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ERISA Health Plan Denials: Exploring Models for External Review

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A discussion featuring

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ERISA Health Plan Denials

Federal policymakers face growing pressure from several quarters to bolster consumer protections available to the 125 million people in private-sector employee health plans. Spurred by consumer reaction to some managed care practices, provider attempts to improve their bargaining position with purchasers, and a flurry of state legislation that might conflict with federal law, Congress and the executive branch are considering a continuum of controversial proposals. Some of these would alter or establish internal health plan grievance procedures, impose external review of plan decisions, and provide greater access to court remedies for plan members. While there is great variation in the reform proposals and disagreement about how much consumers might be hurt by the current limitations of their appeal and legal options, a pivotal issue is whether patients disputing health plan denials of medical treatment or coverage should have access to independent, external review of plan decisions.

This Forum session will explore the experience of two existing models for reviewing managed care plan decisions, one used by the Medicare program and another by the state of Florida. Taking into account what other states have done, the meeting also will explore key issues facing federal policymakers currently attempting to reconstruct and integrate the elements of the grievance, appeals, and legal processes available to consumers under the Employee Retirement Income Security Act of 1974 (ERISA), which governs about 2.5 million private-sector employee health plans. (As touched on later, ERISA bars states from regulating private-sector employee health plans but allows them to regulate many functions performed by insurers and managed care organizations serving ERISA plans.) The discussion also will consider how to enhance consumer protections without blunting plan sponsors' ability to contain costs.

PROBLEMS

The protections available to consumers involved in disputes with health plans can be viewed as a continuum: first involving internal review, then external review, and finally judicial review. Advocates of increased consumer protections¹ argue that current laws and regulations governing private-sector plans leave people exposed to potential physical and financial harm resulting from plan denial of coverage and treatments, often on grounds that the treatments are not medically

necessary or are experimental. Groups representing employers and health plans generally defend the flexibility that ERISA gives them to administer benefit plans in a nationally uniform and cost-effective manner and argue that the law already offers consumers adequate tools to address plan denials of treatments or payment.

ERISA currently has no requirement for external, independent review of a plan's denial of a benefit, including medical treatment denied under a utilization review program. A plan participant appealing a denial must go through an internal grievance process before being able to access the courts. The law states that every ERISA plan shall "afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim."² Under regulations further defining ERISA's claim procedure, a plan has 90 days to make a determination on a request for a plan benefit by a participant.³ An extension of up to 90 more days is available for "special circumstances." The plan may establish a reasonable time period of no less than 60 days in which a claimant may request an appeal. According to the regulations, an appeal decision is supposed to be made promptly—not later than 60 days after the plan's receipt of the request for review or, if an extension is required due to special circumstances, not later than 120 days after receipt of a request for review. Despite the length of time allowed

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for a claim decision under the regulations, most employer plans process claims far more expeditiously, according to employer representatives. A denial must be in writing and must detail the reason the claim was denied, including references to the provision of the plan supporting the denial.

Once an ERISA plan's internal grievance and appeals process is exhausted, legal remedies available to consumers in court are narrow compared to state law remedies. The law permits participants to seek recovery of benefits in a federal court but does not allow them to redress unreasonable delay, fraud, malice, emotional distress, or other harms.⁴ Participants cannot recover actual out-of-pocket costs, such as additional medical expenses or lost wages incurred as a consequence of denied coverage. Perhaps most significant, given the proliferation of preauthorization of medical care as a common feature of health plans, ERISA provides no remedy for injuries caused by denials of treatment or payment, other than eventual coverage of a benefit promised in the plan documents.

