



ADMINISTRATIVE RULES OF MONTANA

6.6.3130 APPEALING AN INSURER'S DETERMINATION THAT THE BENEFIT TRIGGER IS NOT MET

- (1) For purposes of this rule, "authorized representative" means a person authorized to act as the covered person's personal representative within the meaning of 45 CFR 164.502(g) promulgated by the Secretary under the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act and means the following:
 - (a) a person to whom a covered person has given express written consent to represent the covered person in an external review;
 - (b) a person authorized by law to provide substituted consent for a covered person; or
 - (c) a family member of the covered person or the covered person's treating health care professional only when the covered person is unable to provide consent.
- (2) If an insurer determines that the benefit trigger of a long-term care insurance policy has not been met, it shall provide a clear, written notice to the insured and the insured's authorized representative, if applicable, of all of the following:
 - (a) the reason that the insurer determined that the insured's benefit trigger has not been met;
 - (b) the insured's right to internal appeal in accordance with (3), and the right to submit new or additional information relating to the benefit trigger denial with the appeal request; and
 - (c) the insured's right, after exhaustion of the insurer's internal appeal process, to have the benefit trigger determination reviewed under the independent review process in accordance with (4).
- (3) The insured or the insured's authorized representative may appeal the insurer's adverse benefit trigger determination by sending a written request to the insurer, along with any additional supporting information, within 120 calendar days after the insured and the insured's authorized representative, if applicable, receives the insurer's benefit determination notice. The internal appeal shall be considered by an individual or group of individuals designated by the insurer, provided that the individual or individuals making the internal appeal decision may not be the same individual or individuals who made the initial benefit determination. The internal appeal shall be completed and written notice of the internal appeal decision shall be sent to the insured and the insured's authorized representative, if applicable, within 30 calendar days of the insurer's receipt of all necessary information upon which a final determination can be made.
 - (a) If the insurer's original determination is upheld upon internal appeal, the notice of the internal appeal decision shall describe any additional internal appeal rights offered by the insurer. Nothing in this rule shall require the insurer to offer any internal appeal rights other than those described in this rule.

- (b) If the insurer's original determination is upheld after the internal appeal process has been exhausted, and new or additional information has not been provided to the insurer, the insurer shall provide a written description of the insured's right to request an independent review of the benefit determination as described in (4) to the insured and the insured's authorized representative, if applicable.
 - (c) As part of the written description of the insured's right to request an independent review, an insurer shall include the following, or substantially equivalent, language: "We have determined that the benefit eligibility criteria ("benefit trigger") of your [policy][certificate] has not been met. You may have the right to an independent review of our decision conducted by long-term care professionals who are not associated with us. Please send a written request for independent review to us at [address]. You must inform us, in writing, of your election to have this decision reviewed within 120 days of receipt of this letter. Listed below are the names and contact information of the independent review organizations approved or certified by your state insurance commissioner's office to conduct long-term care insurance benefit eligibility reviews. If you wish to request an independent review, please choose one of the listed organizations and include its name with your request for independent review. If you elect independent review, but do not choose an independent review organization with your request, we will choose one of the independent review organizations for you and refer the request for independent review to it."
 - (d) If the insurer does not believe the benefit trigger decision is eligible for independent review, the insurer shall inform the insured and the insured's authorized representative, if applicable, in writing and include in the notice that reasons for its determination of independent review ineligibility.
 - (e) The appeal process described in this section is not deemed to be a "new service or provider" as referenced in ARM 6.6.3128 and therefore does not trigger the notice requirements of that rule.
- (4) The insured or the insured's authorized representative may request an independent review of the insurer's benefit trigger determination after the internal appeal process outlined in (3) has been exhausted. A written request for independent review may be made by the insured or the insured's authorized representative to the insurer within 120 calendar days after the insurer's written notice of the final internal appeal decision is received by the insured or the insured's authorized representative, if applicable.
- (a) The cost of the independent review shall be borne by the insurer.
 - (b) Within five business days of receiving a written request for independent review, the insurer shall refer the request to the independent review organization that the insured or the insured's authorized representative has chosen from the list of certified or approved organizations the insurer has provided to the insured. If the insured or the insured's authorized representative does not choose an approved independent review organization to perform the review, the insurer shall choose an independent review organization approved or certified by the commissioner. The insurer shall vary the selection of authorized independent review organizations on a rotating basis.
 - (c) The insurer shall refer the request for independent review of a benefit trigger determination to an independent review organization, subject to the following:

