

House Consumer Affairs Subcommittee Am. #1

AMENDMENT NO. \_\_\_\_\_

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by deleting all of the language following the enacting clause and by substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, is amended by adding Sections 2 through 13, inclusive, as a new part to be appropriately designated.

SECTION 2. As used in this act, unless the context otherwise requires:

(1) "Clinical peer" means a physician or other health care professional who holds a nonrestricted license in a state of the United States and in the same or similar specialty as typically manages the medical condition, procedure or treatment under review.

(2) "Commissioner" means commissioner of commerce and insurance.

(3) "Complaint" means a complaint made by or on behalf of a covered person regarding:

(A) a determination by a health plan or its designated utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed, and based upon the information provided, does not meet the health plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced or terminated;

(B) the availability, delivery or quality of health care services, including but not limited to delay, timing or location of services, appropriate skill level of

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health care professional, denial of coverage for emergency and related services, or any other health plan action, policy or practice which hinders the receipt of covered health care services;

(C) claims payment, handling or reimbursement for health care services;

or

(D) matters pertaining to the contractual relationship between a covered person and a health plan.

(4) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

(5) "Consumer" means an individual in the general public who may or may not be an enrollee or purchaser of health care services from a health plan. For purposes of serving on a governing body under this act, consumer is an individual who resides in the state; has lived in the state for at least five (5) years immediately preceding appointment to a governing body; has never been authorized to practice a healing art; and has never had a substantial personal, business, professional, or pecuniary connection with a healing art or health care facility or plan, except as a patient.

(6) "Covered benefits or benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

(7) "Covered person" means a person participating in a managed health care plan, including a person who is covered as an eligible dependent of another person or a

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person acting on the covered person’s behalf including a health care professional.

(8) “Department” means department of commerce and insurance;

(9) “Discharge planning” means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

(10) “Enrollee” means a person covered by a health insurance policy or managed care plan including a person who is covered as an eligible dependent of another person.

(11) “Evidence of coverage” means any certificate, agreement, policy, or contract issued to a subscriber that sets out the coverage and other rights to which such person is entitled under a health plan.

(12) “Health care facility” means an institution providing health care services or a health care setting, including but not limited to hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

(13) “Health care professional” means a physician, nurse and other health professional licensed, accredited or certified to perform specified health care services consistent with state law.

(14) “Health care or health care services” means a broad set of services, including mental health services, substance abuse services, and acute, chronic,

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preventive, restorative and rehabilitative care which are delivered in many different settings by many different health care professionals.

(15) "Health plan" means a health delivery and insurance financing system in which a network of contracted providers, including behavioral health organizations, guarantees the provision of health benefits to a defined population for a fixed payment, including but not limited to, any insurance policy or contract issued or entered into under Tennessee Code Annotated, Title 56, Chapters 7, 26, 27, 28, 29, 30, or 32. Health plan does not include plans covering enrollees in the TennCare program, which operates under a Federal waiver pursuant to Tennessee Code Annotated, Title 71.

(16) "Health plan agent" means a person who represents a health plan in the solicitation, negotiation, procurement, or effectuation of health plan enrollment or membership.

(17) "Managed care plan" means a health delivery and insurance financing system in which a network of contracted providers guarantees the provision of health benefits to a defined population for a fixed payment.

(18) "Network" means the group of participating providers providing services for a managed care plan.

(19) "Participating provider" means a provider who, under contract with a health plan, has agreed to provide health care services to covered persons with an expectation of receiving payment other than coinsurance, copayments, deductibles, directly or indirectly from the health plan.

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(20) "Second opinion" means a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health service or denial of service to assess the clinical necessity and appropriateness of the initial proposed health service or denial of service.

(21) "Utilization review organization" means an entity that conducts utilization review, other than a health carrier performing a review for its own health plans.

(22) "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, perspective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review.

**SECTION 3.**

(a) A health plan shall establish a complaint procedure consistent with the requirements of this act.

(b) A health plan shall have written procedures for receiving and resolving complaints. A copy of the complaint procedures, including all forms used to process complaints, shall be filed with the department of commerce and insurance. Any subsequent material modifications to the documents shall also be filed. In addition, a health plan shall file annually with the department of commerce and insurance a certificate of compliance stating that the health plan has established and maintains, for each of its health benefit plans, complaint procedures that fully comply with the

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provisions of this act and other applicable state laws and regulations. The commissioner of commerce and insurance has authority to disapprove any filing that fails to comply with this act or other applicable laws or regulations.

