Fast Facts:

- Under the Patient Bill of Rights, HMOs and insurers are required to establish internal formal enrollee grievance procedures.
- Michigan permits multiple layers of review.
- Under PRIRA, covered persons or insureds must first exhaust the health carrier's internal grievance process before seeking external review.

A Patient's Right to Independent Review

Has Michigan's act changed after *Rush Prudential HMO, Inc v Moran*?

By Eric J. Wexler

Michigan is one of 42 states that has adopted an external review law as a remedy for insureds when health insurance companies make adverse medical benefit determinations.[1] External review withstood its first significant challenge on June 20, 2002, when the United States Supreme Court ruled that it is saved from preemption under the Employee Retirement and Income Security Act of 1974 (ERISA) as long as it is intended to regulate insurance and "does not enlarge the claim beyond the benefits available in any action brought under [29 USC] 1132(a)."[2] Despite the decision, Michigan's external review law remains vulnerable to a preemption challenge.

In the Beginning

Michigan's Patient's Right to Independent Review Act (PRIRA) took effect on October 1, 2000, but consumers have had the right to pursue grievances against their health plans since 1978.[3] Prior to the repeal of the Michigan Health Maintenance Act on June 29, 2000, health maintenance organizations (HMOs) were required to maintain an internal appeal process that allowed enrollees to file a grievance as to the operations of the organization.[4] HMOs were required to establish and maintain reasonable procedures for receiving, processing, and resolving enrollee complaints.[5] If an enrollee exhausted a plan's grievance process, the enrollee was given the opportunity to pursue the grievance further with a three-person advisory commission. Under the statute, the advisory commission was empowered to render determinations of the validity of the grievance and direct measures it considered appropriate under the circumstances. The advisory commission reported to the Michigan Department of Community Health (DCH).[6]

The Patient Bill of Rights

The state's grievance procedure landscape began to change in 1997 with the passage of the Michigan Bill of Patient's Rights Act (PBR).[7] Under the PBR, HMOs and insurers are required to establish internal formal enrollee grievance procedures. The PBR contains unique definitions, which determine whether an insured has a basis to appeal a benefits determination.

Adverse Determination and Grievance

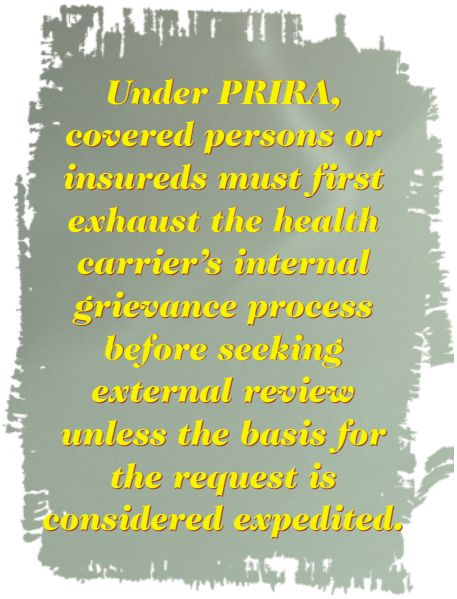
The terms adverse determination and grievance were defined for the first time and continue to remain in effect under PRIRA. Under the PBR, adverse determination is defined as:

> *[A] determination that an admission, availability of care, continued stay or other health care services had been reviewed and denied. Failure to respond in a timely manner to request for determination constitutes an adverse determination.*[8]

The term *grievance* is defined as:

> *[A] complaint on behalf of an enrollee submitted by an enrollee or a person, including, but not limited to, a physician authorized in writing to act on behalf of the enrollee regarding:*
>
> *(i) the availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review.*
>
> *(ii) Benefits or claims payment, handling, or reimbursement for health care services.*
>
> *(iii) Matter pertaining to the contractual relationship between an enrollee and the organization.*[9]

Timeframes for submitting grievances or grievances related to an adverse determination were also established as a result of the legislation. HMOs are required to make decisions within 35 calendar days of receipt of a written grievance.[10] Determinations of expedited grievances must be made within 72 hours.[11] An expedited grievance requires immediate attention in the event a physician substantiates that the failure to address the matter "would seriously jeopardize the insured's or enrollee's ability to regain maximum function." An insured or enrollee has ten days from the date of the determination to request that an independent review organization (IRO) conduct an external review.[12]



PRIRA

PRIRA allows insureds to challenge adverse determinations made by a health carrier or its designee utilization review organization. Under PRIRA, covered persons or insureds must first exhaust the health carrier's internal grievance process before seeking external review unless the basis for the request is considered expedited.[13] An expedited external review request is defined as:

> *The adverse determination involves a medical condition of the covered person for which the time frame for completion of an expedited internal grievance would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function as substantiated by a physician either orally or in writing.*[14]

