Independent Medical Review: Expanding Legal Remedies to Achieve Managed Care Accountability

Leatrice Berman-Sandler
Loyola University Chicago, School of Law

Follow this and additional works at: http://lawecommons.luc.edu/annals
Part of the Health Law and Policy Commons

Recommended Citation
Leatrice Berman-Sandler Independent Medical Review: Expanding Legal Remedies to Achieve Managed Care Accountability, 13 Annals Health L. 233 (2004).
Available at: http://lawecommons.luc.edu/annals/vol13/iss1/8

This Article is brought to you for free and open access by LAW eCommons. It has been accepted for inclusion in Annals of Health Law by an authorized administrator of LAW eCommons. For more information, please contact law-library@luc.edu.
Independent Medical Review: Expanding Legal Remedies to Achieve Managed Care Accountability

Leatrice Berman-Sandler*

I. INTRODUCTION AND BACKGROUND

The Supreme Court's decision in Rush Prudential HMO, Inc. v. Moran placed the state-based statutory remedy of independent medical review ("IMR") on stronger legal footing. IMR is increasingly being used to settle disputes between patients and their health insurers over what is medically necessary or experimental or investigational care ("E/I"). Services

* J.D. Candidate, Loyola University Chicago School of Law, May 2004; Adjunct faculty, Department of Preventive Medicine, Northwestern University Medical School; Immediate Past-Chair, Medical Care Section, American Public Health Association. Thanks to John Blum, Professor, Loyola University Chicago School of Law for intellectual support and guidance; Mark Rust, Attorney, for his insights on ERISA; Elissa Koch, for her skillful editing and support; Jennifer Roach, for her assistance in manuscript preparation, and my family for their support and patience.

1. See generally Rush Prudential HMO, Inc. v. Moran, 536 U.S. 355 (2002) (holding that an Illinois statutory provision applicable to HMOs, mandating independent external review of medical necessity disputes, was not preempted by ERISA).

2. Health plans contract with individuals to provide medically necessary services as determined by medical standards and clinical protocols that the plans adopt. See Sara Rosenbaum et al., Who Should Determine When Medical Care is Medically Necessary, 340 NEW. ENG. J. MED. 229, 229-30 (1999) (discussing the legal underpinnings of the term "medical necessity" and the nature of disputes over what is medically necessary). Simply stated, medical necessity disputes occur between health plans and patients, or health plans and treating physicians on behalf of their patients, because the patient disagrees with the doctor or the health plan about the appropriate standard of care or course of treatment for a specific condition. See Sara Rosenbaum, Managed Care and Patients' Rights, 289 JAMA 906, 906 (2003). Medically necessary services presuppose a set of professional standards that guide physicians' and other providers' treatment of patient problems and medical conditions. See infra Part III.C.5; Rosenbaum et al., supra note 2, at 229-30. Disputes can be over any procedure, drug, supply, device, or diagnostic plan that a treating physician might intend for a patient. Fred LeMire & John Hess, UNIVERSITY HOSPITAL CONSORTIUM GLOSSARY OF TERMS IN MANAGED CARE CONTRACTING (1995). As part of managed care, services rendered by a health care provider are reviewed to determine whether the services are medically necessary, a process referred to as utilization review ("UR"). Some services require pre-authorization; others are concurrently or retrospectively reviewed by UR staff. Id. The UR staff make initial determinations as to whether a service should be authorized as medically necessary, or whether the patient should be reimbursed after the service has been
deemed medically necessary are generally covered by insurance; care deemed E/I is typically not covered. The Court in *Moran* held that by mandating IMR in Illinois, the state created an obligation equivalent to adding a mandated insurance benefit or extra-contractual term to a health policy governing the relationship between the insurer and the insured. Such legislative conduct was found to be well within the traditional authority of the state as insurance regulator, and was thus not preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"). In addition, the Court noted the remedies advanced by the IMR process—to receive the services to which one is entitled or to receive reimbursement for the services—are consistent with the structure and scope of ERISA remedies and are not in conflict with its enforcement scheme.

IMR, also referred to as external appeal or external review, has become an important feature of managed care and insurance reform legislation, but provided. Thereafter, the plan's Medical Director reviews UR denials and issues a formal determination of approval or denial for care. UR is a core component of managed health care because it is critical to the oversight mechanism and key to controlling cost and ensuring that only necessary care is provided.

3. Some procedures or treatment protocols are deemed experimental or investigational ("E/I") because they are not considered routine medical care or are not scientifically proven to treat or cure the specific condition, illness, or diagnosis for which their use is proposed. *LEMIRE & HESS, supra* note 2. Often, E/I includes promising treatments that have not been fully tested in clinical research trials. E/I can encompass medical, surgical, psychiatric, substance abuse, or other health care services and supplies, treatments, procedures, drug therapies, or devices disallowed by the health plan. *Id.* In addition, many E/I denials involve "off-label" drug use, i.e., using FDA-approved pharmaceuticals for a purpose other than that for which the drug was approved.

4. The Illinois Statute states that each HMO shall provide a mechanism for timely review by an unaffiliated physician holding the same class of license as the primary care physician and who will be jointly selected by patient or his legal representative, the primary care physician, and the HMO in the event that the physician and the HMO disagree on the medical necessity of the physician's proposed treatment. If the reviewing physician determines that the treatment is medically necessary, the HMO shall authorize the treatment. *215 ILL. COMP. STAT. 125/4-10 (2002).* Throughout the *Moran* opinion, the Court discussed the Illinois law as adding "an extra layer of review" as an additional contract term, which the reviewer interprets as determining the HMO's obligation or freedom from duty to provide care. *Moran,* 536 U.S. at 373, 384, 386.


6. *Id.* at 385.

Independent Medical Review

Michigan began to use external appeals for commercially insured populations as early as 1978. Moreover, at the federal level, Medicare, Medicaid, Veterans Health (Tristar), and Federal Employees Health Plan programs have had versions of external appeals for many years. Still, as the health care system has shifted from a fee-for-service model to a managed care model, IMR has been featured as a critical response to patient concerns over the increased number of insurance coverage denials.

Although a detailed analysis of managed care is beyond the scope of this paper, at its core, the financial structure in managed care can promote incentives that run counter to the needs of individual patients. Managed care contracting between purchasers, such as employers, pension and welfare funds, and governments and insurers, as well as between insurance plans and providers and patients, is predicated on setting budgets and establishing financial incentives to curtail unnecessary utilization. To achieve this, managed care attempts to restrict choice of providers and self-referral, which curbs the freedom of consumers to travel through the medical care system at will to seek the care and the practitioners they want. Utilization curbs are also achieved by proactively employing review mechanisms and financial incentives, where the latter is tied to the amount a patient will pay directly out-of-pocket and the amount a provider will be reimbursed. All of this flows from the logic of managed care to effectuate lower costs.

After exposure to managed care restrictions constraining patient choice, coupled with several cases finding health plans liable for prohibiting or delaying experimental treatment, the American public began to distrust the process of managed care and question the integrity of care denials. As a
result, advocates and reformers in the 1980s and early 1990s sought legislation to correct a variety of problems with managed care and advocated for unbiased internal grievance and appeal procedures using neutral third parties. A later wave of legislation followed in the mid-to-late 1990s, which strengthened and added new mechanisms of external appeal.

Given the interest in IMR systems by state governments, and the existence of recent Supreme Court decisions, this paper will report the findings of a qualitative survey of several states in an effort to expand what is known about IMR. The central question is whether IMR is a viable legal remedy and a productive way to exact accountability from the health insurance and managed care industry. A second and related inquiry concerns the relationship between IMR and ERISA and whether IMR procedures could be expanded and strengthened to cover more health plan participants. Because managed care accountability is evolving dynamically in both the legislature and the courtroom, the availability of state-based statutory remedies is of great interest. This paper, therefore, will report on the role of IMR and its future.

Part II will identify the attributes of IMR by briefly reviewing key findings from national studies that have described the external appeal process. Part III will describe results of a four-state survey of New York, California, Pennsylvania and Michigan. The survey gathered information about the IMR process, key implementation issues, and IMR’s impact on beneficiaries and entities that participate in IMR. Part IV will discuss the continuing way in which ERISA preemption challenges states’ abilities to


18. *See generally KAISER ASSESSMENT*, supra note 7 (assessing the status of external review programs across the country).

make IMR available to wider populations receiving care from employer self-funded plans in light of the Moran and Kentucky Association of Health Plans v. Miller20 Supreme Court decisions. Part V will review current ideas for changing the statutory framework and the adjudicatory process to effectuate greater impact for patients yet will implicate the challenge created by ERISA’s civil enforcement scheme for implementing changes in the current IMR process.21 Although Moran stabilized IMR, it also demonstrated that ERISA’s civil enforcement scheme will continue to constrain the future development of state-based dispute resolution mechanisms and remedies.22 Finally, Part VI will address whether federal and state law can be harmonized given the overriding public equities at stake.

II. THE NATURE OF IMR AND EXTERNAL APPEAL

External appeals—formal dispute resolution processes between patients and their health insurers—are now available in forty-two jurisdictions, including the District of Columbia.23 Through this process, patients access external reviews of care denials after exhausting at least one level of a health plan’s internal appeals process and receiving an adverse determination.24 Although there are a variety of complaint and grievance mechanisms in place at health plan and state government levels in response to the consumer movement, external appeal or independent medical review, is available for disputes specifically focused on the medical necessity of a medical treatment or service.25 While a greater number of grievances and consumer complaints are received by states on matters of benefits coverage, quality of care, or claims payment,26 the most serious area for patient protection has been in the realm of denying medically necessary care or life sustaining E/I care.27

21. 29 U.S.C. § 1132(a) provides a private right of action to receive or recover benefits or clarify future benefits due under the terms of an ERISA-sponsored health plan; primarily, this entitles the beneficiary to equitable relief, contractual damages for benefits owed (for which the beneficiary has already paid), and, at the discretion of the court, attorney’s fees. Jana K. Strain & Eleanor D. Kinney, The Road Paved with Good Intentions: Problems and Potential for Employer-Sponsored Health Insurance Under ERISA, 31 Loy. U. Chi. L.J. 29, 39 (1999).
23. KAISER ASSESSMENT, supra note 7, at 1.
24. CONSUMER UNION GUIDE, supra note 7, at 18.
25. See supra note 2 for discussion of the framework in managed care that has led to medical necessity disputes.
Important differences in IMR across the states reflect variations in the degree to which legislative provisions provide consumer protection. These differences can be significant and must be mastered by consumers if they want to successfully mount appeals.²⁸ Yet, at the same time, a prototype is emerging that acts as a guidepost for the refinement of these systems across the country. The attributes of this model are as follows:

- Most states have set up mechanisms directly managed by an independent state agency, such as Departments of Insurance (DOI), Managed Health Care, Health Services or Public Health. Several states, however, still allow health plans to administer the external review process directly, and eight states have health plans decide if a dispute is eligible for external review.²⁹
- Although states differ on when a patient can exit a health plan’s internal process, all states require a denial from an internal appeal process prior to allowing a patient to enter the IMR system.³⁰
- Most states target all health plans, including HMOs. Yet, thirteen jurisdictions only target licensed HMOs, and one state only targets HMO group plans.³¹
- Most states only allow appeals for the denial of medically necessary or E/I care, although nine states allow external review for coverage, reimbursement or claims-related disputes.³²
- All states allow for expedited reviews in cases where a delay in receiving services will cause severe harm or disability. These expedited reviews provide decisions within twenty-four to seventy-two hours.³³
- Most states allow for retrospective review or external review after services have been provided, but a few states will only allow appeals if services have not been provided.³⁴
- Most states mandate a series of steps that health plans must take to inform beneficiaries about the availability of IMR and how

²³, 1993); Corcoran v. United HealthCare, 965 F.2d 1321 (5th Cir. 1992); Studdert & Gresenz, supra note 15, at 864.

²⁹. KAISER ASSESSMENT, supra note 7, at 17.
³⁰. CONSUMER UNION GUIDE, supra note 7, at 18.
³¹. KAISER ASSESSMENT, supra note 7, at 9; CONSUMER UNION GUIDE, supra note 7, at 16.
³². KAISER ASSESSMENT, supra note 7, at 9.
³³. CONSUMER UNION GUIDE, supra note 7, at 18.
³⁴. Id. at 17.
and when to access the system. Typically, mandates include information in certificates of coverage, benefit handbooks, and letters of denial in the internal appeal process.  

- Most states do not charge an application fee, but fifteen states charge a nominal fee. This fee is waived for those unable to pay.  

- Most states use independent review organizations ("IROs"). IROs are accredited by a national organization and/or meet licensure requirements established by states. These organizations recruit panels of providers who conduct reviews and who meet established criteria reflecting expertise in specific clinical areas. IROs are required to ensure that a reviewer has appropriate expertise for specific matters and no conflict of interest, such as institutional or health plan affiliations or past history that might bias a review. Often state statutes require reviewers in specialty areas to be randomly assigned. Typically, only one reviewer is assigned to medical necessity reviews, although statutory provisions usually require three independent reviewers for E/I care disputes. Twenty-seven states have health plans choose the external review entity.  

- Most states routinely employ de novo review of medical necessity in their IMR process irrespective of health plan definitions, and only seven states bind their reviewers to health plan definitions of medical necessity. "Binding" is defined as whether the health plan’s denial of care is consistent with its own protocols for deciding what is medically necessary and appropriate. Nevertheless, most plans do not define medical necessity in their coverage certificates, and most state statutes do not define medical necessity. Rather, statutes specify the type of evidence based on professional standards, clinical guidelines and medical literature to be reviewed, in order to give broad discretion to an external reviewer in determining what is the best medical care in a specific case. As a result, presumptions in

35. KAISER ASSESSMENT, supra note 7, at 10-11; CONSUMER UNION GUIDE, supra note 7, at 11.  
36. KAISER ASSESSMENT, supra note 7, at 14.  
37. Id. at 15.  
39. KAISER ASSESSMENT, supra note 7, at 17.  
40. Id. at 18.  
41. Id. at 18-19.  
42. Id. at 17-18.
favor of health plan denials that have evolved in the common law, requiring plaintiffs' lawyers to prove that plans are arbitrary and capricious in the application of or in deviation from their standards, have been neutralized in the IMR process. 43

- Most states bind the health plan to the results of the IRO, 44 but allow consumers to advance a judicial claim.
- Health plans are typically assessed across the board for the costs of the IMR review system. Also, plans often pay for each review in which they are specifically involved, irrespective of whether the denial is upheld, modified or overturned. Only nine states do not assess plans for the costs, one state has a volunteer reviewer panel, and one state has the enrollee and the plan split the cost. 45

In brief, the above elements comprise the IMR prototype emerging across the states and these core elements serve as a benchmark for the subsequent review of specific state systems.

III. IMPLEMENTATION AND VIABILITY OF IMR IN FOUR STATES

A. Introduction to Findings

In reviewing national experience with external review, several states stand out for a variety of reasons: Minnesota, Michigan, California, and Florida exemplify states with long track records for both managed care and external review; New Mexico allows a filing of an external appeal at the same time as an internal appeal to fast-track the system, and Connecticut, California, New York, and Maryland have developed active Patient Advocacy Units, HMO Help Centers, or Ombudsmen programs, which offer unique consumer support; Pennsylvania, New York, California, Florida, and Michigan have outstanding state oversight and reporting capacity in place; and New York, California, and Texas are noteworthy for their population size and high annual volume of cases. In addition, a number of states are creating statute-based rights to sue health plans such as breach of duty of ordinary care or duty to provide medically necessary


44. KAISER ASSESSMENT, supra note 7, at 25. See, e.g., 40 PA. CONS. STAT. § 991.2162 (c)(6) (2002).

45. KAISER ASSESSMENT, supra note 7, at 27.
health care. The availability of these new causes of action broadens the ability to bring a claim forward beyond that of traditional tort claims, such as negligence, wrongful death, or vicarious liability or contract law claims including bad faith or fraud. Because of their progressive approach, all of the states above are promising laboratories for deeper exploration of IMR, its implementation, its scope, its limitations, and its impact.

