



STATE OF NEW YORK
INSURANCE DEPARTMENT
AGENCY BUILDING ONE
EMPIRE STATE PLAZA
ALBANY, NY 12257

Circular Letter No. 5 (1999)
February 19, 1999

TO: ALL INSURERS LICENSED TO WRITE ACCIDENT & HEALTH INSURANCE IN NEW YORK STATE, ARTICLE 43 CORPORATIONS AND HEALTH MAINTENANCE ORGANIZATIONS

RE: MANAGED CARE GRIEVANCE AND UTILIZATION REVIEW APPEAL DATA

This circular letter will provide guidance to insurers and health maintenance organizations (HMOs) about how grievance and utilization review (UR) appeals should be reported to the Insurance Department. The purpose of this circular letter is to facilitate the consistent reporting of information among HMOs and insurers for inclusion in the Department's Annual Consumer Guide, which will be published in September 1999. This circular letter is not intended to impose additional requirements on the grievance procedures or utilization review processes that are already in place.

Section 210(b)(1) of the New York State Insurance Law mandates that HMOs and insurers report to the Insurance Department the number of grievances filed pursuant to 4408-a of the Public Health Law (as added by Chapter 705 of the Laws of 1996) or Section 4802 of the Insurance Law, and the number of such grievances where a determination was reversed in whole or in part compared to the number of determinations that were upheld. Section 210(b)(2) of the Insurance Law also requires HMOs and insurers to report the number of appeals to UR determinations which were filed pursuant to Article 49 of the Public Health Law or Article 49 of the Insurance Law and the number of adverse determinations which were reversed versus the number upheld. HMOs and insurers must include grievance and UR appeal information in the annual statements they are required to file with the Insurance Department.

The following will address the issues that were raised by insurers and HMOs when filing grievance and UR appeal data with the Insurance Department:

What is a Grievance?

- Pursuant to Section 4408-a of the Public Health Law and Section 4802 of the Insurance Law, the grievance procedure is used to seek a reversal of any determination other than a utilization review determination. Grievances may include, but are not limited to, denials of access to a referral or a determination that a benefit is not covered.

Insurers and HMOs, for purposes of reporting information in their respective annual statements, should only report the number of grievance determinations that have been subject to the formal grievance procedure. In 1998, the Department found that some plans included the number of all complaints in their annual statements, regardless of whether the complaint related to a determination or was subject to the formal grievance procedure. Insurers and HMOs should not include complaints that are not related to a plan determination or that are not subject to the formal grievance procedure when reporting information in their annual statements. In addition, oral complaints that are not acknowledged in writing, or otherwise subject to the formal grievance procedure, should not be reported in the annual statement.

Which Entities Should Report Grievance Information?

- All HMOs, as well as insurers offering a contract that meets the definition of a managed care health insurance contract in Section 4801(c) of the Insurance Law should report, in their annual statement, the number of initial grievances filed. Insurers should not report grievance information to the Department in their annual statement if they do not have a product meeting the 4801(c) definition. *

*Those insurers that have voluntarily implemented a grievance procedure not subject to the provisions of Chapter 705 of the Laws of 1996 are encouraged to report grievance information; be certain, however, to note that such information comes from a voluntary program.

Number of Grievances Filed:

- Insurers and HMOs should only be including the number of initial grievances filed and not the number of grievance appeals in the number of grievances filed column of their respective annual statements.
- Section 4802 of the Insurance Law and Section 4408-a of the Public Health Law provide for two levels of internal review of grievances, an initial (first level) grievance review and an appeal of that initial grievance determination. It has come to the Department's attention that some insurers and HMOs are recording a single grievance that has gone through both levels of internal review as two separate grievances. When a grievance is subject to the two levels of review, HMOs and insurers should only count the grievance once for the purpose of reporting information in their annual statements.

When Should a Grievance be Considered Closed?

