H-4

1.3. Filing Date. --

1.4. Effective Date. --

§114-96-1. Definitions.

In addition to the definitions found in W. Va. Code of St. R. §114-95-2, the following definitions apply:

2.1. "Final adverse determination" means an adverse determination that has been upheld by the issuer at the completion of the internal grievance procedures or an adverse determination with respect to which the internal grievance procedures have been exhausted.

2.2. "Grievance" means a written complaint or, if the complaint involves an urgent care request submitted by or on behalf of a covered person, an oral complaint, regarding:

2.2.a. Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;

2.2.b. Claims payment, handling or reimbursement for health care services; or

2.2.c. Matters pertaining to the contractual relationship between a covered person and an issuer.

§114-96-3. Grievance Reporting and Recordkeeping Requirements.

3.1. An issuer shall maintain written records to document all grievances received, including the notices and claims associated with the grievances.

3.1.a. The records of all grievances initiated in each calendar year shall be arranged in a separate register, the contents and form of which shall be prescribed by the Commissioner.

3.1.b. The records shall be retained for the longer of five (5) years or until the Commissioner has adopted a final report of an examination that contains a review of the register for that calendar year.

3.1.c. The issuer shall make the records available for examination by the Commissioner and such other persons designated by the Commissioner.

3.2. An issuer shall annually submit to the Commissioner, at such time and in a format prescribed by the commissioner, a report containing a compilation and analysis of the grievances filed, their disposition and their underlying causes.

§114-96-4. Grievance Review Procedures.

4.1. Whenever an issuer fails to adhere to the requirements of section 5 or section 7 of this rule with respect to receiving and resolving grievances involving an adverse determination, the covered person shall be deemed to have exhausted the provisions of this rule and may file a request for external review in accordance with the procedures outlined in W. Va. Code of St. R. §114-97-1 *et seq.*

4.1.a. Notwithstanding subsection 1 of this section, the provisions of section 5 of this rule shall not be deemed exhausted based on a *de minimis* violation that does not cause, and is not likely to cause, prejudice or harm to the covered person as long as the issuer demonstrates that the violation was for good cause or due to matters beyond the control of the issuer and that the violation occurred in the context of an ongoing, good faith exchange of information between the issuer and the covered person.

4.1.a.1. The exception provided in subdivision a of this rule does not apply if the violation is part of a pattern or practice of violations by the issuer.

4.1.a.2. An issuer shall, within ten (10) days of receiving a written request from a covered person, provide a written explanation of basis, if any, for asserting that the alleged violation of section 5 or 7 of this rule does not entitle the covered person to claim exhaustion.

4.1.b. If an independent review organization rejects the grievance involving an adverse determination for immediate review on the basis that the issuer met the requirements of

the exception provided in subdivision a of this rule, the covered person has the right to resubmit and pursue a review of the grievance under this rule.

4.1.b.1. In this case, within a reasonable time but not exceeding ten (10) days after the independent review organization rejects the grievance involving an adverse determination for immediate review, the issuer shall provide to the covered person notice of the opportunity to resubmit and, as appropriate, pursue a review of the grievance under this rule.

4.1.b.2. For purposes of calculating the time period for re-filing the benefit request or claim under this paragraph, the time period shall begin to run upon the covered person's or, if applicable, the covered person's authorized representative receipt of the notice of opportunity to resubmit.

4.2.

4.2.a. An issuer shall file a copy of the procedures required under subsection 4.1 of this rule, including all forms used to process requests made pursuant to section 5, 6 and 7 of this rule, with the commissioner. Any subsequent material modifications to the documents also shall be filed.

4.2.b. The commissioner may disapprove a filing received in accordance with subdivision a of this subsection that fails to comply with this rule.

4.3. In addition to subsection 4.2, an issuer shall file annually with the commissioner, as part of its annual report required by section 3 of this rule, a certificate of compliance stating that the issuer has established and maintains, for each of its health benefit plans, grievance procedures that fully comply with the provisions of this rule.

4.4. A description of the grievance procedures required under this section shall be set forth in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage provided to covered persons.