B. Methodology

Arizona, California, Connecticut, Florida, Maryland, Michigan, Minnesota, New York, Pennsylvania, and Texas were singled out for the reasons described above; five of these states were pursued. Two attempts to gain Florida's participation were made, including direct communication with personnel in its Agency for Health Care Services. Ultimately, however, Florida was excluded from the study when it became clear that data from four states was generating sufficiently rich information about IMR and that major themes from the four states were being repeated despite remaining differences in state approaches. Therefore, it was presumed that evidence from additional states would provide only marginal information to characterize IMR. Consequently, original research focused on four states, specifically, California, Michigan, New York, and Pennsylvania.

Thereafter, specific state agencies which administer IMR were identified from existing reports. Agency directors or program managers were contacted via telephone, often identified by reception or hotline staff. A telephone interview of sixty to ninety minutes was scheduled with staff who either directed the program or were sufficiently familiar to provide detailed information, for example, lead attorneys who drafted annual reports and reviewed state data.

A discussion guide was developed to retrieve a standard set of information across states. The questionnaire/discussion guide was divided into three sections evaluating how the program works, how well it works, and how it links to other remedies available to the consumer. The first section focused on validating and updating information available from the Kaiser and Consumer Union studies and emphasized how the remedy worked for the consumer, the role of the parties, the various definitions of medical necessity, and the nature of the problems coming up for review. Section Two focused on emerging problems in the system from the

47. KAISER ASSESSMENT, supra note 7, at 1.
48. CONSUMER UNION GUIDE, supra note 7, at 1.
viewpoint of state agency personnel—examining how the states were refining the program, developing relationships with the health insurance industry, and understanding the perceived impact on industry and consumers. The last section of the questionnaire was devoted to clarifying if, when, and how often consumers file a civil action while going through external review or as a result of external review. Additionally, state respondents were asked to identify any pending or anticipated legislative change that would impact IMR. Statutory provisions were reviewed before these interviews to capture the major configuration of each state’s program and its distinct features.

C. Study Findings

Interviews with personnel in this four-state survey provided an in-depth view of IMR systems. Chart One summarizes the major features of the IMR system in the four states.49 Discussion below amplifies the chart in the following areas: (1) legislative history and program scope; (2) key IMR features and trends; (3) nature of the dispute resolution process and roles of key parties; (4) state oversight mechanisms; (5) definitions of medical necessity; (6) impact on health plans; and (7) IMR links to subsequent judicial action.

1. Legislative History

With the passage of the Health Maintenance Act in 1978, Michigan signed its first external appeal law focused exclusively on HMOs.50 The Act granted enrollees who exhausted a plan’s grievance process the opportunity to pursue the grievance further with a three-person advisory commission.51 In 1997, the Michigan Bill of Patient’s Rights Act passed, thereby mandating that HMOs and other insurers establish internal formal enrollee grievance procedures.52 The bill defined the term “adverse determination,”53 a definition that remains in affect under the most recent legislation, the Patients Rights and Independent Review Act (“PRIRA”) of 2000.54 PRIRA repealed the HMO Act of 1978 and refined the external appeal regimen under the jurisdiction of the Department of Insurance and

49. See Appendix A, Chart I.
52. Wexler, supra note 50, at 20.
its Office of Financial and Insurance Services ("OFIS").

Pennsylvania’s move toward managed care accountability dates back to the HMO Act of 1972. This was followed by Health Department regulations in the early 1980s and technical guidelines, which were further refined in 1991. In 1998, Pennsylvania passed Act 68, the Quality Health Care Accountability and Protection Act. Act 68 redesigned the state’s consumer complaint system by establishing a new consumer and provider grievance system, requiring the certification of utilization review organizations, and providing other protections related to disclosures, continuity of care, and prompt payment of claims. New regulations were promulgated in 2001 which fashioned the system that currently exists in Pennsylvania under the jurisdiction of the Department of Health.

New York has enacted a spate of laws addressing health insurance and managed care consumer protections. The Managed Care Reform Act of 1996 included many consumer protections, such as requiring access to specialists, preserving continuity of care when a provider is no longer participating in a network, formulating a prudent layperson standard for emergency care, mandating disclosure of coverage information to subscribers, prohibiting gag clauses in provider contracts, and requiring health plans to have grievance procedures and a utilization review appeal for disputes affecting access to care, referral to providers and benefit


57. E-mail from Stacy Mitchell, Dir., Bureau of Managed Care, Pa. Dep’t of Health, to Leatrice Berman-Sandler (May 28, 2003, 16:42:36 CST) (on file with author).

58. 40 PA. CONS. STAT. § 991.2102-2163 (2003) (articulating the key provisions of the Quality Health Care Accountability and Protection Act as part of Title 40-Pennsylvania’s Insurance Code).


determinations. The External Appeal Law of 1998 expanded these protections by adding a new title to Article 49 of the Insurance and Public Health Law, thus enabling consumers to obtain an IMR if a plan upholds an adverse medical necessity determination or an E/I treatment determination after an internal appeal. The New York State Insurance Department and Department of Health often jointly play major roles in implementing these laws.

California has a long history of regulating managed care through the Knox-Keene Act of 1975. Managed care plans, including some preferred provider organizations (“PPOs”), are licensed under Knox-Keene and most Californians (approximately twenty million) are insured under such plans. Knox-Keene historically provided only an informal process by which an enrollee who was denied coverage could appeal to a health plan, and, if unsatisfied with the result, could file a complaint with the state. Although some health plans offered independent external review of denials, IMR was not universal and there was no oversight. In 1996, the Friedman-Knowles Act amended Knox-Keene and required HMOs to provide external IMRs for specific classes of patients who requested E/I treatments and were denied. Knox-Keene was further amended in 1998 to add the current external appeal system for medically necessary care and administratively integrated all IMRs including those for E/I care disputes. The 1999 amendments also restructured the internal grievance process in an attempt to standardize and broaden both internal reviews and eligibility for IMR.

64. N.Y. PUB. HEALTH & INS. LAW § 4914.
67. Id. at 1; Interview with Tom Gilevich, supra note 16; E-mail from Tom Gilevich, Counsel, Cal. Dep’t of Managed Health Care, to Leatrice Berman-Sandler (Oct. 2, 2003, 18:23:15 CST) (on file with author).
68. CAL. HEALTH & SAFETY CODE § 1370.4; CAL. INS. CODE § 10145.3(a)(4) (1999).
69. Interview with Tom Gilevich, supra note 16; IMR REPORT 2002, supra note 65, at 1; IMR REPORT 2003, supra note 66, at 1; CAL. HEALTH & SAFETY CODE §1374.30(d)(1) (2003); 2001-39 CAL. REG. L. BULL. (Sept. 28, 2001); CAL. CODE REGS., tit. 28, §§ 1300.68, 1300.68.01, 1300.70.4, & 1300.74.30.
Unlike E/I care reviews, medical necessity reviews were no longer contingent upon a physician recommendation for a certain service, but only required that the patient had been seen by a physician, denied a service, and participated in the plan’s own internal grievance process for thirty days. The Health Plan Division in the Department of Corporations, which provided oversight for Knox-Keene plans, became the Department of Managed Health Care ("DMHC") in California’s Business, Transportation and Housing Agency in July 2000. Note that the California Department of Insurance ("DOI") continues to regulate traditional indemnity health insurers and some preferred provider plans; thus, California’s Insurance Code is a mirror-image of the Knox-Keene IMR provisions.

2. Key IMR Features and Trends

All four states generally follow the prototype model described in Part II. However, they reflect important differences in a variety of areas.

a. Plans Subjected to IMR

Michigan, New York and California target all health plans with the major exception of Medicare and employer-sponsored self-insured plans. Pennsylvania’s system is limited to managed care plans. All four states make the external appeal process available to certain Medicaid beneficiaries, although New York only makes external appeals available to Medicaid Managed Care beneficiaries. However, all states inform Medicaid beneficiaries of their rights to a Medicaid fair hearing; appeals can be made directly to the state department administering that program so that Medicaid enrollees have multiple avenues to appeal their rights.

70. CAL. HEALTH & SAFETY CODE § 13474.30(j)(3).

71. Interview with Tom Gilevich, supra note 16. California also established the HMO Help Center which is a division of the DMHC and which handles complaints. CAL. HEALTH & SAFETY CODE § 1368.02 (2003).

72. The DOI manages approximately seventy IMRs per year compared to 700 or so which come from Knox-Keene plans. The DOI uses the same contractors and follows the same rules. See JOHN Q. REPORT, infra note 78.

73. See Interviews, see supra note 16.

74. 40 PA. CONS. STAT. § 991.2162(a) (2003).

75. E-mail from Kristin O’Neill, Senior Attorney, Health Bureau, N.Y. DOI, to Leatrice Berman-Sandler (Oct. 7, 2003, 16:00:06 CST) (on file with author). See also Interviews, supra note 16.

76. PENNSYLVANIA Q&A, supra note 59; e-mail from Kristin O’Neill, Senior Attorney, Health Bureau, N.Y. DOI, to Leatrice Berman-Sandler (Oct. 7, 2003, 16:00:06 CST) (on file with author); e-mail from Tom Gilevich, Counsel, Cal. Dep’t of Managed Health, to Leatrice Berman-Sandler (Oct. 2, 2003, 18:23:15 CST) (on file with author). See also Interviews, supra note 16.
New York subjects all health care plans, including dental health plans, to its IMR requirements. California IMR applies not only to comprehensive medical plans, but also to mental health, pharmacy, and Preferred Provider/Point of Service plans or networks considered adjunct to already existing licensees under both Knox-Keene and the Insurance Code. 77 Dental, chiropractic and vision care plans are exempt in California. California’s IMR mandate originally included disputes involving Medicare+Choice plans, but the state health plan association filed suit, successfully asserting federal law preempted Medicare enrollees from using the state IMR system. 78 Michigan’s IMR is used for all licensed health insurers, HMOs, Alternative Finance and Delivery Systems which are typically provider sponsored, and Blue Cross/Blue Shield of Michigan. 79 However, those insured by Medicare supplemental, disability income, hospital indemnity, and specified accidental, credit, self-funded or long-term care plans do not qualify for external reviews. 80 Therefore, many of these insured groups are not eligible for IMR. This holds true in all four states, although in New York, any hospital indemnity plan that conducts utilization review would be subject to New York’s external appeal law. 81

b. Disputes Eligible for IMR

Pennsylvania, New York and California review only medical necessity disputes and classify E/I cases as a sub-category of medical necessity cases. 82 Michigan has the most expansive review authority. With the exception of cases involving clear, statutorily valid coverage exclusions and cancellations of coverage, Michigan will review all health plan denials for care or coverage. Conversely, California limits its reviews to care disputes that arise before care is actually received with the exception of disputes

77. CAL. HEALTH & SAFETY CODE §§ 1345(f), (o) (2003); CAL. HEALTH & SAFETY CODE §§ 1374.30 (b), (i) (2003) (defining qualifying health plans and language regarding what type of health care service contracts must meet grievance and IMR requirements).


80. MICH. COMP. LAWS § 550.1903(s) (2002) (defining health carrier). Exclusions were confirmed in interview with Paul Duguay, supra note 16.

81. See e-mail from Kristin O’Neill, Senior Attorney, Health Bureau, N.Y. DOI, to Leatrice Berman-Sandler (Oct. 7, 2003, 16:00:06 CST) (on file with author).

82. Interviews, supra note 16; e-mail from Kristin O’Neill, Senior Attorney, Health Bureau, N.Y. DOI, to Leatrice Berman-Sandler (Oct. 7, 2003, 16:00:06 CST) (on file with author). Specific distinctions are found in statute and are referenced throughout this report.
over emergency and urgent care.  

c. Access Hurdles: Pre-Required Internal Health Plan Reviews

A review of only four states demonstrates the problem of access and the diversity of state-based pre-requisites for an IMR. The states differ on whether patients must first exhaust health plan internal appeals processes before requesting external review from the state. Specifically, Michigan and Pennsylvania require exhaustion of health plans' internal appeals processes.

Although all of these states require grievances to go through at least some level of internal review, Pennsylvania's system has health plans determine if disputes are deemed either complaints or grievances, a critical state statutory distinction. A complaint is defined as a dispute or objection regarding a participating health care provider or coverage issue, including contract exclusions, limitations, non-covered benefits, and operations and management issues. Complaints can be filed orally or in writing with a plan, or by a provider with written consent of a patient. After a two-step review at the plan level in Pennsylvania, decisions on complaints can be appealed to the Department of Health or the Insurance Department depending on the nature of the complaint. Unless there is gross negligence brought to the attention of the state in the assignment, complaints are not eligible for external review.

As distinguished from a complaint, a grievance is a request by an enrollee or a health care provider, with the consent of the enrollee, to have a managed care plan review the denial of a health care service based on medical necessity and appropriateness. Only grievances are subject to external review; however, similar to complaints, they are initially appealed in a two-step internal review, after which they can be externally appealed. In Pennsylvania, this appeal is made directly to the plan, unlike the other three states where an IMR request is made directly to the state. Nevertheless, the Department of Health assigns the case to a certified IRO. Moreover, Pennsylvania requires patients to act within shorter time frames;

85. 40 PA. CONS. STAT. §§ 991.2102, 992.2161.
86. 40 PA. CONS. STAT. § 991.2102; PENNSYLVANIA Q&A, supra note 59, at Question 2.
87. Interview with Stacy Mitchell, supra note 16.
88. 40 PA. CONS. STAT. §§ 991.2102; PENNSYLVANIA Q&A, supra note 59, at Question 2.
89. 40 PA. CONS. STAT. § 991.2162 (2003).
enrollees must appeal within fifteen days of a denial.\textsuperscript{90} Pennsylvania’s enrollees can request expedited two-day internal reviews with a plan, but there are no expedited appeals at the external level.\textsuperscript{91} In other words, expedited appeals are not reviewed by the state at a “third” level, but rather go straight to an IRO, which is required to issue an expedited decision in two business days.\textsuperscript{92} By contrast, in Michigan, after a multi-step appeal leading to a final determination, a patient may file directly with the state.\textsuperscript{93} In New York, patients need only go through their health plan’s first level of appeal as a pre-requisite to seeking an IMR.\textsuperscript{94} New York will also accept applications after an initial health plan denial if the insured and the health plan agree to waive the next level of internal appeal.\textsuperscript{95} Patients more typically submit to the state’s IMR when their case is pending at a second level of plan review.\textsuperscript{96} Thus, due in part to these concurrent tracks, an appeal making its way through a health plan is eligible for review at the state level after an initial determination. Consequently, 259 cases were dismissed in 2000 while in the state’s IMR queue as a result of health plans reversing earlier denials based on additional information made available to the plan during the state’s external appeal process.\textsuperscript{97} Indeed, in New York, if patients attempt to exhaust the internal appeal process, they may miss the forty-five day time limit in which they must act to file an external appeal after an initial denial.\textsuperscript{98} This timeframe begins to run after the first health plan determination. If patients obtain an agreement from their health plan to waive the internal appeal process altogether, a letter to this effect serves as a final determination paving the way for an external appeal.\textsuperscript{99} Last, if a health plan misses the statutory deadline for responding to an internal appeal, the health service must be covered by the health plan and the

\begin{itemize}
\item \textsuperscript{90} 40 PA. CONS. STAT. § 991.2162; CONSUMER UNION GUIDE, supra note 7, at 60.
\item \textsuperscript{91} 40 PA. CONS. STAT. § 991.2161(e).
\item \textsuperscript{92} 28 PA. CODE § 9.709(k) (2003).
\item \textsuperscript{93} MICH. COMP. LAWS §§ 550.1907, 550.1911 (2002).
\item \textsuperscript{94} N.Y. INS. LAW § 4914 (2003).
\item \textsuperscript{95} Interview with Judy Doyle and Kristin O’Neill, supra note 16.
\item \textsuperscript{96} E-mail from Kristin O’Neill, Senior Attorney, Health Bureau, N.Y. DOI, to Leatrice Berman-Sandler (Oct. 7, 2003, 16:00:06 CST) (on file with author) (noting that not all plans have a second level of review); interviews with Judy Doyle and Kristin O’Neill, supra note 16.
\item \textsuperscript{97} N.Y. 2001 REPORT, supra note 63, at 24.
\item \textsuperscript{98} Interview with Judy Doyle and Kristin O’Neill, supra note 16; KAISER ASSESSMENT, supra note 7, at 12.
\item \textsuperscript{99} N.Y. 2001 Report, supra note 63; e-mail from Kristin O’Neill, Senior Attorney, Health Bureau, N.Y. DOI, to Leatrice Berman-Sandler (Oct. 7, 2003, 16:00:06 CST) (on file with author).
\end{itemize}
external appeal becomes unnecessary.\textsuperscript{100}

