

# Does Iowa’s Health Care External Review Process Replace Common-Law Rights?

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*ABSTRACT: The Patient Protection and Affordable Care Act (“ACA”) established a federal external review process that enabled covered persons to appeal to independent reviewers if their health insurers deny coverage for a particular health care service. The ACA also required each state to implement an adequate external review process. Iowa’s appellate courts have not decided whether the external review process is “exclusive”—meaning covered persons must use the process to challenge insurers’ adverse benefit determinations—or “cumulative”—meaning covered persons may bypass the process and file an action in a district court. This Note argues that Iowa’s external review process is cumulative. The application of two rules of statutory interpretation—the new-right test and the comprehensive-scheme test—suggests that courts should construe Iowa’s external review statute as a supplement to, rather than a replacement of, a covered person’s common-law rights against an insurer. While the external review process provides a covered person with beneficial protections and a faster, less expensive, and often more convenient means to challenge an insurer’s denial of coverage, its short statute of limitations, exclusion of oral testimony, and limited jurisdiction may motivate a covered person to pursue traditional litigation in some circumstances.*

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## I. INTRODUCTION

The Patient Protection and Affordable Care Act (“ACA”) is one of the most scrutinized and controversial laws in recent American history.<sup>1</sup> Much of the attention surrounding the law has focused on the “individual mandate,” health insurance exchanges, and the expansion of eligibility for Medicaid.<sup>2</sup> Yet, the law contains other facets that, despite their low profile, significantly affect insurance companies, medical providers, and consumers.<sup>3</sup>

One such facet, and the focus of this Note, is the ACA’s requirement that most private insurers<sup>4</sup> comply with either a state or federal “external review process.”<sup>5</sup> The process is a procedure that allows covered persons<sup>6</sup> to appeal insurers’ decisions to deny benefits for specified reasons<sup>7</sup> to an

1. See David Goldin, *External Review Process Options for Self-Funded Health Insurance Plans*, 2011 COLUM. BUS. L. REV. 429, 430; Sara Rosenbaum, *Realigning the Social Order: The Patient Protection and Affordable Care Act and the U.S. Health Insurance System*, 7 J. HEALTH & BIOMEDICAL L. 1, 1–4 (2011).

2. See generally KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM: SUMMARY OF THE AFFORDABLE CARE ACT (2013), available at <http://www.kaiserfamilyfoundation.files.wordpress.com/2011/04/8061-021.pdf> (describing the major aspects of health care reform—such as the individual mandate (the requirement that most Americans obtain health insurance or pay a penalty), exchanges from which people can buy health insurance, and funding to allow states to expand Medicaid—but not describing external review).

3. See *id.*; ANNIE L. MACH & BERNADETTE FERNANDEZ, CONG. RESEARCH SERV., R42069, PRIVATE HEALTH INSURANCE MARKET REFORMS IN THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA) (2012), available at [http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1909&context=key\\_workplace](http://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1909&context=key_workplace); Andrew B. Wachler & Jesse Adam Markos, *The New Consumer Appeals Process*, HEALTH LAW., June 2011, at 21, 21.

4. Some insurers are exempt from the external review requirement. See *infra* notes 47–49 and accompanying text (noting that “grandfathered plans” are exempt from the requirement to establish an external review process). Except when necessary to distinguish them, this Note uses the term “insurers” to refer to both “group health plans and health insurance issuers in the group and individual markets.” See Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 43,330, 43,331 (July 23, 2010) [hereinafter Interim Final Rules] (to be codified at 26 C.F.R. pts. 54 & 602, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 147) (defining “group health plan” as including both self-insured and insured employer-based group health plans); see also *infra* notes 51, 58 (defining various types of health plans).

5. 42 U.S.C. § 300gg-19(b) (2006 & Supp. V 2011); Interim Final Rules, *supra* note 4, at 43,332. The ACA also requires all insurers to establish an internal review process, which allows a covered person to challenge an insurer’s initial adverse benefit determination in a process conducted by the insurer. 42 U.S.C. § 300gg-19(a). Although the internal and external review processes are closely related, this Note focuses on the latter. For more information regarding internal review, see 29 C.F.R. § 2560.503-1(h) (2013) and Interim Final Rules, *supra* note 4, at 43,332–34.

6. This Note uses the term “covered persons” to refer to insureds. See IOWA CODE § 514J.102(11) (2013) (“‘Covered person’ means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan.”).

7. State external review processes must allow covered persons to appeal “adverse benefit determinations,” which include denials “based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.” Interim Final Rules, *supra* note

independent review organization (“IRO”).<sup>8</sup> Although the external review requirement makes up less than five pages of a more than 900-page law,<sup>9</sup> it established unprecedented consumer protections and has spawned substantial new federal regulations and new statutes in almost every state.<sup>10</sup>

In Part II, this Note describes the origins of the external review process. It then examines the federal regulations that govern the current process and mandate minimum consumer-protection requirements. Part II also presents Iowa’s external review process as amended in 2011 to comply with the ACA.<sup>11</sup>

Part III considers an important question Iowa’s appellate courts have not yet answered: May a covered person bypass the external review process—meaning the process is “cumulative”—or, as one district court held,<sup>12</sup> does the external review process provide the “exclusive” means to challenge an insurer’s adverse benefit determination? Iowa’s external review statute is silent on this question. After examining applicable rules of statutory interpretation<sup>13</sup> and public policy considerations, this Note argues that Iowa’s external review process is cumulative rather than exclusive.

Part IV considers how Iowa’s cumulative external review process affects covered persons’ efforts to challenge adverse benefit determinations and influences their litigation strategies. Covered persons might often elect to use the external review process. However, the process’s short statute of limitations, limits on discovery and oral testimony, and limited jurisdiction may motivate covered persons to pursue traditional litigation in some cases.

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4. at 43,334–35; *see also* IOWA CODE § 514J.105. The federal external review process allows covered persons to seek review of the same types of denials as well as rescissions of coverage. *See* Interim Final Rules, *supra* note 4, at 43,336.

8. *See* 42 U.S.C. § 300gg-19(b) (requiring the establishment of an external review process). The Iowa Code defines an “independent review organization” as “an entity that conducts independent external reviews of adverse determinations and final adverse determinations.” IOWA CODE § 514J.102(25). *See* IOWA CODE § 514J.111 for information regarding the process Iowa’s Insurance Commissioner uses to approve IROs to conduct external reviews.

9. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.).

10. *See infra* Part II.B.1 (discussing consumer protections).

11. *See* IOWA CODE § 514J.101 (describing compliance with the ACA as one of the purposes of the law).

12. *See* *Lamb v. Time Ins. Co.*, No. 10-0241, 2011 WL 944430, at \*4–5 (Iowa Ct. App. Mar. 21, 2011) (noting the district court’s conclusion that the external review process is exclusive, but declining to reach that question and granting summary judgment for the insurer on other grounds).

13. When determining whether a statute is cumulative or exclusive, Iowa courts ask whether the statute creates a “new right” and whether it creates a “comprehensive scheme.” *See infra* Part III.B–C.

## II. BACKGROUND

Health insurance is the means through which most Americans obtain health care.<sup>14</sup> Nearly sixty-four percent of Americans have some form of private health insurance, which they obtain through their employers or purchase individually.<sup>15</sup> Eighty-six percent of Americans with private insurance, and fifty-five percent of all Americans, have employer-based insurance.<sup>16</sup>

This Part considers Iowa's external review processes before Congress enacted the ACA in 2010. Specifically, this Part considers (1) barriers that prevented covered persons from accessing pre-ACA external review processes, (2) the current external review processes, (3) the consumer protections the current process requires, and (4) Iowa's external review statute as amended to comply with the ACA.

### A. EXTERNAL REVIEW PROCESSES BEFORE THE ACA AND BARRIERS TO EXTERNAL REVIEW

Years before Congress enacted the ACA, policymakers recognized the need for an independent mechanism that allowed covered persons and insurers to resolve disputes regarding adverse benefit determinations.<sup>17</sup> Such disputes arose because an insurer could refuse to pay for a covered person's care if the insurer found that: a medical provider rendered the care outside of the coverage period, the policy did not cover the care, or the insurer believed that the care was not medically necessary or was experimental.<sup>18</sup> Recognizing the need for dispute resolution in this context, forty-three states and the District of Columbia had some type of external review process

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14. Eleanor D. Kinney, *Administrative Law Protections in Coverage Expansions for Consumers Under Health Reform*, 7 J. HEALTH & BIOMEDICAL L. 33, 35 (2011).

15. CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2011, at 21 (2012), available at <http://www.census.gov/prod/2012pubs/p60-243.pdf>.

16. *Id.*

17. See TRUDY LIEBERMAN ET AL., KAISER FAMILY FOUND. & CONSUMERS UNION, A CONSUMER GUIDE TO HANDLING DISPUTES WITH YOUR EMPLOYER OR PRIVATE HEALTH PLAN, 2005 UPDATE 2 (2005) (describing the pre-ACA external review processes).

18. See U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-11-268, PRIVATE HEALTH INSURANCE: DATA ON APPLICATION AND COVERAGE DENIALS 20-21 (2011) [hereinafter GAO REPORT ON PRIVATE HEALTH INSURANCE], available at <http://www.gao.gov/new.items/d11268.pdf> (noting that most denied claims result from duplicate submissions and missing information, twenty percent of claim denials result from the insurer's determination that the policy had not yet begun or had terminated, and many of the remaining denials result from the insurer's determination that the service is not medically necessary).

before enactment of the ACA.<sup>19</sup> In addition, some health plans voluntarily provided access to external review processes.<sup>20</sup>

Notwithstanding the existence of these processes, many covered persons could not access an adequate external review. Most significantly, a covered person who had a self-insured-employer-based plan had no legal right to access an external review process.<sup>21</sup> The Employee Retirement Income Security Act (“ERISA”) caused this shortcoming because it preempts state regulation of self-insured-employer-based plans.<sup>22</sup> Because state external review statutes do not apply to these plans—and before the ACA, no federal external review requirement existed<sup>23</sup>—if an insurer denied benefits to a participant in a self-insured plan, her only remedy was to file an expensive action under ERISA in a district court.<sup>24</sup> Before the ACA, covered persons who had non-ERISA governed plans could use state external review processes. However, many states imposed barriers that limited the use of external review, such as restricting it to certain types of claims.<sup>25</sup> Moreover, in 2010, at least six states had no external review laws.<sup>26</sup>

Prior to the ACA, even if covered persons were eligible for an external review process, they may not have been able to access it. In part, this was due to the considerable variation among external review statutes and the ineligibility of various plans for external review. This lack of consistency frustrated covered persons’ efforts to challenge adverse benefit determinations and complicated insurers’ ability to comply with the law.<sup>27</sup> The federal external review regulations assert that “[t]hese uneven

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19. LIEBERMAN ET AL., *supra* note 17.

