Washington State
House of Representatives
Office of Program Research

BILL ANALYSIS

Health Care & Wellness Committee

HB 1956

Brief Description: Creating independent review organizations.

Sponsors: Representative Moeller.

Brief Summary of Bill

- Permits a person covered by a health plan to seek review by an independent review organization (IRO) of the issuer's final adverse benefit determination or internal adverse benefit determination under certain circumstances.
- Requires the Office of the Insurance Commissioner to certify IROs and make information about IRO determinations available in an online database.

Hearing Date: 2/13/15

Staff: Alexa Silver (786-7190).

Background:

Requests for External Review.

An enrollee in a health benefit plan may seek review by a certified independent review organization (IRO) if: (1) a health carrier denies, modifies, reduces, or terminates coverage of or payment for a health care service; and (2) the enrollee has exhausted the carrier's grievance process or the carrier has exceeded timelines for grievances. Reviewers for the IRO make determinations regarding the medical necessity or appropriateness of, and the application of plan provisions to, health care services for an enrollee.

Within three days of receiving a request for review, the carrier must provide the IRO with certain documents. The covered person has five business days to submit additional information. The IRO is required to forward this information to the carrier, and upon receiving this information, the carrier may reverse its final adverse benefit determination.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

The carrier must inform the covered person of the right to external review, must explain the process to exercise that right, and may not establish a minimum dollar threshold for external review. During the external review, the carrier must continue providing a health service to the covered person under certain circumstances, but if the IRO affirms the issuer's decision, the covered person may be responsible for the cost of the service.

An enrollee or carrier may request an expedited external review by the IRO if the determination: (1) concerns an admission, availability of care, continued stay, or service for which the covered person received emergency services but has not been discharged from a facility; or (2) involves a medical condition for which the standard review time frame would seriously jeopardize the covered person's life, health, or ability to regain maximum function.

Independent Review Organization Review Process.

Upon receiving documents from the carrier and the enrollee, the IRO's expert reviewers make a determination regarding the medical necessity or appropriateness of, and the application of coverage provisions to, health care services for the enrollee. The determination must be consistent with the plan unless it is unreasonable or inconsistent with evidence-based medical practice.

Only clinical reviewers may determine medical necessity and appropriateness. Expert clinical reviewers should have substantial, recent clinical experience dealing with the same or similar health conditions, treatments, or services. Determinations of medical necessity must be based on the clinical reviewers' expert clinical judgment after consideration of relevant medical, scientific, and cost-effectiveness evidence and medical standards of practice. In considering medical standards of practice in Washington, reviewers may use national standards of care if there is no evidence that state standards are different. In addition, the service or treatment should be considered part of the standard of practice if the failure to provide it would be inconsistent with the degree of care, skill, and learning expected of a reasonably prudent provider acting in similar circumstances.

Only contract specialists may make determinations about application of plan provisions. The IRO must request additional provisions from the plan coverage agreement as necessary to have an adequate context for determinations. The IRO and contract specialists may assume that the plan is consistent with the insurance code. Primary responsibility for determining consistency with the insurance code rests with the Office of the Insurance Commissioner (OIC).

Reviews Involving Experimental or Investigational Treatments.

In cases involving experimental or investigational treatments, the IRO must ensure that adequate clinical and scientific experience and protocols are taken into account. At least part of the clinical reviewer's experience must have been obtained in the previous three years. The clinical reviewer must consider and include in his or her written opinion certain specified information, such as whether medical or scientific evidence demonstrates that the service or treatment is more likely than any standard service or treatment to be beneficial without substantially increasing the adverse risks. The IRO must include certain information in its notification of the results and rationale for the decision, including the written opinion of each clinical reviewer.

Independent Review Organization Determinations.

An IRO is required to notify the enrollee and the carrier of the result and rationale for the determination within 15 days of receiving all necessary information or 20 days after receiving the request (or 25 days in exceptional circumstances), whichever is earlier. For expedited external reviews, the IRO must issue its determination within 72 hours. The notification must include the clinical basis for the determination, the reviewers' qualifications, and, if applicable, the rationale for any interpretation regarding the application of plan provisions. The carrier must timely implement the determination and pay the IRO's fees.

If an IRO finds a pattern of substandard or egregious conduct by an issuer, it may notify the OIC.

Oversight by the Office of the Insurance Commissioner and the Department of Health.

The OIC maintains a rotational registry system for assigning IROs. It is required to adopt rules implementing the statutory procedures for IRO reviews, taking into consideration relevant standards adopted by national managed care accreditation organization and the National Association of Insurance Commissioners.