Similarly, California will allow the patient to jump into the state’s IMR program either after completing a grievance process as prescribed by state law or by participating in the grievance process for at least thirty days without resolution.\textsuperscript{101} California provides the most generous timeframe under which a patient can file for an IMR or appeal any grievance determination.\textsuperscript{102} However, based on a sample of one-quarter of all patients who have gone through the IMR process seeking medical necessity review since 1999, 60% reported that they did not know when the clock started or stopped on this required thirty-day time period.\textsuperscript{103} Slightly less than 50% of patients from the same sample reported that their health plan notified them of their eligibility for an external review at the thirty-day mark; 27% of patients reported that they were never notified.\textsuperscript{104}

d. Trends in Volume and Access

Chart Two compares data reported in the Kaiser reports and directly by states with more recent information received through this study.\textsuperscript{105} Trends suggest increasing consumer use of external appeals within the last two years, but also suggest a leveling off in the larger states, such as New York and California.\textsuperscript{106} As a benchmark, the Kaiser Family Foundation and the American Association of Health Plans report that states with IMR systems average about .7 reviews per 10,000 enrollees and range from .2 to 1.7 per 10,000 members.\textsuperscript{107} Among the four states reviewed in this study, annual statistics are lowest for Pennsylvania. This may reflect that the external review application process is directly managed by health plans. However,
despite the low average, overall use of IMR in Pennsylvania has more than doubled in the last two years, including an increasing number of provider appeals.\textsuperscript{108} Furthermore, Pennsylvania staff reports increased promotion of IMR through a revised web site, new brochure, and grass roots outreach to consumer groups.\textsuperscript{109} Likewise, use of IMR in Michigan doubled between year one, just after the PRIRA legislation went into effect, and year two.\textsuperscript{110} Therefore, both the number of applications for dispute resolution and the number of cases being determined in both Michigan and Pennsylvania have increased from prior reporting periods.\textsuperscript{111}

In the larger states, New York and California, the annual rate of increase for IMR applications and determinations appears to be stabilizing or going down, but the absolute number of annual applications are rising slightly.\textsuperscript{112} Recent trends follow a concerted jump in applications attributable to the new IMR legislation. Additionally, outreach and promotion of the IMR benefit is ongoing in these states.\textsuperscript{113}

In 2001, California’s HMO Help Center provided help to 179,966 individuals.\textsuperscript{114} About 67,000 of these calls were either from providers or were for general information, resolved through the digital interactive voice response system.\textsuperscript{115} Several thousand additional calls involved resolving problems on the spot with the support of patients rights representatives (905 calls) or required handling by clinical staff (1133 calls). An additional 4740 formal complaints raised issues of coverage, denial of payment, access, quality of care, billing and disputes over health care services; of these, 723 complaints, or 15%, went into the IMR system in 2001 and approximately

\textsuperscript{108} Interview with Stacy Mitchell, Pennsylvania, \textit{supra} note 16.
\textsuperscript{109} \textit{Id.}
\textsuperscript{110} \textit{See} Appendix B, Chart II.
\textsuperscript{111} \textit{Id.}
\textsuperscript{112} \textit{Id.; IMR REPORT 2002, supra} note 65; IMR REPORT 2003, \textit{supra} note 66; JOHN Q. REPORT, \textit{supra} note 78, at 51.
\textsuperscript{113} \textit{See} N.Y. 2001 REPORT, \textit{supra} note 63, at 4, 13 (noting that New York provides a toll free hotline to help consumers file external appeal requests; information and applications are posted on the web site of both Insurance and Health departments; brochures describing the system are disseminated; both departments have participated in information meetings with health plans, providers and consumer groups and staff are available on weekends and holiday to handle expedited requests). \textit{See also} JOHN Q. REPORT, \textit{supra} note 78, at 41 (stating that California has conducted outreach to providers through medical groups and associations; specialty cancer treatment centers; employer and consumer groups and rehabilitation providers; and PT, mental health and chemical dependency providers). California has an extensive website, provides newsletter articles, brochures and posters, and works with health plans to incorporate IMR information on their home pages. \textit{Id. See also} Appendix B, Chart II.
\textsuperscript{114} JOHN Q. REPORT, \textit{supra} note 78, at 3.
\textsuperscript{115} \textit{Id.}
113 of these were withdrawn or resolved while being processed.\textsuperscript{116} Therefore, only 610 cases in California were sent to independent review in 2001.\textsuperscript{117} Thus, in the final analysis, 13\% of formal complaints completed IMR.

Since New York started its IMR program in June of 1999, it has received approximately 16,000 calls (5200 calls in year one, 3800 calls in year two, and over 6500 calls from July 2001 to December 2002) on the state’s external appeal hotline; however, not all calls were directly related to external appeal. Of these calls, 1405 actual requests for IMR were made in year one, 1675 in year two, and 2128 from July 2001 to December 2002, which is equal to an estimated comparable twelve-month rate of 1418 calls. Altogether of the 16,000 calls, 5208 translated to actual IMR requests, or 33\% of all calls received.\textsuperscript{118} In light of rejection rates for incomplete applications or applications ineligible for review, 2971, or 52\%, of requests resulted in a completed review. When coupled with an additional 722 appeals reversed by health plans while cases were pending, almost 71\% of appeal requests have had complete determinations in New York’s IMR program since its inception, comprising approximately 23\% of all calls coming into the external appeal hotline.\textsuperscript{119}

The Kaiser Foundation reports that external review requests are winnowed down to fewer actual requests because of lack of public awareness, the length of the internal and external appeal processes, filing fees, filing deadlines, claims thresholds, and limits on types of cases eligible for external review, all of which create barriers to access.\textsuperscript{120} Some of these factors are at work in these four states. Other industry experts attribute low numbers to a lack of consumer awareness that reviews and appeals are an option, as well as a lack of information about how to apply.\textsuperscript{121} Yet other analysts suggest that the “paucity of upper level appeals” within the health plan internal appeal process, to which IMR is often linked, could either “reflect satisfaction with first-level decisions” or

\begin{thebibliography}{99}
\bibitem{116} Id. at 35.
\bibitem{117} Id. at 36.
\bibitem{118} See Appendix B, Chart II for updated data from New York through the end of December 2002, which marked the three and one-half year mark for the program. Although the program is growing at a steady rate, the annual growth rate has leveled off.
\bibitem{119} N.Y. STATE DEP’T OF INS. & DEP’T OF HEALTH, N. Y. STATE EXTERNAL APPEAL PROGRAM 2002 at 9, 14 (JULY 2001-DEC. 2002); N.Y. 2001 REPORT, supra note 63, at 9-10, 29; e-mail from Kristin O’Neill, Senior Attorney, Health Bureau, N.Y. DOI, to Leatrice Berman-Sandler (Oct. 7, 2003, 16:00:06 CST) (on file with author).
\bibitem{120} KAISER ASSESSMENT, supra note 7, at 10-14.
\bibitem{121} Travis Ketterman, The Supreme Court Endorses the Right to Second Opinions for HMO Participants, 91 ILL. B.J. 66, 92 (2003).
\end{thebibliography}
that enrollees are simply worn down by the process and reticent to press on.\footnote{122} A recent study in California of patients who used IMR confirmed some of these suggestions.\footnote{123} The report indicated that patients are stalled in the grievance process on their way to IMR.\footnote{124} Less than half of patient respondents reported that their health plan followed timeframes set by statute. Patients also do not track timeframes, thus staying in the internal grievance process much longer than needed.\footnote{125} Patient surveys indicate that many people go through multiple internal appeal levels before they realize that IMR is an option.\footnote{126} Specifically, California’s study indicates that two-

\footnote{122. Studdert & Gresenz, \textit{supra} note 15.}
\footnote{123. California commissioned two studies to look at program implementation and impact. \textit{IMR Report} 2002, \textit{supra} note 65; \textit{IMR Report} 2003, \textit{supra} note 66, at 2. The most recent survey of IMR participants during 2001 had a consumer response rate of 25\% among IMR participants, 49\% among their physicians and sampled health plans representing 94\% of all reviews performed. \textit{IMR Report} 2003, \textit{supra} note 66. Consumers in the study went through the IMR process from 1999-2001. The two studies obtained the subjective impression of participants. \textit{Id.; IMR Report} 2002, \textit{supra} note 65. The recent report attempted to compare how impressions changed in 2001, when DMHC assumed responsibility for handling IMRs in California. \textit{IMR Report} 2003, \textit{supra} note 66, at 10. While the 2001 respondents disproportionately represented those who were successful in the IMR process, the study revealed that despite the major revamping and promotion of California’s system, patient awareness “remained essentially unchanged” from 2000 to 2001. \textit{Id.} This was not an adequate timeframe for evaluating change in the system, but the report concluded that targeting patients with information before they are in a position to consider IMR for themselves may have little impact. \textit{IMR Report} 2003, \textit{supra} note 66, at 2. Less than one-third of patients said the DMHC helped them understand the IMR process, despite California’s sophisticated system. \textit{Id.} at 18. Likewise, in the 2001 survey, patients going through the state-based E/I review system reported in greater numbers that information was not available to them early in their process, nor did they receive enough support in mounting their case and submitting information for the IMR. \textit{IMR Report} 2002, \textit{supra} note 65, at 10-15. Although new regulations allowed them to move directly to a State review, they did not know their rights. \textit{Id.} at 33-34. Last, patients report wanting direct contact with the IRO. \textit{IMR Report} 2003, \textit{supra} note 66, at 5. Comments included being able to call to ask questions or verify that correct information has been received and being able to participate through a hearing process where they could be physically present. \textit{Id.} In response to these findings, the DMHC has tried to conduct information campaigns for consumers, providers and others about the availability of IMR. Interview with Tom Gilevich, \textit{supra} note 16. In 2002, the Department contacted 878 organizations to promote the IMR system, held a provider-focused outreach campaign, and developed a dedicated IMR web page on the DMHC Web site. \textit{IMR Report} 2003, \textit{supra} note 66, at 35.}
\footnote{124. \textit{IMR Report} 2003, \textit{supra} note 66, at 35.}
\footnote{125. California data from the IMR 2003 Report confirms that of the grievances received in its internal process, plans overturned their denials on average 40-50\% of the time, and many cases eligible for IMR dissipate to less than 100 cases per plan per year. \textit{IMR Report} 2003, \textit{supra} note 66, at 36. Because California does not accept IMR requests if services are already rendered (with the exception of urgent and emergency care), this also substantially reduces IMR requests from PPO patients. Interview with Tom Gilevich, \textit{supra} note 16.}
\footnote{126. \textit{IMR Report} 2003, \textit{supra} note 66, at 33-35.}
thirds of patients were not aware of IMR before they used it, and very few physicians knew about it before one of their patients used it.\footnote{Id. at 3.} Targeting patients with information before they are in a position to consider IMR for themselves seems to have little impact.\footnote{Id. at 2.} This is negative news for recent state initiatives to promote IMR. On the other hand, broad education in the general public and promotion in health plan and insurance materials may be helpful in creating better public awareness about IMR and word of mouth support at the point when a patient needs advice about disputing denial of care.

In sum, there is a tremendous funneling effect both within health plans and from health plans to state-based IMR, as the number of eligible candidates who actually complete the review process is contrasted to the number of requests for IMR per year. Although there have been gains in the IMR process, there are also barriers, specifically that patients may not fully understand their rights.\footnote{Additionally, California's IMR Reports suggest that two-thirds of beneficiaries sampled were not aware that the IMR was an independent system and that the medical experts used had no significant financial interest or bias toward the health plan, provider or medical facility. Furthermore, a majority of beneficiaries also did not know whether the health plan played a role in selecting the reviewer. IMR REPORT 2002, supra note 65, at 10, 14.} Therefore, states may need to implement more effective ways to reach patients about such rights in order to make expectations clearer and provide tools for patients to move through the grievance process more effectively.\footnote{Recommendations from recent California reports suggest that the state might benefit from rethinking how patients receive IMR applications, specifically for E/I patients. Patients disputing the denial of an experimental treatment typically do not exhaust their internal process, so they do not receive notice about the availability of appealing to the state's IMR system; likewise, they do not directly receive an application from the health plan. Other ideas being considered by the state include: developing "How To" books to assist with both promotion of IMR and to help patients get through the process; increased monitoring of health plans; and strengthening the transparency and involvement of patients, physicians and health plans in the review process. The report also stated a need to further study how cultural or language differences might impact patient experiences in reaching IMR. IMR REPORT 2003, supra note 66, at 34-36. See also IMR REPORT 2002, supra note 65, at 20-23.}

e. Eligibility for IMR

As seen from the above data, part of the funneling effect comes from statutory exclusions.\footnote{See supra text Part III.C.2.a-d.} The biggest reason for rejecting applications in New York is patient or provider ineligibility. Twenty-seven percent of
rejections stem from patients having ineligible insurance, for example those who are self-insured or who are covered by Medicare, out-of-state insurance coverage, federal employee benefits, automobile insurance, or workers compensation.132 Moreover, 25% of applications are incomplete and remain so even after two requests from state agency personnel. In addition, another 16% of applicants miss the forty-five day time limit after a health plan denial and another 16% of applications dispute coverage or contractual issues, not medical necessity.133 In California, where timeframes are more liberal, IMR applications are rejected largely because health plan members are raising reimbursement issues which comprise 33% of all applications, or coverage issues which comprise 28% of applications.134 Only 19% of applications are turned away because patients have not completed internal health plan appeals or applications remained incomplete.135

In sum, the IMR process reflects the fact that state regulators, with the exception of Michigan, did not intend external review for all health plan denials. Rather, the IMR is exclusively focused on medical treatment questions, which contributes greatly to the funneling affect faced by this dispute resolution system.

\[
f. \text{Frequent Disputes, E/I vs. Medical Necessity, Expedited vs. Standard}
\]

The most frequent disputes center around routine patient care issues such as length of hospital stays; durable medical equipment, for example electric versus manual wheelchairs; and pharmaceuticals, such as brand versus generic.136 The majority of medical necessity cases in New York in 2000 focused on requests for coverage of surgical services, inpatient and outpatient mental health care, and inpatient hospital length of stay.137

132. N.Y. 2001 REPORT, supra note 63, at 23. Ineligible provider appeals (127 rejections) are included in the twenty-seven percent figure. Health care providers only have a limited right to request an external appeal in New York. They may request an external appeal of a retrospective final adverse determination; therefore, if the initial utilization review was prospective (before treatment) or concurrent (while treatment was being rendered), the health care provider would be ineligible to request an external appeal. E-mail from Kristin O'Neill, Senior Attorney, Health Bureau, N.Y. DOI, to Leatrice Berman-Sandler (Oct. 7, 2003, 16:00:06 CST) (on file with author).