20. See GERALDINE DALLEK & KAREN POLLITZ, KAISER FAMILY FOUND., EXTERNAL REVIEW OF HEALTH PLAN DECISIONS: AN UPDATE 2 (2000), available at <http://www.kaiserfamilyfoundation.files.wordpress.com/2013/01/external-review.pdf>.

21. See Interim Final Rules, *supra* note 4, at 43,339; DALLEK & POLLITZ, *supra* note 20, at 5; Wachler & Markos, *supra* note 3; see also *infra* note 58 (defining employer-based self-insured plans).

22. Roy F. Harmon, *An Assessment of New Appeals and External Review Processes—ERISA Claimants Get “Some Kind of a Hearing.”* 56 S.D. L. REV. 408, 412 (2011) (noting that ERISA’s “deemer clause”—which states “an employee benefit plan . . . shall [not] be deemed to be an insurance company”—removes self-insured plans from state insurance regulations (quoting 29 U.S.C. § 1144(b)(2)(B) (2006))).

23. See Interim Final Rules, *supra* note 4, at 43,339; Wachler & Markos, *supra* note 3.

24. Wachler & Markos, *supra* note 3; see *infra* note 142 (describing cases involving claims for benefits under section 502(a) of ERISA (codified at 29 U.S.C. § 1132(a))). In addition to the cost, a covered person’s efforts to sue for benefits under ERISA are made difficult by the deference courts generally give to the plan administrator’s determinations. See *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) (noting that the ordinary standard of review of a plan administrator’s decision is *de novo* “unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan”).

25. See LIEBERMAN ET AL., *supra* note 17.

26. Interim Final Rules, *supra* note 4, at 43,339.

27. *Id.*

protections created an appearance of unfairness, increased cost for issuers and plans operating in multiple States, and may have led to confusion among consumers about their rights.”<sup>28</sup>

Some states limited external review procedures to certain types of claims or certain types of health plans (such as Health Maintenance Organizations (“HMOs”)).<sup>29</sup> For example, some pre-ACA external review statutes, including Iowa’s, limited eligibility for external review to benefit denials involving an insurer’s determination that the requested benefits were not “medically necessary.”<sup>30</sup> This was problematic because it is often difficult for covered persons (and courts) to distinguish denials based on medical necessity from an insurer’s other justifications for denying coverage.<sup>31</sup> For example, a doctor may contend that a surgery to correct a child’s crossed eyes is medically necessary (so as “to promote the child’s well-being and physical and emotional development”) while an insurer may contend that a policy excludes surgery for cosmetic procedures.<sup>32</sup>

In addition, the potentially long duration of insurers’ internal review processes may have prevented covered persons from appealing adverse benefit determinations.<sup>33</sup> Filing fees also commonly prevented covered persons from obtaining external review of their claims.<sup>34</sup> Several states had filing fees of fifty dollars<sup>35</sup> and at least one state, Rhode Island, required covered persons to pay for half the cost of the external review,<sup>36</sup> which as of the year 2000, could cost several hundred dollars.<sup>37</sup> Additionally, some pre-2010 state statutes limited eligibility for the external review process to claims that exceeded a specified monetary value.<sup>38</sup> Oklahoma, perhaps the most extreme example, barred external review for any denied claim worth less than \$1000.<sup>39</sup>

Moreover, before 2010, some states imposed short filing deadlines.<sup>40</sup> Pennsylvania required that covered persons file a request for external review

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28. *Id.*

29. LIEBERMAN ET AL., *supra* note 17, at 6.

30. DALLEK & POLLITZ, *supra* note 20, at 5; *see* IOWA CODE § 514J.3 (repealed 2011) (“This chapter does not apply to . . . denials of coverage not based on medical necessity.”).

31. DALLEK & POLLITZ, *supra* note 20, at 8.

32. *Id.*

33. *Id.* at 4.

34. *Id.* at 5.

35. *Id.*; *see also* IOWA CODE § 514J.4(2) (repealed 2011) (requiring a \$25 filing fee unless the covered person shows “good cause” and providing that “[t]he filing fee shall be refunded if the enrollee prevails in the external review process”).

36. KAREN POLLITZ ET AL., KAISER FAMILY FOUND., ASSESSING STATE EXTERNAL REVIEW PROGRAMS AND THE EFFECTS OF PENDING FEDERAL PATIENTS’ RIGHTS LEGISLATION 13 (2002).

37. DALLEK & POLLITZ, *supra* note 20, at 5.

38. *Id.*

39. *Id.* at 5 tbl.2.

40. *Id.* at 5.

within fifteen days of receiving a final adverse benefit determination from the insurer.<sup>41</sup> In addition to Iowa, at least eight other states plus the District of Columbia imposed filing deadlines of sixty days or less.<sup>42</sup>

A final limitation of pre-ACA external review statutes was that some state processes for selecting an Independent Review Organization (“IRO”) created conflict-of-interest concerns.<sup>43</sup> For example, before 2010 several states, including Iowa, allowed insurers to select an IRO from an approved list maintained by the state insurance commissioner.<sup>44</sup> Policy analysts, such as Geraldine Dallek and Karen Pollitz, feared that the process of soliciting and directly contracting with the insurer undermined the IRO’s independence and increased the potential of pro-insurer bias.<sup>45</sup> Despite these barriers, covered persons who appealed adverse benefit determinations through external review were frequently successful.<sup>46</sup> This likely motivated policymakers to expand and strengthen external review processes.

### B. THE CURRENT EXTERNAL REVIEW PROCESS

The ACA substantially modified the external review process. The law standardized both the internal and external review processes and addressed many of the barriers that deterred covered persons from challenging adverse benefit determinations.<sup>47</sup> The statute provides that all non-grandfathered plans<sup>48</sup> shall be subject to an external review process similar

41. *Id.* at 5 tbl.2.

42. *Id.*; see also IOWA CODE § 514J.4(1) (repealed 2011) (providing for a sixty-day statute of limitations).

43. DALLEK & POLLITZ, *supra* note 20, at 11–12.

44. *Id.*; see also IOWA CODE § 514J.7 (repealed 2011).

45. DALLEK & POLLITZ, *supra* note 20, at 12.

46. GAO REPORT ON PRIVATE HEALTH INSURANCE, *supra* note 18, at 22, 24 tbl.5 (examining six states and noting a 23% reversal rate in Ohio, the lowest of any state, and a 54% reversal rate in California, which was one of the highest); POLLITZ ET AL., *supra* note 36, at 3–4 (listing data from forty-one states and indicating that the insurer’s decisions were overturned an average of 45% of the time and modified in an additional 6% of cases in the states where modification was permissible).

47. See Interim Final Rules, *supra* note 4, at 43,341 (“These interim final regulations will help transform the current, highly variable health claims and appeals process . . . . This will cause some participants to receive benefits that, absent the fuller protections of the regulation, they might otherwise have been incorrectly denied.”).

48. Grandfathered plans are those that have had at least one member continuously enrolled since March 23, 2010. Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 34,538, 34,541 (June 17, 2010) (to be codified at 26 C.F.R. pts. 54 & 602, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 147). If an employer establishes a new policy after March 23, 2010, then that policy loses grandfathered status. *Id.* The number of Americans in grandfathered plans appears to be falling faster than expected. Compare Interim Final Rules, *supra* note 4, at 43,340 (estimating seventy-eight million people to be in non-grandfathered plans by 2013), with KAISER FAMILY FOUND. & HEALTH RESEARCH &



to the National Association of Insurance Commissioners (“NAIC”) Uniform External Review Model Act process.<sup>49</sup>

Whether a state or the federal external review process applies to a covered person depends on which type of plan she has.<sup>50</sup> If the covered person has a “group” or “individual market plan,”<sup>51</sup> then that covered person’s insurer must comply with a state external review process.<sup>52</sup> Similarly, “non-federal government” or “church plans”—which ERISA does not govern<sup>53</sup>—are also subject to state external review processes.<sup>54</sup> However, state processes will only apply to any of these plans if the process meets federally established consumer protection requirements.<sup>55</sup> If they do not, or if a state fails to establish an external review process,<sup>56</sup> the federal external review process will apply to covered persons in that state.<sup>57</sup>

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EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2013 ANNUAL SURVEY 46, 199 (2013), *available at* <http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20132.pdf> (reporting that in 2013, sixty-four percent of people with employer-sponsored health insurance (roughly 95.36 million people) were in non-grandfathered plans).

49. 42 U.S.C. § 300gg-19(b) (2006 & Supp. V 2011). NAIC was a logical organization to undertake designing the external review process. Ben Nelson, *About the NAIC*, NAT’L ASS’N INS. COMMISSIONERS, [http://www.naic.org/index\\_about.htm](http://www.naic.org/index_about.htm) (last visited Jan. 24, 2014) (“The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight.”).

50. *See* Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Processes, 76 Fed. Reg. 37,208, 37,210–12 (June 24, 2011) [hereinafter Amended Interim Final Rules] (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. § 147) (describing requirements for various types of plans).

51. A “group” or “individual market plan” refers to a plan in which the covered person’s employer purchases health insurance from an insurance company or the covered person purchases coverage directly from an insurance company. *Id.* at 37,209.

52. *Id.* at 37,211.

