Order Code RL30077

CRS Report for Congress

Received through the CRS Web

Managed Care: Recent Proposals for New Grievance and Appeals Procedures

March 1, 1999

(name redacted)
Legislative Attorney
American Law Division

ABSTRACT

This report discusses recent proposals for new grievance and appeals procedures in managed care plans. This report considers specifically the work of the President's Advisory Committee on Consumer Protection and Quality in the Health Care Industry, legislative proposals, and proposed regulations of the Department of Labor.

Several bills have already been introduced in the 106th Congress to address this issue. The Patients' Bill of Rights, H.R. 358/S. 6, the Patients' Bill of Rights Plus Act, S. 300, and the Patients' Bill of Rights Act, S. 326 each provide for new grievance and appeals procedures. This report will be updated as warranted by legislative activity.

Managed Care: Recent Proposals for New Grievance and Appeals Procedures

Summary

Because managed care is premised on notions of cost and the ability to control the utilization of health care services, many fear that decisions involving access to treatment and reimbursement are made improperly; that the cost of treatment plays an increasingly important role in the decision-making process. Concern over decision-making and treatment costs has prompted greater attention to the rights of participants to appeal denials of treatment and to file grievances about other plan decisions. Some believe that improved grievance and appeal rights would not only empower patients, but enhance access to treatment and improve the quality of care provided. Others, including the managed care industry, contend that new requirements are likely to disrupt existing appeals systems that already work well.

As the 106th Congress considers enacting legislation for improved grievance and appeals procedures, it may review various recent proposals for guidance. This report will discuss the work of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, legislative proposals, and proposed regulations of the Department of Labor.

Contents

Managed Care: Recent Proposals for New Grievance and Appeals Procedures

In November 1997, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry ("the Commission") issued a report that addressed managed care and the rights of patients. In addition to recommending improved disclosure of information and better access to emergency care, the "Consumer Bill of Rights and Responsibilities" ("Consumer Bill of Rights") also addressed enhanced grievance and appeals procedures for participants in managed care organizations. Among its provisions, the report identified the right of consumers to a "fair and efficient process for resolving differences with their health plans. . . including a rigorous system of internal review and an independent system of external review."[1]

Because managed care is premised on notions of cost and the ability to control the utilization of health care services, many fear that decisions involving access to treatment and reimbursement are made improperly; that the cost of treatment plays an increasingly important role in the decision-making process.[2] For example, many managed care plans offer incentives to physicians who do not order designated services.[3] Concern over decision-making and treatment costs has prompted greater attention to the rights of participants to appeal denials of treatment and to file grievances about other plan decisions. Some believe that improved grievance and appeal rights would not only empower patients, but enhance access to treatment and improve the quality of care provided.[4] Others, including the managed care industry, contend that new requirements are likely to disrupt existing appeals systems that already work well.

The Commission's interest in improved grievance and appeals procedures has been shared by Congress. During the 105th Congress, various proposals were introduced with specific provisions for grievance and appeals procedures.[5] On July

---

[1] National Advisory Commission on Consumer Protection and Quality in the Health Care Industry, *Consumer Bill of Rights and Responsibilities* (Washington, D.C.: National Advisory Commission on Consumer Protection and Quality, Nov. 1997).

[2] Eleanor D. Kinney, *Consumer Grievance and Appeal Procedures in Managed Care Plans*, 10 NO. 3 Health Law. 17 (1998).

[3] *Id.*

[4] Tracy E. Miller, *Center Stage on the Patient Protection Agenda: Grievance and Appeal Rights*, 26 J. L. Med. & Ethics 89 (1998).

[5] H.R. 1415, 105th Cong. (1997); H.R. 3605, 105th Cong. (1998); H.R. 4250, 105th

(continued...)

24, 1998, H.R. 4250 was passed by the House of Representatives. Although a motion was made to consider H.R. 4250 in the Senate, that motion was tabled on October 9, 1998. In addition to this legislative response, the Department of Labor has sought comments on a proposed regulation that would establish new standards for the processing of claims under the Employee Retirement Income Security Act of 1974 (ERISA).[6] If adopted in its current form, the proposed regulation would address some of the concerns raised by Congress.