134. JOHN Q. REPORT, supra note 78, at 32.

135. An additional eight percent of accepted applications are reversed by health plans while in the IMR process. JOHN Q. REPORT, supra note 78, at 32.

136. Summary statement based on Interviews, supra note 16, and all reports.

137. N.Y. 2000 REPORT, supra note 61, at 32.
During 2001, while these disputes were still most prevalent, there were increases in pharmaceutical and ancillary therapy services, such as chiropractic care.138 Commonly disputed conditions and procedures include bariatric surgery, such as gastric bypass surgery for obesity; cosmetic surgery, such as breast reductions; oral-maxillofacial procedures including temporomandibular jaw surgery, and dental procedures such as crowns, implants, and dentures; interdisc-electrothermal therapy; physical therapy; and custodial care, specifically the use of occupational and physical therapy in the home setting.139

In California medical necessity cases, prescription drug therapy, cosmetic or reconstructive surgery, other surgical procedures, durable medical equipment and specialist referrals comprised the bulk of disputes. In addition, obesity, morbid obesity, back pain, cancer, and arthritis were the most frequently noted diagnoses. In E/I reviews, prescription drug therapy and interdiscal-electrothermal therapy for back pain were the most frequently disputed procedures, while musculoskeletal complaints and cancer care were the most frequent diagnoses.140 The off-label use of prescription drugs is also included within the scope of E/I in most states.141

Experimental or investigational applications, by definition, require more supportive documentation and are reviewed according to more rigorous scientific criteria.142 The number of E/I applications differ across the four states studied; these differences may reflect distinct provider cultures. Of the cases brought forward, 7-8% of cases reviewed in both New York and Michigan are E/I, while 25% of cases in California are E/I.143 Historically, California only accepted E/I requests for external review, which may explain why California activity is greater in this area.144 Moreover, California personnel report that there is no uniformity in how health plans label E/I versus medical necessity cases within the state.145

There is also variation across the states in differentiating expedited from standard reviews. Of total reviews in California, 15% are expedited
compared to New York, where only 6-7% of appeals are expedited.\textsuperscript{146} Moreover, in California, 45% of E/I reviews are expedited, compared to 6% of medical necessity reviews.\textsuperscript{147}

g. Overturn Rates

There is heightened focus on reversal rates, also called overturn rates, as a result of IMR.\textsuperscript{148} In this four state sample, the variance in reversal, or overturn, rates is not large—32-45% of health plan decisions are either overturned or modified.\textsuperscript{149} Nationally, consumers are successful in the external review about half of the time, although the variation across states is much greater, ranging from 21% in Arizona and Minnesota to 72% in Connecticut.\textsuperscript{150} This wide range reflects both state size, reporting artifacts, and unique state characteristics.\textsuperscript{151}

Compared to overall reversal rates, overturn rates for E/I cases are lower in all states in this sample. New York personnel note that some health plans consult outside experts when rendering E/I determinations, so that plan decisions may be pre-reviewed by an outside agency before they reach the state.\textsuperscript{152} Additionally, prior IMR decisions also have had some impact on changing health plan protocols in the E/I area. Yet, E/I reversal rates continue to vary across states.\textsuperscript{153} As a result of these variations, the National IRO Organization is interested in developing data collection techniques and data repositories for the purpose of developing national benchmarks and comparisons across states to standardize outcomes.\textsuperscript{154}

3. The Nature of IMR as a Dispute Resolution Process and the Role of Key Parties

The IMR procedure is largely a paper process and is typically a clinical

\begin{footnotesize}
\begin{enumerate}
\item[146.] N.Y. 2001 REPORT, \textit{supra} note 63, at 51-53.
\item[147.] \textit{Id.} at 48; N.Y. 2001 REPORT, \textit{supra} note 63, at 51-53. Data by type of review was not available in the N.Y. 2000 Report.
\item[148.] See Appendix B, Chart II.
\item[149.] \textit{Id.}
\item[150.] KAISER ASSESSMENT, \textit{supra} note 7, at vi, 3.
\item[151.] \textit{Id.} at 3.
\item[152.] Interview with Judy Doyle and Kristin O'Neill, \textit{supra} note 16; e-mail from Kristin O'Neill, Senior Attorney, Health Bureau, N.Y, DOI, to Leatrice Berman-Sandler (Oct. 7, 2003, 16:00:06 CST) (on file with author). \textit{See also} N.Y. 2001 REPORT, \textit{supra} note 63, at 46.
\item[153.] In New York, forty percent of E/I cases are overturned. N.Y. 2001 REPORT, \textit{supra} note 63, at 47. In California, eighteen percent of E/I are reversed. JOHN Q. REPORT, \textit{supra} note 78, at 4.
\item[154.] Interview with Tom Gilevich, \textit{supra} note 16.
\end{enumerate}
\end{footnotesize}
review of the situation at issue.\textsuperscript{155} Even the \textit{Moran} Court dubbed it a "second-opinion," as the review and determination is made by a physician reviewing an existing record.\textsuperscript{156} Physician reviewers are chosen for their relevant expertise, and the evidence collected is limited to the patient's medical record and other material submitted by a health plan, patient, and the treating physician. The review itself is not a formal legal adjudication involving the collection of evidence, discovery, or a hearing.\textsuperscript{157} Instead, IMR looks like a consumer protection and complaint system where a state agency using an adjunct, independent medical reviewer, assesses whether a health plan has followed prescribed regulatory conduct. The review of conduct includes elements of procedural due process for the handling of internal complaints and grievances,\textsuperscript{158} disclosure and communication of key information about coverage, benefits, and reasons for denial of care; and how beneficiaries can subsequently apply for external review.\textsuperscript{159}

By design, the external review remedy employs limited fact-finding and discovery. The IMR reviewer works independently, typically on contract with an IRO. This organization holds a contract with a state to make an assessment of the medical facts in light of clinical evidence, national standards of care, and a specific patient's needs. With the medical record and the medical literature, the IRO reviewer decides whether care is medically necessary or appropriate. The reviewer submits findings to the state, and the health or insurance commissioner is authorized to accept or reject the determination, providing the disputing parties with the reviewer's rationale and background materials as requested.\textsuperscript{160} Nevertheless, IMR looks to some reviewers like a stripped-down and informal version of alternative dispute resolution ("ADR"). The \textit{Moran} Court, in fact, vigorously debated whether IMR is an alternative dispute mechanism because IMR involves states conducting an arbitration-like weighing of facts and circumstances that is binding on the health plan.\textsuperscript{161} Yet unlike ADR, all parties, particularly the patient, can move forward into court if desired. In a few jurisdictions, parties can enter into formal arbitration after IMR should it be necessary.\textsuperscript{162}

Furthermore, IMR is quite different from the agency-based adjudicative

\begin{footnotesize}
\begin{enumerate}
\item[155.] Interviews, \textit{supra} note 16.
\item[157.] Interviews, \textit{supra} note 16; Reports, \textit{supra} note 105.
\item[158.] Interviews, \textit{supra} note 16.
\item[159.] \textit{Id.}
\item[160.] \textit{Id.} \textit{See also infra} text accompanying notes 163-179.
\item[161.] \textit{See infra} Part V. \textit{See Moran}, 536 U.S. at 394-96 (Thomas J., dissenting).
\item[162.] \textit{Infra} Part III.C.7, \textit{Links to Subsequent Judicial Action or Suit}.
\end{enumerate}
\end{footnotesize}
system, which typically involves an administrative hearing and appeal before an Administrative Law Judge. 163 Even though hearings are not incorporated within the state’s external review process, some states mandate that health plans hold hearings at the second appeal level, while other states give plans discretion to hold hearings as needed. 164 Specifically, Pennsylvania mandates that a hearing take place before a grievance committee. 165 Pennsylvania estimates that consumers participate eighty to ninety percent of the time at such grievance hearings either by telephone or in person. 166 New York mandates only one level of internal appeal review before a patient can request an external appeal so that hearings are held at the discretion of the plan. 167 Michigan does not mandate an in-person hearing for the internal review process, but staff estimates that hearings, including conference calls, are used in thirty percent of cases or less. 168

a. Role of IROs and State Staff

The need for independent review has increased over the last five years and several IROs dominate the industry, holding major contracts across the country. 169 The quality of the reviews and qualifications of the reviewers have improved, have enhanced the credibility of the IMR process, and have increased the level of satisfaction within state government. 170 In each state, there is an interface between state agency staff and IROs and a pre-review of all appeals to differentiate contract and coverage disputes from medical necessity disputes. 171 State agency personnel working with patients, health plans, and providers check files for eligibility and completeness and then send them out for IRO determinations. 172

In Michigan, where most denials by law are subject to external appeal,
contractual claims must be separated out because such claims are not sent to IROs. These contract-based appeals are handled directly by staff analysts and legal counsel in Michigan’s Office of Financial and Insurance Services (“OFIS”). Specific contractual claims, particularly complicated payment and contractual matters requiring medical interpretation, are sent to external review. After the IRO decision, the DOI routinely reviews all determinations. The Commissioner of Insurance ultimately has authority and can reject an IRO determination; however, ninety-eight percent of IRO determinations are accepted.

In New York, external appeal applicants often present issues not eligible for review, such as disputes about the use of out-of-network providers. These appeals are sent to the Consumer Services Bureau of the New York DOI and are handled as consumer complaints. Department of Insurance analysts further review applications to determine whether a health plan is subject to the external appeal law, whether the application is complete, and whether the patient or provider has conformed to required timelines. Insurance department attorneys are also available to sort out health plan denials based on medical necessity or E/I, from coverage and other types of complaints that are not eligible for external appeal. Eligible appeals are then randomly assigned to IROs.

Similarly, in California’s Department of Managed Health Care (“DMHC”), attorneys review all coverage and termination of benefits disputes, including payment disputes frequently related to out-of-network care. Legal staff has the authority to issue binding orders to health plans and enrollees on these matters, as well as prepare files for IMR. California has three IROs on contract, but uses one firm as its primary contractor. Single reviewers are used in medical necessity disputes, but the Department has discretion to request more than one reviewer for complicated or high profile disputes or when there is concern for clinical specialty-based bias. Three reviewers are assigned for reviews involving

173. Id.
174. Id.
175. Interview with Paul Duguay, supra note 16.
176. Interview with Judy Doyle and Kristin O’Neill, supra note 16; e-mail from Kristin O’Neill, Senior Attorney, Health Bureau, N.Y. DOI, to Leatrice-Berman Sandler (Oct. 7, 2003, 16:00:06 CST) (on file with author).
177. Interview with Judy Doyle and Kristin O’Neill, supra note 16.
179. Interview with Tom Gilevich, supra note 16.
180. Id.
181. Id.
182. Id.
b. Role of Physicians

As a matter of statutory law, physicians must be involved in certifying the need for E/I reviews and for expedited reviews. Expedited review requires attestation that severe imminent harm or disability is at stake for a patient. However, standard reviews for medical necessity do not require physician participation unless physicians, with written consent from patients or families, are applying on behalf of patients, and the general consensus is that physician participation is sub-optimal.

IMRs benefit greatly from physician involvement; physicians enhance the quality and thoroughness of materials prepared and some state respondents reported disappointment that physicians are not more frequently and more directly involved as patient advocates. California staff reports that fewer than half of the physicians are active in the preparation of IMR cases; approximately 50% of the physicians were informed and knew that their patient had initiated an IMR, and only 27% of the physicians reported that they had all of the information necessary to assist their patients during an IMR. Furthermore, 35% of those physicians sampled who had patients involved in reviews reported that they did not know the outcome of the review. This lack of involvement and advocacy on behalf of patients was cited as one of the major areas of disappointment in California with respect to IMR. Therefore, despite

183. Id.
184. CAL. CODE REGS., tit. 28, § 1300.74.30(d)(4) (2003) (certifying expedited review); CAL. HEALTH & SAFETY CODE § 1370.4.30(a)(2) (2003) (certifying that the enrollee has a condition for which standard therapies have not been effective); MICH. COMP. LAWS §§ 550.1907(3)(a), 550.1913(1)(a) (2002) (certifying expedited review); N.Y. PUB. HEALTH § 4914(2)(c)(2003) (certifying expedited review) and § 4910(2)(b) (certifying need for experimental treatment).
185. CAL. CODE REGS., tit. 28, § 1300.74.30 (d)(4); MICH. COMP. LAWS § 550.1913(1)(a); N.Y. PUB. HEALTH § 4914(2)(c); 40 PA. CONS. STAT. ANN. § 991.2161(e) (2003).
186. CAL. HEALTH & SAFETY CODE § 1374.30 (j), (m)(3) (2003); N.Y. INS. LAW § 4810(2) (2003); N.Y. PUB. HEALTH § 4914(2)(a); 40 PA. CONS. STAT. ANN. § 991.2162(a) (2002); MICH. COMP. LAWS § 550.1907(3)(a)(ii).
188. IMR REPORT 2003, supra note 66, at 22.
189. Id. at 23.
190. Although there are sample surveys in California that quantify and focus on the rather disappointing lack of physician involvement, respondents from three of the four states interviewed echoed similar disappointment at the inconsistent level of involvement and the untapped resources of physicians for assisting health plan members mount appeals. Interviews, supra note 16.
outreach to professional associations and medical groups in all of the states, physicians appear less engaged in the external appeal process than is preferred by state government personnel.\(^\text{191}\)

Moreover, treating physicians report that they want to be more involved with the review, and specifically, with the IRO reviewer.\(^\text{192}\) Recommendations from California studies suggest that physicians would like to be notified if their patient is in IMR and when the review has been initiated.\(^\text{193}\) They want to receive more feedback and explanation regarding decisions and rationale as well as better access to the reviewer in order to discuss the case.\(^\text{194}\) Physicians would like to see a more open and broad review process, including the consideration of more updated information and the use of more appropriate experts.\(^\text{195}\) However, it is not clear that these are the correct ideas, as greater involvement of treating and health plan physicians might bias reviews.\(^\text{196}\) Data on physician behavior, as gleaned from state officials and special studies, provide mixed messages on how involved physicians want to be.\(^\text{197}\) It is reasonable, however, to conclude that physicians are not adequately engaged.\(^\text{198}\)

c. Role of Attorneys

Patients are able to use representatives or attorneys in both internal and external appeals, but they rarely do.\(^\text{199}\) Attorneys are not required to access the process and respondents report that few patients wish to spend the money unless they have secured family or pro-bono assistance.\(^\text{200}\) State respondents estimate that attorneys are involved in less than five percent of cases which come before the agencies.\(^\text{201}\) Attorneys do tend to get involved

\(^{191}\) Id.
\(^{192}\) IMR REPORT 2003, supra note 66, at 40-41, 44.
\(^{193}\) Id.
\(^{194}\) Id. at 41.
\(^{195}\) Id. at 4.
\(^{196}\) IMR REPORT 2002, supra note 65, at 5.
\(^{197}\) Interviews, supra note 16.
\(^{198}\) Naturally, both physician and consumer satisfaction with the IMR process is highly correlated to the outcome of the reviews. California's studies also suggest that IMR reviews have less impact on physician practices. Only six percent of doctors interviewed reconsidered the efficacy of treatments they recommended based on the IMR review. IMR REPORT 2003, supra note 66, at 4. Health plans also would like more information on the rationale of decisions if one purpose or byproduct of IMR is to have influence over future medical policy or coverage decisions. Id.
\(^{199}\) Interviews, supra note 16.
\(^{200}\) Id.
\(^{201}\) Interviews with Tom Gilevich and Paul Duguay, supra note 16.
when big-ticket items are at stake, but because legal representation is so infrequent, it is hard to assess if attorney representation is outcome determinative.