53. Interim Final Rules, *supra* note 4, at 43,335.

54. Amended Interim Final Rules, *supra* note 50, at 37,211.

55. 42 U.S.C. § 300gg-19(b)(1) (2006 & Supp. V 2011); *see also infra* Part II.B.1 (discussing consumer protection requirements).

56. As of July 2012, Alabama and Nebraska had no external review process. BLOOMBERG BNA, PORTFOLIO 1700-1ST: MANAGED CARE CONTRACTING: ADVISING THE MANAGED CARE ORGANIZATION, Doc. 12 (2012).

57. 42 U.S.C. § 300gg-19(b)(2); Amended Interim Final Rules, *supra* note 50, at 37,211. Until 2014, the Department of Health and Human Services (“HHS”) considered a state external review process sufficient if it conformed to a “NAIC-similar process,” which meets most, but not all of the consumer protection requirements. U.S. DEP’T OF LABOR, TECHNICAL RELEASE 2011-02: GUIDANCE ON EXTERNAL REVIEW FOR GROUP HEALTH PLANS AND HEALTH INSURANCE ISSUERS OFFERING GROUP AND INDIVIDUAL HEALTH COVERAGE, AND GUIDANCE FOR STATES ON STATE EXTERNAL REVIEW PROCESSES (2011), [hereinafter TECHNICAL RELEASE 2011-02], *available at* <http://www.dol.gov/ebsa/pdf/tr11-02.pdf>.

If the covered person has an “employer-based self-insured plan,”<sup>58</sup> she is eligible to participate in the federal external review process.<sup>59</sup> ERISA governs these plans, and as a result, they are not subject to state external review processes.<sup>60</sup> Because no federal external review process existed before Congress enacted the ACA, providing covered persons in employer-based self-insured plans with a new means to challenge adverse benefit determinations is a significant reform.<sup>61</sup>

The ACA requires that the federal external review process meet similar requirements as the state processes, and the statute allows the Department of Health and Human Services (“HHS”) to develop further standards.<sup>62</sup> An August 2010 technical release announced that, until further notice, the Labor and Treasury Departments would not take enforcement actions against insurers that either contract with a private IRO or voluntarily comply with a state external review process.<sup>63</sup> States may choose whether to allow these plans to participate in the state process.<sup>64</sup> Iowa allows employer-based self-insured plans to voluntarily comply with the state’s external review process as an alternative to the federal process.<sup>65</sup> This will greatly increase the number of plans eligible for Iowa’s external review process, as insurers may perceive benefits to using Iowa’s process instead of the federal process.<sup>66</sup> Accordingly, the scope and rules governing Iowa’s external review process affect a large number of covered persons.

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58. An “employer-based self-insured plan” refers to an employer-based plan for which the employer directly bears the risk of loss. *See* Amended Interim Final Rules, *supra* note 50, at 37,210–11. An employer will likely have a third-party administrator—such as Blue Cross and Blue Shield, CIGNA, or Aetna—manage its self-insured plan. *See* LIEBERMAN ET AL., *supra* note 17, at 6.

59. Interim Final Rules, *supra* note 4, at 43,339. Grandfathered plans are exempt from this requirement. *See supra* notes 48–49 and accompanying text.

60. Interim Final Rules, *supra* note 4, at 43,335 (noting that ERISA preempts state external review laws as applied to employer-based self-insured plans); *see also supra* notes 22–24 and accompanying text (discussing ERISA preemption).

61. Interim Final Rules, *supra* note 4, at 43,339.

62. 42 U.S.C. § 300gg-19(b)(2).

63. U.S. DEP’T OF LABOR, TECHNICAL RELEASE 2010-01: INTERIM PROCEDURES FOR FEDERAL EXTERNAL REVIEW RELATING TO INTERNAL CLAIMS AND APPEALS AND EXTERNAL REVIEW UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 2–3 (2010) [hereinafter TECHNICAL RELEASE 2010-01], *available at* <http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf>; *see also* Amended Interim Final Rules, *supra* note 50, at 37,211 (summarizing the interim enforcement safe harbor).

64. *See* TECHNICAL RELEASE 2010-01, *supra* note 63, at 3 (“States may choose to expand access to their State external review process to plans that are not subject to the applicable State laws such as self-insured plans, and such plans may choose to voluntarily comply with the provisions of that State external review process.”).

65. IOWA ADMIN. CODE r. 191-76.2(2)(c) (2012).

66. One potential advantage of self-insured plans using Iowa’s external review process is that the federal process allows covered persons to seek external review for rescissions of coverage while the state process does not. *See supra* note 7.

### 1. The ACA's Consumer Protection Requirements

The ACA minimizes many of the barriers that previously prevented covered persons from appealing adverse benefit determinations.<sup>67</sup> To that end, the ACA includes requirements that: (1) IROs' decisions are binding on insurers and binding on covered persons "except to the extent that other remedies are available under State or Federal law";<sup>68</sup> (2) expedited external review is available in some circumstances;<sup>69</sup> (3) when covered persons are eligible for expedited external review, IROs must notify covered persons of their determinations within seventy-two hours;<sup>70</sup> (4) IROs provide decisions within forty-five days of a non-expedited external review;<sup>71</sup> (5) states provide covered persons access to the external review process irrespective of the monetary value of their claims;<sup>72</sup> (6) covered persons must have at least four months to request an external review;<sup>73</sup> (7) IROs avoid conflicts of interest;<sup>74</sup> and (8) insurers bear the cost of the external review process.<sup>75</sup> Although these consumer protections may not remove every obstacle that prevents a covered person from appealing an adverse benefit determination, they may aid many covered persons.

### 2. Iowa's Amended External Review Process

In order to meet the ACA's consumer protection requirements, Iowa amended its external review statute in 2011.<sup>76</sup> In July 2011, the HHS announced that Iowa's process satisfied the federal requirements.<sup>77</sup>

The amended external review statute has a broader scope than Iowa's previous external review statute, which the legislature originally enacted in

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67. See Kinney, *supra* note 14, at 60 ("The appeal provisions in [t]he ACA . . . will end the piecemeal protections that apply only in some states to some plans, and . . . will also facilitate consumers in navigating the complex system."); see also 42 U.S.C. § 300gg-19(b)(1); TECHNICAL RELEASE 2011-02, *supra* note 57, at 2-4.

68. TECHNICAL RELEASE 2011-02, *supra* note 57, at 3. As noted, if states comply with a reduced list of consumer protection requirements, which HHS refers to as a "NAIC-similar process," HHS will consider the state's external review program sufficient until January 1, 2014. See *id.* at 4-5. As of July 10, 2012, thirteen states were in compliance with the NAIC-similar process, but not the stricter Interim Final Regulations. The Ctr. for Consumer Info. & Ins. Oversight, *Affordable Care Act: Working with States to Protect Consumers*, CENTERS FOR MEDICARE & MEDICAID SERVICES, [http://www.cms.gov/CCIIO/Resources/Files/external\\_appeals.html](http://www.cms.gov/CCIIO/Resources/Files/external_appeals.html) (last visited Jan. 24, 2014).

69. TECHNICAL RELEASE 2011-02, *supra* note 57, at 2-3.

70. *Id.* at 3.

71. *Id.*

72. *Id.*

73. *Id.*

74. *Id.*

75. *Id.*

76. See IOWA CODE § 514J.101 (2013).

77. Press Release, Iowa Ins. Div., HHS Notifies Iowa Approving External Review Process (July 29, 2011), *available at* <http://www.iid.state.ia.us/node/666053>.

1999.<sup>78</sup> For example, the previous statute only allowed covered persons to seek review of adverse benefit determinations based on insurers' determinations of medical necessity.<sup>79</sup> The current process allows review of denials based on insurers' determinations of "medical necessity, appropriateness, health care setting, level of care, or effectiveness."<sup>80</sup> In addition, Iowa's current statute allows a covered person to challenge an insurer's refusal to pay for a benefit that it deems "experimental or investigational."<sup>81</sup> Although Iowa based both iterations of its external review statute on a NAIC Uniform Model Act,<sup>82</sup> both Iowa statutes contain unique features. For example, unlike the Model Act, both iterations of Iowa's statute explicitly allow a covered person to appeal an IRO's decision to a district court.<sup>83</sup>

Although the current external review process will generally make it easier and less costly for a covered person to challenge an insurer's adverse benefit determination,<sup>84</sup> some covered persons might desire to bring an action in a district court against an insurer that denies coverage for a reason that is eligible for external review.<sup>85</sup> Accordingly, both versions of Iowa's external review statute raise an important question that the remainder of this Note seeks to answer: May a covered person bypass the external review process completely and immediately challenge an insurer's decision in a district court—meaning the process is "cumulative"? As discussed in Part IV, the resolution of this question has important implications for covered persons. If the process is "exclusive"—meaning it is the only way to challenge an adverse benefit determination—it will limit a covered person's choice of forum and potentially prevent her from asserting all aspects of her claims

78. See IOWA CODE § 514J.1 (repealed 2011) (noting that the statute was enacted by 1999 Iowa Acts ch. 41, § 7 (effective Jan. 1, 2000)).

79. *Id.* § 514J.3 (repealed 2011) ("This chapter does not apply to . . . denials of coverage not based on medical necessity.").

80. *Id.* § 514J.102(1) (2013) (defining "adverse determination"); *id.* § 514J.105 (allowing a covered person to seek review of final adverse determinations).

81. *Id.* § 514J.109.

82. Press Release, *supra* note 77.

83. Compare IOWA CODE § 514J.110(2)(a) (stating a covered person may appeal an IRO's decision to a district court), with UNIF. HEALTH CARRIER EXTERNAL REVIEW MODEL ACT § 11.B (2010), available at <http://www.dol.gov/ebsa/pdf/externalreviewmodelact.pdf> ("An external review decision is binding on the covered person except to the extent the covered person has other remedies available under applicable federal or State law."). Iowa's external review statute is consistent with the NAIC Model Act in that the IRO's decision is binding on the insurer "except to the extent the health carrier has other remedies available under applicable . . . law." IOWA CODE § 514J.110(1); UNIF. HEALTH CARRIER EXTERNAL REVIEW MODEL ACT § 11.A.

