House
Legislative
Analysis
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APPEALS PROCEDURES FOR DISPUTED INSURANCE CLAIMS

House Bill 5573 as enrolled
Public Act 250 of 2000
Sponsor: Rep. Lauren Hager

House Bill 5576 as enrolled
Public Act 251 of 2000
Sponsor: Rep. Charles LaSata

House Committee: Health Policy
Senate Committee: Health Policy

Second Analysis (7-20-00)

THE APPARENT PROBLEM:

Health carriers in Michigan are required to establish an internal grievance process to handle disputed claims. If the dispute cannot be resolved to an insured person's satisfaction, the person can appeal the decision to the commissioner (or his or her designee) of the Office of Financial and Insurance Services (OFIS) or, in the case of a person enrolled in an HMO, to a task force appointed by the Department of Community Health. Besides differences in how the external review process functions, the internal grievance processes can differ between Blue Cross Blue Shield, commercial health insurers, and HMOs. The dual arrangement for external reviews, coupled with the differing internal review processes, can be confusing to consumers, especially for those who change health plans, and to health care providers who are trying to provide their patients with needed care. Legislation based on proposals by the OFIS has been proposed to create a uniform appeals process for all insurers for both internal and external review procedures.

THE CONTENT OF THE BILLS:

House Bill 5573 would shorten the time frame for Blue Cross/Blue Shield of Michigan for internal reviews of disputed claims. House Bill 5576 would create the "Patient's Right to Independent Review Act", which would establish a uniform external appeals process for all health carriers. Specifically, the bills would do the following:

House Bill 5573 would amend the Nonprofit Health Care Corporation Reform Act (MCL 550.1404), which regulates Blue Cross Blue Shield of Michigan, to make changes to the internal and external grievance procedure. Currently, a member is entitled to a managerial-level conference with representatives of the corporation to settle disputes over benefits or claims. If the dispute cannot be settled, the member is also entitled to a hearing with the commissioner of the Office of Financial and Insurance Services. The bill instead would specify that if the dispute cannot be resolved during the conference with BCBSM representatives (or if a conference was not provided within 30 days of the member's request), then the member would be entitled to a review, beginning October 1, 2000, before an independent review organization under the Patient's Right to Independent Review Act, which would be created by House Bill 5576.

Currently, the final determination in a dispute resolution must be made in writing by BCBSM within 90 days after the member submits a written grievance. The bill would reduce this time frame to 35 days. As is currently permitted, this 35-day period may be tolled for any period of time that the member is permitted to take under the grievance procedure. However, under the bill, the time period could also be tolled for no more than ten days if BCBSM did not receive requested information from a health provider. When an adverse determination is made, the bill would require BCBSM to provide, in writing, a statement with the reasons for the adverse determination, along with a written notification in plain English that the member has the right to request an external review under the Patient's Right to Independent Review Act. Under current law, BCBSM must have a method in place to provide

summary data on the number and types of complaints and grievances that are filed. Beginning April 15, 2001, the bill would require summary data for the prior calendar year to be filed annually with the commissioner on forms provided by him or her.

The bill would delete a provision allowing a member to request further review by BCBSM or by the commissioner for an adverse determination of an expedited internal review, thus bringing the act into conformity with provisions pertaining to expedited reviews contained in the Patient's Right to Independent Review Act. Further, the bill would clarify that a member could give written authorization to any person, including, but not limited to, a physician, to act on his or her behalf at any stage in a grievance proceeding.