(c) The health plan shall notify covered persons and persons considering enrolling of the complaint procedure, as provided below:

(1) A description of the complaint procedure 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.

(2) A health plan shall inform each covered person of the complaint procedure at the time of initial enrollment and annually thereafter, with any material modification highlighted and clearly explained. Notices explaining the complaint procedure, in plain English written for no higher than a sixth grade reading level and in the languages commonly used by covered persons, shall be posted in the offices and facilities operated by the health plan and shall be available upon request.

(3) All documents relating to the complaint procedure shall include a statement of a covered person's right to contact the department for assistance at any time. The statement shall include the telephone number and address of the agency or office designated by the department.

(4) A description of the complaint procedure shall be included in the materials given to persons considering enrolling in the health plan.

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SECTION 4.

(a) A complaint procedure may be initiated orally, in person or by telephone, or in writing by a covered person. If the complaint procedure is initiated orally, the health plan staff shall reduce the complaint to writing and give the covered person a copy.

(b) In order to permit a covered person to initiate promptly a complaint about a denial, termination or reduction of service, a health plan shall comply with the following:

(1) If a covered person has requested a health care service and that request has been denied, in whole or in part, the health plan or its participating providers or facilities shall issue a timely written denial no later than twenty-one (21) days after the request was made which explains the reason for the denial, notifies the covered person of the complaint procedure, and provides the name and telephone number of the person to call for information and assistance.

(2) The health plan or its participating providers or facilities shall give the covered person no less than ten (10) days advance written notice of a proposed termination or reduction of services already being provided. The notice shall explain the reason for the termination or reduction, notify the covered person of the complaint procedure and provide the name and telephone number of the person to call for information and assistance.

(c) The health plan shall, within five (5) days after the complaint has been initiated, provide to the person who initiated it the written information listed below. Upon

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request, the information shall be in a language other than English if that language is one commonly used by covered persons in the plan. The information shall include:

- (1) an explanation of the health plan complaint procedure as a whole;
- (2) the name, address and telephone number of the person designated to coordinate the complaint procedure for the health plan;
- (3) the health plan's time limit for completing first-level review;
- (4) notice of the following rights:
  - (A) that the covered person may submit written information for first-level review;
  - (B) that if the health plan fails to meet the time limit for first-level review the complaint shall be considered automatically resolved in favor of the covered person.
  - (C) that expedited review may be available and how to request it;
  - (D) that health care services already being provided shall continue, with no change in financial liability, pending resolution of the complaint; and
  - (E) that alternate dispute resolution may be available in certain situations.

SECTION 5.

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(a) The health plan shall have the complaint reviewed by a person or persons who were not involved in the determination or other action that is the subject of the complaint.

(b) Where resolution of the complaint requires medical expertise, the health plan shall ensure that the review is conducted by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The clinical peers shall not have been involved in the initial determination.

(c) A covered person may submit written material, but does not have the right to attend first-level review.

(d) In cases where the covered person has not received the services in question or is faced with a termination or reduction of services already being provided or the complaint involves a health plan action, policy or practice which hinders receipt of covered health care services, the health plan shall, fourteen (14) days after the complaint was initiated, provide to the covered person a written decision, meeting the requirements of subsection (e) below. A health care professional who ordered or requested the services in question, or who opposes the termination or reduction in question, must also receive a copy of the decision within fourteen (14) days.

(e) The written decision shall contain:

(1) the names and titles of the person or persons participating in the first-level review ("the reviewers");

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(2) a statement of the reviewers' understanding of the covered person's complaint and the significant facts;

(3) 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 health plan's position, and a copy of the relevant portions of any clinical practice guidelines relied on by the reviewers;

(4) a summary of the written and oral evidence which the reviewers relied on in reaching their decision; and

(5) a copy of the written procedures governing second-level review, including applicable time limits, the covered person's rights with respect to the review meeting, and the right to continuation of services.

(f) If a health plan fails to meet the time limits specified in this section, the complaint shall be deemed automatically resolved in favor of the covered person.

