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# Patient Protection and Mandatory External Review: Amending ERISA's Claims Procedure

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## Summary

This report discusses the existing claims procedure required by the Employee Retirement Income Security Act of 1974 (ERISA), and legislative efforts in the 106th Congress to amend ERISA to provide for the mandatory external review of denied benefits. Although most of the patient protection bills introduced in the 106th Congress included provisions for external review and more rigorous standards for the internal review of denied benefits, this report focuses on the Patients' Bill of Rights Plus Act of 1999, S. 1344, passed by the Senate on July 15, 1999, and the Bipartisan Consensus Managed Care Improvement Act of 1999, H.R. 2990, passed by the House of Representatives on October 7, 1999.

The need to improve existing grievance and appeals procedures for individuals receiving health care coverage through employer-sponsored benefit plans was recognized in most of the patient protection bills introduced during the 106th Congress.[1] Although H.R.2990, as introduced by Representatives Talent and Shadegg, was concerned primarily with tax deductions and incentives, the remaining bills each provided for modified grievance and appeals procedures: S. 6 and S. 1256, introduced by Senator Daschle; S. 300, introduced by Senator Lott; S. 326, introduced by Senator Jeffords; S. 374, introduced by Senator Chafee; H.R. 358, introduced by Representative Dingell; H.R. 216, introduced by Representative Norwood; H.R. 448, introduced by Representative Bilirakis; H.R. 719, introduced by Representative Ganske; H.R. 1133, introduced by Representative Nadler; H.R. 2095, H.R. 2089, and H.R. 2926 introduced by Representative Boehner; H.R. 2723, introduced by Representatives Norwood and Dingell; and H.R. 2824, introduced by Representatives Coburn and Shadegg.[2]

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[1] See Jean P. Hearne, *Patient Protection and Managed Care: Legislation in the 106th Congress*, CRS Issue Brief IB98017.

[2] See Hearne, *supra* note 1 (H.R. 2089 was offered as part of a package of eight other bills). On (continued...)

Under existing law, employer-sponsored benefit plans are required to provide only a "reasonable opportunity. . . for a full and fair review by the appropriate named fiduciary" if a participant is denied a plan benefit.[3] To accomplish such "full and fair review," the Department of Labor (DOL) requires that plans establish review procedures for participants interested in appealing benefit denials.[4] The internal review structure outlined by the DOL has few guidelines: the appropriate named fiduciary has 60 days to issue a decision after receiving a claimant's request for review; under special circumstances, the fiduciary has up to 120 days after the receipt of the request for review to issue a decision.[5] These minimal guidelines have promoted little uniformity among the internal review procedures of employer-sponsored plans. Further, while some plans provide external review procedures, none are required.

Although the managed care industry contends that the existing claims procedure works well and fears that an additional level of review will increase costs, many believe that improved procedures will not only empower patients, but enhance access to treatment and improve the quality of care provided.[6] The creation of a mandatory external review process for benefit denials is one of the most fundamental changes being considered by Congress. Proponents argue that external review would act as an oversight mechanism that could identify procedural errors, provide substantive review, and detect patterns of inappropriate denials.[7] In addition, they believe that external review would assure participants of an impartiality and independence that may be lacking in the internal review process.[8]

Congress is not alone in focusing on the external review process. In its report on managed care and the rights of patients, the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry stated that consumers were entitled to a "fair and efficient process for resolving differences with their health plans. . . [including] an independent system of external review."[9] Numerous states have enacted statutes that require independent review for managed care participants who believe that their claims for benefits have been wrongfully denied.[10] However, in *Corporate Health Insurance, Inc. v. Texas Department of Insurance*, the U.S. Court of Appeals for the Fifth

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[2] (...continued)
July 15, 1999, the Senate passed an amended version of S. 300 as S. 1344.

[3] 29 U.S.C.A. § 1133(2) (West 1985 & Supp. 2000).

[4] See 29 C.F.R. § 2560.503-1.

[5] 29 C.F.R. § 2560.503-1(h).

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

[7] *Id*. at 92.

[8] *Id*.

[9] 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).

[10] See also Candace L. Romig, *Patient Rights Still Hot Topic in Congress and the States*, AORN J., May 1, 1999, at 1031.

