House
Legislative
Analysis
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PATIENT'S RIGHT TO INDEPENDENT REVIEW ACT

House Bill 5576
Sponsor: Rep. Charles LaSata
Committee: Health Policy

Complete to 5-3-00

A SUMMARY OF HOUSE BILL 5576 AS INTRODUCED 4-12-00

The bill 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 specific diseases 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. An "adverse determination" would be defined as an admission, availability of care, continued stay, or other health care service that is a covered benefit but, based upon a review of information provided to the health carrier, did not meet requirements for medical necessity and other criteria for coverage and so was denied.

External review. The bill would establish the procedure for an external review and set time frames for an independent review organization to review a case and make recommendations. The commissioner would have to review the recommendation of the review organization, make a decision on whether to uphold the recommendation of the review organization, and then notify the person as to the determination. Decisions of the external review process would be binding on both the person who requested the review and the health carrier, except for any remedies available under existing law. In situations where a person's health would be jeopardized by a delay in treatment, a person could request an expedited external review to be conducted. 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 independent review organization. Once the case for an expedited review was assigned to a review organization, the review organization 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 regarding the external review process, including the right to request such a review and the commissioner's phone number and address.

Independent review organizations. Independent review organizations would have to be approved by the commissioner, 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 review organization 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 independent review organizations to conduct external reviews. Neither an independent review organization nor a clinical peer reviewer working on behalf of a review organization 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 independent review organization 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 independent review organizations.

Violations. A person who violated the bill could request a hearing before the commissioner under the Administrative Procedures Act. 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 $500 for each violation (up to $2,500 for each violation if the person knew or should have known that he or she was in violation of the bill), but fines would be capped at $25,000. License sanctions could also be taken. Violation of a cease and desist order could result in an additional fine of $10,000 for each violation, license sanctions, or both. Fines collected under the bill would be credited to the general fund. Further, the commissioner could apply to the Ingham County Circuit Court for an order to enjoin a violation of the bill.

The bill would take effect October 1, 2000.

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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.