

ALEC EXPOSED

"ALEC" has long been a secretive collaboration between Big Business and "conservative" politicians. Behind closed doors, they ghostwrite "model" bills to be introduced in state capitols across the country. This agenda-underwritten by global corporations--includes major tax loopholes for big industries and the super rich, proposals to offshore U.S. jobs and gut minimum wage, and efforts to weaken public health, safety, and environmental protections. Although many of these bills have become law, until now, their origin has been largely unknown. With **ALEC EXPOSED**, the Center for Media and Democracy hopes more Americans will study the bills to understand the depth and breadth of how big corporations are changing the legal rules and undermining democracy across the nation.

ALEC's Corporate Board

--in recent past or present

- AT&T Services, Inc.
- centerpoint360
- UPS
- Bayer Corporation
- GlaxoSmithKline
- Energy Future Holdings
- Johnson & Johnson
- Coca-Cola Company
- PhRMA
- Kraft Foods, Inc.
- Coca-Cola Co.
- Pfizer Inc.
- Reed Elsevier, Inc.
- DIAGEO
- Peabody Energy
- Intuit, Inc.
- Koch Industries, Inc.
- ExxonMobil
- Verizon
- Reynolds American Inc.
- Wal-Mart Stores, Inc.
- Salt River Project
- Altria Client Services, Inc.
- American Bail Coalition
- State Farm Insurance

For more on these corporations, search at www.SourceWatch.org.

DID YOU KNOW? Corporations VOTED to adopt this. Through ALEC, global companies work as "equals" in "unison" with politicians to write laws to govern your life. Big Business has "a VOICE and a VOTE," according to newly exposed documents. **DO YOU?**

Home → [Model Legislation](#) → Health and Human Services

RESCISSION EXTERNAL REVIEW ACT

Section 1. Short Title. This Act may be cited as the "Rescission External Review Act."

Section 2. Purpose. The purpose of this Act is to assure that covered persons have an opportunity for an independent external review when coverage is rescinded.

Section 3. Definitions. When used in this Act, the following definitions apply:

A. "Authorized representative" means a person to whom a covered person has given express written consent to represent the covered person in an external review.

B. "Independent review organization" means an entity that conducts independent external reviews of rescission determinations.

C. "Rescission determination" means an initial determination involving a rescission or modification of coverage as a result of a material misstatement or fraud, including a determination that has been upheld by a health insurer at the completion of the health insurer's internal grievance procedures.

Section 4. Applicability and Scope.

A. Except as provided in Paragraph B, this Act shall apply to all health insurers offering health insurance coverage to residents of this state.

B. The provisions of this Act shall not apply to a policy or certificate that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity, long-term care insurance, vision care, or any other limited supplemental benefit or to a Medicare supplemental policy of insurance, as defined by the **{insert state insurance commissioner}** by regulation, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

Section 5. Required Disclosures.

A. Within **{insert time frame otherwise required by state law}** of issuing a health insurance contract, the health insurer shall send a copy of the completed written application to the applicant with a copy of the health insurance contract issued by the health insurer, along with a notice that states all of the following:

1. The applicant should review the completed application carefully and notify the health insurer within **{insert time frame otherwise required by state law}** of any inaccuracy in the application.

2. Any material misrepresentation or material omission in the information submitted in the application may result in the cancellation or rescission of the plan contract.

3. The applicant should retain a copy of the completed written application for the applicant's records.

B. If new information is provided by the applicant within the time frame permitted by Paragraph A, the health insurer shall review that information and make the appropriate change to its underwriting determination.

Section 6. Medical History Review.

A. Once a health insurer has issued an individual health insurance contract, the health insurer shall not rescind or cancel the health insurance contract unless all of the following apply:

1. There was a material misrepresentation or material omission in the information submitted by the applicant in the written application to the health insurer prior to the issuance of the health insurance contract that would have materially affected the underwriting classification or eligibility decision.

Did you know that global pharmaceutical company Bayer Healthcare was the corporate co-chair in 2011?

2. The health insurer maintains and has relied upon written medical underwriting policies and procedures in making the determination to issue an individual health insurance contract.

3. The applicant misrepresented or omitted material information on the application prior to the issuance of the health insurance contract.

4. The health insurer sent a copy of the completed written application to the applicant with a copy of the health insurance contract issued by the health insurer, along with the written notice required by Section 5.

B. If a health insurer obtains information after issuing an individual health insurance contract that the covered individual may have omitted or misrepresented material information during the application for coverage process, the health insurer may investigate the potential omissions or misrepresentations in order to determine whether the health insurance contract should be amended, rescinded or canceled.

C.

1. Upon initiating an investigation for potential rescission or cancellation of a health insurance contract, the health insurer shall provide a written notice to the covered individual that it has initiated a claims investigation. The notice shall be provided by the health insurer within 10 days of the initiation **{or insert other time frame identified in a state's prompt pay or clean claims law}** of the investigation.

