

A TOUGH PILL TO SWALLOW: THE IMPACT OF STATE INDEPENDENT REVIEW LAWS ON APPROPRIATE HEALTH CARE CLAIMS HANDLING

Introduction

In an effort to balance cost-containment and patient rights, most states have enacted some form of external or independent review legislation. “External” or “independent” review refers to a mandatory dispute resolution process for health care claim denials that is independent of the disputing health care plan and claimant. Thus, an enrollee may question the decision of the health care plan through a process that is completely independent of financial incentives. At the same time, the decision is examined by an impartial reviewer who, unlike a treating physician, has no relationship with the patient.

The particulars of independent review differ from state to state, but the statutes all require the use of an independent reviewer when requested by an insured, the treating physician, or some other individual acting on behalf of the patient. Consequently, health care plans are faced with the burden of complying with a wide variety of statutory requirements. The intent of this paper is to assist these plans by identifying and summarizing key elements of the current independent review statutes.

Types of Health Care Plans Impacted by Independent Review Laws

Logically, an analysis of an independent review statute should begin with the scope of the statute. In most states, the independent review statute applies to all health plans or all health benefit plans. Some states, however, only extend independent review to Health Maintenance Organizations (“HMOs”). Other states limit the applicability of independent review to managed care plans or plans that perform utilization reviews.

Unfortunately, states frequently use the terms “health plans” and “health benefit plans” interchangeably, and they have not been consistent in how they define either term. Each state’s

terminology and definitions, therefore, must be examined in order to identify exactly what types of plans are affected. Generally, however, the term “health plans” refers to coverage that provides hospital, medical, and/or surgical benefits. Further, the term “health benefit plans” generally refers to any policy, contract, certificate, or agreement that provides, delivers, arranges for, pays for, or reimburses any of the costs of covered health care services. Although these definitions encompass a wide variety of plans, independent review usually does not apply to a number of the following coverages: accident only, fixed indemnity for hospital confinement and/or medical expenses, disability, specified disease, long-term care, credit, vision, dental, and/or workers’ compensation. Typically, these coverages are specifically excluded from the scope of the independent review statute or the statutory definition of health plans/health benefit plans.

Other terms are more consistently defined. An HMO, for example, is defined as an organization that provides or arranges for the delivery of comprehensive health care services on a prepaid basis, except to the extent the enrollee is responsible for copayments and/or deductibles. At a minimum, the covered health care services should include inpatient and outpatient hospital services, ambulatory diagnostic treatments, preventive health care services, emergency care, laboratory and x-ray services, and physician services. Where the statute is limited to managed care plans, it applies to HMOs, preferred provider organizations, point of service organizations, health insurance issuers, prepaid health care plans, and other similar entities that provide for the financing or delivery of health care services or benefits to enrollees through (i) arrangements with specific providers or provider networks for furnishing health care services or benefits, and (ii) financial incentives to enrollees who use participating providers and procedures under the plan.

Additionally, utilization review generally refers to processes used by health plans to control costs. Through utilization review, health plans manage the use of health care services in a variety of ways. The utilization review process may be prospective, concurrent, or retrospective. A plan using prospective review may require prior authorization for hospitalizations and certain treatments, such as physical therapy, or lab tests, such as an MRI. Other examples of prospective review include mandatory referrals from the primary care physician to a specialist and second opinions obtained before recommended surgeries.

Moreover, if the health care plan encompassed by the statute is an employee welfare benefit plan, it may also be subject to independent review.¹ The Employer Income Security Act Employee Retirement Income Security Act of 1974 (“ERISA”)² defines an employee welfare benefit plan as any plan, fund or program established or maintained by an employer for the purpose of providing participants or their beneficiaries with, among other things, benefits in the event of sickness, accident, disability or death.³ At one time, ERISA generally preempted the application of independent review to certain employee welfare benefit plans. As a result of the Supreme Court’s recent decision, however, employee welfare benefit plans governed by ERISA are not necessarily exempt from the requirements of such statutes.⁴ In order to apply to employee benefit plans, a statute must: (1) be a law that regulates insurance; (2) not create a new cause of action; and (3) not authorize a new form of relief. If a state law satisfies these standards, then, according to the Supreme Court, it is not preempted by ERISA. An independent review statute still may be subject to preemption, however, if the procedures prescribed are more elaborate than

¹ Generally, self-insured plans are not subject to independent review because most independent review statutes only regulate insurers.

² See 29 U.S.C. § 1001 *et seq.*

³ See 29 U.S.C. § 1002(1).