84. Interim Final Rules, *supra* note 4, at 43,342.

85. For example, a covered person may want to file a traditional lawsuit because the external review process provides a short (four month) statute of limitations period. See *infra* text accompanying notes 192–203 (discussing the statute of limitations and other reasons a covered person may wish to bypass the external review process).

against an insurer. However, if the process is cumulative, she must carefully consider how to challenge her insurer's adverse benefit determination.

### III. MAY A COVERED PERSON BYPASS THE EXTERNAL REVIEW PROCESS?

After examining Iowa's rules of statutory interpretation, this Part argues that Iowa's external review process is not the exclusive means to challenge insurers' adverse benefit determinations. Iowa's external review statute does not explicitly address whether a covered person can bypass the external review process and elect to immediately file an action in court,<sup>86</sup> and Iowa appellate courts have not resolved this issue.<sup>87</sup> However, the district court in *Lamb v. Time Insurance Co.* held that the process is exclusive.<sup>88</sup> The Iowa Court of Appeals affirmed *Lamb* on different grounds and declined to reach the exclusivity question.<sup>89</sup>

To determine a correct construction of the statute, this Note examines Iowa case law addressing whether other Iowa statutes are cumulative or exclusive. This Part first explains that whether a statute is cumulative or exclusive turns on legislative intent, which courts seek to determine by looking to the text of the statute and its context. This Part then addresses the two default rules Iowa courts use to determine whether a statute is cumulative or exclusive: whether the statute creates a new right (the "new-right test") and whether the statute creates a comprehensive scheme for resolving a particular type of dispute (the "comprehensive-scheme test").<sup>90</sup> Finally, this Part demonstrates that the public policy goals underlying the ACA and Iowa's statutes suggest that Iowa's external review process should

86. *Lamb v. Time Ins. Co.*, No. 10-0241, 2011 WL 944430, at \*4 (Iowa Ct. App. Mar. 21, 2011) ("Chapter 514J does not expressly state whether its remedies are exclusive or nonexclusive."). The *Lamb* court held that once a covered person begins the external review process, she cannot abandon the process and file a separate action in a district court. *Id.* at \*6.

87. *See id.* at \*5 ("[I]n the end, we need not decide whether chapter 514J displaces the common law whenever a health insurer denies an insured's claim based on medical necessity.").

88. *Id.* at \*4.

89. *Id.* at \*5-6. The Court of Appeals suggested that because the external review statute creates a comprehensive means to appeal an insurer's "denial of coverage based on medical necessity," it might be exclusive. *Id.* at \*4; *see also infra* Part III.C.1 (explaining that statutes that create comprehensive schemes are generally exclusive). Yet, the court declined to affirm the district court's ruling on that basis. *See Lamb*, 2011 WL 944430, at \*5 ("Again, we do not decide whether the administrative remedy is *exclusive* . . .").

90. In addition, Iowa courts have held that a statutory process is not exclusive if it is unable to adequately adjudicate the dispute between the parties. *Charles Gabus Ford, Inc. v. Iowa State Highway Comm'n*, 224 N.W.2d 639, 647 (Iowa 1974) ("Inadequacy of [a] remedy to provide the relief a litigant seeks constitutes some indication the remedy is not exclusive . . . ." (citing *Goldstein v. Groesbeck*, 142 F.2d 422 (2d Cir. 1944))). Because the text of the statute, the new-right test, and the comprehensive-scheme test indicate that the statute is not exclusive, whether the process can adequately adjudicate the dispute between the parties is largely beyond the scope of this Note.

be cumulative—meaning it does not supplant a covered person’s common-law rights to challenge an insurer in court.

A. *LEGISLATIVE INTENT AND THE TEXT OF IOWA’S EXTERNAL REVIEW STATUTE*

As is often the case in Iowa,<sup>91</sup> there is little legislative history to illuminate whether the legislature intended Iowa’s external review statute to be cumulative or exclusive. Accordingly, to determine legislative intent, this Subpart “look[s] first to the words of the statute itself as well as the context of the language at issue.”<sup>92</sup>

Iowa’s external review statute does not explicitly state whether it is cumulative or exclusive.<sup>93</sup> The statute provides that “[a] covered person or the covered person’s authorized representative *may* file a written request for an external review.”<sup>94</sup> Intuitively, the word “may” suggests that the statute provides a voluntary forum, not a mandatory one. However, this intuition requires careful examination because Iowa courts have repeatedly held that a plaintiff must exhaust administrative remedies before filing an action in district court, even when the relevant statute provides that the plaintiff “may” appeal an administrative decision in the manner articulated in the statute.<sup>95</sup> These cases are important because the exhaustion-of-

91. See, e.g., *Iowa Comprehensive Petroleum Underground Storage Tank Fund Bd. v. Mobil Oil Corp.*, 606 N.W.2d 359, 365 (Iowa 2000) (“[E]xtensive history of [the relevant] Iowa statute is not readily available.”); *Vivian v. Madison*, 601 N.W.2d 872, 874 (Iowa 1999) (“There is surprisingly little to discover with regard to the legislative history of the Iowa Civil Rights Act.”); *Seeman v. Liberty Mut. Ins. Co.*, 322 N.W.2d 35, 41 (Iowa 1982) (noting “no clear indication of legislative intent” regarding whether section 507B.4(9)(f) of the Iowa Code creates a private cause of action).

92. *Jacobson Transp. Co. v. Harris*, 778 N.W.2d 192, 197 (Iowa 2010). Although this Note properly directs its primary attention to the text of Iowa’s external review process, the federal external review regulations intimate that the process is cumulative. The federal regulations do not appear to *require* a state to make its process cumulative. See Interim Final Rules, *supra* note 4, at 43.344–45 (explaining that a covered person will be deemed to have exhausted an insurer’s internal appeals process if the insurer fails to adhere to the applicable regulations and stating that “under such deemed exhaustion, the claimant may initiate an external review and pursue any available remedies under *applicable law*, such as judicial review” (emphasis added)). However, the regulations appear to contemplate that the external review process is cumulative. *Id.* at 43.334 (“[Limiting] health insurance issuers offering individual health insurance coverage [to] one level of internal appeals . . . allows the claimant to seek either external review *or* judicial review immediately after an adverse benefit determination . . .” (emphasis added)).

93. See IOWA CODE § 514J.105 (2013). Importantly, “silence [in the statute] does not indicate the legislature intended for the chapter’s remedy to be nonexclusive; silence on the subject renders the matter ambiguous and requires [the court] to proceed under the rules of statutory construction.” *Van Baale v. City of Des Moines*, 550 N.W.2d 153, 155 (Iowa 1996).

94. IOWA CODE § 514J.107(1) (emphasis added).

95. See *Riley v. Boxa*, 542 N.W.2d 519, 522–23 (Iowa 1996) (construing IOWA CODE § 414.10 and citing cases).

administrative-remedies doctrine relates to, but is not the same as, the question of whether the statute is cumulative or exclusive.<sup>96</sup>

In one case interpreting the word “may,” *Riley v. Boxa*, the plaintiff sought approval from the City of Cedar Rapids Building Department to convert an office building in a non-residential zone into apartments.<sup>97</sup> The city denied the plaintiff’s request.<sup>98</sup> The Iowa Code and a Cedar Rapids ordinance allowed her to appeal the Building Department’s decision “to the board of adjustment.”<sup>99</sup> Instead of following this procedure, the plaintiff filed a petition in the district court.<sup>100</sup> The Iowa Supreme Court affirmed the district court’s decision to dismiss her case because she did not exhaust her administrative remedies.<sup>101</sup> The court rejected the plaintiff’s contention that the statutory phrase “[a]ppeals . . . may be taken” demonstrated “that the legislature intended the appeal [procedure] to be permissive and not mandatory.”<sup>102</sup> The court noted that it has “held that other statutes which also used the term ‘may’ have nevertheless required the administrative remedy to be exhausted before resort to the courts.”<sup>103</sup>

Similarly, in *Lamb v. Time Insurance Co.*, the plaintiff began the health insurance external review process, the IRO ruled against him, and he then brought an entirely new suit against the insurance company in district court.<sup>104</sup> The plaintiff in *Lamb* made an analogous argument to the plaintiff in *Riley*—that he could choose whether to appeal the IRO’s external review decision to the district court as allowed by what was then Iowa Code section 514J.13(2) or initiate a separate action because the statute provided that a covered person “*may* appeal the [IRO’s] decision . . . by filing a petition for

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96. The issue of whether a statute is cumulative or exclusive is related to—but distinct from—the requirement in the Iowa Administrative Procedure Act (“IAPA”) that plaintiffs aggrieved by an agency action must exhaust administrative remedies before seeking judicial review. See IOWA CODE § 17A.19(1); see also *Charles Gabus Ford, Inc. v. Iowa State Highway Comm’n*, 224 N.W.2d 639, 647 (Iowa 1974) (noting the similarity between the doctrine of exhaustion of administrative remedies and the question of whether a statute is cumulative or exclusive). The IAPA does not govern Iowa’s external review process. IOWA CODE § 514J.110(1) (“The external review process shall not be considered a contested case under chapter 17A.”). Accordingly, this Note addresses whether the legislature intended chapter 514J of the Iowa Code to supplant the common-law means to challenge an insurer’s adverse benefit determination; the issue is not whether a covered person must exhaust the external review procedure before appealing to a district court.

97. *Riley*, 542 N.W.2d at 520–21.

98. *Id.* at 521.

99. *Id.* (citing IOWA CODE § 414.10).

100. *Id.*

101. *Id.* at 524.

102. *Id.* at 522 (internal quotation marks omitted) (citing IOWA CODE § 414.10).

103. *Id.* (citing *Pruess Elevator, Inc. v. Iowa Dep’t of Natural Res.*, 477 N.W.2d 675, 677 (Iowa 1991)).