4.5. The grievance procedure documents shall include a statement of a covered person's right to contact the commissioner's office for assistance at any time. The statement shall include the telephone number and address for the commissioner's office.

§114-96-5. First Level Reviews of Grievances Involving an Adverse Determination.

5.1. Within 180 days after the date of receipt of a notice of an adverse determination sent pursuant to W. Va. Code of St. R. §114-96-1 *et seq.*, a covered person may file a grievance with the issuer requesting a first level review of the adverse determination.

5.2.

5.2.a. The issuer shall provide the covered person with the name, address and

telephone number of a person or organizational unit designated to coordinate the first level review on behalf of the issuer.

5.2.b. In providing for a first level review under this section, the issuer shall ensure that the review is conducted in a manner under this section to ensure the independence and impartiality of the individuals involved in making the first level review decision.

5.2.c. In ensuring the independence and impartially of individuals involved in making the first level review decision, the issuer shall not make decisions related to such individuals regarding hiring, compensation, termination, promotion or other similar matters based upon the likelihood that the individual will support the denial of benefits.

5.3.

5.3.a.In the case of a review of an adverse determination involving utilization review, the issuer shall designate a review panel of health care professionals, none of whom shall have been involved in the initial adverse determination.

5.3.b.If a panel designated pursuant to subdivision a of this subsection does not include a clinical peer, then the issuer shall ensure that a clinical peer is available for consultation to the panel and the panel shall consult with such clinical peer.

5.3.c. In conducting a review under this section, the reviewer or reviewers shall take into consideration all comments, documents, records and other information regarding the request for services submitted by the covered person, without regard to whether the information was submitted or considered in making the initial adverse determination.

5.4.

5.4.a.

5.4.a.1. A covered person does not have the right to attend, or have a representative in attendance, at the first level review, but the covered person is entitled to:

5.4.a.1.A. Submit written comments, documents, records and other material relating to the request for benefits for the reviewer or reviewers to consider when conducting the review; and

5.4.a.1.B. Receive from the issuer, upon request and free of charge, reasonable access to, and copies of all documents, records and other information relevant to the covered person's request for benefits.

5.4.a.2. For purposes of subparagraph B, paragraph 1 of this subdivision, a document, record or other information shall be considered "relevant" to a covered person's request for benefits if the document, record or other information:

5.4.a.2.A. Was relied upon in making the benefit determination;

5.4.a.2.B. Was submitted, considered or generated in the course of making the adverse determination, without regard to whether the document, record or other information was relied upon in making the benefit determination;

5.4.a.2.C. Demonstrates that, in making the benefit determination, the issuer or its designated representatives consistently applied required administrative procedures and safeguards with respect to the covered person as other similarly situated covered persons; or

5.4.a.2.D. Constitutes a statement of policy or guidance with respect to the health benefit plan concerning the denied health care service or treatment for the covered person's diagnosis, without regard to whether the advice or statement was relied upon in making the benefit determination.

5.5. For purposes of calculating the time periods within which a determination is required to be made and notice provided under subsection 5.6, the time period shall begin on the date the grievance requesting the review is filed with the issuer in accordance with the issuer's procedures established pursuant to section 4 of this rule for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

5.6.

5.6.a. An issuer shall notify and issue a decision in writing or electronically to the covered person within the time frames provided in subdivisions b and c of this subsection.

5.6.b. With respect to a grievance requesting a first level review of an adverse determination involving a prospective review request, the issuer shall notify and issue a decision within a reasonable period of time that is appropriate given the covered person's medical condition, but no later than thirty (30) days after the date of the issuer's receipt of the grievance requesting the first level review pursuant to subsection 5.1.

5.6.c. With respect to a grievance requesting a first level review of an adverse determination involving a retrospective review request, the issuer shall notify and issue a decision within a reasonable period of time, but no later than sixty (60) days after the date of the issuer's receipt of the grievance requesting the first level review made pursuant to subsection 5.1.

5.7.