⁴ See *Rush Prudential HMO, Inc. v. Moran, et al.*, 536 U.S. 355 (2002).

the Illinois independent review statute, the statute imposes onerous burdens,⁵ and/or the statute undermines or creates different rights and remedies from those provided in ERISA.⁶

Types of Claim Determinations That May be Resolved by Independent Review

Once the company has identified the applicable plans, it must determine what types of adverse claim determinations are eligible for independent review. Significantly, states differ as to what types of adverse determinations are eligible for independent review. Depending on the statute, adverse claim determinations can include any decision to deny, reduce, limit, or delay a proposed or delivered health care service. Indeed, enrollees may seek review for a broad range of health plan determinations involving medical and/or legal issues. Medical issues encompass claim denials based on the ground that the treatment is not medically necessary, appropriate, or effective. Legal issues involve health care services that are denied based on coverage parameters, limitations, or exclusions set forth in the health plan contract.

In most states, independent reviews are limited to disputes over medical issues. These states ordinarily conduct a threshold review under which cases that do not involve medical issues are rejected as not appropriate for independent review. Other independent review programs, however, hear all types of disputes, including both medical and legal issues. Even where the program provides for review of all types of disputes, it also may require that the disputes be separated by type. This initial review is conducted in order to distinguish disputes that require a medical expert from non-medical disputes requiring expertise in the areas of contract interpretation or statutory analysis.

⁵ In *Moran*, the Supreme Court examined the independent review statute enacted in Illinois and found that the statute was not preempted by ERISA. Presumably, the courts could find that any statute which is more elaborate or onerous than the Illinois statute still could be preempted.

⁶ ERISA provides that a civil action may be brought by a plan participant or beneficiary to, *inter alia*, “recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.” 29 U.S.C. § 1132(a).

The initial review of appealed disputes may seem to add a layer of complexity to the independent review process when the statutes provide for review of all types of disputes. The benefit, however, is that the broad application of the independent review statute affords enrollees with the comprehensive protection of an extended review for all types of disputes. At the same time, regulatory staff experts are allowed to direct non-medical disputes to more appropriate resources for resolution.

With respect to states that limit independent review to medical issues, some may additionally provide independent review for claims that are denied because the treatment is deemed to be experimental or investigatory. Indiana, Kentucky, and Oklahoma, for example, provide independent review for all disputes involving experimental and investigatory treatments. In Colorado, all denials of such treatments also are subject to independent review, unless the treatment is specifically excluded as a benefit under the contract. Other states, such as Georgia and Ohio, provide independent review of experimental and investigatory claim denials only for terminally ill patients. In New York, the experimental or investigatory treatment must be for a life-threatening or disabling condition in order for independent review to apply.

Internal Reviews and the Exhaustion Requirement

Independent review is the last step in a mandatory multi-level appeal process. Generally, statutes require health plans to establish a multi-level appeal process that starts with an internal review of the claim denial. If the internal process does not resolve the dispute, insureds may seek an objective review of their claim through the independent review process.

Most states require exhaustion of the internal appeals process before a plan member can seek independent review. In Florida, however, an enrollee may submit a copy of the grievance to the independent review entity before the internal appeal is complete, and the entity is free to

conduct an investigation before the plan renders a decision. Further, Kansas authorizes the insurer and enrollee to waive the exhaustion requirement and proceed directly to independent review.

The states that require exhaustion of the internal appeals process typically provide certain exceptions. Some states, for example, provide that exhaustion of plan remedies is not required for cases in which the health plan fails to complete the internal appeals process within specified time frames. Other prescribed exceptions include reviews for cases involving life-threatening illnesses, emergency situations, and other similar circumstances. In South Carolina, exhaustion of plan remedies only is applicable when the dispute involves a retrospective determination. Absent a prescribed exception, a claimant who fails to exhaust the internal appeals process ordinarily will be precluded from obtaining independent review.

Other Prerequisites to Independent Review

In order to obtain independent review, many states require plan participants to satisfy other prerequisites. The prerequisites to independent review fall into the following categories: (1) statutory time frames for requesting the external review; (2) minimum threshold benefit amounts; and (3) filing fees.

Notably, a claimant who fails to request independent review in a timely manner may be precluded from obtaining independent review. The maximum statutory time frames during which a claimant may submit a request for an independent review range from no limit in Vermont, to two years in Michigan, to fifteen days in Pennsylvania. Most states prescribe a deadline within the thirty- to sixty-day timeframe. The statutes must be carefully examined, however, because the period is not measured from the same starting point in every state. In some

states, the period is measured from the date of the adverse claim decision. For other states, the period is measured from the completion of the internal appeals process.