104. *Lamb v. Time Ins. Co.*, No. 10-0241, 2011 WL 944430, at \*1–3 (Iowa Ct. App. Mar. 21, 2011); see also *supra* notes 86–89 and accompanying text (introducing *Lamb*).

judicial review.”<sup>105</sup> The court, applying the doctrine of exhaustion of administrative remedies,<sup>106</sup> rejected this argument.<sup>107</sup>

*Riley* and *Lamb* likely do not govern whether the words “[a] covered person . . . may make a request for an external review” render the external review statute cumulative or exclusive.<sup>108</sup> Though *Lamb* concerns the same chapter of the Iowa Code at issue in this Note, *Riley* and *Lamb* are distinguishable because each of the plaintiffs started an administrative process but did not finish it.<sup>109</sup> This Note concerns plaintiffs who are contemplating *whether to start* a statutory dispute resolution process.

*George v. D.W. Zinser Co.* is more on point.<sup>110</sup> *George* addressed a somewhat similar question as *Riley* and *Lamb*, but came to a different result.<sup>111</sup> In *George*, the court held that the Iowa Occupational Safety and Health Act (“IOSHA”) is not exclusive, and it therefore did not bar the plaintiff’s claim of wrongful termination.<sup>112</sup> Although the court also stated, without attempting to distinguish *Riley*, that the plaintiff need not exhaust his administrative remedies because the language of the statute was

105. *Id.* at \*5 (internal quotation marks omitted) (citing IOWA CODE § 514J.13(2) (repealed 2011)). Notably, this is not the section of the external review statute directly relevant to determining whether the statute is cumulative or exclusive. That section is Iowa Code section 514J.105. *See supra* note 93 and accompanying text.

106. As noted above, the IAPA does not apply to the external review process. *See supra* note 96. The *Lamb* court, reasoning by analogy, found it significant that “the insured availed himself of *part* of the administrative process, but stopped going further when he did not like the outcome.” *Lamb*, 2011 WL 944430, at \*5. The court stated: “we believe it is appropriate to apply the doctrine of exhaustion of administrative remedies.” *Id.*

107. *Lamb*, 2011 WL 944430, at \*5.

108. IOWA CODE § 514J.105 (2013) (emphasis added); *see supra* note 93 and accompanying text.

109. *See supra* text accompanying notes 97–103 (discussing *Riley*); *supra* text accompanying notes 104–07 (discussing *Lamb*). The cases that *Riley* cites to support its holding (that the words “may appeal” do not alter the requirement that the plaintiff exhaust administrative remedies) also concern plaintiffs that abandoned an administrative process. *See Riley v. Boxa*, 542 N.W.2d 519, 522 (Iowa 1996) (citing *Pruess Elevator, Inc. v. Iowa Dep’t of Natural Res.*, 477 N.W.2d 675, 677 (Iowa 1991)). In *Pruess Elevator*, which considered the Iowa Department of Natural Resources’ (“DNR”) order that *Pruess Elevator* propose a method to destroy a shipment of corn contaminated by aflatoxin, a carcinogen, *Pruess Elevator* submitted three proposals, each of which the DNR rejected. *Pruess Elevator*, 477 N.W.2d at 676–77 (citing IOWA CODE § 455B.388 (1989)). *Pruess Elevator* then appealed to an administrative law judge for a stay of the DNR’s action, which the judge denied. *Id.* at 677. *Pruess Elevator* then “totally abandoned the administrative process” and filed “a petition for judicial review in the district court.” *Id.* Because the plaintiff did not exhaust its administrative remedies, the Iowa Supreme Court affirmed the district court’s decision to deny judicial review. *Id.* at 678.

110. *See George v. D.W. Zinser Co.*, 762 N.W.2d 865 (Iowa 2009).

111. *See id.* at 872.

112. *Id.* The plaintiff alleged that his employer fired him after he reported IOSHA violations. *Id.* at 867. The plaintiff filed a complaint with the Iowa Division of Labor Services Occupational Safety and Health Bureau (“the Division”), which dismissed his complaint. *Id.* at 866–67. As the Division investigated his complaint, the plaintiff “filed a lawsuit in the district court containing the same retaliation claim.” *Id.* at 867.



permissive,<sup>113</sup> the court devoted its primary attention to whether IOSHA was exclusive. The court reasoned that:

The fact that the statute creates an administrative remedy does not indicate such a remedy is exclusive. The language in section 88.9(3) is permissive. [It states:] “An employee who believes that the employee has been discharged . . . in violation of this subsection *may* . . . file a complaint with the commissioner alleging discrimination.”<sup>114</sup>

The court held, “[i]f the legislature had intended . . . [to create an] exclusive remedy and preclude a private cause of action, it could have done so expressly.”<sup>115</sup> The court further reasoned that IOSHA’s underlying “policy of encouraging employees to improve workplace safety” indicates that the statute is not exclusive.<sup>116</sup>

The issue of whether Iowa’s external review process is cumulative or exclusive is more similar to the issue presented in *George* than in *Riley*. Unlike the plaintiffs in *Riley* and *Lamb*, a covered person who chooses to bring an action in the district court instead of initiating the external review process is not attempting to abandon an administrative process.<sup>117</sup> Rather, the covered person is choosing between two potential means of recovery. Mirroring the legislative silence in the statute at issue in *George*, the legislature did not provide any indication that the external review statute is exclusive. In addition, the policy behind Iowa’s external review statute, which is “to assure that covered persons have the opportunity for an independent review of an adverse determination,”<sup>118</sup> suggests that the legislature intended to expand covered persons’ preexisting rights, rather than supplant covered persons’ rights to file an action in district court challenging insurers’ decisions. Thus, despite case law that potentially suggests that the word “may” in the external review statute does not ensure that the statute is cumulative rather than exclusive, the nature of the external review process indicates that the external review process is cumulative.

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113. See *id.* at 872 n.1 (noting that the exhaustion “doctrine does not apply if . . . [the] remedy is permissive only or not exclusive of the judicial remedy” (quoting *Riley*, 542 N.W.2d at 522)). Interestingly, the court made no explicit effort to distinguish *Riley*’s analysis of the word “may.” See *id.*

114. *Id.* at 872 (quoting IOWA CODE § 88.9(3)(b)(1) (2007)).

115. *Id.* This statement seems inconsistent with the court’s statement in *Van Baale* that “silence [in a statute] does not indicate the legislature intended for the chapter’s remedy to be nonexclusive.” *Van Baale v. City of Des Moines*, 550 N.W.2d 153, 155 (Iowa 1996).

116. *George*, 762 N.W.2d at 872 (citing IOWA CODE §§ 88.1, 88.9(3)).

117. *Lamb* makes clear that if a covered person begins the external review process, she cannot quit and file an action in the district court. *Lamb v. Time Ins. Co.*, No. 10-0241, 2011 WL 944430, at \*5 (Iowa Ct. App. Mar. 21, 2011); see also *supra* notes 104–07 and accompanying text.

118. IOWA CODE § 514J.101 (2013).

B. WHETHER IOWA'S EXTERNAL REVIEW STATUTE CREATES A NEW RIGHT

Because a textual analysis of Iowa's external review statute may not be dispositive,<sup>119</sup> it is necessary to consider an additional rule of statutory interpretation that courts use to determine whether a statute is cumulative or exclusive: whether the statute creates a new right unavailable at common law, the new-right test.<sup>120</sup>

When a statute "points to a specific method for enforcement of the new right," courts presume that "this method must be pursued exclusively."<sup>121</sup> The converse of this rule is also true:

[W]here a statute prescribing a remedy does not create a new right or liability, but merely provides a new remedy for an independent right or liability already existing, the general rule is that the remedy thus given is not regarded as exclusive but as merely cumulative of other existing remedies . . . .<sup>122</sup>

The court in *Walthart v. Board of Directors of Edgewood-Colesburg Community School District* applied the new-right test.<sup>123</sup> In *Walthart*, the Iowa Supreme Court considered a teacher's petition for certiorari challenging the school board's decision to terminate her employment.<sup>124</sup> The court held that the district court lacked jurisdiction to grant certiorari because Iowa Code section 279.17 provided the teacher with her exclusive remedy.<sup>125</sup> The statute allowed her to appeal to an adjudicator whom the school board and the teacher select jointly.<sup>126</sup> In determining whether the statute provided the teacher's exclusive remedy, the court found it significant that "[t]he right to appeal a board's termination to an adjudicator was part of a major overhaul of teacher-termination law."<sup>127</sup>

119. This uncertainty results from the court's apparently inconsistent treatment of the word "may" in *Riley* and *George*, see *supra* note 113, and the Court's conflicting statements concerning the effect of statutory silence. Compare *Van Baale*, 550 N.W.2d at 155 (stating that textual silence regarding whether a statute is exclusive or cumulative renders the statute ambiguous), with *George*, 762 N.W.2d at 872 ("If the legislature had intended . . . [to create an] exclusive remedy . . . it could have done so expressly.").

120. See *Van Baale*, 550 N.W.2d at 155–56 (stating the major factors in determining whether a statute is cumulative or exclusive are whether the statute creates a new right and whether it creates a comprehensive means to obtain the remedy).

121. *Id.* at 155; see also *Walthart v. Bd. of Dirs. of Edgewood-Colesburg Cmty. Sch. Dist.*, 667 N.W.2d 873, 878 (Iowa 2003) (citing this language with approval).

122. *Walthart*, 667 N.W.2d at 877 (quoting 1A C.J.S. *Actions* § 14, at 388 (2002)).

123. *Id.* at 878.

124. *Id.* at 874–75. The board decided to terminate Ms. Walthart after students, including her son, had a party on her property, and several students left the party drunk and then died in a car accident. *Id.* at 874.

125. *Id.*

126. *Id.*; see also IOWA CODE § 279.17(2) (2013).

127. *Walthart*, 667 N.W.2d at 878 (citing *Bruton v. Ames Cmty. Sch. Dist.*, 291 N.W.2d 351, 352 (Iowa 1980)).