Federal courts of appeals are divided on the issue of whether ERISA preempts state lawsuits against managed care plans challenging the quality of the medical care provided by their contracting physicians.⁵ A growing number of federal courts hold that ERISA does not prohibit patients from suing a managed care organization for vicarious liability of physicians who are its agents. (Not all federal circuit courts have addressed the question of whether a health maintenance organization [HMO] can be vicariously liable for medical malpractice, but a majority of the circuits that have considered the issue do permit these suits. A minority of circuits refuse to recognize this concept.)⁶ Thus, under the current state of the law, if a court concludes that a person was injured by a substandard *medical* decision, a plaintiff injured by a plan denial may stand some chance of recovering damages, but if the case is characterized as a *coverage* decision, ERISA confines plaintiffs to recovering benefits *per se*. In *Corcoran v. United Healthcare, Inc.*,⁷ for example, the court characterized a plan's decision to deny hospital care to a woman with a problem pregnancy (and instead to supply several hours of daily home nursing care) to be a determination about covered plan benefits. When the fetus died, allegedly as a result of the mother's not being in a hospital setting, she could not recover damages for this loss.

Many argue that the regulations governing ERISA's claims process, which were promulgated in 1977, are antiquated as far as health plans are concerned. When

the regulation was developed, disputes over benefits almost always involved payment and occurred after services had been rendered. Managed care practices such as preauthorization of medical services were not widely used. Today, many disputes involve denial of medical care itself. The length of the grievance process alone may create a barrier for participants needing immediate medical attention who are involved in disputes with plans over benefit denials. Many of the suits that go to court are brought by members of a deceased patient's family. A hypothetical "worst-case scenario" illustrates the problem from the participant's point of view: A patient needs an expensive surgery. An insurer undergoing solvency problems denies the request on the grounds of medical necessity in order to delay incurring a major expense. The patient dies by the time the case goes to court. The court rules that the patient was entitled to the surgery under the contract, but the patient is no longer alive. The family has no way to collect damages both to compensate for wrongful death and to deter plans from making a similar decision in the future.

While declining to make recommendations on whether to expand ERISA plan participants' legal remedies, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry recently concluded that all consumers should have a right to a fair and efficient process to resolve disputes with health plans, providers, and institutions serving them, including a rigorous system of internal review and an independent system of external review.⁸ The commission concluded that both the internal and external appeals systems should resolve disputes in a timely manner, with decisions involving emergency or urgent care being given expedited consideration consistent with time frames that the Medicare program requires of its risk contractors. It also recommended that external reviews be conducted by appropriately credentialed professionals who were not involved in the initial decision and have no conflict of interest.

DEPARTMENT OF LABOR POSITION

The U.S. Department of Labor (DOL), which administers ERISA, is considering revamping its claims procedure requirements. In a request for information concerning proposed changes, the department noted that the current regulation was drafted in response to concern about plan practices prior to the passage of ERISA, particularly with respect to participants' lack of information about claims procedures generally. The

current regulation makes no distinction between pension and health plans. The department also noted that many changes have since occurred in the health care marketplace, in health policy, and in business communications. In broaching its concern about “timely resolution of requests for medical treatment from group health plans,” the labor department also pointed to Medicare’s expedited review process as a possible model.⁹ While considering changes to ERISA plans’ internal grievance process requirements, labor department officials have publicly stated that they have no jurisdiction to require external review of plan decisions. Such a requirement would require an act of Congress.

In May 19 testimony before the Senate Committee on Labor and Human Resources, Olena Berg, assistant secretary of DOL’s Pension and Welfare Benefits Administration, said that the department intended to publish a proposed claims procedure regulation within 60 days. Comments received by the department indicated consensus that the time frames need to be shorter. According to Berg, DOL considers it within its regulatory authority to do the following:

- Make clear that a benefit denial includes adverse determinations under a utilization review program, denials of access to (or reimbursement for) medical services, denials of access to (or reimbursement for) specialists, and any decision that a service, treatment, drug, or other benefit is not medically necessary.
- Require that benefit claims and appeals involving urgent care be processed with a time frame appropriate to the medical emergency, but no more than 72 hours.
- Require, with respect to non-urgent claims, that the plan either decide the claim or notify the claimant that the claim is incomplete within 15 days of receiving the claim (claimants then would have at least 45 days to provide any information to complete the claim and, once complete, the claim would have to be decided within 15 days).
- Require that, if a non-urgent claim is denied, the claimant be afforded at least 180 days to appeal and that a decision on the appealed claim be made within 30 days of receipt of the appeal by the plan.
- Require consultation with qualified medical professionals in deciding appeals involving medical judgments.
- Require that appealed claims be reviewed *de novo* (that is, review may not be limited to information and documents considered in the initial claims

denial) and be decided by a party other than the one who made the original claim determination.