House Bill 5576 would create the "Patient's Right to Independent Review Act", which would enable persons with health insurance to request a review by an independent review organization to resolve disputes over covered benefits. The bill would apply to all health carriers (defined as entities that are subject to the state's insurance laws which provide a plan of health insurance, health benefits, or health services) that perform utilization reviews. Policies or certificates that provided coverage only for accident or accident-only coverage, long-term care insurance, or for supplemental policies would not be affected by the bill. (See the bill for a complete list of exemptions. Though not specifically mentioned, the federal Employee Retirement Income Security Act [ERISA] would most likely exempt self-insured plans from the requirement to provide an external review process.) Under the bill, once a person had exhausted all the internal appeal processes with his or her health carrier, he or she could request an external review of an adverse determination from the commissioner of the Office of Financial and Insurance Services (OFIS). A written request would have to be submitted within 60 days of receiving the adverse determination from the health carrier (currently, a person has up to two years to request an external review). An "adverse determination" would be defined as an admission, availability of care, continued stay, or other health care service that had been reviewed by a utilization review organization and been denied, reduced or terminated. Failure by a health carrier to respond in a timely manner to a request for a determination would constitute an adverse determination.

External review. The bill would establish the procedure and time lines for an external review and set time frames for an independent review organization (IRO) to review a case and make recommendations. The commissioner would have to first conduct a preliminary review to see if a request met criteria for an external review, assign the case to an IRO and notify the health carrier that the case has been referred to an IRO, review the recommendation of the IRO to ensure that it is not contrary to the terms of coverage under the person's health benefit plan, then provide written notification in plain English to the person and the health carrier of the decision to uphold or reverse the recommendation of the IRO. Except for any remedies available under existing and applicable state or federal law, an external review decision and an expedited external review decision would be the final administrative remedies available under the bill.

In situations where a person's health would be seriously jeopardized by a delay in treatment, a person could request, within 10 days of receiving an adverse determination, an expedited external review to be conducted. The request for an expedited external review could be filed simultaneously with a request for an expedited internal review. An expedited external review would have to be completed within 72 hours of the commissioner assigning the case to an IRO. If the person had not first completed the internal appeal process available with his or her health carrier, he or she could be required to do so before the commissioner would assign the case to an IRO. Health carriers would have to provide required information within 12 hours of notification that a request for an expedited review had been granted. Once the case for an expedited review was assigned to an IRO, the IRO would have to make its recommendations to the commissioner within 36 hours; the commissioner would then have up to 24 hours to review the recommendation and make a determination. Health carriers would be required to give members and enrollees information in plain English regarding the internal grievance and external review procedures, including the right to request such reviews and the commissioner's toll-free phone number and address.

Independent review organizations. IROs would have to be approved by the commissioner (IROs could not own or be a subsidiary of a health plan, or have a material professional, familial, or financial conflict of interest), and the commissioner could charge an application fee for both initial approval and reapproval. An approval would be effective for two years, and could be terminated by the commissioner if the IRO did not meet minimum standards set under the bill. The minimum standards would include adhering to strict reporting criteria and adopting written policies governing the external review process that would have to, at a minimum, include a quality assurance

mechanism. The bill would also establish standards and criteria regarding clinical peer reviewers assigned by IROs to conduct external reviews. Neither an IRO nor a clinical peer reviewer working on behalf of an IRO would be civilly liable for damages for opinions rendered in the course of an external review unless the opinion was rendered in bad faith or involved gross negligence. Further, the IRO would have to maintain for three years written records (in aggregate form and by health carrier) of the requests for external reviews conducted in a calendar year. An annual report would have to be submitted to the commissioner that included, among other things, the total number of requests for external review, the number of requests resolved and the breakdown as to whether the adverse determination was upheld or reversed, and the average length of time for cases to be resolved. Health carriers would be required to keep similar information and would also have to submit an annual report that was nearly identical to the one required of IROs.

Violations. Upon finding that a violation had occurred, the commissioner would have to serve the violator with a cease and desist order along with a written copy of the findings. In addition, the commissioner could levy a fine up to $1,000 for each violation (up to $5,000 for each violation if the person knew or should have known that he or she was in violation of the bill). License sanctions could also be taken.