In sum, IMR legislative reforms attempt to standardize and develop consumer responsive processes which do not require formal legal support and which mitigate the need to go to court. The internal grievance hearing and the IMR process are not considered legal proceedings. Given the nature of the process, attorneys are not needed, except in complicated cases in which significant dollars are at stake or in cases when health plans refuse to comply with a binding decision. In those cases, patients retain attorneys to either threaten or proceed to court.

d. Role of Health Plans

New York staff summed up the role and reactions of the managed care industry across the country as being generally responsive and compliant. Plans administrators appreciate the IMR program and the input it provides, follow its results, and are apt to make adjustments to their systems in response. Pennsylvania staff reported that complaints from plans initially focused on onerous notice and procedural requirements, such as mandated internal grievance hearings, but health plans have since adjusted to these and similar requirements. Plans have institutionalized statutory mandates related to both internal and external procedures and they fund the system through special assessments or payment for specific reviews.

California data, on the other hand, reveal that, although adjusted, not all health plans are compliant. For example, plans in California do not always follow patient notification requirements as specified in the law. Although health plans report high levels of compliance with results, a number of patients report significant difficulty obtaining approved services after IMR reverses a health plan’s decision. Moreover, the states do not consistently track health plan compliance with the results of an IMR, but rather most non-compliant cases come to the state’s attention through the

202. Interview with Paul Duguay, supra note 16. For example, an attorney was involved in the development of an external appeal involving adolescent anorexia where the dispute involved expensive institutional care.
203. Interview with Tom Gilevich, supra note 16.
204. Interview with Judy Doyle and Kristin O’Neill, supra note 16.
205. Id.
206. Interview with Stacy Mitchell, supra note 16.
207. See Appendix A, Chart I.
However, plans have accepted IMR protocols and IRO review standards and today health plans are called upon to play extensive roles in the internal review and notification process. In Pennsylvania, health plans manage the external appeal directly including the application process. In California, plans are proactive in facilitating E/I appeals to get an objective third party opinion; thirty-three percent of E/I reviews in California were initiated by plans in 1999 and 2000. Such examples of buy-in and support co-exist with cited examples of non-compliance.

e. Ombudsmen Functions

Although none of the four states evaluated have formal ombudsmen programs to shepherd consumers through the process, they do provide a mix of similar support. Pennsylvania has no formal program in its Bureau of Managed Care, but the Department of Health ("DOH") regulations require plans to assign disinterested staff persons to help enrollees get organized and prepare for internal plan hearings, which are prerequisites to the external appeal. The Pennsylvania DOH will look into any allegation that enrollees have been disadvantaged in the grievance process. Once at the external appeal level, state staff facilitates transmittal of the application to the IRO working with both patients and plans, but DOH does not review the record before, during, or after transmittal.

Michigan's OFIS has been authorized by the PRIRA legislation to establish consumer protection procedures. OFIS provides toll-free telephone service to explain the external review process, to make sure consumers know correct complaint procedures, and to refer those ineligible for IMR to other state or federal agencies. For example, health plan denials for non-payment of premiums are triaged by OFIS but sent to a separate consumer protection staff handling contractual disputes. OFIS does not view itself as an advocate for either side in a dispute, but if there is ambiguity in contract terms or provisions, it is typically interpreted against the drafter, the health plan. Michigan code provisions mandating specific benefit coverage are also taken into consideration in reviewing denials and

210. Interviews with Tom Gilevich and Stacy Mitchell, supra note 16.
211. 40 PA. CONS. STAT. § 991.2162 (2002).
212. IMR REPORT 2002, supra note 65, at 6.
213. Interview with Stacy Mitchell, supra note 16.
214. E-mail from Stacy Mitchell, Dir. of Managed Care, Pa. Dep't of Health, to Leatrice Berman-Sandler (Oct. 2, 2003, 15:37:14 CST) (on file with author).
216. Interview with Paul Duguay, supra note 16.
conduct.\textsuperscript{217}

New York does not have an official ombudsmen unit, but has a large consumer services bureau in the DOI and a consumer complaint department in the health department properly known as the Office of Managed Care, Bureau of Certification and Surveillance. Both of these units actively respond to consumers and their complaints. New York has an external appeal hotline for consumers to ask questions and receive assistance with completing external appeal applications. The Insurance Department's Health Bureau staffs its hotline with examiners who are assisted by attorneys as needed.\textsuperscript{218} There is also an Office of Consumer Protection within the Attorney General's Office, which refers complaints on medical care to the above state agencies.\textsuperscript{219}

California's DMHC runs an HMO Help Center that provides around-the-clock support for consumers by mail and phone.\textsuperscript{220} A staff of ten consumer representatives provides initial screening and advice, supported by a contractor who provides twenty-four hour call coverage and around-the-clock back up. Consumer representatives are further supported by a group of nurses who sort issues of coverage from issues of medical care. The nursing staff mediates complaints on the spot between health plans and consumers, and if needed, connects consumers directly to a decision-maker in a health plan to settle a dispute. Early hospital discharge complaints are handled immediately in this manner, as are other urgent issues. If grievances are not settled, representatives assist consumers with the filing of formal complaints to health plans. California also has a free standing Office of the Patient Advocate, providing public information and referrals.


Oversight in all four states is provided through the executive power of the commissioners or superintendents in the agencies as authorized by law. In California, a clinical advisory panel consisting of five members appointed by the Director of the DMHC, meets quarterly in a public forum to provide expert assistance to ensure that the IMR system is meeting quality standards sufficient to protect the public's interests.\textsuperscript{221} The panel

\begin{footnotesize}
\textsuperscript{217} Id.
\textsuperscript{218} E-mail correspondence with Kristin O'Neill, Senior Attorney, Health Bureau, N.Y. DOI, to Leatrice Berman-Sandler (Oct. 7, 2003, 16:00:06 CST) (on file with author).
\textsuperscript{219} Id.
\textsuperscript{220} Description provided in interview with Tom Gilevich, \textit{supra} note 16. \textit{See also} \textit{JOHN Q. REPORT}, \textit{supra} note 78, at 11-22.
\textsuperscript{221} \textit{CAL. HEALTH & SAFETY CODE} § 1347.1 (2003). California statute specifies that the members must consist of professors of medicine from California public and private medical
\end{footnotesize}
reviews redacted IMR decisions to assess whether the decision is consistent with "best medical practice." The panel recommends approaches to reducing clinical errors, improving patient safety, increasing the practice of evidence-based medicine, and promoting and overseeing studies of the IMR program.

Furthermore, IMR regulations provide states with authority to take enforcement action against plans whose action or inaction frustrates or impedes the IMR system. Departments monitor health plan notification requirements and internal grievance procedures, and administrative penalties are assessed for patterns of non-compliance or problems in the health plan review system. California has assessed penalties for failure to provide records to the IRO within required timeframes, failure to provide proper notice about filing a grievance and access to IMR, and inaccurate notice as to how to contact the DMHC and IRO. California officials are aware that some plans fail to provide information as required in denial letters and health plan certificates of coverage and handbooks. This problem can be more prevalent in network model health plans or HMOs, where administrative functions, such as utilization review, authorization and denial of care, are delegated to physician groups. In these arrangements, there is a greater probability that corporate health plan offices will not adequately monitor the results and the processing of first level determinations, which are sent directly by medical groups to members. Additionally, California, with some of the strongest sanctions, charges a penalty of $5000 per day when a health plan fails to implement an IMR decision within five days of its adoption by the Department. The legality of similar state penalties charged to an ERISA health plan was recently at issue in Connecticut General Life Insurance Company v. Maryland Insurance Commissioner on the basis that the external review system was preempted. The Maryland Court of Appeals, relying on

schools and two members must be practicing physicians.

222. Interviews, supra note 16.

223. CAL. HEALTH & SAFETY CODE § 1347.1.

224. See, e.g., MICH. COMP. LAWS § 550.1929 (2002); CAL. HEALTH & SAFETY CODE § 1341.9 (2003) (establishing the powers of the Department of Managed Health Care); CAL. HEALTH & SAFETY CODE § 1386 (2003) (establishing the power to assess administrative penalties); CAL. CODE REGS. tit. 28, § 1300.86 (2001) (establishing the factors that DMHC's Director will consider in assessing penalties).

225. MICH. COMP. LAWS § 550.1929.

226. Interview with Tom Gilevich, supra note 16.

227. JOHN Q. REPORT, supra note 78, at 50.

Moran, specifically found that state conduct did not improperly enlarge benefits owed to a beneficiary beyond an ERISA action and that state administrative remedies and civil penalties were appropriate. By denying certiorari, the Supreme Court allowed the decision to stand.

5. Defining Medical Necessity

Defining medical necessity is at the core of the IMR process, but there is no generic definition. As background, definitions differ across health plans and are usually broad. Health plan definitions, thought to be a tautology—what the health plan deems medically necessary is so—are likely in practice to be narrow, self-serving, and, accordingly, suspect. Like legal determinations, medical necessity determinations can only be defined in relationship to a specific case and a specific set of facts. Under the fee-for-service model, medical necessity corresponded to the individual decision of the treating physician. This approach obviously conflicts with "managing care" and the potential benefits to be derived from systems of care that have the capacity to benchmark and compare treatment decisions in real-time against evidence-based clinical standards and care guidelines. However, financial incentives facing health plans can distort judgments about what is medically necessary.

Consequently, IMR reviewers in a majority of jurisdictions have been allowed by statute to review cases de novo and without the deference accorded health plan definitions more commonly found in the judicial forum. Of the four states, only Pennsylvania law binds its reviewers to health plan definitions of medical necessity. Michigan reports that health plans often try to define medical necessity, but the guideposts used are too general and "very subjective."

The four states studied also do not define medical necessity directly. New York statute establishes that health care plans are expected to act

230. Id.
231. Broad definitions are a double-edged sword. Breadth is necessary because it is difficult to determine, at the health plan level, a definition of medical necessity that would work across a wide variety of patients and presenting health conditions; on the other hand, breadth provides a health plan and its Medical Director with a great deal of discretion. See Frank A. Sloan & Mark A. Hall, Market Failures and the Evolution of State Regulation of Managed Care, 65 LAW & CONTEMP. PROBS. 169, 193 (2002). Therefore, both states and plans use standards of review to operationalize this definition.
232. Id.
233. Interview with Tom Gilevich, supra note 16.
234. 40 PA. CONS. STAT § 991.2162(c)(5) (2002).
235. Interview with Paul Duguay, supra note 16.
reasonably and appropriately in the best interest of the patient using sound medical judgment. New York law further provides that IMR reviewers can consider clinical standards as presented by the health plan and can uphold them as appropriate, but are not bound by them. California statute only stipulates the criteria that reviewers must apply in adjudicating a medical necessity claim. According to the statute, necessity is based on the specific needs of an enrollee and five criteria: 1) peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service; 2) nationally recognized professional standards; 3) expert opinion; 4) generally accepted standards of medical practice; and 5) treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

Pennsylvania staff note that external appeals are not about disputes over medical necessity, but over what is deemed medically appropriate. Most disputes do not typically revolve around "need." For example, there is no dispute that a patient needs treatment for prostate cancer; rather, the dispute centers around what protocol to use and where to go for care, for example, in or out-of-network. From Michigan’s staff perspective, disputes raise both need and appropriateness issues and each dispute is patient specific. Additionally, issues of medical necessity inevitably overlap with issues of coverage. Most plans strive to have clear certificates of coverage and airtight exclusions, which clarify what they will not cover regardless of medical need. For example, plans will not cover participation in Phase One or Phase Two drug studies, cosmetic surgery, or custodial care. However, patients dispute these coverage exclusions when they need care. Therefore, agency staff often review health plan contracts or certificates of coverage to determine whether an exclusion was in effect at the time of the denial; whether contract language is misleading or whether care can be received in or out-of-network for certain conditions, procedures or specialty

237. N.Y. INS. LAW § 4914(b)(4).
239. CAL. HEALTH & SAFETY CODE § 1374.33.
240. This may not be an important distinction because one cannot always distinguish the concepts of necessity and appropriateness in practice. However, Pennsylvania’s statute includes appropriateness in defining what constitutes a grievance, and this allows more types of cases to go to IMR. Interview with Stacy Mitchell, supra note 16. See also e-mail correspondence with Stacy Mitchell, Dir. of Managed Care, Pa. Dep’t of Health, to Leatrice Berman-Sandler (Oct. 2, 2003, 15:37:14 CST) (on file with author).
241. Interview with Stacy Mitchell, supra note 16.
242. Interview with Paul Duguay, supra note 16.
243. Interviews, supra note 16.
244. Id.
services; and whether the plan has failed in any of its administrative obligations relative to handling the claim.245

Furthermore, compliance and contractual reviews precede, and determine, the results of many appeals, which appear to focus on medical necessity. Benefits and exclusions must match state coverage mandates, so specific services, such as prosthesis and reconstructive surgery after a mastectomy, or nutritional supplementation after a phenylketonuria (PKU)246 finding in an infant, become specifically relevant on the basis of both need and state coverage mandates.247 Also, because employers can carve out certain areas of coverage in customized benefit plans, staff analysts must understand employer prerogatives in relationship to ERISA, compliance with insurance law, and state exemptions.248

As a result of the overlap between coverage and medical need, Michigan analysts, who cover a wider range of disputes because they review all denials, must give deference to the certificate of insurance, which has the effect of a binding contract. The certificate will often control the analysis as to whether a dispute is really about coverage or care.249 At the same time, the certificate is used as a guide for all disputes only if reasonable under common law and consistent with state statute.250 Moreover, if a coverage issue involves an assessment of medical necessity, or raises ambiguities as to whether coverage or care is involved, it will be sent to the IRO.251 If medical standards have changed or the definition of medical necessity in an insurance contract is too narrow, not workable, or obsolete, the IRO has freedom to deviate.252 Likewise, if a plan defines E/I treatment in a narrow or restrictive way that appears unreasonable, the IRO's judgment will trump the plan's coverage definitions.253

Even in Pennsylvania, which is bound by the health plan definition, the IRO reviewer has the freedom to function in a similar way.254 While being bound might create a presumption in the health plan's favor, Pennsylvania uphold and reversal/overturn rates are not much different than states where

---

245. Id.
246. A screening test routinely administered to newborns to measure amino acids to identify/prevent mental retardation.
247. Interview with Tom Gilevich, supra note 16. Other interviewees expressed similar situations in their respective states. See also Interviews, supra note 16.
248. Interview with Tom Gilevich, supra note 16.
249. Interview with Paul Duguay, supra note 16.
250. Id.
251. Id.
252. Id.
253. Id.
254. Interview with Stacy Mitchell, supra note 16.
there is no deference to health plan definitions.\textsuperscript{255} In sum, definitions of medical necessity do not provide applicable standards. Legislatures have made health plan definitions non-binding.\textsuperscript{256} Even when given deference, these definitions are meaningful only if reasonable in relationship to a specific case and consistent with state law and professional standards. Health plan definitions and discretion, while controlling in a courtroom setting, are empty vessels once an appeal gets to the level of an IMR, where the clinical standard has replaced the legal standard.\textsuperscript{257} Last, medical necessity continues to be intermingled with coverage and contractual obligations, which are given greater deference in the pre-IMR review process. In this respect, the greater battlefield in settling disputes over care is in the area of contracts, certificates of coverage, and benefits. Control over what is or is not covered in the standard benefit package, and patient expectations as to what is entailed in a comprehensive health plan, may be the more significant area for patient advocates in the next phase of IMR.\textsuperscript{258} Insurers will strive to draft clearer contracts with airtight exclusions, while states will continue to pass condition and procedure-specific legislation in response to public expectations regarding what constitutes essential health services.