This report will discuss the Consumer Bill of Rights, the various legislative proposals, and the Department of Labor's proposed regulation. The Consumer Bill of Rights and almost all of the proposed legislation recognize a need for both internal and external review of treatment and reimbursement decisions. In general, internal review involves review by responsible plan personnel with the authority to correct mistakes. External review provides an oversight mechanism that could identify procedural errors, provide substantive review, and detect patterns of inappropriate denials.[7] It is also seen as assuring participants of an impartiality and independence that might be lacking in the internal review process.[8] Although the Department of Labor's proposed regulation does not provide for external review, it does seek to refine the review process for participants in group health plans.

Consumer Bill of Rights and Responsibilities

The Commission believes that enhanced internal and external review procedures would benefit participants in three ways.[9] First, they would assist in obtaining access to appropriate services in a timely manner, thus increasing the likelihood of positive health outcomes. Second, improved procedures would bridge communication gaps between participants and their health plans and providers. Third, improved procedures would empower participants and facilitate greater respect for the institutions that serve them.

The recommendations contained in the Consumer Bill of Rights seek to make the resolution of grievances more timely and more reliable. The Consumer Bill of Rights makes separate recommendations for internal and external appeals systems. Among its recommendations for an internal appeals system are the review of decisions involving emergency or urgent care within 72 hours, a claim review process conducted by health care professionals who are credentialed in the area of the relevant treatment, and timely written notification of preliminary and final decisions. Such written notification would include information on appeals to the external appeals system.

---

[5](...continued)
Cong. (1998); S 644, 105th Cong. (1997); S 2330, 105th Cong. (1998); S 1890, 105th Cong. (1998).

[6] 63 Fed. Reg. 48, 390 (1998).

[7] Miller, *supra* note 4 at 92.

[8] *Id.*

[9] *Consumer Bill of Rights and Responsibilities*, *supra* note 1.

Under the Consumer Bill of Rights, an external appeals system would be available after consumers have exhausted all internal processes. In cases of urgently needed care, external review would be more readily available, with resolution to be achieved within 72 hours. External review would be conducted by health care professionals who are credentialed in the area of relevant treatment. These professionals would not have been a part of the internal appeals system. Finally, an external appeals system would follow a standard of review that promotes evidence-based decision-making and relies on objective evidence.

Legislative Action

During the 105th Congress, numerous legislative proposals were introduced to address the reform of managed care. While each of the bills addressed appeals procedures in some form, there was some variance with respect to the timing of review and the manner in which review would be conducted. Two of these bills, the Patients' Bill of Rights Act of 1998 and S. 2330, have been reintroduced in the 106th Congress with minimal changes.

Patient Access to Responsible Care Act of 1997 (PARCA), H.R. 1415/S. 644. PARCA, introduced by Representative Charlie Norwood (R-GA) and Senator Alfonse D'Amato (R-NY), sought to amend ERISA[10] and the Public Health Service Act (PHSA)[11] to include new patient protection standards, including a new appeals process. Unlike the Consumer Bill of Rights, PARCA did not provide for internal and external review. Under PARCA, a plan or health insurance issuer would simply have to establish and maintain an "accessible appeals process" that reviewed adverse prior authorization determinations.[12] Appeals for urgent care services would receive expedited treatment. These appeals would be reviewed within 1 hour after a request for review was made. Appeals for other services would be reviewed within 24 hours after a request was made. Review would be conducted by an appropriate clinical peer professional in the same or similar specialty as would typically provide the treatment at issue.