- (i) the independent review organization shall be on a list of certified or approved independent review organizations that satisfy the requirements of a qualified long-term care insurance independent review organization contained in this rule;
 - (ii) the independent review organization shall not have any conflicts of interest with the insured, the insured's authorized representative, if applicable, or the insurer; and
 - (iii) such review shall be limited to the information or documentation provided to and considered by the insurer in making its determination, including any information or documentation considered as part of the internal appeal process.
- (d) The insured or the insured's authorized representative may submit at any time new or additional information not previously provided to the insurer but pertinent to the benefit trigger denial. If the insured or the insured's authorized representative has new or additional information not previously provided to the insurer, whether submitted to the insurer or the independent review organization, such information shall first be considered in the internal review process, as set forth in (3).
 - (i) If new information is received by the independent review organization from the insured or the insured's authorized representative, the independent review organization shall provide copies of any documentation or information provided to the insurer for its review.
 - (ii) While this information is being reviewed by the insurer, the independent review organization shall suspend its review and the time period for review is suspended until the insurer completes its review.
 - (iii) The insurer shall complete its review of the information and provide written notice of the analysis and results of the review to the insured, the insured's authorized representative, if applicable, and the independent review organization within five business days of the insurer's receipt of such new or additional information.
 - (iv) If the insurer maintains its denial after such review, the independent review organization shall continue its review, and render its decision within the time period specified in (4)(g). If the insurer overturns its decision following its review, the independent review request shall be considered withdrawn.
- (e) The insurer shall acknowledge in writing to the insured and the insured's authorized representative, if applicable, that the request for independent review has been received, accepted, and forwarded to an independent review organization for review. Such notice will include the name and address of the independent review organization.
- (f) Within five business days of receipt of the request for independent review, the assigned independent review organization shall notify the insured, the insured's authorized representative, if applicable, and the insurer, that it has accepted the independent review request and identify the type of licensed health care professional assigned to the review. The assigned independent review organization shall include in the notice a statement that the insured or the insured's authorized representative may submit in writing to the independent review organization, within seven days following the date of receipt of the notice, additional information and supporting documentation that the independent review organization should consider when conducting its review.

- (g) The independent review organization shall review all of the information received, and provide the insured, the insured's authorized representative, if applicable, and the insurer written notice of its decision within 30 calendar days from receipt of the referral referenced in (4)(c). If the independent review organization overturns the insurer's decision, it shall:
 - (i) establish the precise date within a specific period of time under review that the benefit trigger was deemed to have been met;
 - (ii) specify the specific period of time under review for which the insurer declined eligibility, but during which the independent review organization deemed the benefit trigger to have been met; and
 - (iii) for tax-qualified long-term care insurance contracts, provide a certification (made only by a licensed health care practitioner as defined in section 7702B(c)(4) of the Internal Revenue Code) that the insured is a chronically ill individual.
- (h) The decision of the independent review organization with respect to whether the insured met the benefit trigger will be final and binding on the insurer.
- (5) The independent review organization's determination shall be used solely to establish liability for benefit trigger decisions, and is intended to be admissible in any proceeding only to the extent it establishes the eligibility of benefits payable.
- (6) Nothing in this rule shall restrict the insured's right to submit a new request for a benefit trigger determination after the independent review decision, should the independent review organization uphold the insurer's decision.
- (7) Nothing contained in this rule limits the insurer's ability to assert any rights it may have under the policy related to:
 - (a) an insured's misrepresentation;
 - (b) changes in the insured's benefit eligibility; or
 - (c) terms, conditions, or exclusions of the policy, other than failure to meet the benefit trigger.
- (8) The requirements of this rule apply to a benefit trigger request made on or after January 1, 2020, under a long-term care insurance policy.

Authorizing statute(s): 33-1-313, 33-22-1121, MCA

Implementing statute(s): 33-18-201, 33-22-1102, 33-22-1121, 33-22-1124, 33-22-1125, MCA

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