However, according to Berg and other DOL officials, bolstering ERISA’s internal claims procedure is not enough to adequately protect consumers. DOL Associate Solicitor for Plan Benefits Security Marc I. Machiz recently testified that, while the department can promulgate a more protective claim processing regulation, it cannot assure compliance with that regulation if no cost is imposed on plans for failing to comply. According to Machiz:

Under current law, a plan fiduciary who fails to assure compliance with the time limits or notice provisions of our current regulation, or any future regulation, is not accountable for that failure. At best, an aggrieved participant may treat the claim as denied and proceed to court, still without the benefit of a clear explanation of his denial or access to pertinent documents that might help him evaluate or prove his claim. Perhaps after wasting critically important weeks attempting to avail himself of the plan’s claims procedures, he may find himself in court with his health already injured and his need for treatment mooted by the progress of his illness, or even death. If the plan’s delay in providing a decision, or recalcitrance in providing critical information causes injury, the participant has no recourse, and the responsible fiduciary suffers no consequences.¹⁰

Because of financial incentives to delay providing costly medical treatment and the labor department’s limited ability to strengthen consumer protection by revamping the internal grievance process, the department is advocating that Congress increase the legal remedies available to ERISA plan participants injured by denials of medical care. In addition, the department is urging Congress to enact legislation providing independent, external review of plan decisions.

Under its authority to protect employee welfare plans, DOL can investigate complaints regarding health plan conduct and file suit to impose fines or an injunction. ERISA, however, does not explicitly empower DOL to pursue court cases or administrative remedies on behalf of individuals disputing health plan benefit denials.¹¹

BILLS BEFORE CONGRESS

Many of the consumer protection bills before Congress would establish the right to an external appeal for ERISA plan participants while further defining internal appeal procedures. These include H.R. 3605/S. 1890 (sponsored by Rep. John D. Dingell [D-Mich.] and

Sens. Edward M. Kennedy [D-Mass.] and Tom Daschle [D-S.D.]; S. 1712 (Sens. James M. Jeffords [R-Vt.] and Joseph I. Lieberman [D-Conn.]); and a recent discussion draft of a bill sponsored by Rep. Charlie Norwood (R-Ga). (An earlier version, sponsored by Norwood and Sen. Alfonso M. D'Amato [R-N.Y.], is H.R. 1415/S. 644. Norwood later introduced H.R. 2960, in order to limit circumstances under which employers would be exposed to liability under state tort law.) The bills generally amend ERISA and the Public Health Service Act to apply similar standards to both ERISA plans and state-licensed insurers and HMOs. All but the Jeffords bill would amplify the legal remedies available to ERISA plan participants. (Jeffords's staff have characterized his bill's external review feature as a substitute for increased court remedies.) All three of the above-mentioned bills feature expedited review of plan denials in the internal grievance process, but only the Dingell and Norwood bills provide for expedited review at the external appeals stage.

Generally speaking, the bills before Congress are being pushed by provider and consumer interests, while most employer, insurer, and managed care plan interest groups oppose laws that would limit their ability to contract with providers, constrain their ability to organize provider networks and design managed care products, increase regulatory requirements for consumer protection, and pull back the shield that ERISA provides them from legal liability. As an increasing number of states are passing such laws, pressure will continue to grow for Congress to set national consumer protection standards, especially with regard to multi-state plans that often object to having to comply with a variety of state regulations.