### 1. Whether the New-Right Test Requires a Completely New Right

One potential interpretation of the court's holding in *Walhart* is that a statute might be exclusive if it provides a party substantially more rights, even if some rights existed previously. For example, the court stated that the statutory changes in Iowa Code section 279.17 "provided a new right in the form of *more* protection for teachers in termination proceedings."<sup>128</sup> In addition, the court noted that "[p]rior to that revision, a teacher had few rights in challenging a termination for cause, *as compared to the present*."<sup>129</sup> Given this language, it might be reasonable to conclude that if a statute creates a *mostly* new right, the statute is exclusive.

A more accurate interpretation of *Walhart*, however, would seem to be that a statute only satisfies the new-right test—meaning it is exclusive—if the statute creates an entirely new right. The court's statement in *Walhart*, that "[t]he extensive rights now accorded to teachers, including the right to an appeal to an adjudicator, were *not known* prior to the 1976 Act," supports this interpretation.<sup>130</sup> The court's previous explanation, in *Bruton v. Ames Community School District*, of how extensively the 1976 Act altered teachers' employment contracts further supports the second interpretation of *Walhart*. *Bruton* analyzed the 1976 Act and the history of statutes governing contracts between teachers and school boards.<sup>131</sup> In that case, the court stated that the statute "completely revised the procedure for terminating school teachers' contracts."<sup>132</sup> The court noted that although the 1976 statute "retained some provisions of the previous statute," it made "several substantial changes."<sup>133</sup> First, after the 1976 Act, a school board could not terminate teachers at-will; it could only do so with "just cause."<sup>134</sup> Second, the 1976 Act allowed teachers to appeal to an adjudicator and eventually to the district court as described above.<sup>135</sup> Thus, the statute created an entirely new right.

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128. *Id.* (emphasis added).

129. *Id.* (emphasis added).

130. *Id.* (emphasis added).

131. *Bruton*, 291 N.W.2d at 352–55.

132. *Id.* at 352 (quoting *Bd. of Educ. v. Youel*, 282 N.W.2d 677, 678 (Iowa 1979)) (internal quotation marks omitted).

133. *Id.* at 354.

134. *Id.* at 355 (internal quotation marks omitted) (citing IOWA CODE § 279.15(2) (1977)).

135. *Id.* at 354–55. The court stated:

Compare § 279.13, The Code 1975 ("the action of the board shall be final"), with §§ 279.17 and 279.18, The Code 1977 (under section 279.17 the nonprobationary teacher can appeal from the board's decision to an adjudicator, whose decision supersedes the board's decision, and under section 279.18 either party can appeal from the adjudicator to the courts).

*Id.* at 355. Before the 1976 Act, a school board had "final authority to terminate . . . teacher contracts at the end of the year." *Id.* at 354–55.

*Van Baale v. City of Des Moines* further supports the conclusion that only a truly new right will satisfy the new-right test. In that case, the court held that Iowa Code section 400.20, which allowed a police officer to appeal his termination to a civil service commission, provided the police officer's exclusive means to challenge the city's decision to terminate him.<sup>136</sup> The court reasoned, "Chapter 400 creates a new right to continued employment (subject only to removal for cause) that *did not exist at common law* where public employment was at-will."<sup>137</sup> Because the statute created a new right, the court determined that the appeal procedure was exclusive.<sup>138</sup>

## 2. Application of the New-Right Test to Iowa's External Review Statute

Although Iowa's external review process created a convenient procedure and established significant consumer protections, it did not create entirely new rights for covered persons. Before Iowa enacted its original external review statute in 1999,<sup>139</sup> a covered person could bring breach-of-contract actions against an insurer that denied her benefits.<sup>140</sup> For example, in *Witcraft v. Sundstrand Health & Disability Group Benefit Plan*, the plaintiff brought a successful action against an insurer that determined treatment for infertility did not constitute an "illness" under the policy.<sup>141</sup>

On one hand, the external review statute would seem to satisfy the new-right test. Even though traditional causes of action were available, there appear to be few Iowa cases concerning a covered person's state-law claims against a health insurer arising from a denial of benefits.<sup>142</sup> In addition, the

136. *Van Baale v. City of Des Moines*, 550 N.W.2d 153, 155–56 (Iowa 1996).

137. *Id.* at 156 (emphasis added).

138. *See id.*

139. *See* IOWA CODE § 514J.1 (repealed 2011) (noting that the statute was enacted by 1999 Iowa Acts ch. 41, § 7 (effective Jan. 1, 2000)).

140. *See* *Witcraft v. Sundstrand Health & Disability Grp. Benefit Plan*, 420 N.W.2d 785 (Iowa 1988); *Kitchen v. Time Ins. Co.*, 232 N.W.2d 863, 865 (Iowa 1975) (finding for plaintiff and determining alcoholism is a "sickness" within the meaning of the insurance policy).

141. *Witcraft*, 420 N.W.2d at 789–90.

142. Notably, there are *many* cases involving plaintiffs' claims against employer-based self-insured plans under section 502(a) of ERISA (codified at 29 U.S.C. § 1132(a)). *See, e.g.,* *Crews v. Sara Lee Corp.*, No. 08-CV-113-LRR, 2010 WL 3000378, at \*4–7 (N.D. Iowa July 27, 2010) (involving plaintiff's claims that his employer improperly denied benefits for his premature child); *Davidson v. Wal-Mart Assocs. Health & Welfare Plan*, 305 F. Supp. 2d 1059, 1064 (S.D. Iowa 2004) (involving plaintiff's claims resulting from her health plan's denial of coverage for surgical breast reconstruction); *Munsen v. Wellmark, Inc.*, 257 F. Supp. 2d 1172, 1175 (N.D. Iowa 2003) (involving plaintiffs' claim that their health plan wrongfully denied private-duty home nursing care for their disabled son). However, health plans governed by ERISA are not subject to Iowa's external review statute (unless they agree to participate) and non-ERISA plans cannot use ERISA's civil enforcement provision. *See supra* note 60 and accompanying text. Accordingly, section 502(a) ERISA claims do not have direct bearing on whether the external review process provides a new right for state-regulated plans.

primary state law governing insurers does not provide a private cause of action.<sup>143</sup>

Notwithstanding these limitations, however, the external review process is distinguishable from the 1976 Act concerning teacher contracts. As noted above, that Act created an entirely new right to challenge a school board's decision.<sup>144</sup> Unlike the school board's decision before the 1976 Act, an insurer's adverse benefit decision was not beyond judicial review before the adoption of the external review process.<sup>145</sup> Even though the external review statute codified many novel consumer protections and may make it easier for covered persons to challenge adverse benefit determinations,<sup>146</sup> the external review statute likely does not create a new right sufficient to satisfy the new-right test. This suggests that Iowa's external review statute is cumulative rather than exclusive.

C. WHETHER IOWA'S EXTERNAL REVIEW STATUTE CREATES A COMPREHENSIVE SCHEME

Because the outcome of the court's examination of the new-right test discussed in the previous Subpart is uncertain, courts may examine a second rule of statutory interpretation governing whether a statute is cumulative or exclusive: the comprehensive-scheme test. This Subpart defines the comprehensive-scheme test and examines the Iowa Court of Appeals' dicta asserting that Iowa's external review process creates a comprehensive scheme. Although it is a close question, this Subpart concludes that Iowa's external review statute does not create a comprehensive scheme because the external review process cannot resolve all aspects of disputes between covered persons and insurers regarding denials of benefits.

1. Definition of the Comprehensive-Scheme Test and Application in *Lamb*

Iowa courts have stated that “[w]here the legislature has provided a *comprehensive scheme* for dealing with a specified kind of dispute, the statutory

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143. *Seeman v. Liberty Mut. Ins. Co.*, 322 N.W.2d 35, 43 (Iowa 1982). The Insurance Commissioner has authority to investigate insurers suspected of engaging “in an unfair method of competition or an unfair or deceptive act or practice.” IOWA CODE § 507B.7 (2013). If the Commissioner finds such practices, she can impose civil penalties, and in some cases suspend or revoke the insurer's license to sell insurance in Iowa. *Id.* The Iowa Supreme Court has held that IOWA CODE § 507B does not provide a private cause of action. *Seeman*, 322 N.W.2d at 43; *see also* *Terra Indus., Inc. v. Commonwealth Ins. Co. of Am.*, 990 F. Supp. 679, 684–85 (N.D. Iowa 1997) (noting the court has “never retreated from [its] conclusion” in *Seeman* that “the legislature implicitly intended the insurance commissioner's powers to be the exclusive means of enforcing § 507B.4(9)(f)”).

144. *See supra* text accompanying notes 134–35.

145. *See supra* text accompanying notes 139–40.

146. *See supra* Part II.B.1.

remedy provided is generally exclusive.”<sup>147</sup> The Iowa Supreme Court does not appear to have thoroughly discussed what constitutes a “comprehensive scheme.”<sup>148</sup> The court has stated that the comprehensive-scheme test is a “variation” of the new-right test described above.<sup>149</sup> Iowa courts have not clarified whether a court will hold that the statute is exclusive if a statute satisfies this “variation” but not the new-right test.<sup>150</sup>

Significantly, although *Lamb* did not decide whether the external review statute is exclusive, the court determined that the statute “created a comprehensive scheme for dealing with the denial of coverage . . . based on medical necessity.”<sup>151</sup> The court supported this conclusion by quoting Iowa Administrative Code rule 191-76.1, which states that it “is intended to implement Iowa Code chapter 514J [and] to provide a *uniform process* for enrollees . . . to request an external review of a coverage decision based upon medical necessity.”<sup>152</sup>

## 2. Application of the Comprehensive-Scheme Test to Iowa’s External Review Statute

The external review statute did not create a comprehensive scheme. Notwithstanding *Lamb*’s dicta, the Iowa Supreme Court should not conclude that the statement of legislative purpose in Iowa’s external review statute is a sufficient indication that the statute is a covered person’s exclusive remedy. The statement of legislative purpose that *Lamb* quotes does not address whether the statute should be cumulative or exclusive.<sup>153</sup>

Furthermore, *Lamb*’s interpretation of this statement does not align with the general rule of statutory interpretation that a remedial statute

147. *Van Baale v. City of Des Moines*, 550 N.W.2d 153, 156 (Iowa 1996) (emphasis added) (quoting 1A C.J.S. *Actions* § 14 n.55 (1985)) (internal quotation marks omitted). The Iowa Supreme Court approved this language again in *Walhart*. *Walhart v. Bd. of Dirs. of Edgewood-Colesburg Cmty. Sch. Dist.*, 667 N.W.2d 873, 878 (Iowa 2003).