5.7.a. Prior to issuing a decision in accordance with the time-frames provided in subsection 5.6 of this rule, the issuer shall provide free of charge to the covered person any new or additional evidence, relied upon or generated by the issuer, or at the direction of the issuer, in connection with the grievance sufficiently in advance of the date the decision is required to be provided to permit the covered person a reasonable opportunity to respond prior to that date.

5.7.b. Before the issuer issues or provides notice of a final adverse determination in accordance with the time-frames provided in subsection 5.6 of this rule that is based on new or additional rationale, the issuer shall provide the new or additional rationale to the covered person free of charge as soon as possible and sufficiently in advance of the date the notice of final adverse determination is to be provided to permit the covered person a reasonable opportunity to respond prior to that date.

5.8. The decision issued pursuant to subsection 5.6 of this rule shall set forth in a manner calculated to be understood by the covered person:

5.8.a. The titles and qualifying credentials of the person or persons participating in the first level review process (the reviewers);

5.8.b. Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider and, if applicable, the claim amount;

5.8.c. A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. For purposes of this subdivision, an issuer:

5.8.c.1. Shall provide to the covered person as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse determination; and

5.8.c.2. Shall not consider a request for the diagnosis code and treatment information, in itself, to be a request for external review pursuant to W. Va. Code of St. R. §114-97-1 *et seq.*;

5.8.d. A statement of the reviewers' understanding of the covered person's grievance;

5.8.e. The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the issuer's position;

5.8.f. A reference to the evidence or documentation used as the basis for the decision;

5.8.g. For a first level review decision issued pursuant to subsection 5.6 of this rule that upholds the grievance:

5.8.g.1. The specific reason or reasons for the final adverse determination, including denial code and its corresponding meaning, as well as a description of the issuer's standard, if any, that was used in reaching the denial;

5.8.g.2. The reference to the specific plan provision on which the determination is based;

5.8.g.3. A statement that the covered person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant, as the term "relevant" is defined in paragraph 2, subdivision a, subsection 5.4 of this rule, to the covered person's benefit request;

5.8.g.4. If the issuer relied upon an internal rule, guideline, protocol or other similar criterion to make the final adverse determination, either specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the final adverse determination and that a copy of the same will be provided free of charge to the covered person upon request;

5.8.g.5. If the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgement for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provide to the covered person free of charge upon request; and

5.8.g.6. If applicable, instructions for requesting:

5.8.g.6.A. A copy of the rule, guideline, protocol or other similar criterion relied upon in making the final adverse determination as provided in paragraph 4 of this subdivision; and

5.8.g.6.B. The written statement of the scientific or clinical rationale for the determination, as provided in paragraph 5 of this subdivision;

5.8.h. If applicable, a statement indicating:

5.8.h.1. A description of the process to obtain an additional voluntary review of the first level review decision, if the covered person wishes to request a voluntary review pursuant to section 7 of this rule;

5.8.h.2. The written procedures governing the voluntary review, including any required time frame for the review;

5.8.h.3. A description of the procedures for obtaining an independent external review of the final adverse determination pursuant to W. Va. Code of St. R. §114-97-1 *et seq*. if the covered person decides not to file for an additional voluntary review of the first level review decision involving an adverse determination; and

5.8.h.4. The covered person's right to bring a civil action in a court of competent jurisdiction;

5.8.i. If applicable, the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner."; and

5.8.j. Notice of the covered person's right to contact the Commissioner's office for assistance with respect to any claim, grievance or appeal at any time, including the telephone number and address of the Commissioner's office.

5.9.

5.9.a. An issuer shall provide the notice required under subsection 5.8 of this rule in a culturally and linguistically appropriate manner in accordance with federal regulations.

5.9.b. To be considered to meet the requirements of subdivision a of this subsection, the issuer shall:

5.9.b.1. Provide oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests and claims and appeals in any applicable non-English language;

5.9.b.2. Provide, upon request, a notice in any applicable non-English language; and

5.9.b.3. Include in the English version of all notices, a statement prominently displayed in any applicable non-English language clearing indicating how to access the language services provided by the carrier.

