

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.
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- Intuit, Inc.
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- 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?**

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Independent External Review for Health Benefit Plans Act

{Title, enacting clause, etc.}

Section 1. {Title} This Act may be cited as the Independent External Review for Health Benefit Plans Act

Section 2. {Definitions}

(A) "Enrollee" means an individual covered under a health benefit plan. In the case of a minor child, the term includes the parent or legal guardian of the child, and in the case of an incapacitated or partially incapacitated person, the legal guardian of the person.

(B.1.) "Health benefit plan" means individual or group hospital or medical insurance coverage plan, a not for profit hospital or medical service, a prepaid health plan, a health maintenance organization, or preferred provider plan that requires utilization review. A health benefit plan shall not include indemnity health insurance policies, including those using a contract or provider network, so long as the policy does not require certification for appropriateness of care, accident-only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, specified disease, hospital indemnity confinement, limited benefit health insurance, worker's compensation or similar insurance, or automobile medical payment insurance.

Or Alternative definition of "health benefit plan:"

(B.2.) Health benefit plan" means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer which:

(1) either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use, health care providers managed, owned, under contract with or employed by the health insurance issuer; and

(2) requires utilization review.

A health benefit plan shall not include accident-only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, coverage issued as a supplement to liability insurance, specified disease, hospital indemnity confinement, limited benefit health insurance, worker's compensation or similar insurance, or automobile medical payment insurance.

(C) "Independent external review" means a review by an independent external review entity of a decision by a health benefit plan to deny reimbursement for or coverage of a medical treatment or service that is otherwise a covered benefit.

(D) "Independent external review entity" means an individual or an organization certified by the {insert appropriate agency: Insurance Commissioner or the Department of Insurance or other appropriate agency} to conduct external reviews.

(E) "Internal review" means procedures established by the health benefit plan for an internal reevaluation of an initial decision to deny reimbursement for or coverage of a medical treatment or service that is otherwise a covered benefit and a determination by the health benefit plan to grant or deny coverage or reimbursement.

(F) "Expert reviewer" means an individual employed by or under contract with the independent external review entity to conduct independent external review.

Section 3. {Request for Independent External Review}

(A) An enrollee shall have the right to request an independent external review to examine the health benefit plan's coverage decision if the enrollee meets the following criteria:

(1) The enrollee has been denied coverage based on a determination that the service or treatment which would otherwise be a covered benefit does not meet the definition of "medical necessity" set forth in the enrollee's evidence of coverage and the service or treatment is not considered experimental or investigational;

(2) The enrollee is a member of the health benefit plan in good standing or is otherwise eligible to receive covered benefits under the health benefit plan;

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

(3) The enrollee has exhausted the internal review, if any, except that the health benefit plan and the enrollee may jointly agree to waive this requirement; and

(4) The cost of the service or treatment for the coverage at issue would require the health benefit plan to incur {insert amount, i.e. \$1,000 or \$2,500} or more expenditure to cover such treatment or service.

[Drafting note: This paragraph is optional, and the threshold should be determined by each state. This may be waived in the case of life threatening situations.]

(B) A health care provider shall have the right to request an external review on behalf of an enrollee if:

(1) The enrollee provides the health care provider with a written authorization that specifies the service or treatment that is the subject of the independent external review;

(2) The enrollee provides the health benefit plan with a written authorization to release the enrollee's medical records to the independent external review entity;

(3) The health care provider delivers to the health benefit plan a copy of the enrollee's written authorization concurrently with the request for review.

(C) The health benefit plan shall have written policies describing the independent external review process. The health benefit plan shall disclose the availability of the independent external review process and how enrollees may access the process in the health benefit plan's evidence of coverage or other disclosure forms.

[Drafting note: Section III (C) is optional.]

Section 4. {Independent External Review Process}

(A) The health benefit plan shall notify eligible enrollees in writing of the opportunity to request the independent external review at the time of the final internal review decision to deny coverage. The enrollee may file a request for independent external review with the health benefit plan no later than sixty (60) calendar days after receiving such notification.

