SESSION OF 2006

SUPPLEMENTAL NOTE ON HOUSE SUBSTITUTE FOR SENATE BILL NO. 522

As Recommended by House Committee on Insurance

Brief*

House Sub. for SB 522 would enact new law to provide insureds with certain appeals rights for adverse health care decisions made through a utilization review process. Specifically, the bill would require every health insurance plan for which utilization review is performed to include a description of the plan's procedures for an insured to obtain internal review of an adverse decision. The description would be required to include all applicable time periods, contact information, rights of the insured, and available levels of appeal. If the health insurer uses a utilization review organization, its insured is to be notified of the name of the organization. The plan also would be required to provide an insured with written or electronic notification of any adverse decision and a description of the plan's review procedure, including the insured's right to external review as provided in KSA 40-22a14. In addition, the plan would be required to notify the insured of the insured's right to waive the second appeal or internal review and proceed directly to the external review.

If the health insurance plan utilization review contains a provision for two levels of internal review of an adverse health care decision, the plan would be required to allow the insured to voluntary waive the insured's right to the second appeal or internal review. The waiver is to be made in writing to the plan and would constitute an exhaustion of all available internal appeal or review procedures.

The bill also would provide that if an insured elects to request the second appeal or internal review of a health care decision that is adverse to the insured, the insured would have the right to appear in person before the health insurance plan or utilization review organization's designated representatives at the second appeal or internal review meeting. If a majority of the designated representatives of the health plan or utilization review organization deciding the appeal

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*Supplemental notes are prepared by the Legislative Research Department and do not express legislative intent. The supplemental note and fiscal note for this bill may be accessed on the Internet at http://www.kslegislature.org

or review cannot be present in person, by telephone, or by other electronic means, at least one is required to be a physician and be present in person, by telephone, or by other electronic means. Any physician or health care provider serving as a reviewer in the second appeal or internal review could not be held liable in damages to either the insured or the health insurance plan for any opinion the provider rendered as part of the appeal or review.

All second appeals or internal reviews would be required to provide that the insured has the right to:

- Receive, upon request, from the plan or utilization review organization, copies of all documents, records, and other information that are not confidential or privileged relative to benefits;

- Have a reasonable and adequate amount of time to present the insured's case to a designated representative or representatives of the plan or utilization review organization who will be deciding the second internal appeal or review;

- Submit written comments, questions, documents, records and other material relating to the request for benefits for the panel to consider when conducting the second internal appeal or review meeting both before and, if applicable, after the second internal appeal or review meeting;

- Prior to or during the second internal appeal or review meeting, ask questions relevant to the subject matter of the appeal or review of any representative of the plan or utilization review organization serving on the internal appeal or review panel provided that such representative may respond verbally if the question is asked in person during an insured's appearance before the internal appeal or review panel or in writing if the questions are asked in writing, not more than 30 days from receipt of such written questions;

- Be assisted or represented at the second appeal or internal review meeting by an individual or individuals of the insured's choice; and

- Record the proceedings of the second appeal or internal review meeting at the expense of the insured.

The bill also would provide that the insured, or insured's authorized representative who wishes to appear in person before the second appeal or internal review panel consisting of the health insurance plans or utilization review organization's designated representative or representatives is to make the request to the health insurance plan or utilization review organization within five working days before the date of the scheduled meeting. The bill would create an exception for emergency medical conditions, allowing that in such case, the request must be made no less than 24 hours prior to the scheduled review meeting.

Finally, the plan or utilization review organization would be required to provide the insured a written decision that sets forth the relevant facts and conclusions supporting its decision within:

- 72 hours if the second internal appeal or review involves an emergency medical condition as defined in subsection (b) of KSA 40-22a13;
- Fifteen business days if the second internal appeal or review involves a pre-service claim; and
- 30 days if the second internal appeal or review involves a post-service claim.

Background

SB 522 was introduced by the Financial Institutions and Insurance Committee at the request of Senator Allen who indicated that the bill would afford basic rights in the appeal of adverse health care decisions. Proponents of the bill highlighted the ability to expedite the appeals process and the importance of protecting Kansas consumers by clarifying or stating steps associated with the internal review process. Proponents of the bill included Senator Allen, Gary Sherrer, and representatives of the Kansas Insurance Department, the Office of the Governor, the National Association of Social Workers Kansas Chapter, the Kansas Association of Health Plans, America's Health Insurance Plans, the Kansas Medical Society, and a psychologist in private practice. Mr. Sherrer presented testimony to the Committee specific to a family member's experience with the appeal of an adverse health care decision. Senator Allen, the Kansas Association of Health Plans, and America's Health Insurance Plans presented amendments for consideration.

The Senate Committee on Financial Institutions and Insurance amended the bill to clarify notification provisions, provide immunity from liability for physicians and health care providers in the internal appeal and review process, clarify the time allowed for response to questions submitted by the insured and the issuing of the written decision, and establish a process for creation of a record of the proceeding and requirements for the record. An amendment to cross-reference to adverse decision, as defined in the statutes governing the external review of utilization review organizations also was adopted.

The Senate Committee of the Whole further amended the bill to remove a provision added to the bill by the Senate Committee to establish a process for creation of a record of the proceeding and requirements for the record. The Senate Committee of the Whole amendment restores the recording provision contained in the original bill.

The House Committee on Insurance recommended a substitute bill. The substitute incorporates provisions of SB 522, as amended by the Senate Committee of the Whole, with a number of amendments that were proposed by the Kansas Association of Health Insurance Plans in consultation with a number of parties appearing as proponents to the original bill. The amendments include Department of Labor standards for the response time for internal appeals or reviews and also allow for a panel that has one member or only has one member present at the appeal or review meeting, that the member be a physician and be present in one of the acceptable manners identified in the bill. The Committee also made an amendment to require a health insurance plan to notify the insured of the insured's right to waive the second appeal or internal review and proceed directly to the external review process. Technical amendments are made to made references to the panel or review consistent.

The fiscal note prepared by the Division of the Budget on the introduced version of the bill indicates that passage of the bill would have no fiscal effect.