Circuit determined that the independent review provisions of the Texas Health Care Liability Act are preempted by ERISA.[11] The Fifth Circuit contended that the provisions impermissibly attempt to impose a state administrative regime on coverage determinations.[12] Because the states may be unable to mandate external review for individuals enrolled in employer-sponsored plans, the proposed bills would modify ERISA's requirements.

## Patients' Bill of Rights Plus Act of 1999, S. 1344

The Patients' Bill of Rights Plus Act of 1999, S. 1344, was introduced by Senator Trent Lott (R-MS) on July 8, 1999, and passed by the Senate on July 15, 1999. S. 1344 sought to amend ERISA to provide additional requirements for group health plans and health insurance issuers offering coverage in connection with group health plans.

If enacted, S. 1344 would have required group health plans and health insurance issuers to develop written procedures for addressing grievances. A grievance was defined by the bill as any complaint made by a participant or beneficiary that does not involve a coverage determination. Once a grievance was addressed, a resulting determination would not have been appealable.

S. 1344 would have allowed participants and beneficiaries to appeal any adverse coverage determination to an internal review process. An adverse coverage determination was defined as any determination under the plan which results in a denial of coverage or reimbursement. A participant or beneficiary seeking internal review would have been allowed at least 180 days after the date of the adverse coverage determination to make an appeal. Review would have been conducted by an individual with appropriate expertise who was not involved in the initial determination. Appeals involving issues of medical necessity or experimental treatment would have been conducted by physicians with appropriate expertise.

Internal review would have been completed within 30 working days of receiving the request for review. Where delay could jeopardize the life or health of the claimant, S. 1344 would have required that review was completed no later than 72 hours after receiving the request for review. A request for expedited review would have to include documentation of a medical exigency by the treating health care professional. For routine determinations, notice of the decision would have to be issued no later than 2 working days after the completion of review. For expedited determinations, notice would have to be issued within the 72-hour review period. Failure to issue a timely decision would been treated as an adverse coverage determination for purposes of obtaining external review.

If enacted, S. 1344 would have required all plans and issuers to have written procedures to permit access to an independent external review process. External review would have been available to selected adverse coverage determinations. Those determinations included coverage decisions that (1) are based on medical necessity and

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[11] 215 F.3d 526 (5th Cir. 2000).

[12] For further discussion of *Corporate Health Insurance, Inc. v. Texas Department of Insurance*, see (name redacted), *ERISA's Impact on Medical Malpractice and Negligence Claims Against Managed Care Plans*, CRS Report 98-286A (2000).

exceed a significant financial threshold; (2) are based on medical necessity and involve a significant risk of placing the life or health of the participant in jeopardy; or (3) involve an experimental or investigational treatment. To obtain external review, a claimant would have to complete the internal review process and file a written request for review within 30 working days of receiving the internal review decision.

Within 5 working days after receiving the request for external review, the plan or issuer would have selected an external appeals entity.[13] This external appeals entity would have designated an external reviewer who would conduct the review. The external reviewer would have to (1) be appropriately credentialed or licensed to deliver health care; (2) not have any material, professional, familial, or financial affiliation with the case under review; (3) have expertise in the diagnosis or treatment under review and be a physician of the same specialty, when reasonably available; (4) receive only reasonable and customary compensation from the plan or issuer; and (5) not be held liable for decisions regarding medical determinations. The external reviewer would have been required to consider all valid, relevant, scientific, and clinical evidence to determine the medical necessity, appropriateness, or experimental nature of the proposed treatment.

Review would have been conducted in accordance with the medical exigencies of the case, but would have to be completed within 30 days of the date on which the reviewer was designated or all necessary information was received, whichever was later. For cases where delay could jeopardize the life or health of the participant, review would have to be conducted within 72 hours of the date on which the reviewer was designated or all necessary information was received, whichever was later. The determination of the external reviewer would have been binding upon the plan or issuer.

## Bipartisan Consensus Managed Care Improvement Act of 1999, H.R. 2990

The Bipartisan Consensus Managed Care Improvement Act of 1999, H.R. 2990, combined two bills: the Quality Care for the Uninsured Act of 1999, originally H.R. 2990, was introduced by Representatives James M. Talent (R-MO) and John B. Shadegg (R-AZ) on September 30, 1999, and the Bipartisan Consensus Managed Care Improvement Act of 1999, originally H.R. 2723, was introduced by Representatives Charlie Norwood (R-GA) and John D. Dingell (D-MI) on August 5, 1999.[14] The combined bill was passed by the House of Representatives on October 7, 1999. H.R. 2990 would not only have required group health plans and health insurance issuers to provide an external review process for denied claims, but would have also established new deadlines for the internal review process and mandated the creation of a formal grievance system.