6. Impact on Health Plans

Respondents report that IMR has impacted the managed care industry in several specific ways.\textsuperscript{259} On the positive side, for example:

- External review gives health plans credibility.\textsuperscript{260}

\begin{itemize}
\item \textsuperscript{255} K\textsc{aiser} A\textsc{ssessment}, \textit{supra} note 7, at 4.
\item \textsuperscript{256} Interviews, \textit{supra} note 16. See also K\textsc{aiser} A\textsc{ssessment}, \textit{supra} note 7, at 18 (showing the wide discretion given to the external review agent in determining whether care is medically necessary or appropriate).
\item \textsuperscript{257} Rosenbaum et al., \textit{supra} note 2, at 229-30.
\item \textsuperscript{258} Clark C. Havighurst, \textit{Consumers Versus Managed Care: The New Class Actions}. 20 \textsc{Health Affairs}, July-Aug. 2001, at 8, 19-20; John D. Blum, \textit{Overcoming Managed Care Regulatory Chaos Through a Restructured Federalism}, 11 \textsc{Health Matrix} 327, 327 (2001). See also Studdert & Gresenz, \textit{supra} note 15, at 868-69.
\item \textsuperscript{259} IMR \textsc{Report} 2003, \textit{supra} note 66, at 29. Five of seven health plans surveyed for a California report responded that they were positively impacted by the plan. However, one of the plans reported that the IMR system challenged its credibility with subscribers and two plans felt that IMR has had little impact. \textit{Id}.
\end{itemize}
The caliber of documentation and the evidence base behind treatment decisions in health plans seems to have improved. IMR decisions provide an incremental and stable feedback loop for plans. Too many reversals indicate problems. While not having precedential value, IMR determinations change health plan clinical policy over time. Specifically, this is evidenced in the area of emerging technologies and drug regimens. In California, where six separate reviewers reversed 100% of health plan denials involving bariatric surgery (gastric bypass surgery), citing National Institutes of Health (NIH) guidelines, health plans changed their approval guidelines for the procedure. Given demonstrated and potential effects on health plan practices in Michigan, state personnel liken the cumulative impact of the IMR remedy to an ongoing class action, because it puts ongoing, consistent pressure on the industry on behalf of patients as if they are acting collectively.

As a byproduct of IMR, state agencies are identifying the need for clearer state regulations on permissible contract exclusions and exemptions. Specifically, custodial care and cosmetic surgery in New York fall into this category and have demanded attention from the state. These examples suggest that the IMR

261. Interviews, supra note 16.
263. IMR REPORT 2003, supra note 66, at 28.
264. Interview with Tom Gilevich, supra note 16.
265. Interview with Paul Duguay, supra note 16.
266. Health plans in New York have questioned the applicability of the external appeal process to determinations that surgical services are cosmetic or that care is custodial because of Insurance Department Regulation 62, promulgated years prior to the External Appeal Law. N.Y. 2001 REPORT, supra note 63, at 17. This regulation permits plans to exclude these areas from coverage. New York, in light of the IMR process, however, considers these services to raise medical necessity issues. Id. As well, custodial care which involves help in transferring, eating, dressing, bathing, toileting and other such related activities (all considered activities of daily living that would not be covered) often is appropriately intermingled with rehabilitation or private care/skilled nursing care. Id. Specifically, New York has made the following statement:

New York State Insurance Law and corresponding regulations require most plans to provide coverage for surgical services. Regulation 62 does permit plans to exclude coverage for cosmetic surgery but provides an automatic exception to the cosmetic surgery exclusion for reconstructive surgery. Reconstructive surgery is one exception to the cosmetic surgery exclusion but is not the only type of surgery that is considered medically necessary. If the reconstructive surgery exception is not met, the plans must still consider whether the surgery is medically necessary or cosmetic. It is the Insurance Department's position that
process serves a normative function and keys the health plan system to evolving professional care standards.

- Health plans have demonstrated a high level of compliance with IMR procedures and decisions. Very few cases have proceeded to court. 267

- There has been a remarkable democratization in the availability of information, accessible on the Internet, about health plan grievances, health plan track records, and external appeal experiences. New York and California produce extensive annual reports on the IMR experience, HMO Complaint and Grievance Reports, and consumer information about health plans. 268 Web postings include information about complaints and calls, as well as the number of internal and external complaints and grievances by specific plan name. States calculate ratios of complaints per member and rank health plans accordingly. California also reports reversal and uphold rates by general categories of cases or by procedures and conditions. 269 Furthermore, Michigan and California post all of their IMR review decisions on department web sites with patient names redacted. 270 California provides information that identifies the nature of the issue raised in the review and the result. 271 Michigan lists all decisions by name of the health plan with a brief description of not only the issue and decision, but also the rationale for the decision by each case. 272 A consumer in Michigan interested in mounting an appeal can view all previous decisions about that condition both across plans as well as by specific plan. 273 As a result, consumers are

whenever surgery itself is a covered benefit under a policy, a determination that the surgery is cosmetic is a 'medical necessity' determination subject to both utilization review and external review requirements.

_id.

267. New York and California report only a few known court actions. In one California case, an IMR decision overturned a health plan denial, but the insurer went to court and won. Interview with Tom Gilevich, supra note 16.

268. Reports, supra note 105.

269. IMR REPORT 2003, supra note 66, at 28.


273. _Id._
able to make more informed and reasonable decisions about whether to pursue a specific appeal.

Despite the positive effects of IMR, there have been some negative ramifications. For example:

- States report that early resistance from the managed care industry to IMR regulation has merely yielded acceptance of its political necessity, rather than proactive acceptance or endorsement.\(^{274}\)
- Many plans have tightened contractual exclusions to make it quite clear what they will and will not cover.\(^{275}\) (However, plans can only "reasonably restrict" coverage given competitive market forces and state mandates.\(^{276}\) In addition, if health plans move to unduly restrict benefits, state legislators across the country are poised to respond with new condition and procedure-specific benefit expansions.\(^{277}\))
- In the strongest reaction to the overall adjudicatory scheme, Blue Cross-Blue Shield in Michigan has mounted a constitutional challenge to the IMR process on the basis that it violates due process and the rules of evidence, i.e., it neither allows testimony nor cross-examination of the IRO reviewer.\(^{278}\)

7. Judicial Action or Suit and the IMR Link

As early conflict resolution is clearly in the best interest of consumers and less expensive than filing lawsuits, IMR is believed to provide benefits to consumers and plans. All respondents reinforced the notion that external appeals reduce the perception of bias, provide an outlet for consumers and, thus, reduce litigation for plans.\(^{279}\) Even though all jurisdictions surveyed provide access to the judicial forum after IMR, external appeal, in effect, insulates the managed care industry from lawsuits.

Nevertheless, some states place restrictions on access to the judicial forum. California and Pennsylvania passed legislation requiring that the IMR process must be exhausted before a plaintiff can proceed to court. Of the four states sampled, only Pennsylvania creates a presumption against a

\(^{274}\) Interviews, \textit{supra} note 16.

\(^{275}\) Interview with Paul Duguay, \textit{supra} note 16.

\(^{276}\) \textit{Id.}\n
\(^{277}\) Interviews, \textit{supra} note 16.

\(^{278}\) \textit{Id.}\n
\(^{279}\) \textit{See also} Agrawal & Hall, \textit{supra} note 46, at 278.
plaintiff if the IMR process upholds a health plan denial. In comparison, New York and Michigan allow concurrent jurisdiction and access to the courts. Even though Michigan allows concurrent IMR and court jurisdiction, some judges hold cases pending the results of the IMR. Despite the variance across states, an IMR decision would be admissible as evidence in a court proceeding in any state.

Notwithstanding the patient’s right to appeal a case in state court, Pennsylvania staff can recall only one lawsuit filing after an IMR denial was upheld. Likewise, one lawsuit is currently pending in New York, and several have been filed in Michigan. Generally, plaintiffs bring both tort and breach of contract actions; overall, however, few people have proceeded to court.

Of the four states sampled, California stands out for creating a new private right of action against a health care service plan or managed care entity for a breach of the duty of ordinary care to provide medically necessary health care services under California Civil Code § 3428. As a prerequisite for this claim, a health care service must be a covered benefit provided by the plan. To find a health plan liable, a failure to exercise ordinary care must result from a denial, delay, or modification of a health care service recommended for, or furnished to, a subscriber or enrollee. Furthermore, the subscriber or enrollee must suffer substantial harm. Substantial harm means loss of life, loss or significant impairment of limb or bodily function, significant disfigurement, severe and chronic physical pain, or significant financial loss. A health plan can be held liable for health care services recommended or furnished by an out-of-plan provider, but the provider must be practicing within the scope of his or her practice and the health care service must be recommended or furnished prior to the inception of the action, although the recommendation need not be made prior to the occurrence of harm. This new cause of action is directed solely against health plans and managed care entities; its provisions explicitly protect health care providers or employers and plans cannot seek

281. Interview with Paul Duguay, supra note 16.
282. See KAISER ASSESSMENT, supra note 7, at 28 (showing that nine states across the country have created a new cause of action related to health plan or managed care entity liability).
284. CAL. CIV. CODE § 3428(a)(1), (2).
285. CAL. CIV. CODE § 3428(b).
286. CAL. CIV. CODE § 3428(b).
indemnity from health care providers. Additionally, subscribers cannot contractually waive this right.

Although IMR is not a categorical prerequisite for this cause of action, plaintiffs must establish that they have “exhausted the procedures provided by the applicable independent review system.” An exception is made only in cases where substantial harm has occurred or will imminently occur prior to the completion of the review. As a result, if an enrollee does not apply for an IMR and attempts to obtain damages from the health plan for negligence, the cause of action may be dismissed. Counsel at the DMHC is not aware of any claims based on this new cause of action, as mandatory arbitration provisions and ERISA have significantly limited the number of actions brought against California health plans.

D. Summary

The consensus opinion among staff from the four state sample is that IMR works and aids both consumers, providers, and the states. Enrollees seem to find IMR fair and impartial, and state agencies feel the reviews impart important information to patients about treatment options. Despite this, recent reports from California indicate that consumers and their providers may want more disclosure and greater detail about final determinations and rationales. Consumers appear to need more guidance and support in negotiating the process, and physicians and state personnel report that physicians are not sufficiently involved. In conclusion, state respondents reported interest in making very specific operational refinements in IMR. However, none of these reflect a shift in policy with respect to the underlying remedial scheme. For example:

- Pennsylvania has considered ways to alleviate tight time frames

287. CAL. CIV. CODE § 3428(d)-(f).
288. CAL. CIV. CODE § 3428(k)(1).
289. CAL. CIV. CODE § 3428(k)(2)(A), (B).
290. JOHN Q. REPORT, supra note 78, at 51.
292. Interview with Tom Gilevich, supra note 16.
293. Interviews, supra note 16.
294. Interview with Stacy Mitchell, supra note 16.
295. IMR REPORT 2003, supra note 66, at 3.
296. See supra Part III.C.2.a-d (focusing on limitations in eligibility, patient “know-how” with respect to their right to a review, how to exercise that right and how to negotiate the administrative hurdles).
297. See supra Part III.C.3.b.
for patients filing appeals who require more time to gather documentation. Because time frames are based in statute and cannot be waived, the state works with health plans to be flexible in these situations. Although the DOH has considered legislative amendment, it believes it can administer the system without legislative change. Michigan staff also would like to loosen time frames and provide greater leeway for the state and parties to waive the transaction time limits for mounting an appeal from beginning to end. This would require legislative change. The state would also like to increase caseload to have greater impact.298

- An anomaly in the California legislation excluded some PPO enrollees insured by plans licensed through Knox-Keene and under the jurisdiction of the DMHC, unlike those insured under products regulated by the California DOI.299 These enrollees were not eligible for review after they received treatment, even though they may not have had an opportunity to obtain authorization or denial before in-network services were rendered.300 This problem was recently corrected through legislative change.301 Additionally, California staff would like to address concerns raised in the IMR reports, such as using the IMR database to foster policy debate about care delivery and coverage as well as improving the appeal process and relationships among the parties in the appeal process.302 Presently, DMHC is focusing on promulgation of access standards for managed care, including standards for provider network configurations. Therefore, refinements in IMR, which require legislative action, are not imminent.

In sum, states may be tinkering at the margins of the IMR system, but they are overwhelmingly satisfied with the current nature of the dispute resolution process. Furthermore, states are developing increasingly sophisticated infrastructures to handle complaints and triage external, independent reviews.

298. Interview with Paul Duguay, supra note 16.
299. See supra Part III.C.1, 2.a-b.
300. *Id*; e-mail correspondence with Tom Gilevich, Counsel, Dep’t of Managed Health Care, to Leatrice Berman-Sandler (Oct. 2, 2003, 18:23:15 CST).
301. E-mail correspondence with Tom Gilevich, Counsel, Dep’t of Managed Health Care, to Leatrice Berman-Sandler (Oct. 2, 2003, 18:23:15 CST).
302. IMR REPORT 2002, supra note 65, at 1, 20-24; IMR REPORT 2003, supra note 66, at 2-6, 39-42; interview with Tom Gilevich, supra note 16.
IV. ERISA PREEMPTION EXPLORED

Despite the viability of the IMR remedy and its strengthened foothold post-*Moran*, it is not available to a majority of those beneficiaries covered by employer-sponsored health plans because of ERISA preemption. Nevertheless, the Supreme Court has been steadily supporting expanded state regulation of ERISA health plans and has recently opened some new doors.

Given the desire to create a national uniform system for regulating multi-state employer welfare and pension funds, ERISA preempts state laws that "relate to" ERISA benefit plans. However, certain state laws, including those that regulate insurance, banking, and securities, are carved out and saved from preemption by the ERISA "savings clause" because such laws remain in the traditional and political terrain of state governments and state regulators. ERISA issues are further complicated by the "deemer clause," which creates exceptions to the savings clause. The deemer clause prohibits states from directly regulating employer plans as if they were insurance entities. However, employers often use insurance carriers and other third party administrators in various ways to support benefits administration. In the health arena, this takes various forms such as assuming or sharing financial risk, administering the plan, and/or coordinating benefit services; this further complicates ERISA preemption analysis and forces one to determine whether insurance regulation attaches to a specific employer benefit arrangement. As a result of attempts to fit legitimate state health plan regulation into the ERISA puzzle created by relationships between the "relate to," "savings" and "deemer clauses," the Supreme Court has codified a common law distinction between self-funded insured plans, which can be reached by insurance regulation, and self-funded non-insured plans, which are protected by ERISA preemption.

---

303. 29 U.S.C. § 1144(a) (2000). See also N. Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 645 (1995) ("relating to" an ERISA plan is its own complicated analysis of whether a law actually is directed at the plan and would destroy uniform and integrated federal law guiding the plan or is something akin to a law of general applicability [like a state tax on providers or health plans] which would only indirectly affect the employer plan).

304. 29 U.S.C. § 1144(b)(2)(A) (hereinafter the "savings clause").

305. 29 U.S.C. § 1144(b)(2)(B) (hereinafter the "deemer clause"). See supra text accompanying notes 343-347 (discussing McCarran-Ferguson factors which the Court uses to determine whether a law is in fact a bona-fide insurance regulation).


It was against this backdrop that the Supreme Court decided Rush Prudential HMO, Inc. v. Moran.\(^{308}\) In Moran, Deborah Moran sued her HMO for not adhering to the decision of an IMR and for denying reimbursement for an expensive surgical procedure.\(^{309}\) Despite the IMR determination in Ms. Moran’s favor, the HMO viewed the procedure as medically unnecessary and believed it was under no obligation to follow the Illinois mandate. The case specifically raised the question of whether state mandated IMR, a provision of Illinois’ Health Maintenance Organization Act,\(^{310}\) applied to a “self-funded-insured” ERISA plan or, conversely, was preempted because it related to the employer health benefit plan. The Court held that, by virtue of the ERISA savings clause, Illinois’ IMR law was considered to be insurance regulation.\(^{311}\)

ERISA preemption analysis required, first, that the Court identify whether Rush-Prudential was an employer benefit plan or an insurer subject to the law, and second, whether the law in question was insurance regulation eligible to be “saved.” Although Rush-Prudential never clarified its contractual or risk-relationship to the employer, the Court presumed it was acting as insurer, provider, and plan administrator on behalf of the employer.\(^{312}\) The Court made it clear that Rush’s exact status was immaterial because it was clearly an HMO, and the Illinois law was directed at HMOs which by definition are risk-bearing insurance vehicles subject to state regulation.\(^{313}\) Rush-Prudential then argued that it was a provider and HMO regulation was not principally insurance regulation.\(^{314}\) The Court rejected this argument, stating that it did not have to choose among these characterizations, noting that an entity did not have to be


\(^{309}\) Id.