SECTION 6.

(a) Completion of first-level review is a prerequisite for second-level review except in cases involving expedited review. Second-level review must be requested in writing by the covered person.

(b) A health plan shall establish a second-level review panel for each complaint as provided in subsection (c) or (d).

(c) In all cases:

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(1) The health plan shall select a panel of clinical peers who have no financial interest in the health plan. A person who was previously involved with the complaint may appear before the panel to present information or answer questions;

(2) The panel shall have the legal authority to bind the plan to the panel's decision; and

(3) Except as provided below, the review panel shall provide a written decision meeting the requirements of subsection (d) within fourteen (14) working days after the review meeting. If the health plan fails to meet the time limits provided herein, the complaint shall be deemed automatically resolved in favor of the covered person.

(d) The written decision shall include:

(1) the names and titles of the members of the review panel;

(2) a statement of the review panel's understanding of the complaint and the significant facts;

(3) the review panel's decision in clear terms, the contract basis for it, and where a medical issue was involved, the findings of the individual members of the review panel, and a copy of the relevant portions of any clinical practice guidelines relied on by the review panel;

(4) a summary of the written and oral evidence which the review panel relied on in reaching its decision; and

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(5) notice of the covered person's right to appeal to the state, plus information on how to do so.

SECTION 7.

(a) When a health plan proposes to terminate or reduce health care services already being provided, or to terminate or reduce payment for such services, the health plan shall continue to provide or pay for those services pending resolution of the complaint. The covered person shall not be financially liable, beyond the level required prior to the complaint, for services received pending resolution of the complaint, regardless of the health plan's decision. For purposes of this section, a complaint is considered resolved when the covered person receives notice of the second-level review decision or states in writing that he or she does not intend to pursue the complaint any further.

(b) A health plan may use expedited review when continuation of services or payment for services is required; however, the covered person must be afforded a reasonable amount of time under the circumstances to gather and submit evidence and prepare for review meeting.

SECTION 8.

(a) A request for expedited review may be made orally or in writing, at any time, by the covered person, parent, legal guardian, or legal representative and also by a physician not affiliated with the health plan who is familiar with the covered person's medical condition.

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(b) The covered person shall receive expedited review if a health care professional, including one who is not affiliated with the health plan but is familiar with the covered person’s medical condition, either requests expedited review or expresses an opinion that adherence to the time limits applicable to first or second-level review would jeopardize the life or health of a covered person or would jeopardize or unreasonably burden the covered person’s ability to regain maximum function.

(c) The maximum time allowable for expedited review is twenty-one (21) days from the day expedited review was requested to and including the day when the requesting person receives notice of the second-level review decision, unless he or she consents in writing to an extension.

(d) A health plan may use expedited review, as provided in Section 6, when the health plan is required to continue to provide or pay for services pending resolution of the complaint.

**SECTION 9.**

(a) Except as provided in subsection (b), a health plan may provide mediation or other informal mechanisms for resolving complaints, and, upon written request of the covered person, may arrange for binding arbitration at the health plan’s expense.

(b) Arbitration, mediation and other informal mechanisms shall not be used to resolve a disagreement about medical necessity and appropriateness, or a purely factual dispute.

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(c) Except where binding arbitration has commenced, the covered person may at any time terminate the alternate dispute resolution process and return to the regular complaint procedure. The time spent in alternate dispute resolution shall not be included when calculating the time limits for first and second-level review.

SECTION 10.

(a) A covered person who has completed second-level review and is not satisfied with the decision may appeal to the department of commerce and insurance. In all cases involving a denial, termination or reduction of health care services, or of payment for such services, the department shall provide an administrative hearing in accordance with subsection (e).

(b) In other cases, the department may decline to grant a hearing, in which case the covered person must be so notified within five (5) working days. A decision to not grant a hearing should be consistent with the understanding that the appeal is a critical safeguard for individuals whose health and well-being are at stake. Denial of a hearing does not preclude other forms of intervention by the department.

(c) The health plan shall continue to provide or pay for services already being received pending resolution of the appeal.