PRIRA provides that upon receipt of a request for an external review of an adverse determination by a health carrier, the Insurance Commissioner "shall complete a preliminary review of the request and decide whether or not to accept the request for external review."[15]

Upon receipt of a request for an external review, the commissioner then must determine whether to refer the request to an IRO. If an external review request "appears to involve issues of medical necessity or clinical review criteria," the commissioner must decide the determination for review by an IRO. If the request "appears to only involve purely contractual provisions of the health benefit plan," the commissioner *may* conduct his own external review or assign the review to an IRO.[16]

Under PRIRA, there is no specific right to an evidentiary hearing regarding the health carrier's determination prior to the commissioner's final determination. All reviews of a health carrier's benefit determination are reviewed de novo and "the reviewing entity is not bound by any decisions or conclusions reached during the health carrier's utilization review process or the health carrier's internal grievance process." MCLA 550.1911(a).[17]

Seven business days after the date of the notice of the commissioner's acceptance of the request for external review, the health carrier must provide to the reviewing entity "the documents and any information considered in making the adverse determination or the final determination."[18]

Along with the evidence submitted by the health carrier and the covered person, the IRO must consider the following prior to reaching a recommendation:

> *(a) The covered person's pertinent medical records.*
>
> *(b) The attending health care professional's recommendation.*
>
> *(c) Consulting reports from a health care professional and other documents submitted by the health carrier, the covered person, the covered person's authorized representative or the covered person's treating provider.*
>
> *(d) The terms of coverage under the covered person's health benefit plan with the health carrier.*
>
> *(e) The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines, or any other practice guidelines developed by the federal government or national or professional medical societies, boards, and associations.*

(f) Any applicable review criteria developed and used by the health carrier or its designee utilization review organization.[19]

The IRO must provide its recommendation to the commissioner no later than 14 days after the assignment of the request.[20] The IRO's recommendation is required to include all of the following:

(a) A general description of the reason for the request for external review.
(b) The date the independent review organization received the assignment from the commissioner to conduct the external review.
(c) The date the external review was conducted.
(d) The date of its recommendation.
(e) The principal reason or reasons for its recommendation.
(f) The rationale for its recommendation.
(g) References of the evidence or documentation, including the practice guidelines considered in reaching its recommendation.

The commissioner is required to review the recommendation to ensure that it is not contrary to the terms of coverage.[21]

After the commissioner completes a review of the IRO's recommendation, the commissioner must then issue a notice of decision, which includes the "principal reason or reasons for the decision."[22]

PRIRA further provides that "a person aggrieved by an external review decision may seek judicial review within 60 days from the date of the decision in state circuit court."[23] Moreover, the statute does not preclude a health carrier or a covered person from seeking other remedies available under applicable federal or state law.[24]

PRIRA's Effect

Since PRIRA took effect on October 1, 2000, approximately 550 cases have been presented for external review with about 47 percent of the decisions resulting in the covered person's favor.[25]

The Insurance Commissioner's standard for accepting or rejecting the recommendation of an IRO has evolved from a medical necessity approach to a plain and ordinary meaning of the contract standard. In the early stages of PRIRA, in some instances, the commissioner rejected IRO recommendations to uphold the denial of a benefit even if the contract of insurance contained an express exclusion of the medical procedure. Medical necessity dictated coverage of the benefit, he reasoned, because the definitions of basic health services and health maintenance contract, as set forth in MCL 500.3501(b) and (f), must be read into the contract.[26] According to the commissioner, a plan "cannot interpret the provisions of the certificate to deny coverage for medically necessary basic health services because such an interpretation would conflict with the requirements of MCL 500.3501."[27]

Recently, the commissioner has taken a strict construction approach in reviewing decisions recommended for acceptance by the IRO. Although medical necessity remains relevant, if a contract contains an express exclusion of coverage clause, the commissioner is inclined to adhere to the unambiguous, plain meaning of the certificate "to ensure the recommendation is not contrary to the terms of coverage."[28]

PRIRA is Vulnerable to a Preemption Challenge Under Section 1132(a) of ERISA

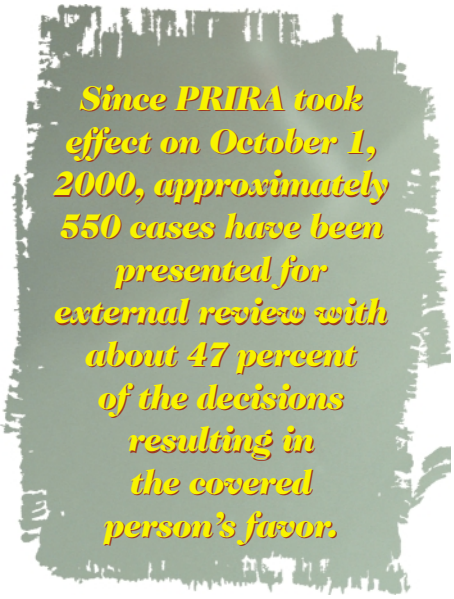
Prior to *Rush,* the Supreme Court made it clear that any state law cause of action that amounts to such an alternative enforcement action is preempted by ERISA because Congress clearly intended for the remedies set forth in ERISA to be exclusive:

> *The six carefully integrated civil enforcement provisions found in subsection 502(a) of the statute provide strong evidence that Congress did not intend to authorize other remedies that it simply forgot to incorporate expressly.* Pilot Life Insurance Company v Dedeaux, *481 US 41, 54 (1987).*

Despite finding that the Illinois HMO Act did not conflict with Section 1132 (a) of ERISA, the Court in *Rush* recognized "that a state might enact an independent review requirement with procedures so elaborate and burdens so onerous, that they might undermine Section 1132(a)."[29] PRIRA might be elaborate enough to be interpreted as a statute that involves the sort of additional remedy the Court would prohibit.[30]

Unlike the Illinois law, Michigan permits multiple layers of review. An IRO conducts the first level of review. After the IRO submits its rationale for the decision, the commissioner is required to review the rationale and either accept or reject the recommendation. If a covered person or carrier is not satisfied with the commissioner's decision, another level of review can occur by pursuing the matter in a state circuit court. In addition, the statute permits the pursuit of other remedies under applicable state or federal law. Under the Illinois HMO Act, only one level of review is permitted, and the HMO is bound by the decision if the reviewing physician concludes that the covered service is medically necessary. According to the Court, the Illinois law is not an arbitration-like remedial device because the reviewer is an independent physician who determines if the benefit is medically necessary.[31]

Michigan IROs, however, are constructed differently and, therefore, PRIRA might be viewed as a device that displaces judicial enforcement of ERISA contrary to Section 1132(a). PRIRA, for example, requires the IRO to consider several factors including any relevant evidence submitted by the carrier or the beneficiary.[32] Not only are medical records and best practice standards fair game for purposes of the review, but the health carrier's certificate of coverage and utilization review criteria must also be evaluated to develop a rationale to support a recommendation to



the commissioner.[33] Moreover, the examination of an adverse determination is not limited to a single physician. A professional appeals staff that includes clinicians and licensed attorneys conducts the reviews.[34] PRIRA's multiple review process, the variety of evidence an IRO must evaluate, and the composition of the IRO fit within the context of the Court's concern regarding burdensome and arbitration-like independent review requirements that may result in the law's preemption.[35]

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Footnotes

1. American Association of Health Plans, Survey of Independent Medical Review: State Laws and Regulations, November 15, 2001.
2. *Rush Prudential HMO, Inc v Moran et al.,* 536 US ___ (2002); 29 USC 1144(b)(2)(A).
3. MCL 500.2026(1)(b).
4. MCL 333.21088, now repealed.
5. Id.
6. See, MCLA 333.21023, now repealed.
7. MCL 333.21035, now repealed and replaced by MCL 500.2213.
8. MCL 500.2213(4)(a).
9. MCL 500.2213(4)(b).
10. MCL 500.2213(1)(k).
11. MCL 500.2213(1)(l).
12. Id.
13. MCL 550.1907(2) and 1913.
14. MCL 550.1913(1)(a)–(b).
15. MCL 550.1911.
16. MCL 550.1911(6)–(7).
17. The Supreme Court in *Rush* viewed de novo review as a permissible standard because "[n]othing in ERISA, however, requires that these kinds of decisions be so 'discretionary' in the first place; whether they are is simply a matter of plan design or the drafting of an HMO contract." *Rush,* slip op at p 29.
18. MCL 550.1911(9).
19. MCL 550.1911(13)(a)–(f).
20. MCL 550.1911(14).
21. MCL 500.1911(15).
22. MCL 550.1911(16).
23. MCL 550.1915(1).
24. MCL 550.1915(2)–(3).
25. "Breakdown of PRIRA Cases as of July 2002," OFIS (7/02).
26. Order of the Commissioner, *Petitioner John Doe v Physicians Health Plan, Inc* (3/2/01).
27. Id.
28. MCL 550.1915(15); See, Order of the Commissioner, *In the Matter of Petitioner v Priority Health* (2/5/02).
29. Id. at 24 n 10.
30. Id. at 23.
31. Id. at 26.
32. MCL 550.1911(9), (13).
33. MCL 550.1911(13)(d), (f).
34. MCL 550.1919; and Letter from The Center For Health Dispute Resolution to Michigan Division of Insurance explaining that "[t]his case has been reviewed by a practicing physician who is board certified in internal medicine, a practicing physician who board certified in general surgery and in surgery critical care and by a licensed attorney on CHDR's professional appeals staff." (12/31/01).
35. See, Joel L. Michaels and Robin J. Bowen, "Rush To Judgment? An Analysis of *Rush Prudential HMO, Inc v Moran,*" *AHLA Health Law Analysis* (August 2002).