(B) The enrollee shall pay a one-time fee of {insert amount e.g. one hundred dollars (\$100)} toward the cost of the independent external review, payable at the time of the request. In the case of a hardship where conditions which are terminal or in the case of an employed person who no longer meet the definition of actively at work, the fee shall be waived. Whenever the expert reviewer finds in favor of the enrollee fee shall be refunded.

(C) The health benefit plan shall be responsible for the remaining costs incurred by the independent external review entity.

(D) The health benefit plan shall contract with only those independent external review entities certified for inclusion on the list maintained by the {insert appropriate agency: Insurance Commissioner or the Department of Insurance or other appropriate agency}.

(E) The health benefit plan shall provide to the independent external review entity a copy of the following documents within five (5) business days of the health benefit plan's receipt of a request for an independent external review:

[Drafting note: The duration can be extended for more than five business days if necessary. In the case of emergencies and life-threatening conditions, an expedited review may be necessary prior to and after the filing date of an independent external review. This may include certification by the doctor of the emergency, with information exchanges to be completed within 24 to 48 hours via facsimile, e-mail, or overnight communication, and the decision should be made within a reasonable number of hours.]

(1) Any information that was submitted to the health benefit plan by or on behalf of the enrollee in support of the enrollee's request for coverage; and

(2) A copy of the contract or evidence of coverage provisions upon which denial of coverage was based, any other relevant documents used by the health benefit plan in determining whether the proposed service or treatment is a covered benefit, and any statement by the health benefit plan explaining the reason for the health benefit plan's decision to deny coverage for the service or treatment.

(F) The independent external review entity shall notify the enrollee and the enrollee's physician of any additional medical information required to conduct the review within five (5) business days of receipt of the documentation required under paragraph E of this section. The health benefit plan shall be notified of this request. The enrollee and the enrollee's physician shall submit the additional information, or an explanation of why the additional information is not being submitted, to the independent review entity and the health benefit plan within five (5) business days of the receipt of such a request. The health benefit plan may, at its discretion, determine that the additional information provided by the enrollee or the enrollee's physician justifies a reconsideration of its coverage denial. A subsequent decision by the health benefit plan to provide coverage shall terminate the independent external review upon notification to the independent review entity.

(G) The independent external review entity shall submit the expert reviewer's determinations to the health benefit plan and the enrollee within thirty (30) business days of receipt of the request for review, except that for life-threatening conditions, as determined by the enrollee's physician, the determinations shall be submitted within {insert timeframe, i.e. 72 hours or seven (7) days } of the receipt of the request for review. At the request of the expert reviewer, the deadline shall be extended by up to five (5) business days for the consideration of additional information requested under

paragraph (E) of this section.

[Drafting note: the deadline of five business days may be extended]

(1) The expert reviewer's determination shall be in writing and shall state the reasons the requested service or treatment should or should not be covered under the terms and conditions set forth in the evidence of coverage.

(2) The expert reviewer's shall make determinations based on the applicable coverage documents, including any defined terms, and shall not expand the contractually agreed upon coverage.

(3) The expert reviewer's determination shall specifically cite the relevant provisions in the evidence of coverage, the enrollee's specific medical condition, and the relevant documents pursuant to paragraph (D) of this section, to support the expert reviewer's decision.

(H) Coverage for the services required under this section shall be provided subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the health benefit plan. Nothing in this subdivision shall be construed to require the health benefit plan to pay for the services of a non-contracting physician, that are not otherwise covered pursuant to the evidence of coverage under the health benefit plan.

[Drafting note: Language may be added that would allow payment of out-of network services providers if the network provider refused to perform a service that a patient paid for out of their own pocket, but which was later determined should have been covered.]

Section 5. {Qualifications of the Independent External Review Entity}

(A) The {insert appropriate agency: Insurance Commissioner or the Department of Insurance or other appropriate agency} shall certify and maintain a list of certified independent external review entities.