The Department of Health (DOH) certifies IROs. The DOH must adopt rules addressing confidentiality, reviewer qualifications, conflicts of interest, timelines for determinations, and reasonable fees. To be certified as an IRO, an organization must submit certain information to the DOH, including owners' names, procedures that will be sued to make determinations, and information about officers, directors, and executives. An IRO may not be owned or controlled by an issuer or an association of issuers or providers.

Independent review organizations are required to maintain written records and conduct annual self-assessments. The DOH may review IROs' performance and revoke their certification. The review process must be free from interference by state government, and while the DOH may conduct investigations, it has no involvement in the disposition of specific cases.

An IRO and its reviewers and employees are not liable for acts or omissions performed within the scope of their duties under the external review law, unless the act or omission was performed in bad faith or involved gross negligence.

Statistical Summary Reports.

Independent review organizations must submit annual statistical reports to the DOH on a form specified by the DOH. The report summarizes reviews, including volumes, types of cases, compliance with timelines, determinations, number and nature of complaints, and compliance with conflict of interest requirements.

Summary of Bill:

Current laws governing certification of independent review organizations (IROs) and IRO determinations are repealed, and provisions related to requests for review, the review process, determinations, and agency oversight are codified in a new chapter of law. Several terms are modified; for example, references to "carrier" are changed to "issuer."

Requests for External Review.

A person covered by a health plan or his or her representative may seek external review by an IRO of either an issuer's internal adverse benefit determination if the issuer has exceeded required timelines or an issuer's final adverse benefit determination (rather than a decision to deny, modify, reduce, or terminate coverage or payment after exhausting the grievance process or after the carrier has exceeded required timelines). An "adverse benefit determination" is a denial, reduction, termination, or failure to make payment for a benefit based on a determination of the enrollee's eligibility, including a failure to cover an item or service because it is determined to be experimental or investigational or not medically necessary or appropriate. A "final adverse benefit determination" is an adverse benefit determination that has been upheld by the issuer at the completion of the internal appeals process or for which the internal appeals process has been exhausted.

Independent Review Organization Review Process and Determinations.

The IRO's determination need not be consistent with the plan if the plan is inconsistent with experimental or investigational treatment protocols (in addition to being unreasonable or inconsistent with evidence-based medical practice).

An IRO's determination is binding on the issuer, and the issuer must promptly (rather than timely) implement the determination. If an IRO observes (rather than finds) a pattern of substandard or egregious conduct by an issuer, it is required to (rather than permitted to) notify the Office of the Insurance Commissioner (OIC).

Oversight by the Office of the Insurance Commissioner.

Responsibility for certifying IROs is transferred from the Department of Health (DOH) to the OIC. To be certified as an IRO, an organization must submit certain information to the OIC. The OIC may review IROs' performance and revoke their certification.

The OIC must:

- adopt rules for certification of IROs covering certain requirements, including conflict of interest, confidentiality, reviewer qualifications, and quality assurance mechanisms;
- develop a reasonable fee schedule for IRO reviews;
- maintain the rotational registry system for assigning IROs; and
- prepare a standardized form for IRO determinations.

Database of Independent Review Organization Determinations.

Issuers must submit redacted IRO determinations to the OIC, and IROs must submit annual statistical summary reports to the OIC instead of to the DOH. The OIC may develop a form for the annual report. The report must include the following information, in addition to any information required by rule:

- the total number of requests for external review;
- the number of requests resolved, the number upholding the issuer's decision, and the number reversing the issuer's decision;

- the number of requests for standard and expedited reviews;
- the number of requests that involved medical necessity, contractual coverage, or experimental or investigational treatments;
- the IRO's compliance with review deadlines and conflict of interest requirements; and
- the number and nature of complaints regarding the IRO.

Information related to requests for review must be provided in the aggregate, by issuer, and by the covered person's ethnicity, race, and primary language spoken.

The OIC must make the redacted determinations and statistical summary reports available to the public in an online database, taking confidentiality, privacy, and public records disclosure into account. The database must include and be searchable by:

- covered person demographic information, diagnosis or condition, and disputed health care service;
- issuer;
- whether the review was for medical necessity, experimental or investigational treatments, or contractual coverage disputes;
- whether the review was standard or expedited;
- the length of time between the request and the notification;
- reviewers' credentials and qualifications;
- the nature of the criteria used to make the determination;
- the final result of the determination and the date it was made;
- a detailed case summary that includes the specific standards, criteria, and medical and scientific evidence leading to the determination; and
- whether the notices and determinations were translated if the covered person was limited English proficient.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect on January 1, 2017.