5.9.c. For purposes of this subsection, with respect to any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten (10) percent or more of the population residing in the county is literate only in the same non-English language, as determined in published federal guidance.

§114-96-6. Standard Reviews of Grievances Not Involving an Adverse Determination.

6.1. An issuer shall establish written procedures for a standard review of a grievance that does not involve an adverse determination.

6.2.

6.2.a. The procedures shall permit a covered person to file a grievance that does not involve an adverse determination with the issuer under this section.

6.2.b.

6.2.b.1. A covered person does not have the right to attend, or to have a representative in attendance at the standard review, but the covered person is entitled to submit written material for the person or persons designated by the carrier pursuant to subsection 6.3 of this rule to consider when conducting the review.

6.2.b.2. The issuer shall make the provisions of paragraph 1 of this subdivision known to the covered person within three working days after the date of receiving the grievance.

6.3.

6.3.a. Upon receipt of the grievance, an issuer shall designate a person or persons to conduct the standard review of the grievance.

6.3.b. The issuer shall not designate the same person or persons to conduct the standard review of the grievance that denied the claim or handled the matter that is the subject of the grievance.

6.3.c. The issuer shall provide the covered person with the name, address and telephone number of a person designated to coordinate the standard review on behalf of the issuer.

6.4.

6.4.a. The issuer shall notify in writing the covered person of the decision with twenty (20) working days after the date of receipt of the request for a standard review of a grievance filed pursuant to subsection 6.2.

6.4.b.

6.4.b.1. Subject to paragraph 2 of this subdivision, if, due to circumstances beyond the issuer's control, the issuer cannot make a decision and notify the covered person pursuant to subdivision a of this subsection withing twenty (20) working days, the issuer may take up to an additional ten (10) working days to issue a written decision.

6.4.b.2. An issuer may extend the time for making and notifying the covered person in accordance with paragraph 1 of this subdivision, if, on or before the twentieth working day after the date of receiving the request for a standard review of a grievance, the issuer provides written notice to the covered person of the extension and the reasons for the delay.

6.5. The written decision issued pursuant to subsection 6.4 shall contain:

6.5.a. The titles and qualifying credentials of the person or persons participating in the standard review process (the reviewers);

6.5.b. A statement of the reviewers' understanding of the covered person's grievance;

6.5.c. The reviewer's decision in clear terms and the contract basis in sufficient detail for the covered person to respond further to the issuer's position;

6.5.d. A reference to the evidence or documentation used as the basis for the decision;

6.5.e. If applicable, a statement indicating:

6.5.e.1. A description of the process to obtain an additional review of the standard review decision if the covered person wishes to request a voluntary review pursuant to section 7 of this rule; and

6.5.e.2. The written procedures governing the voluntary review, including an required time frame for the review; and

6.5.f. Notice of the covered person's right, at any time to contact the Commissioner's office, including the telephone number and address of the Commissioner's office.

§114-96-7. Expedited Reviews of Grievances Involving an Adverse Determination.

7.1. An issuer shall establish written procedures for the expedited review of urgent care requests of grievances involving an adverse determination.

7.2. In addition to subsection 8.1 of this rule, an issuer shall provide expedited review of a grievance involving an adverse determination with respect to concurrent review urgent care requests involving an admission, availability of care, continued stay or health care service for a covered person who has received emergency services, but has not been discharged from a facility.

7.3 The procedures shall allow a covered person to request an expedited review under this section orally or in writing.

7.4. An issuer shall appoint an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed to review the adverse determination. The clinical peer or peers shall not have been involved in making the initial adverse determination.

7.5. In an expedited review, all necessary information, including the issuer's decision shall be transmitted between the issuer and the covered person by telephone, facsimile or the most expeditious method available.

7.6.

7.6.a. An expedited review decision shall be made and the covered person or, if applicable, the covered person's authorized representative shall be notified of the decision in accordance with subsection 8.8 of this rule as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two (72) hours after the receipt of the request for the expedited review.