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[13] S. 1344 identified the following entities as appropriate to serve as external appeals entities:
-- An independent external review entity licensed or credentialed by a state;
-- A state agency established to conduct independent external reviews;
-- Any entity under contract with the federal government to provide independent external review services;
-- Any entity accredited as an independent external review entity; or
-- Any entity meeting criteria established by the Secretary of Labor.

[14] The provisions of the original H.R. 2990 were included in Division A of the new bill and the provisions of H.R. 2723 comprised Division B of the bill.

Under H.R. 2990, group health plans and health insurance issuers would have been required to maintain a system that addressed oral and written grievances. These grievances would have included any aspect of the plan's or issuer's services, but would not include a claim for benefits. Once resolved, grievances would not have been subject to appeal.

If enacted, H.R. 2990 would have permitted a participant, beneficiary, or enrollee to request and obtain an internal review of his claim within 180 days following a denial of a claim for benefits. Review would have been conducted by a named fiduciary if the dispute involved a claim for benefits under the plan. For disputes involving denied coverage, review would have been conducted by a named appropriate individual. If the case involved medical judgment, review would have been conducted by a physician.

Internal review would have been completed in accordance with the medical exigencies of the case, but not later than 14 days after receiving the request for review. If additional information was needed, this deadline could be extended to 28 days. Where delay could seriously jeopardize the life or health of the claimant, review would have to be completed within 72 hours after receiving a request for expedited review. This request could be submitted orally or in writing by the claimant or provider.

H.R. 2990 would have required all plans and issuers to create an external review process. External review would have been available for benefit denials that were either based on medical necessity or involved investigational or experimental treatment. External review would have also been available when a decision as to whether a benefit is covered involved a medical judgment. H.R. 2990 would have allowed the Secretary of Labor to establish additional standards for external review, including a filing deadline. The plan or issuer would have been permitted to condition external review on the exhaustion of the internal review process. In addition, the plan or issuer would have been able to charge a filing fee for external review. However, this fee could not exceed $25.

External review would have been conducted by a certified external appeal entity. For group health plans, the entity would have to be certified either by the Secretary of Labor, under a process recognized or approved by the Secretary of Labor, or by a qualified private standard-setting organization. For state health insurance issuers, the entity would have to be certified by the applicable state authority or under a process recognized or approved by such authority. If the state had not established a certification process, the entity would have to be certified either by the Secretary of Health and Human Services, under a process recognized or approved by such Secretary, or by a qualified private standard-setting organization. The external appeal entity would have to conduct its activities through a panel of not fewer than three clinical peers, and have sufficient medical, legal, and other expertise and sufficient staffing to conduct its activities in a timely manner.

The determination of the external appeal entity would have been made in accordance with the medical exigencies of the case, but not later than 21 days after receiving the request for external review. Where delay could seriously jeopardize the life or health of the claimant, a determination would have to be made within 72 hours after receiving the request for external review. The decision of the external appeal entity would have been binding on the plan and issuer involved in the determination.

Please see the following CRS Issue Briefs and Reports for additional information.

## Issue Briefs

CRS Issue Brief IB98002, *Medical Records Confidentiality*.
CRS Issue Brief IB98017, *Patient Protection and Managed Care: Legislation in the 106th Congress*.
CRS Issue Brief IB98037, *Tax Benefits for Health Insurance*.

## Reports

CRS Report 97-643, *Medical Savings Accounts.*
CRS Report 98-286, *ERISA's Impact on Medical Malpractice and Negligence Claims*.
CRS Report RL30077, *Managed Care: Recent Proposals for New Grievance and Appeals Procedures.*
CRS Report RL30144, *Side by Side Comparison of Selected Patient Protection Bills in the 106th Congress*.

## CRS Series on Managed Health Care

CRS Report 97-482, *The Use of Financial Incentives.*
CRS Report 97-913, *A Primer*.
CRS Report 97-938, *Federal and State Regulation.*