Overview

This bill establishes an external appeals process in chapter 62Q for adverse determinations made by health plan companies and sets requirements for internal appeals processes. It also consolidates, modifies, and adds requirements in chapter 62M governing utilization review decisions made by utilization review organizations and procedures for standard appeals and expedited appeals of these decisions. To conform with these changes, the bill makes several technical and conforming modifications to related statutes.

Section

1  **Enrollee complaint system.** Amends § 62D.11, subd. 1. In a subdivision requiring all HMOs to establish and maintain a complaint system for enrollees, requires the complaint system to comply with the new complaint procedures being established in chapter 62Q. Strikes language defining "provision of health services" and requiring HMOs to inform enrollees of certain information regarding how to appeal HMO internal appeal decisions.

2  **Citation, jurisdiction, and scope.** Amends § 62M.01. Adds community integrated service networks (CISNs) and accountable provider networks (APNs) to the jurisdiction of chapter 62M (governing utilization review organizations and procedures). Specifies that the appeal procedures in chapter 62M are to be used for any complaint from an enrollee that requires a medical determination to be resolved.

3-9  Make a number of minor and technical changes to subdivisions defining terms for chapter 62M. Changes made include replacing references to "patient" with "enrollee,"
replacing references to "attending physician" with "attending health care professional," replacing references to "health carrier" with "health plan company," and adding a reference to CISNs and APNs.

10 **Enrollee.** Amends § 62M.02, subd. 11. Modifies the definition of "enrollee;" the amended definition is similar to the definition of this term in chapter 62Q governing health plan companies.

11 **Health benefit plan.** Amends § 62M.02, subd. 12. Makes a minor change to the definition of health benefit plan.

12 **Health plan company.** Adds subd. 12a to § 62M.02. Defines "health plan company."

13-17 Makes minor or technical changes to sections in chapter 62M.

18 **Responsibility for obtaining certification.** Amends § 62M.04, subd. 1. Requires health plan companies that include utilization review requirements to provide a clear and concise description of the utilization review process to its enrollees in the policy, subscriber contract, or certificate of coverage. Makes a minor change in terminology.

19-21 Make minor changes in terminology used.

22 **Procedures for review determination.** Amends § 62M.05. Modifies procedures governing utilization review determinations, and creates an expedited review determination process.

**Subd. 1. Written procedures.** Deletes a reference to section 72A.201, subd. 4a; with this change, a utilization review organization (URO) needs to conduct reviews in compliance with chapter 62M only.

**Subds. 2 and 3.** Makes a change in terminology and a technical change.

**Subd. 3a. Standard review determination.** Requires an initial determination on all requests for utilization review to be communicated to the enrollee and provider within ten business days of the request, if all information reasonably needed to make the decision has been made available to the URO. (This requirement is in current law and is being moved from another paragraph.) Makes changes to terminology used. When an initial determination is made not to certify, requires notification by telephone within one working day after the determination. Specifies that written notice of determinations not to certify must inform the enrollee and the attending health care professional of the right to appeal to either the external appeal process in chapter 62Q or the internal appeal process for utilization review determinations in chapter 62M.

**Subd. 3b. Expedited review determination.** Establishes an expedited process for making initial utilization review determinations. Requires the expedited process to be used if
the attending health care professional believes that an expedited determination is needed. Requires notifications of expedited initial determinations to be made as quickly as the enrollee's medical condition requires, but no later than 72 hours after the initial request. If the determination is not to certify, requires the URO to also notify the enrollee and attending professional of the right to appeal to either the external appeal process in chapter 62Q or the expedited internal appeal process for utilization review determinations in chapter 62M.

Subd. 4. Failure to provide necessary information. Makes changes to terminology used.

Subd. 5. Notification to claims administrator. If the URO and claims administrator are separate entities, requires the URO to forward a notification of the decision to certify or not to certify to the claims administrator.

