
HOUSE BILL 1066

State of Washington

64th Legislature

2015 Regular Session

By Representatives Tharinger and Moeller; by request of Insurance
Commissioner

Prefiled 01/05/15.

1 AN ACT Relating to certified independent review organizations for
2 addressing long-term care insurance disputes; and adding a new
3 section to chapter 48.83 RCW.

4 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

5 NEW SECTION. **Sec. 1.** A new section is added to chapter 48.83
6 RCW to read as follows:

7 (1) The legislature declares there is a need for a process for
8 the fair consideration of disputes relating to decisions by issuers
9 that offer long-term care insurance to deny, modify, reduce, or
10 terminate coverage of or payment for long-term care services for an
11 insured. This process should consist of an internal appeals process
12 and an independent review process. Therefore, an independent review
13 process for long-term care insurance is created to be established and
14 administered by the commissioner.

15 (2) The definitions in this subsection apply throughout this
16 section unless the context clearly requires otherwise.

17 (a) "Independent review organization" means an organization that
18 conducts independent reviews of long-term care decisions.

19 (b) "Certified independent review organization" means an
20 independent review organization that has received certification from
21 the office of the insurance commissioner.

1 (3) An insured or their appointed representative may seek review
2 by a certified independent review organization of an issuer's
3 decision to deny, modify, reduce, or terminate coverage of or payment
4 for a long-term care service, after exhausting the issuer's internal
5 appeals process and receiving a decision that is unfavorable to the
6 insured, or after the issuer has exceeded the timelines for internal
7 appeals described in the policy or as established by insurance
8 regulation without good cause and without reaching a decision.

9 (4) The commissioner must establish and use a rotational registry
10 system for the assignment of a certified independent review
11 organization to each long-term care insurance dispute. The system
12 must be flexible enough to ensure that a certified independent review
13 organization has the expertise necessary to review the particular
14 medical condition or service at issue in the dispute, and that any
15 certified independent review organization does not have a conflict of
16 interest that will influence its independence.

17 (5) Issuers must provide to the appropriate certified independent
18 review organization, not later than the fifth business day after the
19 date the issuer receives a request for review, a copy of:

20 (a) Any records of the insured that are relevant to the review;

21 (b) Any documents used by the issuer in making the determination
22 to be reviewed by the certified independent review organization;

23 (c) Any documentation and written information submitted to the
24 issuer in support of the appeal; and

25 (d) A list of each physician or provider who has provided care to
26 the insured and who may have records relevant to the appeal. Health
27 information or other confidential or proprietary information in the
28 custody of an issuer may be provided to a certified independent
29 review organization, subject to rules adopted by the commissioner.

30 (6) An insured or their appointed representative must be provided
31 with at least five business days to submit to the certified
32 independent review organization in writing additional information
33 that the certified independent review organization must consider when
34 conducting the external review. The certified independent review
35 organization must forward any additional information submitted by an
36 insured or their appointed representative to the issuer within one
37 business day of receipt by the certified independent review
38 organization.

39 (7) The reviewers from a certified independent review
40 organization must make determinations regarding the medical necessity

1 or appropriateness of, and the application of the long-term care
2 policy's coverage provisions to, services for an insured.
3 "Reviewers," as used in this subsection, means physicians as well as
4 experts in other areas pertinent to long-term care such as nursing.
5 The reviewers' determinations must be based upon their expert
6 judgment, after consideration of relevant medical, scientific, and
7 cost-effectiveness evidence, and medical standards of practice in the
8 state of Washington. Except as provided in this subsection, the
9 certified independent review organization must ensure that
10 determinations are consistent with the scope of covered benefits as
11 outlined in the long-term care policy. Reviewers may override the
12 policy's medical necessity or appropriateness standards if the
13 standards are determined upon review to be unreasonable or
14 inconsistent with sound, evidence-based practice.

15 (8) Once a request for an independent review determination has
16 been made, the certified independent review organization must proceed
17 to a final determination, unless requested otherwise by both the
18 issuer and the insured or the insured's appointed representative.

19 (9) An insured, their appointed representative, a physician, or a
20 provider may request an expedited external review if the insured's
21 physician or provider reasonably determines that following the appeal
22 process response times could seriously jeopardize the insured's life,
23 health, or ability to regain maximum function. The decision regarding
24 an expedited appeal must be made within seventy-two hours after the
25 time the appeal is received by the issuer. An insured, their
26 appointed representative, physician, or provider may also request
27 expedited external review in situations when fairness and justice so
28 require, such as when an insured will lose a desired long-term care
29 provider prior to the completion of the normal appeal process, and
30 will not likely have the option to return to that provider even if
31 the external review is decided in favor of the insured.

32 (10) The certified independent review organization must make its
33 decision to uphold or reverse the adverse benefit determination or
34 final internal adverse benefit determination and notify the insured
35 or their appointed representative and the issuer of the determination
36 as expeditiously as possible but within not more than seventy-two
37 hours after the receipt of the request for expedited external review.
38 If the notice is not in writing, the certified independent review
39 organization must provide written confirmation of the decision within
40 forty-eight hours after the date of the notice of the decision.

1 (11) Issuers must timely implement the certified independent
2 review organization's determination and must pay the certified
3 independent review organization's charges.

4 (12) When an insured or their appointed representative requests
5 independent review of a dispute under this section, and the dispute
6 involves an issuer's decision to modify, reduce, or terminate an
7 otherwise covered long-term care service that an insured is receiving
8 at the time the request for review is submitted and the issuer's
9 decision is based upon a finding that the long-term care service, or
10 level of long-term care service, is no longer appropriate, the issuer
11 must continue to provide the long-term care service if requested by
12 the insured or their appointed representative until a determination
13 is made under this section. If the determination affirms the issuer's
14 decision, the insured may be responsible for the cost of the
15 continued service.

16 (13) Each certified independent review organization must maintain
17 written records and make them available upon request to the
18 commissioner.

19 (14) A certified independent review organization may notify the
20 office of the insurance commissioner if, based upon its review of
21 disputes under this section, it finds a pattern of substandard or
22 egregious conduct by an issuer.

23 (15) The commissioner must develop a reasonable maximum fee
24 schedule that certified independent review organizations must use to
25 assess issuers for conducting reviews.

26 (16)(a) The commissioner must adopt rules to implement this
27 section after considering relevant standards adopted by national
28 accreditation organizations, the Washington state department of
29 health, and the national association of insurance commissioners.

30 (b) The rules adopted under this section must include provisions
31 for the commissioner to certify independent review organizations and
32 to terminate the certification of an independent review organization
33 for failure to comply with the requirements for certification. The
34 commissioner may review the operation and performance of a certified
35 independent review organization in response to complaints or other
36 concerns about compliance.

1 (17) This section is not intended to supplant any existing
2 authority of the commissioner under this title to oversee and enforce
3 issuer compliance with applicable statutes and rules.

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