\(^{310}\) 215 ILL. COMP. STAT. §§ 125/4-10 (2003).

\(^{311}\) Moran, 536 U.S. at 387 (affirming a Seventh Circuit ruling and stating that “regulating insurance tied to what is medically necessary is probably inseparable from enforcing ... state-law standards of reasonable medical care .... The saving[s] clause is entitled to prevail here”).

\(^{312}\) Id. at 363 (inferring that Rush was the plan administrator because the plan’s sponsor granted it discretion to interpret the terms of coverage).

\(^{313}\) Id. at 367 (stating that Rush received a fee from the employer for each recipient and as such was under a risk-bearing contract of some nature to render health services to employees and their families). See also Pegram v. Herdrich, 30 US 211, 218 (2000); Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205, 211 (1979) (reiterating that underwriting and spreading risk are distinctive features of insurance).

solely an insurer to be subject to insurance regulation. Using the common sense test and the McCarran-Ferguson factors as guideposts, the Court confirmed that the IMR provision was insurance regulation because it met two of the three McCarran-Ferguson factors. First, by construing the medical standards under the policy as to what is medically necessary, the IMR interpreted policy terms and regulated an integral part of the policy relationship between the insurer and insured, thus satisfying one of the McCarran-Ferguson factors. The IMR translated “the relationship under the HMO agreement into concrete terms of specific obligation or freedom from duty” and “the interpretation of insurance contracts is at the core of the “business of insurance.” Second, the IMR law regulated a practice limited to entities within the insurance industry, satisfying a second McCarran-Ferguson factor. Because the Illinois IMR law satisfied two factors, it came under the protection of the ERISA savings clause.

Most significantly, the Court clarified that the characterization of an HMO as insurer remains even when it acts in a non-insuring capacity, for example, when providing only administrative services. Rush-Prudential tried to persuade the Court that the Illinois’ law swept too broadly because it would capture organizations that provide no insurance and bear no risk because they have transferred risk to providers or reinsurers or because they only provide administrative services for self-funded plans. The Court rejected these arguments holding that passing risk downstream to providers or upstream to reinsurers does not take the primary insurer out of the insurance business.

In sum, the Court held that Rush-Prudential HMO was an insurance

315. Id.
316. Id. McCarran-Ferguson Act, an antitrust law, had an exemption for the “business of insurance,” recognizing that state governments would force some concerted action on the part of insurance companies in the context of local insurance regulation. 15 U.S.C. § 1011 (2000). To the extent they were regulated by federal law, therefore, insurance companies were immune from federal antitrust scrutiny. The Court had developed factors that define the “business of insurance” in cases which interpreted McCarran-Ferguson, and the Court borrowed these and applied them to ERISA preemption cases. Moran, 536 U.S. at 366-67.
318. Moran, 536 U.S. at 373.
319. Id. at 373-74.
320. Id. at 374.
321. Id. at 373.
322. Id. at 371.
323. Id. at 370-71.
324. Moran, 536 U.S. at 371. Illinois law also defines HMOs to include contractors who might only provide administrative services or arrange health care services for a self-funded plan. Therefore, even “matchmaker” HMOs are insurance entities. Id. at 372.
entity performing insurance functions subject to state insurance regulation, and that the IMR provision was state insurance regulation and, thus not preempted by ERISA.\(^{325}\) Furthermore, Moran implies that IMR mandates apply broadly to ERISA plans using insurance entities, irrespective of exactly what services those entities might be performing. This is true even if the health plan is attempting to hide behind the guise of being the plan administrator with delegated fiduciary responsibilities and even if the law indirectly affects the ERISA plan.\(^{326}\) While the Moran decision is significant, it has been interpreted to be limited to self-funded insured plans and not all ERISA plans.\(^{327}\)

Ten months after the Moran decision, the Court reconsidered insurance regulation of ERISA plans in Kentucky Association of Health Plans, Inc. v. Miller. The Court held that any willing provider ("AWP") laws are insurance regulation, which saves them from preemption.\(^{328}\) Although the facts of Miller and Moran are different, they are critical to understanding how the Court views insurance regulation and ERISA preemption in the health plan context.\(^{329}\) The Court reiterated the breadth of the savings clause by noting that Congress did not limit insurance regulation to only "insurance companies" or "the business of insurance."\(^{330}\) A law need only be a "law... which regulates insurance" to be saved from ERISA preemption.\(^{331}\) The Court re-emphasized that state insurance regulation has an impact on HMOs even if they are not in a risk or insurance relationship with an employer because merely administering self-funded employer plans

\(^{325}\) Id. at 365.

\(^{326}\) Id.

\(^{327}\) Ketterman, supra note 121, at 92.

\(^{328}\) Kentucky Assoc. of Health Plans, Inc. v. Miller, 123 S. Ct. 1471, 1475 (2003). "Any willing provider" laws mandate that any provider willing to meet the requirements of participation in a managed care plan has a right to be on a plan's provider panel and cannot be lawfully denied participation. This conflicts with the practice of managed care plans limiting their provider panels to control both costs and quality of care by using smaller panels and exacting deeper discounts between provider and plan. PAT BUTLER, NAT'L ACAD. FOR STATE HEALTH POLICY, KENTUCKY'S "ANY WILLING PROVIDER" LAW AND ERISA: IMPLICATIONS OF THE SUPREME COURT'S DECISION FOR STATE HEALTH INSURANCE REGULATION 2 (JUNE 2003), available at www.nashp.org.

\(^{329}\) Much of the logic in parsing out the potential meaning of Miller in combination with Moran is a result of personal interview with Mark Rust, Managing Partner and Attorney, Barnes & Thornburg's Chicago Office (April 25, 2003) and presentation by Mr. Rust at the Chicago Bar Association Health Law Committee, May 5, 2003 (hereinafter "Interview with Mark Rust"). Mr. Rust argued the Moran case in front of the Supreme Court and submitted an amicus brief on behalf of the American Medical Association in Miller. Mr. Rust is not responsible for any errors of interpretation of either Moran or Miller.

\(^{330}\) Miller, 123 S. Ct. at 1476 n.1.

\(^{331}\) Miller, 123 S. Ct. at 1475, 1477 (citing 29 U.S.C. § 1144(b)(2)(A) (1974)).
suffices to bring HMOs within the activity of insurance for purposes of the savings clause. 332 Furthermore, the Miller decision altered the McCarran-Ferguson factors, transforming the three-factor test into a two-factor inquiry. Accordingly, a law must be specifically directed toward entities engaged in the provision of insurance and must affect the risk pooling arrangement between the insurer and the insured to be deemed insurance regulation 333.

Thus, Moran and Miller opine that employer plans administered under HMO or insurance contracts can be regulated by state insurance law whether they are risk-bearing or not. Miller suggests that any willing provider laws might be enforceable against HMOs that provide mere access to a provider network for self-insured employers. Additionally, insurance regulation might reach not only an entity that is insuring in the traditional sense of absorbing financial risk, but one that is also merely administering the self-insured plan and providing other insurance-like functions. 334 In both cases, the Court went out of its way to reinforce that self-funded-insured as well as non-insured ERISA plans employ the same kinds of insurance practices that would subject both to state insurance regulations, but for the deemer clause.

As a result of the Miller decision, the legal community has been quick to point out 335 that "the ruling continues another trend, one that has set up a divide between what states can do with respect to insured plans . . . and self-insured plans . . . [which remain] unaffected by the AWP decisions." 336 Nonetheless, these cases put the spotlight on insurance practices of all entities working with self-funded plans, suggesting a broader application of state insurance regulation which further permeates the ERISA barrier. Thus, some doors may have opened as a result of these opinions and others as noted below.

332. Id. at 1476. The Court further acknowledged that self-funded (non-insured) ERISA plans would be subject to such laws, but for the deemer clause (and that Congress clearly recognized this and wrote the deemer clause to save them from direct state regulation), because, by inference, they engage in the same sort of risk pooling arrangements as insurance entities in administering employee benefit plans. Id.

333. Id. at 1479.

334. Id. at 1475. See also U.S. Supreme Court: Impact of Any Willing Provider Decision Could Be seen in Contracting, Choices, 9 HEALTH PLAN & PROVIDER REP. 15, 379 (2003).

335. Ketterman, supra note 121, at 92 (showing how the Moran decision does not apply to the fifty-six million people whose companies are self-insured, and thus not subject to state external review laws).

Door #1: State insurance regulation could be expanded to encompass any organized entity acting on behalf of an employer (or activity on behalf of an employer) performing either traditional insurance risk pooling or merely administrative functions related to the authorization of benefits and the provision of health care services.

In rejecting Rush's arguments that IMR laws should not apply to HMO "matchmaker" entities which simply link a self-funded plan to a provider network, the Moran Court inferred that the Illinois IMR provision would apply to any entity directed by the law to provide covered medically necessary services and administer insurance functions, whether it shares risk or not. The Court in Moran appears to comfortably tolerate some overbreadth in the application of the IMR provision to non-orthodox insurance arrangements or insurance "actors". Guided by this ruling and the two remaining McCarran Ferguson factors, states can see what types of law constitute appropriate insurance regulation—first, any state law that is specifically directed toward entities engaged in insurance practices as defined broadly in Moran and Kentucky v. Miller; and second, any state law that substantially affects the risk pooling arrangement between the insurer and the insured. These factors could encompass any state initiative relating to benefits and any number of regulatory initiatives to place requirements on health plan practices to protect the welfare of state residents. Therefore, newly crafted and broadened insurance regulation might attach to any number of entities providing traditional insurance practices or authorizing care.

Door #2: The broad interpretation of ERISA's deemer clause remains an obstacle for the Court and Congress. However, the Court might be moving toward confronting this barrier to allow states increasingly to attach insurance regulation to all employer-sponsored health plans.

The deemer clause has become a major source of discrimination against beneficiaries in self-funded non-insured plans, fostering, for example, employer practices with reinsurers just to take advantage of ERISA preemption. As inferred by recent opinions, the Court appears to

337. Moran, 536 U.S. at 372.

338. Although the deemer clause would still save most self-funded plans from state regulation if they directly administer insurance functions, states could be more aggressive in clearly delineating activity conducted by third parties which constitutes insurance practice. Exceptions to the savings clause could, perhaps, be narrowed, making it more difficult for employer-based plans to circumvent appropriate state insurance regulation, the outcome of which is discrimination against an entire class of health insurance beneficiaries.

recognize the need to reach all employer plans that provide essentially similar health insurance and care authorization functions. The Court may be inching closer to Justice Stevens' dissenting opinion in *FMC v. Holliday*, where he argued that there is no rational reason for treating self-funded-non-insured plans differently from insured plans, and from the point of view of beneficiaries, these distinctions are unfair.\(^{340}\) Yet, the Court and Congress have regrettably maintained ERISA preemption for self-funded-non-insured plans.

While *Moran* and *Miller* do not directly challenge this, the current Court seems impatient with appellee arguments requiring maintaining the fine-line distinctions among benefits administration, risk spreading, other insurance functions, and provisions of medical care when plaintiffs seek equitable state-based IMR remedies consistent with ERISA's intended civil enforcement scheme.\(^{341}\) Although both of these cases confronted ERISA preemption for self-funded-insured plans, more recent sentiments from the Court echo Justice Stevens' concerns about uniform application of legal principles. Justice Stevens commented that "disparate treatment of similarly situated beneficiaries... somehow supported by an interest in [ERISA] uniformity is singularly unpersuasive."\(^{342}\)

On the other hand, the deemer clause remains a serious obstacle in bridging the gap to a full application of the IMR remedy. The Court in *FMC v. Holliday* specifically rejected a narrow interpretation of the deemer clause that promoted making only those state insurance regulations that are pretexts for impinging upon core ERISA concerns exceptions to the savings clause.\(^{343}\) In rejecting this proposition, the Court recognized that it was reinforcing ERISA's already over-expansive reach and solidifying the unnatural dichotomy between self-funded insured and non-insured health plans.\(^{344}\)

This dichotomy between ERISA insured plans and self-funded plans was

---

\(^{340}\) FMC Corp. v. Holliday, 498 U.S. 52, 65-72 (1990) (Stevens, J., dissenting). *FMC* involved ERISA preemption of a Pennsylvania law providing that there shall be no right of subrogation or reimbursement from a claimant's tort recovery for benefits payable under any program, group contract, or other arrangements for payment in a motor vehicle accident/action. The Court held that ERISA preempted a self-funded plan, despite the savings clause, because a self-funded employer plan cannot be deemed an insurance company; this would not be true of an employer using an insurance-arrangement. *Id.* at 66-72.

\(^{341}\) Interview with Mark Rust, *supra* note 329.

\(^{342}\) *Holliday*, 498 U.S. at 66 (Stevens, J., dissenting).

\(^{343}\) *Id.* at 63.

\(^{344}\) *Id.* at 63-64.
first articulated in *Metropolitan Life Insurance Company v. Massachusetts* when the Court legitimized the distinction, set forth by the Massachusetts Attorney General, allowing state insurance law to directly regulate ERISA-insured plans but not ERISA self-funded plans. The Court acknowledged that enforcing the deemer clause in this manner "results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not." The Court further noted that "by so doing, we merely give life to a distinction created by Congress in the 'deemer clause,' a distinction Congress is aware of and one it has chosen not to alter."

Will this distinction last in the long run? Furthermore, will currently insured ERISA health plans increasingly defect to self-funded-non-insured status given the requirements of managing health benefits and primary insurance risk? These issues are not settled and it is not yet clear how expansive the Court will be in applying insurance regulation to a variety of third party or reinsurance arrangements in the future. With the Court's emphasis on reducing false distinctions, the moment may be ripe for crafting new theories to challenge these distinctions.

Door #3: IMR remedies, although viewed primarily as insurance regulation, could be saved from preemption under grounds related to traditional state authority over medical care quality and treatment, irrespective of the insurance arrangement of an ERISA plan.

A line of cases that has penetrated the ERISA shield by focusing on state regulation of medical care, also opens the door for further IMR support. In *Pegram v. Herdrich*, the Supreme Court discussed the type and range of employer health benefit decisions and how they are treated under ERISA. The Court made a critical distinction between pure benefits administration (or fiduciary decisions), medical treatment decisions, and mixed (benefits and treatment) decisions. The Court suggested that legal claims that fall outside of being fiduciary decisions should not be subject to preemption. Specifically, the court stated that when health plan benefit decisions are sufficiently mixed, "[s]tate law should govern in any case in which medical

---


350. *Id.* at 228-37.
injury is alleged to have flowed from flawed medical judgment, regardless of the context in which that judgment is exercised. This thwarts preemption of state laws that regulate medical care and state claims that allege health plan malpractice by implicating plan administrators or their agents in medical outcome-determinative decisions. An overlapping framework, articulated in Dukes v. U.S. Healthcare, distinguished claims that address the administration, or "quantum" of benefits, from those that challenge the "quality" of benefits and, more specifically, the medical treatment performed under those benefits.