STATE LEGISLATIVE ACTIVITY

The past few years have witnessed a heavy volume of state managed care legislation, including consumer protection measures. In 1997, 25 states enacted a wide variety of laws requiring managed care plans to establish internal grievance procedures and comply with external or independent review processes.¹²

While all 50 states require HMOs or managed care plans to establish internal grievance and appeals processes, the laws vary considerably. Differences include which types of carriers must comply, whether a graduated review process is required, whether explicit time frames are set forth, whether carriers must notify consumers of appeal rights and assist them through the process, whether expedited review is required, what

types of disputes qualify for review, what types of qualification standards apply to reviewers, and whether there are requirements for reporting the number and type of internal grievances to regulators. In 1996, the National Association of Insurance Commissioners (NAIC) released the "Health Carrier Grievance Procedure Model Act," which requires two levels of internal review, specific time periods in which to make decisions, a 72-hour expedited review requirement for cases involving medical urgency, and reporting requirements. (States, of course, are free to copy, ignore, or modify the NAIC model law as they please.)

A growing number of state legislatures have enacted laws providing consumers with mechanisms for external review of their complaints and appeals of managed care plan denials.¹³ As of May 1998, about one-third of the states gave enrollees in health plans access to a review process after the carrier's internal review is completed. Again, there is a great deal of variety among the state laws. The California and Ohio statutes, for example, are limited to reviews of decisions on experimental treatments. In some states, the degree to which external review panels are independent of insurers is debatable (for example, carriers may pick or help pick members of review panels). Key characteristics of state external review programs include the degree to which the reviewers are independent, who pays for the reviews, what types of denials qualify for review, whether decisions are binding, who qualifies to provide the service, and whether expedited decisions are required based on medical urgency.

ERISA Preemption Issues

ERISA bars states from regulating private-sector employer- and union-sponsored health plans but allows states to regulate insurers serving the plans. About 40 percent of the 125 million Americans receiving health coverage through ERISA plans are in self-insured plans. Consequently, many, but not all, areas of consumer protection differ depending on whether an ERISA plan is insured or not.

Which state functions are saved from preemption by ERISA is often disputed in the courts. In the *Metropolitan*¹⁴ case, the Supreme Court determined that states can require the inclusion of particular benefits, such as mental health coverage, in insurance contracts that cover ERISA participants. However, in *Pilot Life*,¹⁵ the court decided that ERISA preempts access to traditional state law remedies for ERISA participants in insured plans as well as self-insured plans (that is, that state remedies were not saved as a function of insurance

regulation). So, far there is little case law to provide guidance on whether state grievance and appeal laws might be preempted, for either insured or self-insured plans. While many believe such state laws may be preempted for self-insured ERISA plans, it is less clear whether they might be preempted for insured ERISA plans. Texas and Missouri recently passed legislation permitting managed care plan enrollees to sue the plans when they are injured by a denial of coverage. The Texas law, which is being challenged in court on grounds that its state remedy provisions are preempted by ERISA, also creates independent review organizations to which managed care enrollees can appeal disputes over coverage.

Even if state grievance and appeal laws might be preempted, carriers serving ERISA plans often adhere to them in actual practice. The American Association of Health Plans, which represents managed care plans, is on record stating that nearly all HMO coverage offered to employees is governed by state grievance and appeal requirements.¹⁶

GAO's HMO SURVEY

In a recent report surveying policies in 38 HMOs in five states, the U.S. General Accounting Office (GAO) identified 11 features (falling into three categories) considered important to a complaint and appeal system by consumer, regulatory, and industry groups that agency staff interviewed.¹⁷ Under the category of "timeliness," the GAO identified the following as key features:

- Explicit time periods for grievances and appeals.
- Expedited review.

Under the category of "integrity of the decision-making process," key elements identified were

- A two-level appeal process.
- Member attendance being permitted at one appeal hearing.
- Appeal decisions being made by medical professionals with appropriate expertise.
- Appeal decisions being made by individuals not involved in previous denials.

Under the category of "effective communication," the key elements were

- Written information being provided, in an understandable way, about how to register a complaint or appeal.

- Acceptance of oral complaints.
- Acceptance of oral appeals.
- Appeal rights being included in notice of denial of care or payment of a service.
- Written notice of appeal denials, including further appeal rights.