Patients' Bill of Rights Act of 1998, H.R. 3605/S. 1890. The Patients' Bill of Rights Act of 1998, introduced by Representative John D. Dingell (D-MI) and Senator Tom Daschle (D-SD), sought to amend ERISA, the PHSA, and the Internal Revenue Code of 1986[13] to comply with new grievance and appeals procedure requirements. Like the Consumer Bill of Rights, the Act provided for both internal and external appeals procedures. Internal review would be conducted by a physician or other health care professional selected by the plan. One or more clinical peers would be included in the review.[14] Review would conclude within 72 hours for cases

---

[10] 29 U.S.C.A. § 1001 et seq. (West 1985 & Supp. 1998).

[11] 42 U.S.C.A. § 201 et seq. (West 1991 & Supp. 1998).

[12] *See* H.R. 1415/S. 644, 105th Cong. § 2(a)(2) (1997).

[13] 26 U.S.C.A. § 1 et seq. (West 1988 & Supp. 1998).

[14] *See* H.R. 3605/S. 1890, 105th Cong. § 191(c)(2) (1998) (A clinical peer is a physician (continued...)

in which delay could jeopardize the life or health of the participant. In all other appeals, review would conclude within 15 business days.

External review would be available for appealable decisions where the amount involved exceeded a significant threshold or the patient's life or health could be jeopardized as a consequence of the decision. Under the Act, a plan could require the completion of an internal review process before a case became eligible for external review. External review would be conducted under a contract between the plan issuer and one or more qualified external appeal entities.[15] Review would permit a de novo determination, an opportunity to submit and review evidence, the assistance of counsel, and the option of making oral presentation. In addition, review would be subject to any standards established by the Secretary of Labor or Secretary of Health and Human Services.

Under the Act, plans and issuers would also be required to establish and maintain a grievance system. This system would allow participants and enrollees to resolve oral and written grievances pertaining to access and the availability of services, quality of care, accessibility of providers, and network adequacy.

Patients' Bill of Rights Act, S. 2330. S. 2330, introduced by Senator Don Nickles (R-OK), sought to amend ERISA to include new provisions for internal and external review processes. Under S. 2330, internal appeals of routine adverse decisions would be resolved within 30 days after the date the request for appeal was received. Appeals involving urgently needed care would be resolved within 72 hours after the request for appeal was received.

External review would require the filing of a written request with the plan or issuer within 30 working days after the receipt of a final denial of a claim. Upon receipt of the request for external review, the plan would have discretion over determining whether external review was appropriate. Appeals involving procedures or treatments costing less than $1,000 would not be eligible for external review.[16] The plan could also avoid external review if it determined that the denied treatment was not medically necessary.

If a plan or issuer determined that external review was appropriate, it would designate an external appeals entity.[17] Subsequently, the external appeals entity would

---

[14](...continued)
or other health care professional who holds a non-restricted license in a state and who is appropriately credentialed in the same or similar specialty that handled the treatment under review.).

[15] *See* H.R. 3605/S. 1890, 105th Cong. § 133(c) (1998) (A qualified external appeal entity is a certified entity that (1) has no real or apparent conflict of interest with the plan or issuer, (2) conducts external appeal activities through clinical peers, and (3) has sufficient medical, legal, and other expertise and staffing to conduct timely external appeals.).

[16] *See* S. 2330, 105th Cong., § 121(a) (1998).

[17] *See* S. 2330, 105th Cong. § 121(a) (1998) (Any of the following may be selected as (continued...)

designate one or more individuals to serve as external reviewers of the request.[18] An external reviewer would be required to complete review no later than 30 working days after either the date of the reviewer's designation or the date on which all necessary information was received, whichever was later. Although the decision of the external reviewer would be binding, enrollees could still seek judicial relief.

S. 2330 would also require that a plan or issuer maintain written procedures for addressing grievances between the plan and enrollees. Determinations under such a grievance procedure would be non-appealable.

