HOUSE BILL REPORT
HB 1956

As Reported by House Committee On:
Health Care & Wellness

Title: An act relating to independent review organizations.

Brief Description: Creating independent review organizations.

Sponsors: Representative Moeller.

Brief History:
Committee Activity:
Health Care & Wellness: 2/13/15, 2/20/15 [DPS].

Brief Summary of Substitute Bill

- Requires independent review organizations (IROs) to submit annual statistical summary reports with specified information to the Department of Health.
- Requires the Office of the Insurance Commissioner to make information about IRO determinations available in an online database.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 8 members: Representatives Cody, Chair; Riccelli, Vice Chair; Clibborn, Jinkins, Moeller, Robinson, Tharinger and Van De Wege.

Minority Report: Do not pass. Signed by 6 members: Representatives Schmick, Ranking Minority Member; Harris, Assistant Ranking Minority Member; Caldier, Johnson, Rodne and Short.

Minority Report: Without recommendation. Signed by 1 member: Representative DeBolt.

Staff: Alexa Silver (786-7190).

Background:

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.

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. 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.

An IRO determination must be consistent with the plan unless it is unreasonable or inconsistent with evidence-based medical practice. Only contract specialists may make determinations about application of plan provisions and only clinical reviewers may determine medical necessity and appropriateness. 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 cases involving experimental or investigational treatments, the IRO must ensure that adequate clinical and scientific experience and protocols are taken into account. 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.

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 a carrier, it may notify the OIC.

The OIC maintains a rotational registry system for assigning IROs, and 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. By rule, IROs are required to submit annual statistical summary 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 Substitute Bill:

The Office of the Insurance Commissioner (OIC) must make independent review organizations' (IROs) annual statistical summary reports available to the public in an online database, taking into consideration laws governing public records disclosure, privacy, and confidentiality, including the Uniform Health Care Information Act and the Health Insurance Portability and Accountability Act. The database must include and be searchable by:

- enrollee demographic information (including age, race, and gender), diagnosis or condition, and disputed health care service;
- carrier;
- 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.

Independent review organizations are required to submit to the Department of Health (DOH) annual statistical summary reports containing the information that must be included in the database, and the DOH must transmit the reports to the OIC.

Substitute Bill Compared to Original Bill:

The substitute bill removes the provisions of the original bill, which: (1) transferred authority to certify independent review organizations (IROs) to the Office of the Insurance Commissioner (OIC); (2) repealed current laws governing certification of IROs; (3) codified the IRO review process, determinations, and agency oversight in a new chapter of law; and (4) provided an effective date of January 1, 2007. The substitute bill maintained the requirement that the OIC establish an online database of IRO determinations, adding the requirement for the Department of Health to transmit annual statistical summary reports to the OIC.

Appropriation: None.

Fiscal Note: Available.

Effective Date of Substitute Bill: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) This is one of the single most important bills for protecting and improving health coverage for consumers. It will create transparency for consumers, the regulator, and the public in general. Washington created the independent review organization (IRO) system as part of the Patient Bill of Rights to review insurer denials after the consumer has exhausted the internal appeal process. The internal appeals process is discouraging, because it is difficult to convince insurers to overturn their denials. The IRO system uses medical reviewers to impartially resolve disputes without the courts. Sometimes the IRO upholds the decision of the insurer, and sometimes the IRO rules in favor of the patient. Many states followed Washington's lead, and the Affordable Care Act incorporates an external review process.

The problem is that insurers may continue to deny coverage for treatments for the same condition for other patients, even after the IRO overturns their decision. California has a detailed database which has helped consumers access decisions in cases that are similar to their own and has helped regulators identify patterns. This bill requires decisions to be publicly searchable, which will allow the public and the Office of the Insurance Commissioner (OIC) to find repeated denials for the same request and will allow families to reference successful IRO decisions as they pursue their own appeals. This bill levels the playing field by giving the OIC and consumers the same information as the health plans.

Currently, there is not much a consumer can do if the health plan does not follow an IRO's decision. There is no action taken if a consumer files a complaint, so the consumer has to go to court. Currently, at the Department of Health (DOH), the process is disconnected from insurance regulation, and it makes sense for the OIC, the regulatory agency with control over insurance companies, to regulate IROs. Having information about IRO decisions will give the OIC an additional piece of information along with other market analysis information to identify players who may be out of sync.

Washington has a strong mental health parity law, but it is not being followed in individual decisions by insurers. There is no way to know how widespread the violations are. Children with autism who are prescribed behavioral health therapy have been routinely denied coverage. An IRO found that behavioral health therapy is medically necessary, but there is no enforcement mechanism. Social workers have been frustrated trying to get their services covered, and clients are not guaranteed confidentiality if they file a complaint with the OIC. One cancer patient was denied benefits for surgery on the grounds that it was experimental. The patient eventually prevailed at the IRO level when the family found an advocate who had previously succeeded in obtaining a reversal for the same procedure under the same plan.

(Opposed) This bill contains redundant requirements. There are concerns about the entity that is appropriate to regulate IROs, because the OIC does not have the necessary expertise, and there is no evidence that the DOH is doing a poor job. The database needs work, because it does not comply with Health Insurance Portability and Accountability Act requirements, and it comes at a high cost. These decisions involve real people, and their information needs to be protected. There are better ways to create transparency, mostly working within existing structures. For example, the OIC could analyze the data they already receive from the DOH. They have already started working on that.

Persons Testifying: (In support) Representative Moeller, prime sponsor; Eleanor Hamburger, Sirianni Youtz Spoonemore Hamburger; Janet Varon, Northwest Health Law Advocates; Len McComb, Washington State Hospital Association; Mary Clogston, Independent Licensed Clinical Social Workers; Barbara Flye, American Cancer Society and Cancer Action Network; and Mira Posner and Arzu Forough, Washington Autism Alliance and Advocacy.

(Opposed) Sydney Smith Zvara, Association of Washington Healthcare Plans.

Persons Signed In To Testify But Not Testifying: None.