(d) In cases where the covered person has not received the services in question or is faced with termination or reduction of services already being received or the complaint involves a health plan action, policy or practice which hinders or delays receipt of services, the administrative hearing shall be held within twenty (20) days after the

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appeal was received, and written decision shall be provided within five (5) working days after the hearing is completed. In other cases, the hearing shall be held within thirty (30) days after the appeal was received and a written decision shall be provided within ten (10) days after the hearing is completed.

(e) In accord with the provisions of Tennessee Code Annotated, Title 4, Chapter 5, for contested case hearings, the administrative hearing shall:

- (1) be conducted by an independent administrative law judge;
- (2) be a de novo review of all relevant facts and arguments, including but not limited to the evidence and decisions produced by the health plan complaint procedure;
- (3) provide the covered person the right to present evidence, call and cross-examine witnesses, and be assisted or represented by a person of his/her choice;
- (4) include additional medical evidence by an independent medical expert provided for the covered person at the health plan's expense when the administrative law judge determines that such evidence is necessary for fair resolution of the issues or for development of the record; and

(5) result in a written decision setting out the judge's findings of fact and conclusions of law.

(f) The decision of the administrative law judge shall be binding on the health plan.

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(g) In order to prevail in an appeal, the health plan must produce sufficient evidence to justify its decision denying, reducing or terminating the services in question or the payment for such services.

(h) An expedited appeal shall be available when the administrative law judge determines that adherence to the time limits provided in this section would jeopardize the covered person's life, health or ability to regain maximum function. The administrative law judge may also provide an expedited appeal in cases where continuation of services or payment for services is required and the expedited procedures would be fair to all parties. In an expedited appeal, the hearing shall be completed and the decision communicated to the covered person within ten (10) days.

SECTION 11. Judicial review of the decision of the administrative law judge shall be available, at the covered person's option, as provided by Tennessee Code Annotated, Section 4-5-322.

SECTION 12. Nothing in this act shall be construed to pre-empt other consumer rights or remedies available under state or federal law, including common law.

SECTION 13.

(a) A health plan shall maintain a register consisting of a written record of all complaints initiated during the past five (5) years. The register shall also include, for the past five (5) years, all complaints which did not go through a complaint procedure but instead were litigated or resolved through alternate dispute resolution. The register shall

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be available for review by the department as defined by regulation. The register shall include at a minimum the following:

- (1) the name of the covered person;
- (2) a description of the reason for the complaint;
- (3) the dates when first and second-level review were requested and completed;
- (4) a copy of the written decision rendered at each level of review;
- (5) If required time limits were exceeded, an explanation of why they were exceeded and a copy of the covered person's consent to an extension of time;
- (6) whether expedited review was requested and the response to the request;
- (7) whether alternate dispute resolution was used and the outcome thereof, including, where binding arbitration was used, a copy of the covered person's request for binding arbitration and a copy of the arbitration decision;
- (8) whether there was an appeal to the department and the result of the appeal;
- (9) whether the complaint resulted in litigation and the result of the litigation.

(b) A health plan shall report annually to the department the numbers, and related information where indicated, for the following:

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- (1) covered lives;
- (2) total complaints initiated;
- (3) total complaints involving medical necessity or appropriateness;
- (4) complaints involving termination or reduction of inpatient hospital services;
- (5) complaints involving termination or reduction of nursing facility or other institutional care;
- (6) complaints involving termination or reduction of other health care services;
- (7) complaints involving denial of health care services where the covered person had not received the services at the time the complaint was initiated;
- (8) complaints involving payment for health care services which the covered person had already received at the time of initiating the complaint;
- (9) complaints resolved at each level of review and how they were resolved;
- (10) complaints where expedited review was provided because adherence to regular time limits would have jeopardized the covered person's life, health or ability to regain maximum function;
- (11) complaints where expedited review was provided because the health plan was required to continue services pending resolution of the complaint;

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(12) complaints which were resolved through alternate dispute resolution and the outcome of that process;

(13) complaints which were appealed to the state and the outcome of the appeal; and

(14) complaints which resulted in litigation and the outcome of the litigation.

SECTION 14. Tennessee Code Annotated, Section 56-32-210(a), is amended by inserting the language "which complies with the provisions of this act and" between the language "system" and "which".

SECTION 15. Tennessee Code Annotated, Section 56-32-210(a), is amended by deleting subsection (c) in its entirety.

SECTION 16. This act shall take effect January 1, 1998, the public welfare requiring it.

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