The GAO reported that most of the 38 HMOs that it contacted had incorporated most of the 11 key elements in their policies. (The GAO study did not determine the extent to which the HMOs actually implemented the policies reported.) The investigators attributed much of the uniformity they found to the influence of the National Committee for Quality Assurance (NCQA). Almost two-thirds of the plans in the study had been surveyed by NCQA for accreditation. However, more than half of the plans did not feature two recommended elements: appeals decisions being made by individuals not involved in previous denials and acceptance of oral appeals.

There was considerable variation among the HMOs in the characteristics of many key elements. For example, time periods for first-level appeals varied from 10 days to 75 days and for second-level appeals from 10 days to two months. One HMO did not have explicit time periods. Thirty-four of 36 HMOs reporting said they used expedited appeal processes in cases where a patient's health might be jeopardized, but the length of time for resolution of such appeals varied. The most common time period for expedited appeals was 72 hours. Two HMOs called for resolution within 24 hours and two others allowed for up to seven days.

The GAO reported that independent external review of plan decisions was considered particularly important by consumer advocates but was not included as an element critical to complaint and appeal systems by regulatory or industry groups.

"EXTERNAL" REVIEW: TWO MODELS

Medicare Appeals

As noted above, many policymakers are looking to the Medicare program for guidance on how to handle "external, independent" appeals. The Medicare appeals system is highly developed and has handled more cases than state appeals systems. However, when considering what to borrow from it for transplantation to the private sector, it is important for policymakers to note that, while the Medicare program offers an appeal function

independent of managed care plans serving beneficiaries, the review is not external to the plan administrator (the Health Care Financing Administration, which runs the Medicare program). With regard to the relationship between the plan sponsor and the consumer, the external appeal remains an internal review function.¹⁸

In the Medicare risk program, there are two mutually exclusive types of procedures for resolving enrollee complaints: (a) the plan-internal “grievance” procedure (from which decisions cannot be appealed outside the managed care plan) and (b) Medicare’s appeals procedure. Disputes about “initial determinations” by the plan, which primarily concern denials of service or payment, are resolved through the appeals procedure. Complaints about matters such as waiting times, physician demeanor and behavior, and adequacy of facilities are considered grievances.

There are five steps available to beneficiaries in the Medicare appeals process:

- Initial determination by the managed care plan.
- A two-step reconsideration in which the plan reviews its initial determination and then the Health Care Financing Administration (HCFA) reviews the case if the plan decision is partially or fully against the beneficiary (this step involves independent review by Medicare’s reconsideration contractor, described below).
- A hearing by an administrative law judge, if at least \$100 is at issue.
- Review by the Appeals Council of the Social Security Administration.
- Judicial review, if at least \$1,000 is at issue.

Health plans contracting with HCFA normally have up to 60 days to issue an initial determination notice. A Medicare enrollee or his or her representative may request an expedited organization determination if the enrollee or representative believes the enrollee’s health, life, or ability to regain maximum function may be jeopardized by the standard 60-day process. If an enrollee or representative makes the request, the plan must decide whether the case qualifies for expedited processing. If a physician makes the request, the process must be expedited, that is, decided in 72 hours or less as medically necessary or appropriate.

If a decision is unfavorable to an enrollee, the plan must inform the enrollee of his or her appeal rights. Plans normally have 60 days to make a reconsideration recommendation. Again, the process can be expedited at this stage on the same grounds as before. If the plan

does not completely reverse its initial decision, it must forward the case to HCFA’s reconsideration contractor, which is the Center for Health Dispute Resolution (CHDR). The HCFA contractor normally decides cases within 30 working days and is required to decide expedited appeals within 10 working days. Expedited processes are not available beyond this point in the appeals system.