If the commissioner found that a health carrier deliberately refused to pay for a covered benefit, the commissioner could order payment of a civil fine and recovery of the cost of the investigation. The fine for a first offense would be set at no more than $25,000 and the fine for a second offense would be set at no more than $50,000. For a third or subsequent offense, the commissioner could require recovery of the cost of the investigation and could levy a civil fine of not more than $280,000 or the amount of the health carrier's total liability for the covered benefits denied, whichever was greater. Fines collected under the bill would be deposited in the Cancer Clinical Trials Fund.

A person who violated the bill could request a hearing before the commissioner under the Administrative Procedures Act. Violation of a cease and desist order could result in an additional fine of $10,000 for each violation, license sanctions, or both. Further, the commissioner could apply to the Ingham County Circuit Court for an order to enjoin a violation of the bill.

Cancer Clinical Trials Fund. All fines collected under the bill would be credited to the Cancer Clinical Trials Fund. Up to $5,000 per year per facility could be appropriated to hospitals, outpatient oncology centers, and other facilities located in the state that are involved in National Institutes of Health phase III or IV cancer clinical trials. A facility that applied to the fund could use the fund money to partially defray costs of patient participation in cancer clinical trials that were not covered by pharmaceutical manufacturers or health carriers.

The fund would be created within the state treasury but would be a separate fund. The state treasurer could invest money in the fund in any manner authorized by law pertaining to the investment of state money. All earnings would be credited to the fund. Money in fund at the close of a fiscal year would remain in the fund and not lapse to the general fund.

The bill would take effect October 1, 2000.

BACKGROUND INFORMATION:

Office of Financial and Insurance Services. Executive Order No. 2000 - 4, which took effect on April 3, 2000, reorganized the state's regulation of insurance, financial institutions, and securities into one office. The powers, duties, and functions of the Insurance Bureau and the Financial Institutions Bureau have been transferred to the newly created Office of Financial and Insurance Services (OFIS), as well as the securities functions of the Corporations, Securities and Land Development Bureau. The Office of Financial and Insurance Services comprises the Division of Insurance, the Division of Financial Institutions, and the Division of Securities.

External review systems. Approximately two dozen states currently have an external review process in place to handle disputes between a health insurer and consumers that could not be resolved with the insurer's internal grievance process. At least six states limit external reviews to those claims involving medical necessity. External review processes are conducted through hearings in some states and through a paper review of the case file in others. At least four states bear the burden for the cost of external review, at least three cover the costs through licensing fees, five states require the health plans to shoulder the cost, one state splits the costs between the health plan and the consumer, and at least two states charge the consumer a filing fee for an external review. The majority of states set a maximum of 30 days in which the external review must be completed. At least half of the states use only health care providers to review the disputed claims, where other states use other professionals, such

as attorneys, and consumers. In most states, the percent of disputed claims decided in favor of the consumer is split fairly evenly, but reportedly ranges from a low of 33 percent in Vermont to a high of 68 percent in Rhode Island. The use of external review also varies among the states. One year, New Mexico had only 10 cases, where Texas had 218. In 1997, Pennsylvania had an external review rate of less than .04 percent cases per 1,000 enrollees.

All Medicare beneficiaries are entitled to an external review after completing their individual plan's internal appeals process. If a health plan upholds the original denial, the case is automatically forwarded to the Center for Health Dispute Resolution (CHDR), which is the external review contractor for Medicare. In 1997, out of 9,000 cases referred for appeal, the CHDR decided about one-third of the claims in favor of the consumer. Data shows that about one to two persons per 1,000 Medicare beneficiaries per year seek to use the external review process. The administrative cost is estimated to be about four cents per Medicaid member per month. (Information was obtained from a policy brief by the California Health Policy Roundtable, a nonpartisan educational and informational forum on health policy issues in California.)