Several statutes also include monetary features that can affect a claimant's eligibility for independent review. A few state statutes, for example, set a minimum threshold amount that must be met in order for the claimant to seek independent review. If the amount of the claim involved does not meet that minimum dollar threshold, the independent review process is not available. Arguably, this requirement eliminates the less serious disputes from the process and reduces cases in which the independent review costs would be disproportionate to the benefit amounts at issue. The minimum threshold amounts are as low as \$100 in Vermont and as high as \$1,000 in Oklahoma.

A handful of states also require a claimant to pay a filing fee in order to request independent review. The fees range from \$25 in states such as Connecticut, Iowa, and Kentucky to \$50 in states such as Oklahoma and Virginia. In Rhode Island, the enrollee pays half of the costs for the independent review up front, and is entitled to a refund if the dispute is resolved in the enrollee's favor. These fees apparently were enacted only to discourage frivolous requests. Indeed, the health care plan bears the costs of the independent review process in most states, and the \$25 to \$50 fees are miniscule in proportion to the actual review costs. Moreover, in most states, the fee may be waived if it creates a financial hardship on the claimant.

These three statutory prerequisites are particularly important to claimants because they can only move forward with a request for independent review by meeting the statutory requirements. These statutory prerequisites also are important to health care plans in two ways. First, health care plans must ensure that their insurance policies, plan documents, and denial letters accurately describe when a claimant is eligible for independent review and the process for

obtaining the review. Second, health care plans need to know when the claimant is not entitled to an independent review – whether it’s because the claimant failed to exhaust the internal appeals process, missed the filing deadline, or otherwise neglected to adhere to the statutory requirements.

Notice Requirements

Independent review statutes are virtually worthless if consumers are unaware of their rights. Several states promote public awareness of their independent review programs through printed brochures, toll-free numbers, and/or websites. The primary source of consumer information regarding independent review statutes, however, is the mandatory materials health care plans must provide. All states with independent review statutes require that health care plans communicate adverse claim decisions in writing and that these communications notify claimants of the right to independent review and the procedures for filing an appeal, including timelines and consumer fees. Typically, these communications also must include information regarding any internal appeals process in place and an explanation of when the internal process may be bypassed or expedited. To ensure compliance, health care plans must conform their claim procedures and adverse decision letters to statutory requirements. This frequently means that the claim procedures and decision letters will vary depending on the type of claim, the nature of the denial, and the state involved.

Most states also require that coverage documents, including insurance policies, plan materials, and summary plan descriptions, provide an explanation of a plan participant’s “right” to any statutory internal and external reviews. Some of the states even require that the explanations regarding these reviews be prominently displayed in a larger or bold-faced type.

The Independent Reviewers

The entity conducting the independent review is authorized by statute to evaluate and resolve disputed claim denials involving health care services. These statutes also govern how the process is conducted. States vary in the prescribed qualifications for the reviewers as well as the procedural steps that they must adhere to.

The impartiality of independent review is a key component of the process. To protect the impartial nature of the process, almost every statute prohibits conflicts of interest with respect to the independent reviewers. This means the independent reviewer cannot have any contracts with or financial interest in the health plan or any relationship with the enrollee involved in the dispute. Typically, independent reviewers must disclose all potential conflicts during a screening process and recuse themselves when they have a connection to the plan or the enrollee. In addition, the statutes prescribe varying methods for selecting or appointing reviewers. The New Mexico Superintendent of Insurance, for example, must appoint a three-member review panel for each case. In Pennsylvania, the Department of Insurance randomly assigns a utilization review entity to conduct the independent review. Similarly, some states contract directly with independent review entities, which will either conduct the reviews or refer the dispute to one of their subcontracting expert reviewers. Several other states allow the health care plan or the enrollee to select who will conduct the review. Where the plan selects the independent reviewers, the statute may require that the choice be rotated among all independent review organizations before a selection may be repeated.

Most states also prescribe specific criteria for the persons participating in the review process. Generally, at least one physician specializing in a field relevant to the claim at issue must participate in the review. Depending on the state and the issues subject to review, the

physician also may need to have expertise in the enrollee's condition and the experimental or investigatory therapies under review. Further, under some statutes, the medical experts do not necessarily have to be physicians. They may be other types of health care providers, such as nurses or physical therapists.

Because disputes may involve legal issues or a combination of both legal and medical issues, independent review statutes also provide for inclusion of lawyers and other types of experts in the process. These persons may be part of an outside reviewing panel or a member of the state agency's in-house legal or regulatory staff. In New Mexico, for example, the review must be conducted by a panel consisting of two physicians licensed to practice medicine in the state and one attorney licensed to practice law in the state.