148. The two main Iowa Supreme Court cases that discuss the new-right test and the comprehensive-scheme test both decided that the statutes at issue were exclusive because they created a new right and neither case discussed the comprehensive-scheme test in detail. *See Walhart*, 667 N.W.2d at 877–78; *Van Baale*, 550 N.W.2d at 155–56.

149. *Van Baale*, 550 N.W.2d at 156.

150. *Van Baale* and *Walhart* focus primarily on the new-right test and *Lamb* focuses primarily on the comprehensive-scheme test; all three cases mention both tests without stating whether either test is sufficient on its own. *See Walhart*, 667 N.W.2d at 877–78; *Van Baale*, 550 N.W.2d at 155–56; *Lamb v. Time Ins. Co.*, No. 10-0241, 2011 WL 944430, at \*4 (Iowa Ct. App. Mar. 21, 2011). Although, in passing, the *Lamb* court cited the articulation of the new-right test in *Van Baale*, the court did not analyze whether Iowa’s external review statute satisfies the test. *Lamb*, 2011 WL 944430, at \*4.

151. *Lamb*, 2011 WL 944430, at \*4.

152. *Id.* (quoting IOWA ADMIN. CODE r. 191-76.1) (internal quotation marks omitted).

153. *See id.*

should be construed liberally.<sup>154</sup> Indeed, the Iowa Supreme Court has explicitly considered the public policy underlying a statute when assessing whether that statute should be cumulative or exclusive. For example, in *George v. D.W. Zinser Co.*, the court stated that because the policy goal of IOSHA is to improve workplace safety, the legislature likely intended the statute to supplement workers' protections rather than supplant workers' private right of action.<sup>155</sup>

The current statement of legislative purpose in Iowa's external review statute provides, "[t]he purpose of this chapter is to provide uniform standards for the establishment and maintenance of external review procedures to assure that covered persons have the opportunity for an independent review of an adverse determination or final adverse determination made by a health carrier."<sup>156</sup> A fair reading of that statement suggests that the public policy goal of the statute is to create a uniform *external review process*, but not necessarily the exclusive means to challenge an insurer's adverse determination. Under that reading, the broader goal of the statute is to "*assure*" covered persons have some opportunity to challenge an adverse determination. Given this public policy, the Iowa Supreme Court should hold that the statute is not exclusive. At least one court has reached a similar holding.<sup>157</sup> In *Goldman v. BCBSM Foundation*, the Eastern District of Michigan held that the federal external review process is not exclusive, notwithstanding statements in the regulations governing the federal external review process that are similar to the Iowa statute's statement of legislative purpose.<sup>158</sup>

Furthermore, a statute is generally exclusive if it creates a comprehensive scheme to address "a specified kind of dispute."<sup>159</sup> The external review statute at issue in *Lamb*, which was limited to denials based

154. See *Van Beeck v. Sabine Towing Co.*, 300 U.S. 342, 350–51 (1937) (footnote omitted) ("It would be a misfortune if a narrow or grudging process of construction were to exemplify and perpetuate the very evils to be remedied. There are times when uncertain words are to be wrought into consistency and unity with a legislative policy which is itself a source of law, a new generative impulse transmitted to the legal system."); State *ex rel. Miller v. Cutty's Des Moines Camping Club, Inc.*, 694 N.W.2d 518, 528 (Iowa 2005).

155. *George v. D.W. Zinser Co.*, 762 N.W.2d 865, 872 (Iowa 2009); see also *supra* text accompanying notes 110–16 (discussing *George*).

156. IOWA CODE § 514J.101 (2013).

157. *Goldman v. BCBSM Found.*, 841 F. Supp. 2d 1021, 1024 (E.D. Mich. 2012); see *infra* text accompanying notes 182–84 (discussing *Goldman*).

158. *Goldman*, 841 F. Supp. 2d at 1024. The federal regulations state: "[t]hese . . . regulations will help transform the current, highly variable health claims and appeals process into a more uniform and structured process." Interim Final Rules, *supra* note 4, at 43,341. Although *Goldman* did not directly discuss this language, the court stated, "nothing . . . indicate[s] that external review by a state agency is a prerequisite to filing an ERISA claim." *Goldman*, 841 F. Supp. 2d at 1026.

159. *Van Baale v. City of Des Moines*, 550 N.W.2d 153, 156 (Iowa 1996) (quoting 1A C.J.S. *Actions* § 14 n.55 (1985)) (internal quotation marks omitted).

on insurers' determinations of medical necessity,<sup>160</sup> could not address the full scope of the "dispute" between the parties. As stated in Subpart II.A, insurers may deny coverage for many reasons.<sup>161</sup> *Lamb* illustrates that insurers may deny coverage of a particular benefit for multiple reasons—such as if the benefit is not medically necessary *and* it is experimental or investigational.<sup>162</sup> The external review statute at issue in *Lamb* only permitted external review of denials based on medical necessity.<sup>163</sup> Accordingly, if the process was comprehensive and exclusive, an insurer could contend that a covered person could only challenge a denial based on medical necessity in the external review process and must challenge any other type of denial—even if concerning the same benefit—in district court.<sup>164</sup> This demonstrates that the external review process that existed before the ACA was not a comprehensive scheme—and was therefore not exclusive.

Iowa's current external review statute has a much broader scope than the statute at issue in *Lamb*.<sup>165</sup> Even though the statute gives the IRO authority to review many aspects of a covered person's claim against an insurer, the statute is still not comprehensive. The current version of the statute allows a covered person to seek external review of an insurer's objection to the "appropriateness, health care setting, level of care, or effectiveness" of the benefit or its determination that the benefit requested is "experimental or investigational."<sup>166</sup>

Like its predecessor, Iowa's current external review statute does not allow a covered person to bring all aspects of a dispute with an insurer regarding a denial of benefits before the IRO. For example, Iowa's current external review process still does not allow a covered person to obtain

160. See IOWA CODE § 514J.3 (repealed 2011) ("This chapter does not apply to . . . denials of coverage not based on medical necessity.").

161. See *supra* note 18 and accompanying text.

162. The insurer in *Lamb* partially defined "medically necessary" as care that "is not for Experimental or Investigational Services." *Lamb v. Time Ins. Co.*, No. 10-0241, 2011 WL 944430, at \*1 (Iowa Ct. App. Mar. 21, 2011). The insurer "refused to reimburse Lamb for [his son's] treatment, stating it was not medically necessary because the treatment was experimental or investigational for Lyme disease." *Id.* Iowa's current external review statute defines separately denials based on medical necessity and the insurer's determination that care is experimental. See *infra* note 166 and accompanying text.

163. IOWA CODE § 514J.3 (repealed 2011) ("This chapter does not apply to . . . denials of coverage not based on medical necessity.").

164. See DALLEK & POLLITZ, *supra* note 20, at 7–8 ("[D]istinguishing between medical necessity and other coverage disputes may give an insurer the opportunity to argue that different kinds of denials are eligible for different levels of protection. . . . [I]t is not always easy to tell what a dispute is about. Medical necessity issues can be hard to distinguish from other kinds of contractual coverage issues, and sometimes a denial can be based on both.").

165. See *supra* Part II.B.2.

166. IOWA CODE § 514J.105 (2013) (allowing a covered person to seek review of final adverse determinations); *id.* § 514J.102(1) (defining "adverse determination"); *id.* § 514J.109(1) (allowing external review of denials based on an insurer's determination that a benefit is experimental or investigational).



external review of an insurer's decision to rescind coverage.<sup>167</sup> In addition, Iowa's current external review statute does not allow the IRO to review denials based on specific exclusions from the policy.<sup>168</sup> As the *Witcraft* case discussed above illustrates, determining the scope of an exclusion from the policy may be difficult.<sup>169</sup> Accordingly, in some cases it will be challenging for a covered person to determine whether her claim is eligible for external review, and she may need to file an action in district court to address all aspects of her dispute with the insurer. This indicates that the external review process is not a comprehensive scheme.

In addition, Iowa's current external review process is not comprehensive because it does not allow covered persons to assert all the claims that may arise out of a dispute regarding an insurer's denial of benefits. Significantly, a covered person cannot use the external review process to recover punitive damages against insurers that acted in bad faith in determining that a procedure was not medically necessary.<sup>170</sup> In *Dolan v. Aid Insurance Co.*, the Iowa Supreme Court recognized a cause of action against insurers that engage in bad-faith conduct.<sup>171</sup> If a covered person succeeds in demonstrating that an insurer acted in bad faith, she may recover punitive damages.<sup>172</sup> Because the external review statute does not allow a covered person to seek punitive damages in the way the Iowa Supreme Court authorized in *Dolan*, the external review statute is not a comprehensive scheme.

In the usual case, a covered person will likely choose to resolve her dispute with an insurer in the external review process.<sup>173</sup> At times, however, such as when the covered person has a colorable bad-faith claim against the insurer, she would prefer to bring an action in a district court. Because the external review statute does not allow the IRO to hear bad-faith claims,<sup>174</sup> even regarding claims within the scope of the external review statute, it is not a comprehensive scheme. Thus, in addition to the reasons stated in the previous Subparts, the external review statute is likely cumulative rather than exclusive.

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167. See *supra* note 7.

168. See IOWA CODE § 514J.102(1) ("Adverse determination" does not include a denial of coverage for a service or treatment specifically listed in plan or evidence of coverage documents as excluded from coverage.").

169. *Witcraft v. Sundstrand Health & Disability Grp. Benefit Plan*, 420 N.W.2d 785, 789–90 (Iowa 1988) (holding that the insurer improperly denied benefits for infertility treatments, which the court determined constituted an "illness" under the policy).

170. See IOWA CODE § 514J.107(13)(a) (giving the IRO power "to uphold or reverse the adverse determination," but not the power to award punitive damages).