ERISA. The Employee Retirement Income Security Act of 1974 (ERISA) was originally enacted to protect against pension plan fraud and mismanagement. The act restricts state regulation of employee benefit plans, including health plans. Though all private-sector health plans are ERISA plans, only self-insured employee health plans are exempted from state regulation under the act; states maintain the authority to regulate insured health plans. It is estimated that between one-third and one-half of people covered under employer-sponsored health plans are in plans that are not subject to state regulation.

State law that directly conflicts with ERISA is preempted by the preemption clause, as is any state law that even "relates" to ERISA. However, a Supreme Court case (*New York State Conference of Blue Cross & Blue Shield Plans* v *Travelers Insurance Co, 514 US 645 (1995))* did limit the scope of the preemption clause in regard to the effect of a state law on a plan's benefits, structure, or administration.

Another provision of ERISA, the savings clause, also limits the scope of ERISA's preemption of state regulation by exempting state laws that regulate insurance from preemption. To be protected from preemption, a state law must meet one of what is known as the McCarran-Ferguson criteria. A state law is "saved" if it is directed at the insurance industry and regulates an activity that spreads risk, involves the terms of the insurer-insured contract, and/or applies only to insurers. Although states are prohibited from directly regulating ERISA plans, the interpretation of the savings clause is that a state may regulate the products offered by HMOs and other health insurers. However, both the preemption and savings clauses have resulted in much litigation; states continue to face challenges in federal courts. Federal rulings have not been consistent on these issues, with the result that what can be done in one federal jurisdiction might not be lawful in another.

Currently, five states have enacted laws to impose liability on health plans for certain types of negligent conduct (Texas, California, Georgia, Arizona, and Washington). A federal district court upheld the managed care liability portion of the Texas law insofar as it relates to disputes over treatment decisions in which the plan controlled, influenced, or participated in treatment decisions. However, the court ruled that ERISA preempted the provisions establishing an external review process on the basis that the definition of "medically necessary" care and the appeal system established in the external review process goes beyond the appeal procedure that is contained within ERISA and therefore would affect the administration of employee health plans. The case is currently under appeal to the Fifth Circuit Court. (Information was obtained from a policy brief entitled "ERISA Case Law Update" issued by the National Governors' Association Center for Best Practices.)

FISCAL IMPLICATIONS:

In a fiscal note dated 6-16-00, the House Fiscal Agency reports that House Bill 5573, which revises requirements regarding the internal review procedures of Blue Cross Blue Shield of Michigan, would have no fiscal impact on the state or on local units of government.

According to the House Fiscal Agency in a fiscal note dated 6-29-00, House Bill 5576, which would create the Patient's Right to Independent Review Act, would add new administrative responsibilities to the Office of Financial and Insurance Services (OFIS). These new administrative responsibilities would increase state costs by an indeterminate amount. In addition, the bill does not clearly specify who would pay the costs incurred by an independent review organization (IRO) in conducting the external reviews. If the Department of Consumer and Industry Services, which houses the OFIS, bears these costs, state costs would further

increase. Regardless of who would bear the costs of the IRO reviews, any new costs incurred would be passed on to the insurance industry because the assessment charged by the OFIS to industry members are based on state costs. Thus, new costs would lead to higher assessments and greater revenue to the state.

ARGUMENTS:

For:

Currently, all health insurers and HMOs operating in the state have both an internal grievance process and a procedure for external reviews for disputed claims. However, time lines and procedures for the various health plans can differ somewhat, leading to confusion for consumers, especially if people change health plans. For example, external reviews for HMOs are handled by a task force under the oversight of the Department of Community Health, but Blue Cross Blue Shield members and members of other insurance plans can request a hearing before the commissioner of the Office of Finance and Insurance Services. House Bill 5576 would instead create one process by which consumers could request an external, independent review of a disputed claim. Under the bill, all persons covered by health insurance could request the commissioner for an independent review of disputed claims once the internal review process had been exhausted. (Internal review procedures would be standardized by Public Act 252 of 2000 [Senate Bill 1209], which would reduce the allowable time for insurers to process internal reviews from 90 days to 35 days.) Further, the bill would specify that if an insurer did not issue a written decision for an internal review within the required time, the internal review process would be considered exhausted and the person could file a request for an external review of the claim.