- A first level grievance should be considered closed, for the purposes of the annual statement, if the subscriber does not appeal the grievance determination within the timeframe required by the insurer or HMO in the calendar year in which the first level grievance determination was rendered. The first level grievance should be considered closed even if the calendar year ends before the timeframe established by the insurer or HMO for filing grievance appeals expires. Insurers and HMOs should report the disposition of the first level grievance in the annual statement.

If the subscriber appeals the first level grievance determination in a subsequent calendar year, and the appeal is considered timely by the insurer or HMO, the insurer or HMO should report the grievance appeal determination in the annual statement as either a grievance closed resulting in a reversal or as a grievance that was upheld. Insurers and HMOs should not count the grievance appeal in the number of

grievances filed column in the annual statement for that subsequent year.

- If a subscriber files a grievance appeal within the same calendar year as the initial first level grievance determination is made, and the plan renders a determination on the grievance appeal, the grievance should be reported as upheld or overturned based only on the disposition of the appeal.
- If a subscriber files a grievance appeal within the same calendar year as the initial first level grievance determination, and the appeal is pending when the calendar year ends, the grievance should be reported as pending in the annual statement.

Point of Service Contracts:

- Several HMOs offer point of service contracts where the in-network coverage is provided by the HMO and the out-of-network coverage is provided by an indemnity carrier, which may or may not be an affiliated company. Grievances should be attributed to the contract providing the in-network portion of coverage for purposes of the annual statement.

What is a Utilization Review Appeal?

- A UR appeal is an appeal of an adverse determination concerning the medical necessity of health care services.

UR Appeals Subject to Expedited and Standard Review:

- The law provides for expedited and standard review of UR appeals. A subscriber who is unsuccessful with an expedited review of a UR appeal may pursue a standard review subject to non-expedited time frames. Insurers and HMOs should, however, only count a UR appeal once if it is subject to both an expedited and standard review.

When a UR Appeal Should be Considered Closed:

- A non-expedited UR appeal should be considered closed when the utilization review agent notifies a subscriber of the appeal determination.
- An expedited UR appeal should be considered closed when the UR agent notifies a subscriber of the expedited appeal determination and the subscriber does not further appeal the determination through the standard UR appeal process in the calendar year in which the expedited appeal determination was rendered. The utilization review appeal should be considered closed even if the calendar year ends before the timeframe established by the insurer or HMO for filing a standard UR appeal expires. Insurers and HMOs should report the disposition of the expedited UR appeal in the annual statement.

If the subscriber appeals the expedited determination in a subsequent calendar year, and the appeal is considered timely by the insurer or HMO, the insurer or HMO should report the appeal determination in the annual statement as either an appeal closed resulting in a reversal or as an appeal closed in which the plan determination was upheld. Insurers and HMOs should not count the appeal in the number of appeals filed column of the annual statement for that subsequent year.

- If a subscriber files a utilization review appeal, and the appeal is pending when the calendar year ends, the UR appeal should be reported as pending in the annual statement.

Utilization Review Agents:

- If an insurer or HMO contracts with a utilization review agent to conduct UR, the HMO or insurer is still responsible for reporting utilization review appeal data and grievance data in their annual statements.

Point of Service Contracts:

- HMOs and insurers should attribute the UR appeal to the HMO contract or insurance contract that the complaint arises under for purposes of the annual statement. If an HMO or insurer is unable to identify the contract that the complaint arises under, the plan should attribute the UR appeal to the contract providing the in-network portion of coverage.

Sale of Business, Assumption or Merger:

- If an insurer or HMO is in the process of a sale, assumption or merger, the plan offering the contract that a grievance or UR appeal arises under should still report the grievance or UR appeal data in its annual statement.

Medicare:

- HMOs should not include the number of grievances and UR appeals under Medicare Cost Contracts, Medicare Risk Contracts or Medicare Plus Choice Contracts in their annual statements.

Medicaid:

- HMOs should not include the number of grievances and UR appeals under Medicaid contracts in their annual statements.

Any questions concerning this circular letter should be directed to:

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