Patient Protection Act of 1998, H.R. 4250. The Patient Protection Act of 1998, introduced by Representative Newt Gingrich (R-GA), was passed by the House of Representatives on July 24, 1998. The Act sought to amend ERISA to include new procedures for the internal and external review of coverage decisions. Internal review would be available upon written request. Review would be conducted by a named fiduciary of the plan and completed within 30 days unless a longer period was prescribed by the Secretary of Labor. For cases involving urgent medical care, the period for review would be reduced to 10 days unless a longer period was prescribed.[19] For cases of emergency medical care, the period for review would be reduced to 72 hours unless a longer period was prescribed.[20]

External review would be available for participants who did not commence review under ERISA, § 502. Those seeking review would need to file a written request within 30 days of receiving the initial adverse decision. Each plan would be required to provide a procedure for review, including the selection of one or more independent medical experts who would examine the validity of the decision. Review would consist of the experts receiving a record of the case and issuing a written report. Review would be completed within 25 days unless a longer period was prescribed by the Secretary of Labor. For decisions involving urgent medical care,

---

[17](...continued)
an external appeals entity: (1) an external review entity licensed or credentialed by a state; (2) a state agency established for the purpose of conducting independent external reviews; (3) any entity under contract with the federal government to provide external review services; (4) any entity accredited as an external review entity by an accrediting body recognized by the for such purpose; (5) any fully accredited teaching hospital; and (6) any other entity meeting criteria established by the Secretary [of Labor] for purposes of this subparagraph.).

[18] *See* S. 2330, 105th Cong., § 121(a) (1998) (An external reviewer is an independent medical expert (1) appropriately credentialed or licenced in any state to deliver health care services; (2) without any affiliation with the case under review, the enrollee, the treating health care professional, the treating institution, or manufacturer of any drug or treatment under review; (3) who is an expert in the treatment under review; (4) who will receive only reasonable compensation for the review; and (5) who will not be held liable for his decisions.).

[19] *See* H.R. 4250, 105th Cong. § 1201(b)(9)(H) (Urgent medical care is medical care in a case in which the failure to provide care within 45 days will reasonably be expected to result in either imminent death or immediate and irreversible deterioration.).

[20] *See* H.R. 4250, 105th Cong. § 1201(b)(9)(I) (1998) (Emergency medical care is medical care in a case in which the failure to provide immediate care will result in placing the health of the participant in serious jeopardy.).

review would be completed within 10 days unless a longer period was prescribed. For decisions involving emergency medical care, review would be completed within 72 hours unless a longer period was prescribed.

Unlike other proposed legislation, the Act also permitted alternative dispute resolution to internal review for decisions involving group health plans.

Department of Labor's Proposed Regulation

On September 9, 1998, the Department of Labor published a proposed regulation that would establish new standards for the processing of group health disability, pension, and other employee benefit claims.[21] These new standards are intended to provide "greater assurance that participants and beneficiaries will be afforded a full and fair review of denied claims."[22] Since its publication, the proposed regulation has generated more than 600 comment letters.[23] The majority of these letters are from businesses and insurers who believe that the new standards are unrealistic.[24]

Under current federal regulations, a plan may establish a period within which a claimant is permitted to seek review of a denied claim. This period must be reasonable and related to both the nature of the benefit that is the subject of the claim and to other attendant circumstances.[25] While providing no definition for "reasonable," the regulations state that a claimant must be given at least 60 days to request review following the receipt of a denial notice. Review is conducted by an "appropriate named fiduciary." This fiduciary may be either the company, service, or organization that administers the plan, or a plan administrator or someone designated by the plan.[26] The appropriate named fiduciary has 60 days after the receipt of a request for review to render a decision. If special circumstances exist, the appropriate named fiduciary is permitted to render a decision as soon as possible.

The proposed regulation seeks to provide an expedited review process for appeals under group health plans. For these appeals, reviews are to be conducted within a reasonable period of time, but not later than 30 days after receipt of the claimant's request for review. For claims involving urgent care, review must be conducted as soon as possible, but not later than 72 hours after receipt of the claimant's request. Under the proposed regulation, the appropriate named fiduciary must consult with a health care professional who has training and experience in the field of medicine involved in the medical judgment.

---

[21] 63 Fed. Reg. 48390 (1998).

[22] *Id*.

[23] *Volume of Complaints Increases Scrutiny of Labor Department's ERISA Claims Rule*, Health Law Reporter (BNA) Vol. 8, No. 3, at 104 (Jan. 21, 1999).