The reporting standards required by the bill would help the commissioner and consumers to identify those health carriers that may not be making treatment decisions based on reasonable standards. The commissioner could identify and investigate those plans that were having more of their decisions questioned and reversed, and consumers could look to see, when choosing a plan to best fit their needs, if a particular plan was recorded as having had a large number of grievances and problems.

The bill would make other improvements. It would prohibit a business or individual with a conflict of interest from being approved as an independent review organization or a clinical peer reviewer. The bill would also establish stiff financial penalties, in addition to license sanctions, for health carriers that did not comply with the new internal and external review procedures. All in all, the bill should create a process that would make external grievance procedures and expedited external grievance procedures more efficient for consumers, health carriers, and health providers.

Against:

A major weakness of House Bill 5576 is the exclusion of a provision that would allow a person who suffers damages to directly sue an HMO. Reportedly, under current law, a person can only sue an HMO for vicarious liability, meaning that if a doctor failed to prescribe proper treatment, the person could sue the doctor for malpractice and could also sue the HMO for vicarious liability because of the contractual relationship between the doctor and the HMO. However, if an HMO denies coverage for a treatment that was prescribed by the doctor for a patient, and the person suffers harm from the lack of treatment, the person cannot sue the HMO. Many feel that it is necessary to statutorily create a cause of action whereby a person can directly bring a lawsuit against an HMO that wrongfully denied treatment coverage and to receive compensation for damages (e.g., loss of wages, loss of consortium, and so forth). Having a statutory cause of action may be the only way to ensure fairness and discourage HMOs from denying coverage based on lack of medical necessity for procedures that should be covered. This would not be a punitive measure, for Michigan law prohibits lawsuits seeking punitive damages; however, creating liability for HMOs would enable those who have suffered loss to collect damages based on those losses.

Response:

Some believe that having an external review process in place has a "sentinel effect". They feel that the existence and utilization of such external review mechanisms encourage health carriers to be more cautious in basing treatment decisions on clinical standards. Further, greater oversight of health plans by the commissioner should be provided by the new reporting standards created under the bill package; in particular, the number of disputed claims going to the external review process and the statistics on how many adverse determinations are overturned. If a plan is denying coverage, and those decisions cannot be supported by external review, it should trigger an investigation by the commissioner, as well as the likelihood that enrollment numbers would drop as consumers take their business elsewhere. Besides, there appears to be disagreement within the legal community regarding the types of legal action that can be taken against HMOs for denial of coverage, with many maintaining that several actions have been successful against HMOs.

Rebuttal:

The fact that a health insurer might have a drop in profits as consumers shop elsewhere is little comfort to a person who, because of not receiving timely medical treatment, has suffered financial loss as a result of not being able to work. Nor is there comfort for the family who has lost a loved one due to delays in treatment when forced to challenge one denial of coverage after another. Health plans and health carriers, like most businesses, respond to issues that affect their pockets. States that allow people to sue HMOs have seen only a handful of lawsuits filed over several years. Therefore, it would seem that creating liability for HMOs does indeed encourage them to be cautious about denying appropriate treatment without opening the floodgates to lawsuits. Besides, apparently people can bring actions against the other types of health insurers in the state, so this would create parity between HMOs and other health insurers.

Against:

Though a step in the right direction, House Bill 5576 remains flawed. For example, though the internal grievance procedures are being shortened in the package of legislation, the external review process still remains too long. Estimates of the process, including time lines specified in the bill and time needed for the various notifications to travel through the mail, could be as long as 75 to 78 days. Though the bill does provide for a streamlined expedited review process for the seriously ill, many who would not fit the strict criteria for an expedited review may nevertheless be in urgent need of treatment. At 75 to 78 days, Michigan will remain a state with one of the longest turnaround times for external reviews in the nation. If time cannot be shaved from the external review process, then the internal grievance process should be eliminated. The internal review process is redundant, unnecessary, and its elimination could save health plans money.