Any party to the reconsideration who is dissatisfied with the reconsideration determination has a right to a hearing before an administrative law judge (ALJ) of the Social Security Administration if the dispute involves at least \$100. The risk contractor is not considered a party to the reconsideration and thus does not have a right to a hearing. Any party dissatisfied with the hearing decision, including the managed care plan, may request the Appeals Council of the Social Security Administration to review to judge’s decision or dismissal. Finally, if the amount in controversy is at least \$1,000, the case may be appealed to a federal district court.¹⁹

Center for Health Dispute Resolution

Medicare’s only reconsideration contractor for managed care for the past nine years, CHDR currently reviews about 1,000 beneficiary appeals each month. Located in the Rochester, New York, area, the organization also acts as an external reviewer for three state programs and contracts with ERISA plans and HMOs.²⁰ CHDR has about 25 full-time staff, most of them attorneys, some also holding clinical degrees. There is one “physician/attorney” and several “nurse/attorneys.” CHDR’s services cost the Medicare program about four cents per managed care enrollee per month. The total value of services in dispute in 1996 came to about 32 cents per member per month. Roughly two-thirds of appeals are decided in favor of plans.

In recent testimony before the House Ways and Means Committee’s health subcommittee, CHDR president David Richardson outlined four positive features of Medicare’s managed care appeal model:

- All denial disputes are eligible for review, not just those involving denials based on “medical necessity.”
- The appeals process is linked to the evolution of coverage policy.
- Appeal rights are widely publicized.
- Disputes of plan denial are automatically referred to independent review performed by a multi-disciplinary team, including physicians.

According to Richardson, Medicare beneficiaries can appeal a broader variety of plan coverage denials than under the NAIC model and most state programs. More than half of Medicare appeals arise due to disputes that do not include issues of medical necessity. These cases may involve, for example, disputes over coverage, appeal procedures that the beneficiary failed to follow, or use of out-of-network providers. While CHDR upholds most coverage denials, it is inevitable that errors of execution occur in large managed care organizations and external review can provide feedback to help plans correct mistakes, Richardson testified.

Despite Medicare's relatively wide definition of appealable denials, only 1 to 2 per 1,000 enrollees a year seek to use the external appeals system. In 1997, about 6 percent²¹ of those whose cases were reviewed by CHDR later sought a hearing before an administrative law judge. Less than 10 percent of the ALJ hearings generated requests for a review by the Appeals Council. Only a very few cases have gone on to court over the years.

Where questions of medical necessity arise, CHDR refers cases to a physician, dentist, or chiropractor for evaluation. Most of these medical professionals practice in the Rochester area. One reason for using local providers is the need to give them enough volume for the center to maintain relationships and quality of service, according to Richardson. The center employs a number of physicians at the Harvard School of Public Health, including one who assists in recruiting physicians for unusual cases and rare diseases.

Data gleaned from the appeals program have helped Medicare develop coverage policy. According to Richardson, CHDR data on denials of emergency room care helped lead to development of the "prudent lay person" standard for determining coverable emergency room episodes. While such linkage remains an important goal, it would be harder for an appeals process to help inform the evolution of coverage policy in the private sector. Instead of one underlying plan structure serving the entire country as in Medicare, the 2.5 million health plans offered under ERISA come in a great variety of plan designs and coverage packages. Still, an argument might be made that external review could be useful in this regard to large employer plans, insurers, or health purchasing cooperatives.

CHDR handles about 300 expedited cases a month, with an average time of resolution of four days. Problems sometimes arise, however, because both the

HMOs and CHDR experience delays in obtaining medical records. (CHDR must obtain medical records by overnight mail due to confidentiality concerns.) Sometimes, in an expedited case, CHDR finds itself in the awkward position of having to obtain medical information that should have been collected when the dispute was at the plan level (where the case also was expedited), thereby expending more resources than it would like and slowing down resolution of the case, according to Richardson.