Appeals of determinations not to certify. Amends § 62M.06. Modifies the standard and expedited appeals processes for decisions not to certify by utilization review organizations.

Subd. 1 and 4. Makes minor changes and changes in terminology used.

Subd. 2. Expedited appeal. If an enrollee pursues an expedited appeal, requires the URO to notify the enrollee and attending professional by phone of its determination as quickly as the enrollee's medical condition requires, but no later than 72 hours after receiving the expedited appeal. If the determination not to certify is not reversed through the expedited appeal, requires the URO to give the enrollee and attending professional, within ten days, information on the right to appeal the decision to the external appeal process in chapter 62Q.

Subd. 3. Standard appeal. In the standard appeal process, requires a URO to notify the enrollee, health care professional, and claims administrator of its determination on the appeal within 30 days of receiving the notice of appeal (under current law, a URO must give notice of its decision within 45 days after receiving the required documentation for the appeal). If an initial determination is not reversed on appeal, requires the URO to include in its notification the right to submit an appeal to the external appeal process in chapter 62Q.

Subd. 3a. Second appeal option. Allows a URO to establish an appeal process that offers a second appeal if the determination not to certify is not reversed through the standard appeal. Specifies that the enrollee need not exhaust a second appeal, if offered by the URO, before appealing through the external appeal process under chapter 62Q.
Makes minor and technical changes and changes in terminology used, including using the term "attending health care professional" instead of "attending physician."

Definitions. Adds § 62Q.68. For a series of sections establishing requirements for complaint resolution processes, defines the terms complaint and complainant.

Subd. 1. Complaint. Means any grievance against a health plan company that is not the subject of litigation and that has been submitted to a health plan company regarding the provision of health care services, including the scope of coverage for services; retrospective denials or limitations of payment for services; eligibility issues; terminations of coverage issues; administrative operations; and the quality, timeliness, and appropriateness of services rendered. Requires any grievance requiring a medical determination in its resolution to be appealed using the procedures in chapter 62M.

Subd. 3. Complainant. Means a person who submits a complaint to a health plan company and who is an enrollee, applicant, or former enrollee, or a person acting on behalf of one of these individuals.

Complaint resolution. Adds § 62Q.69. Requires health plan companies to have internal complaint resolution procedures, establishes procedures for filing complaints, and establishes requirements for notifications of complaint decisions.

Subd. 1. Establishment. Requires a health plan company to establish and maintain an internal complaint resolution process to resolve complaints filed by complainants.

Subd. 2. Procedures for filing a complaint. Allows complainants to file complaints either by telephone or in writing. If the complaint is made orally and is resolved adversely for the complainant, or if the oral complaint is not resolved within ten days, the health plan company must inform the complainant that the complaint may be submitted in writing and must mail a complaint form to the complainant. Lists the information that the complaint form must include. Upon receipt of a written complaint, requires the health plan company to notify the complainant within ten business days that the complaint was received, unless the complaint is resolved in that time. Allows complainants to request help from health plan companies in filing written complaints, and requires health plan companies to provide a clear description of how to submit a complaint and notice that help in filing a complaint is available.

Subd. 3. Notification of complaint decisions. Requires a health plan company to notify the complainant in writing of its decision and reasoning as soon as practical, but no later than 30 days after receiving the written complaint. If the
decision is adverse to the complainant, requires the notification to tell the complainant of the right to appeal the decision to either the internal appeal process or the external appeal process. Also requires the notification to tell the complainant of the right to submit the complaint at any time to either the commissioner of health or the commissioner of commerce.

35 Appeal of the complaint decision. Adds § 62Q.70. Establishes procedures to appeal complaint decisions.

Subd. 1. Establishment. Requires a health plan company to establish an internal appeal process for reviewing health plan company decisions on complaints. Specifies that the people authorized to resolve or recommend the resolution of internal appeals must not be solely the same people who made the initial decisions about complaints. Requires the internal process to allow the receipt of testimony, explanations, and other information.