7.6.b. If the expedited review of a grievance involving an adverse determination with respect to a concurrent review urgent care request, the service shall be continued without liability to the covered person until the covered person has been notified of the determination.

7.7. For purposes of calculating the time periods within which a decision is required to be made under subsection 8.6 of this rule, the time period within which the decision is required to be made shall begin on the date the request is filed with the issuer in accordance with the issuer's procedures established pursuant to section 4 of this rule for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

7.8.

7.8.a. A notification of a decision under this section shall, in a manner calculated to be understood by the covered person, set forth:

7.8.a.1. The titles and qualifying credentials of the person or persons participating in the expedited review process (the reviewers);

7.8.a.2. Information sufficient to identify the claim involved with respect to the grievance, including the date of service, the health care provider and, if applicable, the claim amount;

7.8.a.3. A statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. For purposes of this paragraph, an issuer:

7.8.a.3.A. Shall upon request provide to the covered person, as soon as practicable, the diagnosis code and its corresponding meaning and the treatment code and its corresponding meaning, associated with any adverse determination; and

7.8.a.3.B. Shall not consider a request for the diagnosis code and treatment information, in itself, to be a request for external review pursuant to W. Va. Code of St. R. §114-97-1 *et seq.*;

7.8.a.4. A statement of the reviewers' understanding of the covered person's grievance;

7.8.a.5. The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the issuer's position;

7.8.a.6. A reference to the evidence or documentation used as the basis for the decision; and

7.8.a.7. If the decision involves a final adverse determination, the notice shall provide:

7.8.a.7.A. The specific reasons or reasons for the final adverse determination, including the denial code and its corresponding meaning, as well as description on the issuer's standard, if any, that was used in reaching denial;

7.8.a.7.B. Reference to the specific plan provisions on which the determination is based;

7.8.a.7.C. A description of any additional material or information necessary for the covered person to complete the request, including an explanation of why the material or information is necessary to complete the request;

7.8.a.7.D. If the issuer relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;

7.8.a.7.E. If the final adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

7.8.a.7.F. If applicable, instructions for requesting:

7.8.a.7.F.1. A copy of the rule guideline, protocol or other similar criterion relied upon in making the adverse determination in accordance with subparagraph D, paragraph 7, of this subdivision;

7.8.a.7.F.2. The written statement of the scientific or clinical rationale for the adverse determination in accordance with subparagraph E, paragraph 7 of this subdivision;

7.8.a.7.F.3. A statement describing the procedures for

obtaining an independent external review of the adverse determination pursuant to W. Va. Code of St. R. §114-97-1 et. seq.;

7.8.a.7.F.4. A statement indicating the covered person's right to bring a civil action in a court of competent jurisdiction;

7.8.a.7.F.5. The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state Insurance Commissioner."; and

7.8.a.7.F.6. A notice of the covered person's right to contact the Commissioner for assistance with respect to any claim grievance or appeal at any time, including the telephone number and address of the Commissioner's office.

7.8.b.

7.8.b.1. An issuer shall provide the notice required under this section in a culturally and linguistically appropriate manner in accordance with federal regulations.

7.8.b.2. To be considered to meet the requirements of paragraph 1 of this subdivision, the issuer shall:

7.8.b.2.A. Provide oral language services, such as a telephone assistance hotline, that include answering questions in any applicable non-English language and providing assistance with filing benefit requests and claims and appeals in any applicable non-English language;

7.8.b.2.B. Provide, upon request, a notice in any applicable non-English language; and

7.8.b.3. For purposes of this subdivision, with respect to any United States County to which a notice is sent, a non-English language is an applicable non-English language if ten (10) percent or more of the population residing in the county is literate only in the same non-English language, as determined in published federal guidance.

7.8.c.

7.8.c.1. An issuer may provide the notice required under this section orally, in writing or electronically.

7.8.c.2. If notice of the adverse determination is provided orally, the issuer shall provide written or electronic notice of the adverse determination within three (3) days following the oral notification.

§114-96-8. Penalties.

Any issuer failing to comply with the requirements of this rule is subject to the penalties prescribed in W. Va. Code §33-3-11.