House
Legislative
Analysis
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PRIRA AMENDMENTS

Senate Bill 1208 (Substitute H-1)
First Analysis (12-12-00)

Sponsor: Sen. John J.H. Schwarz, M.D.
House Committee: Health Policy
Senate Committee: Health Policy

THE APPARENT PROBLEM:

Public Act 251 of 2000 created the Patient's Right to Independent Review Act (PRIRA). The act, which took effect June 29, 2000, enables persons with health insurance to request a review by an independent review organization (IRO) to resolve disputes over covered benefits. Requests for reviews are submitted to the commissioner of the Office of Financial and Insurance Services (OFIS). If a preliminary review by the commissioner determines that the request meets specified criteria for an external review, the case is assigned to an IRO. Under current language in the act, the IROs specifically review issues of medical necessity and clinical review criteria and the commissioner is charged with reviewing the recommendation of an IRO to ensure that it is not contrary to the terms of coverage under the person's health benefit plan.

Since enactment of the act, the Office of Financial and Insurance Services (OFIS) has processed 34 requests for external independent reviews. Even though the commissioner is charged with deciding issues involving contractual questions, the act does not specifically allow the commissioner to conduct a review of requests that involve only questions relating to covered benefits of a health plan. Therefore, the current interpretation of the act is that every accepted request for an external review must be assigned to an IRO. According to committee testimony by a representative of the OFIS, the IROs can only make determinations relating to medical necessity and clinical review criteria, and not to contractual questions. Those requests involving only a contractual question are then sent back to the commissioner for a determination.

According to the OFIS, this results not only in an unnecessary expense of conducting the review (a cost of $400 per review), but also results in an unnecessary delay for the person submitting the request for review. At the agency's request, legislation has been proposed to allow the commissioner to conduct the external review in those situations in which a case only involves a question of contracted health benefits.

THE CONTENT OF THE BILL:

Senate Bill 1208 would amend the Patient's Right to Independent Review Act to allow the commissioner to keep a request for an external review and to conduct the external review if the request did not appear to involve issues of medical necessity or clinical review criteria, but only appeared to involve a question of the contractual provisions of a person's health benefit plan, such as covered benefits or accuracy of coding. A written notification, in plain English, would have to be provided by the commissioner within 14 days to the person making the request and to the health carrier that he or she would be keeping the plan for review. The commissioner would have to adhere to all time frames and all criteria in the act that pertain to external reviews done by IROs. If at any time during the commissioner's review of a disputed claim it appeared that the claim involved issues of medical necessity or clinical review criteria, the commissioner would have to immediately assign the request to an IRO. Since reviews could then be done by either an IRO or by the commissioner, some references in the act to an IRO would be changed to "reviewing entity".

The act specifies criteria that the commissioner must use when conducting a preliminary review of a request for an external review. The bill would add that the commissioner must determine whether the health care service that was the subject of the adverse determination or final adverse determination appeared to involve issues of medical necessity or clinical review criteria. The bill would also clarify that the commissioner would be required to assign issues of medical necessity or clinical review criteria to an IRO. Further, under the act, an external review decision and an expedited external review decision are the final administrative remedies available. The bill would add that a person could appeal the external review decision to an appropriate circuit court no later than 60 days from the date of the decision.

MCL 550.1911 et al.

HOUSE COMMITTEE ACTION:

The bill as passed by the Senate was part of a package addressing several insurance issues, and would have created the Patient's Right to Independent Review Act (PRIRA). The legislature instead enacted House Bill 5576, which became Public Act 251 of 2000. The committee substitute was offered to make amendments to the PRIRA.

FISCAL IMPLICATIONS:

According to the House Fiscal Agency, the bill could reduce the number of external reviews involving only contractual matters that are conducted by IROs. Therefore, the agency reports that the bill would likely reduce costs to the Office of Financial and Insurance Services to a small degree. There would be no fiscal impact on local governments. (12-7-00)

ARGUMENTS:

For:

Some requests for an independent external review of a disputed insurance claim involve only a question of the benefits allowed under a health plan. For example, some health plans only provide benefits for 60 days of physical therapy. Visits past the 60-day limit are typically denied coverage. However, a person might still submit a request to the Office of Financial and Insurance Services (OFIS) for an external review if his or her plan rejected payment for treatments received in excess of the 60-day limit. Such a disputed claim clearly contains only a question as to whether the medical services provided were a covered benefit under the person's health plan, and not to whether or not the person still needed additional physical therapy treatment. However, under current interpretation of the Patient's Right to Independent Review Act (PRIRA), all requests accepted for review must be assigned to an independent review organization (IRO). The IRO, though, can only make decisions regarding medical necessity and clinical review criteria. When an IRO is assigned a case similar to the above example, it is sent back to the commissioner to review the benefits of the health plan and decide if the health carrier was justified in denying payment for a claim.

The external review process could be expedited and costs to all involved could be reduced if the commissioner were specifically authorized to conduct an external review and make a final determination in those cases involving only a question of covered benefits. The bill would do just that. It is expected that as more consumers become aware of the PRIRA, that more will request external reviews. The bill would save both time and money, and free the IROs to concentrate on those cases that do indeed involve questions of medical necessities and clinical review. A safeguard is included in the bill, as the commissioner would be required to refer a case to an IRO if, in the process of conducting the review, it became apparent that the case did indeed include questions of medical necessity and clinical review.

For:

The original act is silent on appealing an adverse determination by an IRO or the commissioner. By default, so to speak, a person could appeal their case to a circuit court under provisions of the Revised Judicature Act, which allows a person to bring an appeal within 21 days of an adverse administrative action. The bill would specify that a person could appeal to a circuit court within 60 days, which would conform to provisions within the Insurance Code and the act regulating Blue Cross and Blue Shield of Michigan.

POSITIONS:

The Office of Financial and Insurance Services (OFIS) supports the bill. (12-7-00)

The Michigan Association of Health Plans supports the bill. (12-7-00)

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#This analysis was prepared by nonpartisan House staff for use by House members in their deliberations, and does not constitute an official statement of legislative intent.