Subd. 2. Procedures for filing an appeal. If a complainant notifies a health plan company of a decision to appeal through the internal appeal process, requires the health plan company to give the complainant the option of appealing either in writing or through a hearing.

Subd. 3. Notification of appeal decisions. Requires a health plan company to give a complainant written notice of the appeal decision and all key findings within 30 days of receiving the complainant's written notice of appeal. If the appeal decision is adverse to the complainant, requires the notice to advise the complainant of the right to submit the appeal decision to the external review process. Allows the complainant to request a complete summary of the appeal decision.

36 Notice to enrollees. Adds § 62Q.71. Requires health plan companies to give enrollees a clear, concise description of the complaint resolution procedures and the procedures used for utilization review, as part of the member handbook, subscriber contract, or certificate of coverage. Lists the information that the description must include.

37 Recordkeeping; reporting. Adds § 62Q.72. Requires health plan companies to keep records of all enrollee complaints for the past five years and their resolutions, and to make them available to the appropriate commissioner upon request.

Requires health plan companies to submit data on the number and types of complaints not resolved within 30 days to the appropriate commissioner, and to make this information available to the public on request.

Subd. 1. Definitions. Defines an adverse determination as a complaint decision that relates to a health care service or claim or an appeal decision and that is adverse to the complainant; or any initial determination not to certify or an appeal of a decision not to certify in which the initial decision is not reversed.

Subd. 2. Right to external review. Allows any enrollee, or any person acting on behalf of any enrollee, who has received an adverse determination to submit a written request for external review. Requires the health plan company to participate.

Subd. 3. Contract. Requires the commissioner of administration, in consultation with the commissioners of health and commerce, to contract with an organization to provide independent external reviews of adverse determinations.

Subd. 4. Criteria. Requires the organization performing independent external reviews to be affiliated with an institution of higher learning, and lists criteria that the organization must satisfy.

Subd. 5. Process. Requires the external review entity to provide immediate notice to the enrollee and the health plan company when it receives a request for an external review. Within ten business days, requires the health plan company and enrollee to provide the entity with any information they wish to have considered. Allows an enrollee to be assisted or represented by a person of the enrollee's choice. Permits an independent medical opinion to be sought or a medical review panel to be established. Requires external reviews to be completed as soon as practical, but not later than 40 days after receiving the request, and requires the entity to promptly send written notice of the decision and reasons for it to the enrollee and health plan company.

Subd. 6. Effects of external review. Specifies that decisions are nonbinding on the enrollee and binding on the health plan company. Allows the health plan company to ask for judicial review of the decision, on the ground that the decision was arbitrary and capricious or involved an abuse of discretion.

Subd. 7. Immunity from civil liability. Extends immunity from civil liability to any person who participates in external review, for actions that are not willful or reckless misconduct, taken in good faith, and within the scope of the person's duties.

Subd. 8. Attorney fees. Allows the commissioner to award attorney fees to the enrollee, if warranted.

Subd. 9. Data privacy. Specifies that medical records provided to conduct an external review remain confidential.

Subd. 10. Data reporting. Requires external review
organizations to provide the commissioner with data on the number of reviews held and a summary of each decision. Requires the commissioners to make available to the public, on request, summary data on decisions made under this section.

39-42 Change cross-references in sections 62T.04, 72A.201, and 256B.692, to conform with changes made in this bill.

43 **Repealer.** Repeals sections 62D.11, subd. 1b and 2 (expedited resolutions of complaints for HMOs); 62Q.105 (complaint procedures for health plan companies); 62Q.11 (dispute resolution procedures to be available to settle disputes with health plan companies); and 62Q.30 (expedited fact-finding and dispute resolution process for health plan companies).

Repeals Minnesota Rules, parts 4685.0100, subp. 4 and 4a (definitions in HMO rules); and 4685.1700 (requirements for HMO complaint systems).