The Independent Review Process

When a health care plan makes an adverse claim determination, the enrollee must submit a request for an independent review. In some states, the request must be submitted to the health care plan, and the plan subsequently forwards the request to an independent review entity or the appropriate government agency. In other states, the request must be submitted directly to the regulatory agency charged with supervising or administering the process, such as the Insurance Department or Health Department. Most requests must be in writing, but some states authorize oral requests for emergency situations. When the request is directed to the health care plan, the plan must be diligent in complying with the statutory time frames for acknowledging the appeal and referring it to the appropriate entity.

The independent review process typically begins with a preliminary screening to determine the nature of the dispute and whether the enrollee has complied with the statutory prerequisites. Ordinarily, the preliminary screening is performed by state insurance departments,

but it also may be delegated to the independent review entity. If the independent review process provides for different reviewers based upon whether the dispute involves medical versus legal issues, the preliminary screening facilitates assignment of the dispute to the appropriate reviewers. The screening process also identifies enrollees who are not entitled to an independent review because they missed the statutory filing deadline, failed to exhaust the internal review process, or did not meet other eligibility requirements. States that have a screening process usually require that the enrollee be notified of whether the case has been approved for independent review.

If the dispute is approved for independent review, the independent review entity conducts a *de novo* review of the dispute. This means that the claim is reviewed as if no prior decision had been rendered by the initial claim examiner or during any internal appeal. All facts are considered anew, the enrollee may submit new information, and the independent reviewer is not bound by any previous findings or conclusions.

The review may be performed by conducting (i) a paper review of the file, (ii) a hearing, or (iii) a paper review followed by a hearing. The paper review involves examination of the case file containing the patient history and plan decision. For paper reviews, regulatory staff may perform an initial review, ensuring the completeness of the file and preparing a summary of key information for the medical expert. The expert reviews the file and returns it with a determination regarding the dispute. Under statutes that provide for hearings, the reviewers meet to discuss the case. If the state uses both a paper review and hearing, the hearing is usually preceded by a paper review of the file. In addition, depending on the state, both the health care plan and enrollee may be allowed to participate and present their respective cases at the hearing, with or without legal representation. After the hearing, the reviewers in most states must

forward their findings and recommendations to the appropriate regulatory agency, which will then advise the parties of the final decision. In other states, the reviewers communicate their determination directly to the plan and the enrollee, with a copy to the regulatory agency.

States prescribe widely varying timeframes for completing the review process. Most states allow two weeks to one month for the reviewer's case analysis and recommendation. These timeframes, however, are in addition to the periods prescribed for completing any mandatory internal review process, conducting an initial review and/or preliminary screening of the file for the independent review, and preparing the final decision. Furthermore, the health care plan may be given an additional period of time to implement the decision. Thus, an excessive amount of time may conceivably transpire from the time of the initial denial to the time of a final decision under independent review. When a retrospective case is involved, however, the care already has been provided. Thus, the lengthy timeframes for the appeals process are not an impediment to receiving necessary health care. In addition, expedited reviews with much shorter timeframes are prescribed for cases involving emergencies or life-threatening conditions.

Binding Nature of Independent Review

In many states, the decision on independent review is binding. Generally, this means that, unless a judicial appeal is filed, the health care plan must adhere to the decision. Some statutes expressly provide that the plan's failure to abide by a decision made during independent review may result in fines and penalties. Interestingly, under Oregon's statute, health care plans are allowed to choose whether or not they wish to be bound by the outcome of an independent review. If the Oregon plan agrees to be bound but fails to adhere to the decision, the plan is subject to fines from \$100,000 to \$1 million. When the Oregon plan states that it will not be

bound by the decision, however, an enrollee has the right file a civil action against the plan if it fails to comply with the reviewer's decision. Further, even when a statute does not require specific contract language or expressly provide that the decision is binding, failure to abide by the decision made during an independent review generally weighs heavily against the plan in any subsequent civil suit. Moreover, the decision usually is binding with respect to the claimant, unless he or she files a judicial appeal. Thus, the independent review determination likely will be the "end" of any dispute.

Conclusion

In the epic battle between health care plans seeking uniform standards among states and local legislatures focused on protecting their citizens and the states' longstanding right to dictate insurance law, it appears that the local legislatures have won with respect to independent reviews. The statutes governing independent review are complex, cumbersome, and varied. Moreover, the independent review process can be time-consuming, expansive, and expensive. Health care plans must struggle through numerous laws and regulations in order to comply with each state's requirements. Although independent review statutes protect patient rights and validate health care plan determinations, analyzing and understanding the multitude of requirements is a tough pill to swallow. Hopefully, this presentation has it a little easier.

Sources

Kaiser Family Foundation, “External Review of Health Plan Decisions: An Overview of Key Program Features in the States and Medicare” (1998).

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