Response:

It should be noted that the package of legislation does shorten the time frame for internal grievance processes from 90 days to 35 days. Before judging the time lines to be inadequate, some time should be given to allow the bills to take effect and to see how the process functions. As information is disseminated to educate consumers of their right to appeal adverse determinations, it is not known at this time what impact the bills will have on the number of requests for external reviews. Once the process is up and running, it should become clearer if the time lines set in statute need to be adjusted further. It should also be remembered that the time lines specified in the bill are maximums, not minimums. Hopefully, both internal and external appeals will be handled as quickly as possible and well under the specified maximums.

Against:

The Employee Retirement Income Security Act of 1974 (ERISA), a federal law that regulates employee pension and benefit plans, generally preempts private self-insured and self-funded health plans from regulation under state laws. (Church and governmental self-funded and self-insured plans are exempt from regulation under ERISA, meaning that these self-funded plans would be subject to state insurance regulations.) Therefore, since the majority of persons in Michigan with health insurance are covered by self-insured or self-funded plans, the external review process under the bill is likely to be available for only a small percent of covered persons. The issue of whether or not ERISA would preempt a state external review law for self-funded and self-insured plans is currently being litigated in federal courts. A recent Texas federal court case (*Corporate Health Insurance Inc., et al* v *Texas Department of Insurance),* which is currently under appeal, held that ERISA did indeed preempt a Texas law requiring external review procedures. According to a 1998 report prepared for the Kaiser Foundation that provided an overview of key program features of external review programs, "existing case law could support arguments for and against ERISA's preemption of such laws"; however, should more federal courts follow the lead of the Texas district court, only those covered under individual plans or governmental and church self-insured plans would be able to receive any benefits of the external review process created by the bill.

Response:

It is true that the courts are still deciding issues relating to what types of state regulations are preempted by ERISA for self-insured and self-funded health plans; however, Michigan was one of the first states to establish an external review mechanism in statute. Though House Bill 5576 would add greater continuity and consistency between the various types of health plans and health carriers, the concept and practice of external reviews is not new to the state. For over twenty years, Michigan residents have been able to appeal disputed claims to an external reviewer. In addition, the availability of an independent, external review is seen by many health carriers as being beneficial, as it increases consumer confidence that the plan is working toward serving the enrollee or member in a fair manner. Therefore, whatever is decided in federal court is not expected to have a great impact on health carriers' compliance with external review regulations.

Against:

To resolve disputes under current law, consumers with disputed claims can request a hearing with the commissioner and persons in HMOs can come before a task force appointed by the Department of Community Health. Under House Bill 5576, this face-to-face contact would be eliminated and replaced by a paper review. Also, a person currently has two years in which to request an external review of an adverse determination; the bill would reduce this time frame to 60 days. In addition, the bill is not clear about who would bear the financial burden of providing the external reviews. Though the commissioner could set a fee for independent review organizations to be approved under the act, it is doubtful that the revenue collected would be sufficient to support the cost of the reviews. Finally, though the bill does set fines for those health carriers found to be violating the bill, in some situations it may be cheaper for a health carrier to pay the fine than to pay for the treatment. Therefore, many feel that the penalty section of the bill should contain stricter penalties.

Response:

Apparently, the bill would be a shift to a paper review, but currently, most reviews are at present conducted in that manner. In fact, appeals to the commissioner are currently handled by staff within the Division of Insurance. Under House Bill 5576, it would be doctors making the determination of medical necessity. Input by the division staff would be limited to reviews of contractual language to verify that the person's plan covers any IRO recommended treatments and to monitor the health carrier's compliance with the external review recommendations. Indeed, the process established by the bill offers far more consumer protection than what is currently available.

Analyst: S. Stutzky

■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.