(B) The independent external review entities shall meet the following requirements for certification:

(1) Independent external review entities shall employ or contract with expert reviewers who meet the following requirements to conduct independent external reviews:

(a) Expert reviewers shall be physicians or other appropriate providers who are expert in the treatment of the enrollee's medical condition, and knowledgeable about the recommended service or treatment;

(b) Expert reviewers shall hold a non-restricted license in a state of the United States, and for physicians, a current certification by a recognized American medical board in the area(s) appropriate to the subject of review; and

(c) Expert reviewers shall have no history of disciplinary actions or sanctions (including, but not limited to loss of staff privileges or participation restriction) taken or pending by any hospital, government or regulatory body.

[Drafting note: For the expert's history of disciplinary actions or sanctions, refer to the state's medical records and/or the National Provider Databank]

(2) The independent external review entity shall not be a subsidiary of, nor in any way owned or controlled by, a health benefit plan, a trade association of health benefit plans, a health care provider or a professional association of health care providers.

(3) Neither the expert reviewer, nor the independent external review entity, shall have any material professional, familial, or financial conflict of interest with any of the following:

(a) The health benefit plan whose coverage decision is the subject of the independent external review;

(b) Any officer, director, or management employee of the health benefit plan;

(c) The physician, the physician's medical group, or the independent practice association (IPA) proposing the service or treatment;

(d) The institution at which the service or treatment would be or was provided;

(e) The developer or manufacturer of the drug, device, procedure, or other therapy proposed or used for the enrollee whose treatment is under review; and

(f) The enrollee or the enrollee's guardians or representatives.

(4) The term "conflict of interest" shall not be interpreted to include a contract under which an academic medical center, or other similar medical research center, provides health services to health benefit plan enrollees, except as subject to the requirement of paragraph (3)(d) of this section; affiliations which are limited to staff privileges at a health facility; or an expert reviewer's participation as a contracting provider of the health benefit plan.

(5) Any independent review entity that has received accreditation by a national recognized private accrediting entity, with established and maintained standards shall be deemed to meet the requirements of this section.

Section 6. {Quality Assurance of Independent External Review} The independent review entity shall have a quality assurance mechanism in place that ensures the timeliness and quality of the reviews, the qualifications and independence of the expert reviewers, and the confidentiality of medical records and review materials.

Section 7. {Outcome of Independent External Review}

(A) The determination of the independent external review entity is binding on the health benefit plan and the enrollee. In this Act, binding shall mean that access to the independent external review process by the health benefit plan or enrollee shall be limited to one independent external review for each denial of coverage.

(B) A decision of the independent external review entity in favor of the enrollee shall be final and binding on the health benefit plan. The health benefit plan shall provide appropriate coverage according to the decision without delay and shall be immune from liability for abiding by such decision.

(C) A determination by the independent external review entity in favor of a health benefit plan shall create a rebuttable presumption in any subsequent legal action that the health benefit plan's prior determination was appropriate.

(D) Nothing in this Act shall render the health benefit plan liable for monetary damages arising from any act or omission of the independent external review entity.

(E) An independent external review entity and an expert reviewer assigned by the entity to conduct a review under this Act is not liable for damages arising from the determinations made pursuant to this Act. This paragraph does not apply to an act or omission of the independent review entity that is made in bad faith or that involves gross negligence.

Section 8. {Annual Independent External Review Entity Reporting Requirements}

(A) The independent external review entity shall report to the {insert appropriate agency: Insurance Commissioner or the Department of Insurance or other appropriate agency} and to the state legislature the following information on an annual basis:

- (1) the number of independent review decisions in favor of enrollees;
- (2) the number of independent review decisions in favor of health carriers;
- (3) the average turnaround time for an independent review decision;
- (4) the number of cases in which the independent review entity did not reach a decision in the time frame specified in statute or regulation and reasons for delay;
- (5) the number of resolutions reached prior to an independent external review.

Section 9. {Severability clause}

Section 10. {Repealer clause}

Section 11. {Effective date}

Were your laws repealed?

Adopted by the Health and Human Services Task Force in and approved by the ALEC Board of Directors in 1990. Amended in 1991 and at the Annual Meeting, July 1999.

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