Florida's Appeal Panel

In Florida, HMO subscribers who have exhausted an HMO's internal appeal procedure may appeal to a panel made up of representatives from the state's department of insurance and its Agency for Health Care Administration (AHCA). Created in 1985, the "Statewide Provider and Subscriber Assistance Panel" received 75 to 100 appeals a year from 1993 to 1997, with about 60 percent of the decisions favoring consumers. Disputes involved quality of and access to care, emergency services, unauthorized services, and services deemed not medically necessary.²² One recent case, for example, involved a woman who had been denied coverage for reconstructive surgery of one breast, which had been removed as a preventive measure, while the plan had approved reconstructive surgery for the other breast, which had been removed after actually developing cancer (the plan had approved removal of both breasts). The appeals panel ordered that the plan cover reconstructive surgery for both breasts and the HMO complied.

The Florida appeal panel is just one part of a continuum of mechanisms designed to help HMO members resolve disputes over coverage and other grievances with managed care plans. The Commercial Compliance Unit within AHCA's Bureau of Managed Care, which administers the panel, also staffs a statewide HMO hotline. The hotline receives about 5,000 calls from consumers each month. Most disputes of denied requests for urgently needed medical care do not reach the appeal level but rather are resolved between plans and consumers informally, with assistance of state hotline personnel, or within HMOs' internal grievance process. The vast majority of cases that reach the external appeal stage involve payment issues, not denials of medical care, according to Ree Sailors, who has managed the Commercial Compliance Unit for the past several years.

Under Florida law, HMOs must resolve non-urgent grievances within 60 days and urgent cases within 72

hours. With regard to cases moving on either internal-grievance time track, at a second stage of consideration HMOs are required to make available review panels comprising physicians who did not participate in the original denials. Once the grievance process is completed, unresolved cases can be appealed to the state-wide review panel. The panel makes decisions on three time tracks: within 120 days for routine cases; 45 days for urgent cases; and 24 hours for emergency cases. After coming to a decision, the panel makes a recommendation to the agency with appropriate jurisdiction. The insurance department has jurisdiction over payment issues, while quality of medical care issues come under AHCA's jurisdiction. Florida has a much stronger law overseeing the quality of managed care than most states, according to Sailors. If the agency with appropriate jurisdiction concurs with the panel's decision (it almost always does because staff from both agencies are members of the panel), it issues a regulatory order to the HMO. In all but five cases, HMOs have complied with such orders.

There are many gaps in the types of cases that the appeal panel may hear, some caused by ERISA preemption of state law, according to Sailors. The panel faces a very difficult situation in deciding whether to proceed when a quality-of-care issue involves a person covered by a self-insured employer contracting with an HMO, she added. According to a Florida insurance regulator, the appeals panel does not take cases from self-insured ERISA plans. Medicaid cases can also fall outside the panel's jurisdiction. If a Medicare case involves a quality of care issue that could have a systemic impact, the panel may accept it, but Medicare cases involving coverage issues are directed to the Medicare appeals process, Sailors said.

THE FORUM SESSION

The meeting will begin with three short presentations to be followed by an open discussion. **Geraldine Dallek**, a project director at Georgetown University's Institute for Health Care Research and Policy, will describe key aspects of external review requirements enacted by the states. **Pamela Poulin**, assistant general counsel in the Office of General Counsel of Florida's Agency for Health Care Administration, will explain how Florida's external appeals panel works. **David A. Richardson, Jr.**, president of the Center for Health Dispute Resolution will describe Medicare's appeals system, including the external appeals function provided by his organization.

Issue Questions

Issues to be addressed include the following:

- How would an external appeal requirement enacted by Congress fit into the continuum of consumer protections available to people in ERISA health plans? How would it coordinate with DOL's upcoming revisions of the ERISA claims process, for example? How would access to an external appeals process be enforced?
- What roles should the states play in determining grievance and appeal procedures for managed care plans and insurers serving ERISA plans? Could states build on federal external appeals standards, should they be enacted? What would the states' role be in enforcing standards?
- What substantive lessons can be learned from the experiences of the Medicare program and states such as Florida about operating an external review program? What are the important differences between these programs? To what degree might these systems be replicated in the ERISA world?
- How should one define "external" when designing an external review system for ERISA plans?
- What are the key elements of an external, independent system of reviewing health plan denials? For example, would key elements include
 - the kind of entities whose decisions would be subject to appeal,
 - the types of disputes that could be appealed,
 - timeliness of the process (for example, specific time frames and an expedited feature in case of medical urgency),
 - qualifications of reviewers,
 - the integrity of the process (for example, who chooses reviewers),
 - access to the process (for example, cost to the consumer, information about appeal rights, rigidity of appeal process, whether appeals are automatic or must be requested), and
 - standards applied in making review decisions (for example, for medical necessity issues, are cost/benefit considerations taken into account)?
- In what ways might an external appeals process help the evolution of coverage policy in the private sector? How can consistency be assured?