2. The health insurer shall complete its investigation, and provide written notice of its decision no later than 30 days from the date of the notice sent to the covered individual. The health insurer may stop the 30 days from running if it needs to obtain additional information to complete the investigation. *(Drafting note: This time frame should be adjusted to be consistent with a state's clean claims or prompt pay law.)*

D. Upon completion of its post-issuance investigation, the health insurer shall provide written notice to the covered individual that it has concluded its investigation and has made one of the following determinations:

1. The health insurer determined that the covered individual did not misrepresent or omit material information during the application process and that the subscriber's or enrollee's health insurance contract will not be canceled or rescinded.

2. The health insurer intends to amend, cancel, or rescind the health insurance contract for misrepresentation or omission of material information during the application for coverage process. The notice must also include all procedures required to request a review under the health insurer's appeal or complaint process.

3. The health insurer shall provide the covered individual with the opportunity to provide any evidence or information within 30 days of the final determination that would affect the decision to rescind, cancel, or modify coverage.

Section 7. Notice of Right to External Review.

A.

1. A health insurer shall notify the covered person in writing of the covered individual's right to request an external review at the same time the health insurer sends written notice of a rescission determination upon completion of the health carrier's grievance process, if required; and

2. As part of the written notice required under Paragraph A, Subparagraph 1, a health insurer shall include the following, or substantially equivalent, language: "We have rescinded your health insurance coverage. You have the right to have our decision reviewed by an independent external review entity by submitting a request for external review to the **{insert state insurance commissioner; insert address and telephone number of the state insurance commissioner's office or other unit in the office that administers the external review program}**."

Section 8. Request for External Review.

A.

1. All requests for external review shall be made in writing to the **{insert state insurance commissioner}**.

2. The **{insert state insurance commissioner}** may prescribe by regulation the form and content of external review requests required to be submitted under this section *(Drafting note: These forms should be consistent with appeals forms or procedures already in place.)*

B. A covered individual or the covered individual's authorized representative may make a request for an external review. *(Drafting note: This Section should be consistent with a state's external review process.)*

Section 9. Process for Requesting External Review.

A. A request for an external review shall not be made until the covered individual has exhausted the health insurer's internal appeal process. A health insurer may waive the requirement that an individual exhaust the insurer's internal grievance

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process.

B.

1. Within 30 days after the date of receipt of a notice of a rescission determination pursuant to this Act, a covered individual or the covered individual's authorized representative may file a request for an external review with the **{insert state insurance commissioner}**.

2. Within 10 business days after the date of receipt of a request for external review pursuant to Paragraph B, Subparagraph 1, the **{insert state insurance commissioner}** shall send a copy of the request to the health carrier.

C. Within 10 business days following the date of receipt of the copy of the external review request from the **{insert state insurance commissioner}** under Paragraph B, Subparagraph 1, the health insurer shall complete a preliminary review of the request to determine whether:

1. The covered individual has exhausted the health insurer's internal appeal unless the covered person is not required to exhaust the health insurer's internal appeal process pursuant to Section 7 of this Act; and

2. The covered person has provided all the information and forms required to process an external review.

D.

1. Whenever the **{insert state insurance commissioner}** receives a notice that a request is eligible for external review following the preliminary review conducted pursuant to Paragraph B, within 10 business days after the date of receipt of the notice, the **{insert state insurance commissioner}** shall:

a. Randomly assign an independent review organization from the list of approved independent review organizations compiled and maintained by the **{insert state insurance commissioner}** pursuant this Act to conduct the external review and notify the health insurer of the name of the assigned independent review organization, and

b. Notify in writing the covered person and, if applicable, the covered individual's authorized representative of the request's eligibility and acceptance for external review.

E. Within 10 business days after the date of receipt of the notice provided, the health insurer shall provide to the assigned independent review organization the documents and any information considered in making the rescission determination.

F.

1. Upon receipt of the information, if any, required to be forwarded pursuant to Paragraph D, the health insurer may reconsider its rescission determination that is the subject of the external review.

2. Reconsideration by the health insurer of its rescission determination pursuant to Paragraph F, Subparagraph 1 shall not delay or terminate the external review.

3. The external review may only be terminated if the health insurer decides, upon completion of its reconsideration, to reverse its rescission determination and provide coverage or payment for the health care service that is the subject of the rescission determination.

4.

a. Within three business days after making the decision to reverse its rescission determination, as provided in Paragraph F, Subparagraph 3, the health insurer shall notify the covered person, if applicable, the covered individual's authorized representative, the assigned independent review organization, and the **{insert state insurance commissioner}** in writing of its decision.

b. The assigned independent review organization shall terminate the external review upon receipt of the notice from the health carrier sent pursuant to Subparagraph 4(a) of this Paragraph.

G.

1. The independent review organization shall select a panel of health care professional reviewers and legal reviewers to conduct the independent review within 10 business days after being assigned by the **{insert state insurance commissioner}** to conduct an external review.

2. The panel shall consist of three legal reviewers and must include individuals with expertise and knowledge of the individual health insurance market, including the underwriting process. In the event that the external review requires medical expertise, the legal reviewers shall consult with a health care professional.