[24] *Id*.

[25] 29 C.F.R. 2560.503-1(g)(3).

[26] 29 C.F.R. 2560.503-1(g)(2).

The proposed regulation also provides for more extensive review. All comments, documents, records and other information submitted by the claimant will be reviewed even if such information was not previously submitted and relied upon. The resulting decision is to include not only the specific reasons for the decision and make references to the pertinent plan provisions on which the decision is based, but also advise the claimant of the ability to receive all documents and records relevant to the claim.

The Department of Labor has indicated that the proposed regulation responds to its concerns of unnecessary delay in the resolution of claim disputes.[27] In addition to reducing the number of days in which a review decision must be made, the proposed regulation provides that benefit claim proceedings may not include more than one level of mandatory appeal. Under the proposed regulation, the plans are also precluded from requiring claimants to submit to binding arbitration either as part of the single level of appeal or following the initial review.

The absence of any provisions for external review suggests that legislation may still be necessary to impose additional review. The Department of Labor has stated that it is unable to create an external review process because there is no statutory authority for this kind of review. Under § 503(2) of ERISA, a plan is only required to offer a participant a reasonable opportunity for "full and fair review by the appropriate named fiduciary of the decision denying the claim."[28] While the proposed regulation attempts to achieve some form of impartiality by requiring consultation with a health care professional, it does not require the kind of external review sought by the Commission and Congress.

106th Congress

On January 19, 1999, Senate and House Democrats reintroduced the Patients' Bill of Rights, H.R. 358/S. 6. On January 22, 1999, Senate Republicans reintroduced their managed care legislation as the Patients' Bill of Rights Plus Act, S. 300. While the Patients' Bill of Rights closely resembles its predecessor in the 105th Congress, S. 300 includes one significant change with respect to the external review of claim denials. Under S. 300, external review would be available as long as the cost of the procedure or treatment at issue exceeds a significant financial threshold. A plan is not permitted to deny review to a claimant on the basis of the treatment cost falling below $1,000. This change is also recognized in the Patients' Bill of Rights Act, S. 326. S. 326 was introduced by Senator James M. Jeffords on January 28, 1999. The remaining appeals provisions in S. 326 resemble those in S. 300.

Interest in improved grievance and appeals procedures is likely to increase. Managed care organizations and their appeals processes have become subject to greater scrutiny as a result of lawsuits and multi-million dollar judgments.[29] The Commission's Consumer Bill of Rights, the Department of Labor's proposed

---

[27] 63 Fed. Reg. at 48397 (1998).

[28] 29 U.S.C.A. § 1133(2) (West 1985 & Supp. 1998).

[29] *See* Robert F. Howe, *The People vs. HMOs*, TIME, Feb. 1, 1999, at 46.

regulation, and the proposed legislation in this Congress should provide a basis for considering the best methods for improving existing procedures.

EveryCRSReport.com

The Congressional Research Service (CRS) is a federal legislative branch agency, housed inside the Library of Congress, charged with providing the United States Congress non-partisan advice on issues that may come before Congress.

EveryCRSReport.com republishes CRS reports that are available to all Congressional staff. The reports are not classified, and Members of Congress routinely make individual reports available to the public.

Prior to our republication, we redacted names, phone numbers and email addresses of analysts who produced the reports. We also added this page to the report. We have not intentionally made any other changes to any report published on EveryCRSReport.com.

CRS reports, as a work of the United States government, are not subject to copyright protection in the United States. Any CRS report may be reproduced and distributed in its entirety without permission from CRS. However, as a CRS report may include copyrighted images or material from a third party, you may need to obtain permission of the copyright holder if you wish to copy or otherwise use copyrighted material.

Information in a CRS report should not be relied upon for purposes other than public understanding of information that has been provided by CRS to members of Congress in connection with CRS' institutional role.

EveryCRSReport.com is not a government website and is not affiliated with CRS. We do not claim copyright on any CRS report we have republished.