- Given the proliferation of laws in this area, what type of market might develop for external appeals services? How large might demand be for appeals? How competitive can this “market” be, given its potential size?
- What type of accreditation should be required of reviewers and review organizations? Who should perform this function?

ENDNOTES

1. A provider of external review services reviewing this paper noted that, while external review can be viewed as a “consumer protection,” it also can help plan sponsors in many ways, such as in determining the quality of managed care they are purchasing.
2. ERISA, Sec. 503 (2).
3. 29 C.F.R. 2560.503-1.
4. Patricia Butler and Karl Polzer, “Private-Sector Health Coverage: Variation in Consumer Protections under ERISA and State Law,” National Health Policy Forum, Washington, D.C., June 1996, 49.
5. Patricia Butler, “Managed Care Plan Liability: An Analysis of Texas and Missouri Legislation,” prepared for the Henry J. Kaiser Family Foundation, Menlo Park, California, November 1997, 20.
6. See Phyllis Borzi, “ERISA Preemption and Managed Care: Current Issues of Importance to Employers and Providers,” ALI-ABA Video Law Review: Fiduciary Responsibility Issues under ERISA Qualified Pension and 401(k) Plans, ESOPs, and Managed Care Plans, June 5, 1997.
7. 965 F. 2d 1321 (5th Cir. 1992).
8. President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry, “Quality First: Better Health Care for All Americans: Final Report to the President of the United States” (Washington, D.C.: U.S. Government Printing Office, 1998), A-61.
9. *Federal Register*, 62 (September 8, 1997), no. 173: 47262.
10. Testimony of Marc I. Machiz, associate solicitor for plan benefits security, U.S. Department of Labor, before the Subcommittee on Roles and Responsibilities of Public/Private Purchasers and Quality Oversight Organizations of the Commission on Consumer Protection and Quality in the Health Care Industry, February 25, 1998, 8.
11. Butler and Polzer, “Private-Sector Health Coverage,” 47.
12. Molly Stauffer, “Consumer Grievance Procedures: Internal and External Appeals,” Health Policy Tracking Service, National Conference of State Legislatures, Washington, D.C., May 12, 1998.
13. Stauffer, “Consumer Grievance Procedures.”
14. *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985).
15. *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987).
16. General Accounting Office (GAO), “HMO Complaints and Appeals: Most Key Procedures in Place, but Others Valued by Consumers Largely Absent,” GAO/HEHS-98-119, May 1998, 5.
17. GAO, “HMO Complaints and Appeals,” 7.
18. In the Medicare appeals process, review by an administrative law judge that may follow the external appeal is independent of the Medicare program.
19. Medicare beneficiaries cannot sue the federal government for remedies but can sue health plans in state courts under either tort or contract law to claim compensation for losses and punitive damages. Source: President’s Advisory Commission, “Quality First,” 162.
20. Testimony of David A. Richardson, Jr., president of the Center for Dispute Resolution, before the U.S. House of Representatives Committee on Ways and Means Subcommittee on Health, April 23, 1998. Information about CHDR was taken from a variety of sources, including the testimony cited above and an interview with Richardson by the author.
21. A total of 528 people.
22. Information about the Florida appeals program was gathered by the author from interviews with Ree Sailors, of the state’s Agency for Health Care Administration, and officials in the state insurance department. See also GAO, “HMO Complaints and Appeals.”