3. In selecting the third party review panel, the assigned third party review organization shall select physicians, health care professionals, and attorneys who meet the following qualifications:

a. All legal reviewers assigned by a third party review organization to conduct third party reviews shall be licensed attorneys who:

(1) Have demonstrated expertise in contract and insurance law with knowledge

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of the individual health insurance market, including the underwriting process,

(2) Holds a non-restricted license to practice law in any state or the District of Columbia,

(3) Has no history of disciplinary actions or sanctions that have been taken or are pending by any state bar association, regulatory body or court of law that raise a substantial question as to the legal reviewer's physical, mental, or professional competence or moral character, and

(4) Have no fiduciary interest in legal action against or in defense of a health insurance carrier, nor may they use information obtained during an external review in any subsequent legal action against or in defense of a health insurance carrier.

b. All health care professional consultants shall be physicians or other appropriate health care providers who:

(1) Are knowledgeable about the relevant health care service or treatment that was misrepresented or omitted through recent or current actual clinical experience treating patients with the same or similar medical condition of the covered person,

(2) Hold a non-restricted license in any state or the District of Columbia and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the third party review, and

(3) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency, or unit, or regulatory body that raise a substantial question as to the health care professional reviewer's physical, mental, or professional competence or moral character.

H.

1. Within 15 days after the date of receipt of the request for an external review—or within 30 days if the assigned independent review organization sends written notice to all parties after 15 days—the assigned independent review organization shall provide written notice of its decision to uphold or reverse the rescission determination to:

- a. The covered individual,
- b. If applicable, the covered individual's authorized representative,
- c. The health insurer, and
- d. The **{insert state insurance commissioner}**.

2. The independent review organization shall include in the notice sent pursuant to Paragraph H, Subparagraph 1:

- a. A general description of the reason for the request for external review,
- b. The date the independent review organization received the assignment from the **{insert state insurance commissioner}** to conduct the external review,
- c. The date the external review was conducted,
- d. The date of its decision,
- e. The principal reason or reasons for its decision, and
- f. The rationale for its decision.

(Drafting note: All timeframes in this Section should be consistent with a state's existing external review law in order to ensure consistency and ease of compliance.)

Section 10. Approval of Independent Review Organizations.

A. The **{insert state insurance commissioner}** shall approve independent review organizations eligible to be assigned to conduct external reviews under this Act.

B. The **{insert state insurance commissioner}** shall develop rules including an application form for initially approving and for reapplying independent review organizations to conduct external reviews.

1. Any independent review organization wishing to be approved to conduct external reviews under this Act shall submit the application form and include with the form all documentation and information necessary for the **{insert state insurance commissioner}** to determine if the independent review organization satisfies the minimum qualifications established under this Act and rules developed by the **{insert state insurance commissioner}**.

2.
a. Subject to Subparagraph 2(b) of this Paragraph, an independent review

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organization is eligible for approval under this Section only if it is accredited by a nationally recognized private accrediting entity that the **{insert state insurance commissioner}** has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations under this Act.

b. The **{insert state insurance commissioner}** may approve independent review organizations that are not accredited by a nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.

C.

1. In addition to the requirements set forth in this Act to be approved pursuant this Act to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any reviewer assigned by the independent organization to conduct the external review may have a material professional, familial or financial conflict of interest with any of the following:

a. The health insurer that is the subject of the external review,

b. The covered individual whose treatment is the subject of the external review or the covered person's authorized representative,

c. Any officer, director, or management employee of the health carrier that is the subject of the external review,

d. The health care provider, the health care provider's medical group, or independent practice association recommending the health care service or treatment that is the subject of the external review, or

e. The facility at which the recommended health care service or treatment would be provided.

2. In determining whether an independent review organization or a clinical reviewer of the independent review organization has a material professional, familial or financial conflict of interest for purposes of Paragraph C, Subparagraph 1, the **{insert state insurance commissioner}** shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent material professional, familial, or financial relationship or connection with a person described in Paragraph C, Subparagraph 1, but that the characteristics of that relationship or connection are such that they are not a material professional, familial, or financial conflict of interest that results in the disapproval of the independent review organization or the clinical reviewer from conducting the external review.

(Drafting note: This Section should be consistent with any existing state requirements in order to ensure ease of administration by the regulating entity.)

Section 11. Binding Nature of External Review Decision.

A. A third party review decision is binding on the health carrier to the extent that the health carrier has other remedies available under applicable federal or state law. The results of the external review process shall be admissible in any subsequent legal proceeding associated with a rescissions action as allowed by state or federal law.

B. A covered individual or that covered individual's authorized representative may not file a subsequent request for third party review involving the same rescission decision for which the covered individual has already received a third party review decision pursuant to this Act.

Section 12. Exhaustion of Third Party Review Process. A covered person or the covered person's authorized representative may not pursue litigation of a health carrier's decision to rescind a policy until the covered person has exhausted the third party review process set forth in this Act.

Section 13. Funding of External Review. The health insurer against which a request for a standard external review or an expedited external review is filed shall pay the cost of the independent review organization for conducting the external review.

(Drafting note: This should be consistent with a state's existing requirements.)

Section 14. Severability. If any provision of this Act, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Act, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 15. {Repealer Clause}
Section 16. {Effective Date}

← **Were your laws repealed?**

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