Effective 5/8/2018

31A-22-629 Adverse benefit determination review process.

(1) As used in this section:

(a)

(i) "Adverse benefit determination" means the:

(A) denial of a benefit;

(B) reduction of a benefit;

(C) termination of a benefit; or

(D) failure to provide or make payment, in whole or in part, for a benefit.

(ii) "Adverse benefit determination" includes:

(A) denial, reduction, termination, or failure to provide or make payment that is based on a determination of an insured's or a beneficiary's eligibility to participate in a plan;

(B) denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit resulting from the application of a utilization review; or

(C) failure to cover an item or service for which benefits are otherwise provided because it is determined to be:

(I) experimental;

(II) investigational; or

(III) not medically necessary or appropriate.

(b) "Independent review" means a process that:

(i) is a voluntary option for the resolution of an adverse benefit determination;

(ii) is conducted at the discretion of the claimant;

(iii) is conducted by an independent review organization designated by the commissioner;

(iv) renders an independent and impartial decision on an adverse benefit determination submitted by an insured; and

(v) may not require the insured to pay a fee for requesting the independent review.

(c) "Independent review organization" means a person, subject to Subsection (6), who conducts an independent external review of adverse determinations.

(d) "Insured" is as defined in Section 31A-1-301 and includes a person who is authorized to act on the insured's behalf.

(e) "Insurer" is as defined in Section 31A-1-301 and includes:

(i) a health maintenance organization; and

(ii) a third party administrator that offers, sells, manages, or administers a health insurance policy or health maintenance organization contract that is subject to this title.

(f) "Internal review" means the process an insurer uses to review an insured's adverse benefit determination before the adverse benefit determination is submitted for independent review.

(2) This section applies generally to health insurance policies, health maintenance organization contracts, and income replacement or disability income policies.

(3)

(a) An insured may submit an adverse benefit determination to the insurer.

(b) The insurer shall conduct an internal review of the insured's adverse benefit determination.

(c) An insured who disagrees with the results of an internal review may submit the adverse benefit determination for an independent review if the adverse benefit determination involves:

(i) payment of a claim regarding medical necessity; or

(ii) denial of a claim regarding medical necessity.

(4) The commissioner shall adopt rules that establish minimum standards for:

(a) internal reviews;

(b) independent reviews to ensure independence and impartiality;

(c) the types of adverse benefit determinations that may be submitted to an independent review; and
(d) the timing of the review process, including an expedited review when medically necessary.
(5) Nothing in this section may be construed as:
(a) expanding, extending, or modifying the terms of a policy or contract with respect to benefits or coverage;
(b) permitting an insurer to charge an insured for the internal review of an adverse benefit determination;
(c) restricting the use of arbitration in connection with or subsequent to an independent review; or
(d) altering the legal rights of any party to seek court or other redress in connection with:
(i) an adverse decision resulting from an independent review, except that if the insurer is the party seeking legal redress, the insurer shall pay for the reasonable attorney fees of the insured related to the action and court costs; or
(ii) an adverse benefit determination or other claim that is not eligible for submission to independent review.
(6)
(a) An independent review organization in relation to the insurer may not be:
(i) the insurer;
(ii) the health plan;
(iii) the health plan's fiduciary;
(iv) the employer; or
(v) an employee or agent of any one listed in Subsections (6)(a)(i) through (iv).
(b) An independent review organization may not have a material professional, familial, or financial conflict of interest with:
(i) the health plan;
(ii) an officer, director, or management employee of the health plan;
(iii) the enrollee;
(iv) the enrollee's health care provider;
(v) the health care provider's medical group or independent practice association;
(vi) a health care facility where service would be provided; or
(vii) the developer or manufacturer of the service that would be provided.

Amended by Chapter 319, 2018 General Session