171. See *Dolan v. Aid Ins. Co.*, 431 N.W.2d 790, 794 (Iowa 1988).

172. *Id.* at 793 (noting a covered person may recover punitive damages if the "insurer was guilty of malice, fraud, gross negligence, or an illegal act").

173. See *infra* text accompanying notes 187–91.

174. See *supra* note 170 and accompanying text.

*D. PUBLIC POLICY GOALS INDICATE THAT THE EXTERNAL REVIEW PROCESS SHOULD BE CUMULATIVE*

The previous Subparts demonstrate that the words of Iowa's external review statute and the applicable rules of statutory interpretation suggest that the process is cumulative. Sound public policy considerations further signal that a court should hold that Iowa's external review statute is cumulative. Such a holding would advance the likely aims of the statute<sup>175</sup> and of similar statutes in other states. Some other state courts have held that their external review processes are cumulative.<sup>176</sup> Moreover, this holding would further the ACA's goal of creating uniformity among the state external review processes and between the state and federal processes.<sup>177</sup> Uniformity is a sound public policy goal because the highly varied pre-ACA external review processes made it difficult for insurers to comply with the laws and for consumers to understand the requirements and obtain external review of adverse benefit determinations.<sup>178</sup> As the federal regulations acknowledge, lack of uniformity, both between types of health plans and between state external review processes, provided inadequate protections for some covered persons and contributed to perceptions of unfairness.<sup>179</sup>

Holding that Iowa's external review process is exclusive, as the district court did in *Lamb*,<sup>180</sup> would undermine the ACA's goal of uniformity because at least one court has held that the federal external review process is not exclusive.<sup>181</sup> In *Goldman v. BCBSM Foundation*, the defendant-insurer argued that the court must dismiss the covered person's complaint because he did not complete the external review process.<sup>182</sup> The federal court rejected that argument and held that "[i]t does not appear that the external review process *must* be completed before an individual has the right to sue under

175. See *supra* text accompanying notes 156–57 (discussing the public policy goals that likely motivated the legislature).

176. See *Schulman v. Grp. Health Inc.*, 833 N.Y.S.2d 62, 63 (N.Y. App. Div. 2007) ("The primary purpose of [New York's] external appeal law was to create a new layer of independent and impartial administrative review, which did not previously exist, and which would provide consumers with a low-cost, expedited review option in *addition to the courts*." (emphasis added)). However, some inconsistency between states will remain regardless of how Iowa courts interpret the external review process. See R.I. GEN. LAWS § 23-17.12-7 (2012) ("Any person who has exhausted all administrative remedies available to him or her within the department, and who is aggrieved by a final decision of the department under § 23-17.12-6, is entitled to judicial review pursuant to §§ 42-35-15 and 42-35-16.").

177. See Interim Final Rules, *supra* note 4, at 43,341 ("These interim final regulations will help transform the current, highly variable health claims and appeals process into a more uniform and structured process.").

178. See *supra* notes 27–28 and accompanying text.

179. See *supra* notes 27–28 and accompanying text.

180. See *Lamb v. Time Ins. Co.*, No. 10-0241, 2011 WL 944430, at \*4 (Iowa Ct. App. Mar. 21, 2011).

181. *Goldman v. BCBSM Found.*, 841 F. Supp. 2d 1021, 1024 (E.D. Mich. 2012).

182. *Id.*

ERISA.”<sup>183</sup> Language in the regulations governing the federal external review process supports the court’s conclusion. The regulations state that if an insurer fails to comply with the internal-review requirements, the covered person “may initiate an external review *and* pursue any available remedies under applicable law, such as judicial review.”<sup>184</sup> To maintain uniformity, Iowa courts should construe Iowa’s external review process as cumulative.

#### IV. THE STAKES FOR COVERED PERSONS AND LITIGATION CONSIDERATIONS

The text of the statute, rules of statutory interpretation, and public policy goals suggest that Iowa’s external review statute is cumulative. This conclusion has consequences—whether Iowa’s external review process is cumulative or exclusive significantly affects covered persons. If the Iowa Supreme Court were to hold that the process is exclusive, covered persons could not choose where to challenge insurers’ adverse benefit determinations and might be unable to assert all their claims against insurers.<sup>185</sup> Alternatively, if the court determines that the process is cumulative, covered persons must carefully consider which process to pursue.<sup>186</sup>

Even with a cumulative process, covered persons may often elect to use the external review process because it provides many attractive benefits for covered persons.<sup>187</sup> For example, the IRO’s decisions are binding on insurers, whereas the statute provides covered persons the option of judicial review.<sup>188</sup> In addition, the external review process will likely provide a much faster remedy than traditional litigation.<sup>189</sup> In cases eligible for expedited external review, the IRO must issue its decision “[a]s expeditiously as the covered person’s medical condition or circumstances require, but in no event more than seventy-two hours after the date of receipt of an eligible

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183. *Id.* at 1026.

184. Interim Final Rules, *supra* note 4, at 43:344–45 (emphasis added); *see also supra* note 92 (discussing this language).

185. *See supra* notes 170–72 and accompanying text (discussing an IRO’s inability to hear bad faith claims).

186. Another potentially significant implication, which is beyond the scope of this Note, is whether an IRO’s decision (as affirmed by a district court) precludes a covered person from bringing a new action in a district court based on the same claim. However, a covered person should be mindful of this possibility. *See Lamb v. Time Ins. Co.*, No. 10-0241, 2011 WL 944430, at \*6 (Iowa Ct. App. Mar. 21, 2011) (noting, but not reaching, the insurer’s contention that the plaintiff’s claims were claim-precluded).

187. *See supra* Part II.B.1 (describing consumer protections).

188. IOWA CODE § 514J.110(1)–(2) (2013); *see also supra* note 83.

189. *See* IOWA CODE § 514J.107(13)(a) (noting that the IRO must issue a decision within forty-five days of receiving the request for external review).

request.”<sup>190</sup> Furthermore, the external review process is likely to be much less expensive than an action in court.<sup>191</sup>

Notwithstanding these benefits, there may be circumstances that motivate a covered person to bypass the external review process. For example, the external review statute provides a short statute of limitations.<sup>192</sup> The statute allows a covered person to request an external review within four months of the final adverse benefit determination.<sup>193</sup> This is much shorter than Iowa’s general statute of limitations for actions on written contracts, which is ten years.<sup>194</sup> Even though insurers may often enforce a shorter contractual limitations period,<sup>195</sup> the short limitation period in the external review statute may require some covered persons to bring a more traditional action in district court.<sup>196</sup>

In addition, the external review process cannot hear all claims that a covered person may wish to assert against an insurer.<sup>197</sup> As a matter of convenience, covered persons may wish to bring all claims against an insurer in a single action. A covered person may also choose to bypass external review because it may prevent her from conducting discovery or presenting testimonial evidence.<sup>198</sup> The external review process allows the IRO to consider a broad range of evidence including a covered person’s medical records, the recommendations of her doctor, and “[c]onsulting reports from appropriate health care professionals and other documents submitted by the health carrier, [or] covered person.”<sup>199</sup> However, it does not contain a procedure for depositions or live testimony. The external review process also

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190. *See id.* § 514J.108(7)(a).

191. *See id.* § 514J.115 (“The health carrier . . . shall pay the costs of retaining an independent review organization to conduct the external review.”).

192. *Id.* § 514J.107(1).

193. *Id.*

194. *Id.* § 614.1(5).

195. *See Robinson v. Allied Prop. & Cas. Ins. Co.*, 816 N.W.2d 398, 404–05 (Iowa 2012) (holding that contractual limitations provisions in insurance contracts are enforceable if they are reasonable); *Nicodemus v. Milwaukee Mut. Ins. Co.*, 612 N.W.2d 785, 787–88 (Iowa 2000) (concluding that a two-year contractual limitations period is unreasonable if it requires an insured motorist to “exhaust the tortfeasor’s liability insurance by judgment or settlement” before bringing an action against the motorist’s insurer).

196. Importantly, a covered person who desires to appeal the IRO’s decision to the district court must do so within fifteen days of the IRO’s decision. IOWA CODE § 514J.110(2)(a). Because of this short period, a covered person should likely retain counsel before the IRO process.

197. *See supra* text accompanying notes 170–72 (discussing the possibility of bad-faith claims against insurers).

198. *See* IOWA CODE § 514J.107(12).

199. *Id.* § 514J.107(12)(c).

likely prevents a covered person from presenting additional evidence in the district court demonstrating that the IRO erred.<sup>200</sup>

A final reason a covered person may wish to bypass the external review process is that ERISA allows plaintiffs to recover attorneys' fees.<sup>201</sup> This provision only affects covered persons in employer-based self-insured plans.<sup>202</sup> The possibility of attorneys' fees may prompt some covered persons to immediately bring an action under section 502(a) of ERISA. However, as noted above, there are also disadvantages of filing a claim under ERISA.<sup>203</sup>

## V. CONCLUSION

The health care external review process, which the ACA requires and Iowa codified in Chapter 514J, provides significant consumer protections that will generally make it easier and less costly for covered persons to challenge an insurer's adverse benefit determinations. The external review process raises an important and previously unanswered question: whether the statute is cumulative or exclusive. This Note concludes that the text of the statute, applicable rules of statutory interpretation, and public policy goals suggest that Iowa's external review process is cumulative with covered persons' existing common-law rights.

Because Iowa's external review process is likely cumulative, a covered person must weigh the advantages and disadvantages of using the external review process. The process has great potential to provide covered persons a straightforward and efficient means to challenge adverse benefit determinations. However, there are circumstances in which a covered person would likely elect to bring a traditional action in court. Iowa courts should construe the external review statute to allow for this possibility.

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200. See *id.* § 514J.110(2)(b) ("The findings of fact by the independent review organization conducting the external review are conclusive and binding on appeal.").

201. 29 U.S.C. § 1132(g)(1) (2012).

202. See *supra* note 58 (discussing employer-based self-insured plans); see also *supra* note 65 and accompanying text (noting that Iowa allows these plans to be subject to the state external review process).

203. See *supra* note 24 and accompanying text.