Using either the quantity or quality dichotomy of Dukes or the administrative, medical, or mixed claims continuum of Pegram, courts have been more willing to view quality of care and malpractice claims as exempt from ERISA preemption, irrespective of the insurance arrangements of the employer plan. Such claims invoke concerns which traditionally fall under state jurisdiction. Because IMR targets medical treatment decisions, and by design screens out most benefit, coverage, and eligibility determinations, it falls easily on the medical care/quality side of emerging legal frameworks. States may find this helpful in their attempts to both broaden beneficiary eligibility for IMR as well as broaden IMR regulations to encompass all health plans.

In sum, looking at the dynamic state of current law, the inequities across insurance sub-populations, and the modesty of medical necessity reviews, there might be strong legal and public policy reasons for state legislatures to broaden the application of IMR. Furthermore, there could be strong reasons for the Court to continue to narrow ERISA preemption for a larger constellation of employer-based arrangements.


352. Dukes v. U.S. Healthcare, Inc., 57 F.3d 350, 356-58 (3rd Cir. 1995), cert. denied, 516 U.S. 109 (1995). In Dukes, the plaintiff was asking for damages that went beyond ERISA remedies, yet the Third Circuit held that the plaintiff's claims for damages, under various theories for injuries arising from medical malpractice of HMO-affiliated hospitals and medical personnel, were not claims to recover benefits due or to clarify rights under the terms of their health plan and could be remanded to state court. In re U.S. Healthcare, Inc. also held that an HMO's policy of discharging newborn infants within twenty-four hours after delivery was a medical care determination and not a benefits determination. 193 F.3d 151 (3rd Cir. 1999).


354. Pegram, 530 U.S. at 228.
V. BOXING IN IMR

While the Court may be narrowing the scope of ERISA preemption, in so doing, it has created a box for state-based IMR, which while protecting IMR from preemption, also constrains it. In other words, IMR was saved from preemption on the basis of the Court’s determination that it is not arbitration or an alternative remedy that goes beyond ERISA’s civil enforcement scheme; however, as such, IMR cannot be expanded to embrace characteristics of arbitration or similar alternative remedies, characteristics that would presumably improve the IMR process and would appease many IMR critics. Critics of IMR argue that IMR is too narrow a remedy because the disputes are related to questions of medical care standards only, rather than broader questions of coverage and benefits. Furthermore, critics argue that the remedy of external review does not provide adequate procedural justice. In essence, IMR proponents and critics alike may run up against the constraints placed upon this remedy by the Court, which may limit attempts to broaden IMR or make it more effective.

Specifically, while external review has emerged as the prototype for resolving medical necessity disputes between health plans and consumers, several critics have chronicled its shortcomings. Shirley Eiko Sanematsu, a critic of the California managed care reforms, finds fault with the limitations of the IMR remedy because it excludes review of coverage disputes and too often draws a false distinction between medical care treatment issues and coverage. She believes state IMR regulations take too narrow a view of medical disputes between patient, plan, and provider. Additionally, medical necessity, an objective standard, allows plans to convert care issues into coverage issues. For example, an atypical prescription for baby formula for a rare pediatric allergy is converted by a health plan to a request to cover a “food supplement.” For the infant in question, it is medically appropriate care. Senematsu argues for a more subjective standard to address individual patient needs, allowing a broader review of factors, which would be helpful in determining what

---

357. Id. at 1249. Sanematsu argues that the definition of medical necessity is too narrow and as such does not adequately address individual patient needs. Moreover, IMR as currently conducted converts all care delivery disputes into solely medical care issues.
358. Id. at 1277.
359. Id. at 1269-70.
might be best for a patient.\textsuperscript{360}

Other commentators criticize IMR because it places insufficient emphasis on pre-dispute conflict management, arguing that pre-dispute conflict management would encourage health plans to respond early and effectively to reduce formal disputes.\textsuperscript{361} These reviewers posit a conflict resolution scheme as an alternative to reliance on ADR-type mechanisms, like IMR, or quasi-judicial ADR mechanisms, such as mediation or arbitration.\textsuperscript{362} Specifically, Kathy Cerminara has called for the adoption of improved, institutionalized conflict management strategies within the managed care industry as opposed to the use of ad hoc, traditional ADR approaches.\textsuperscript{363}

Cerminara argues for health plans to improve information disclosure and complaint and grievance resolution in a manner that offers as much procedural justice as possible. Cerminara further believes that many patient frustrations stem from misunderstanding and misinformation rather than a denial of rights.\textsuperscript{364} Accordingly, health care organizations should invest in conflict management rather than react only to "cognizable disputes" and should offer "contextualized ADR possibilities" rather than "cookie cutter" mandates.\textsuperscript{365}

Similarly, Aaron Kesselheim views external appeals as a futile attempt at improving health care delivery.\textsuperscript{366} Kesselheim argues that focusing

\textsuperscript{360} Id. at 1278-80. Senematsu comments that treatment decisions often involve personal goals, interests and religious faith—all of which should be factored into dispute resolution processes; these aspects are not considered in the current dispute resolution mechanisms that view treatment issues through the objective lens of medicine alone. Id. 1276-85. Senematsu views this problem as particularly heightened with respect to treatment decisions at the end of life or with severely damaged infants (what she refers to as futile care). In these situations, dispute resolution should take into account non-biomedical factors. Id. at 1281, 1285. Although she recognizes that IMR is a result of the managed care backlash, principally targeted to place decision-making back in the hands of caregivers, she questions why reviews are limited to physicians, excluding for example, clergy, ethicists, disability rights advocates, and others. Id. at 1270. See also Kesselheim, supra note 260, at 911.


\textsuperscript{362} Cerminara, supra note 361, at 548-50.

\textsuperscript{363} Id. at 560, 583, 585. Cerminara also describes ADR in four separate categories: adjudicatory, consensual, advisory and cross-over techniques, placing external review in the adjudicatory category along with arbitration. Id. at 552.

\textsuperscript{364} Id. at 586.

\textsuperscript{365} Id. at 593.

\textsuperscript{366} Kesselheim, supra note 260, at 886.
resources on IMR diverts managed care entities from developing more effective patient protection measures.\textsuperscript{367} While IMR creates established procedures for appeal, prompt decisions, and methods for empowering patients in the process through providing informal advice and information,\textsuperscript{368} Kesselheim believes these reforms are not enough. External review systems should publicly disseminate trend data on outcomes, report anonymous results to foster patient confidence, universally bind health plans to results, mandate that care is uniformly continued during the time of appeal with costs imposed on insurers,\textsuperscript{369} and provide absolute assurance that plans do not select reviewers.\textsuperscript{370}

Another critic of IMR, Judge Joyce Krutick Craig, represents a different vision of dispute resolution in managed care.\textsuperscript{371} Because managed care grievances raise issues of law, as well as medicine,\textsuperscript{372} these issues are best integrated in a uniform, federal grievance system like the current Medicare appeals procedure which takes place before an ALJ.\textsuperscript{373} Since mixed disputes about coverage and care have been handled for years in Social Security, disability, or Medicare benefit appeals, the corps of 1100 judges in 132 hearing offices\textsuperscript{374} are the most skilled workforce to handle managed care disputes.\textsuperscript{375} This system enables direct involvement of the consumer in a hearing, creates uniformity across states, and requires no affirmative action on the part of the patient, thus enabling much higher rates of review. If a care decision is denied, it is automatically reviewed. This explains why the appeal rates of Medicare, TRICARE (the military health plan program), and the Federal Employees Health Benefit Plan are higher.\textsuperscript{376}

In Judge Craig's view, the current system of IMR, as well as the federal patient protection legislation that proposes to federalize IMR, relies too heavily on an internal, multi-level health plan appeals process and is too time consuming to be effective.\textsuperscript{377} Most patients do not have time to follow

\textsuperscript{367} Id. at 915-16.  
\textsuperscript{368} Id. at 887-88.  
\textsuperscript{369} Id. at 889.  
\textsuperscript{370} Id. at 891. With the exception of adherence to the principle of "uniformly continued treatment during the time of appeal," most state IMR systems are evolving precisely in the manner Kesselheim suggests.  
\textsuperscript{371} See generally Judge Craig, supra note 163 (proposing a unified federal grievance procedure).  
\textsuperscript{372} Id. at 398-402.  
\textsuperscript{373} Id. at 339-402.  
\textsuperscript{374} Id. at 399 (reflecting the numbers in the ALJ judge corps at the time of writing).  
\textsuperscript{375} Id. at 400-01.  
\textsuperscript{376} Judge Morgan, supra note 9, at 18-23.  
\textsuperscript{377} Judge Craig, supra note 163, at 394. Judge Craig reviews the patient protection legislation introduced in 1999-2000, including the Daschle-Kennedy bill and the ultimate bill
through on an appeal, and IMR review requirements fail to provide a patient in one state covered by a managed care organization the same remedies as available in another state covered by the same entity.\textsuperscript{378} As an alternative to the current IMR process, Judge Craig focuses on the need to craft a fast, easy, uniform system offering due process to all sides and similar to the system set up for Social Security, disability, or Medicare benefits appeals.\textsuperscript{379}

Even in light of the criticisms and alternatives presented, IMR still has merit. Senematsu's critique suggests that IMR is seriously flawed because the "coverage versus care" dilemma is fundamentally problematic. Opening up the IMR process to all denials and broadening the review of certain decisions with expert multi-disciplinary panels could accommodate these criticisms. Judge Craig's vision is more difficult to reconcile with IMR. Although her approach responds to some of the criticism leveled against IMR, it also presents a departure from the current ERISA system, is difficult to reconcile with the current state-based IMR approach, and could be viewed as similarly bureaucratic.

Other commentators with more positive assessments of IMR, such as Louise Trubeck, reinforce the notion that the IMR system provides substantive assistance, encourages consumers and plans to resolve disputes informally, has a positive impact on health plan practices and consumer advocacy, and builds consumer confidence in managed care.\textsuperscript{380} Michael Ginsberg, another supporter of IMR, explains that external review appears to raise quality of care and consumer confidence effectively without leading to excessive costs, systematic bias, or resistance from HMOs.\textsuperscript{381}

While IMR will not resolve fundamental problems in the incentive structure of managed care, which is driven by economic and efficiency considerations,\textsuperscript{382} expanding legal remedies beyond the current bounds of which passed the house, the Bi-Partisan Patient Protection Act, infra note 413.

\textsuperscript{378} Judge Craig, supra note 163, at 398.

\textsuperscript{379} Id. at 402 n.641. Judge Craig sees this as an informal, administrative law hearing wherein the patient would have a right to counsel, but because the ALJ is duty bound to protect the rights of the claimant, there is no requirement for representation. Moreover, these hearings are considered non-adversarial and "user friendly."

\textsuperscript{380} Trubeck, supra note 262, at 140, 144.

\textsuperscript{381} Michael E. Ginsberg, HMO Grievance Process, 37 HARV. J. ON LEGIS. 237, 245-47 (2000). Ginsburg argues that instituting HMO tort liability across the board would not improve care beyond the benefits already achieved by IMR. Id. at 246-47. Moreover, external review cures the inevitable problem of incomplete contracting in the health care benefit arena, where it is very difficult to specify exactly what medical services are needed to be covered by insurance given patient heterogeneity. See Sloan & Hall, supra note 231, 192-200.

\textsuperscript{382} See generally Cerminara, supra note 361; Kesselheim, supra note 260; Senematsu,
IMR may be unrealistic. The fragile five-four majority of Moran held that IMR was permissible under ERISA precisely because it was constrained and not an alternate dispute resolution scheme. It appears that state-based remedies, for now, must comfortably settle within the tight boundaries articulated by the Court, boundaries which suggest that only modest expansion in remedies would be tolerated.

Consequently, the more fundamental hurdle facing additional remedies is whether they would be consistent with the Court’s framework in Moran, and thus consistent with ERISA’s civil enforcement scheme. This is especially pertinent because whether IMR was or was not considered arbitration was a pivotal issue in the Moran opinion and was the chief factor producing the five-four split: the majority would have held IMR was preempted if they had thought IMR was arbitration.

Although the majority conceded that IMR has arbitration-like features in that it involves a third party reviewer and forms a binding decision on a plan, IMR does not fully resemble contract interpretation or evidentiary litigation in front of an arbitrator. On the contrary, IMR involves review of limited clinical evidence rather than a fully developed evidentiary function. IMR is not conducted with cross-examination, nor does it exhibit judicial-like power over the disputing parties as exists in the full determination of a case or controversy. The reviewer is not interpreting the law, but rather a single contractual term. More specifically, the reviewer is establishing a medical standard of care. Furthermore, IMR merely requires that ERISA plans provide an additional layer of administrative review or administrative procedure, which the Court likened to a mandated benefit or a mandated procedure. Last, IMR precedes and does not

supra note 356 (demonstrating this basic point as a theme throughout their articles).

383. 29 U.S.C. § 1132(a), (a)(1) (2000). See also 29 U.S.C.A. § 1132(a), (a)(1) (West 2003). ERISA’s civil enforcement scheme permits plan participants to bring an internal appeal to a plan’s fiduciary or administrator and then to file suit in federal court. Such actions are exclusive remedies solely to recover plan benefits, to enforce beneficiary rights under a plan, or to clarify a right to future benefits. More specifically, ERISA limits enrollee damages to statutory penalties, which the secretary can exact from a plan fiduciary, contract damages, equitable relief and, at the discretion of the court, attorney’s fees. See David A. Humiston et al., Navigating the Shoals of ERISA: The Effect of ERISA Preemption on New State Laws Creating Tort Liability Against Managed Care Entities, 14 HEALTH LAWYER (ABA), Aug. 2002, at 3-5, 7-8.


385. Id. at 383.

386. Id.

387. Id. at 384. See also Miles Zaremski, In Furtherance of Accountability in Health Care: Rush Prudential HMO, Inc. v. Moran, 14 HEALTH LAWYER (ABA), June 2002, at 23.

preclude judicial scrutiny and imposes no new obligations or causes of action.389 Thus, IMR does not disturb ERISA's civil enforcement scheme.390 In sum, the majority posited that the preemption and arbitration analogy simply "runs out of steam" in application to IMR.391

On the other side, the dissent viewed the Illinois IMR provision as arbitration, undermining ERISA's exclusive civil enforcement scheme.392 Justice Thomas wrote that Debra Moran had ample and multiple remedial devices under ERISA § 502(a)(1)(B).393 This section includes the right to a civil suit to recover benefits due under the terms of the plan, to obtain a declaratory judgment that she was entitled to benefits, and to enjoin an improper refusal to pay for benefits. Suits under § 502(a)(2) and § 409 would have allowed her to seek removal of the fiduciary, and § 502(g) would have allowed a claim for attorney's fees.394 In the opinion of the dissenting justices, Section 4-10 of Illinois' Health Maintenance Organization Act395 was viewed as an alternate state remedy because it granted a binding determination guiding benefits.396

Justice Thomas chided the majority for its determination that IMR was within the boundaries of the ERISA civil enforcement scheme because it merely added a second opinion provision to state health insurance specifically regulating insurance); Unum Life Ins. Co. of America v. Ward, 526 U.S. 368, 377 (1999) (holding that a California notice prejudice rule is not preempted because it adds a procedural requirement to an insurance contract; procedural requirements that complement rather than contradict ERISA are not preempted). In Unum, the Court rejected the insurance company's suggestion that the notice prejudice rule conflicted with § 1133 of ERISA, which requires plans to provide notice and the opportunity for review of denied claims, or with Department of Labor regulations providing that a claim is filed when the requirements of a reasonable claims filing procedure have been met. Id. at 375-380. By allowing a longer period to file than the minimum filing terms mandated by federal law, the notice prejudice rules complemented rather than contradicted ERISA regulation. Id. at 377. Section 4-10 of Illinois' law resembles the claims procedure rule sustained in Unum where the Court upheld a state law barring enforcement of a policy's claim filing limit even though the state rule could mean the difference between success and failure for a beneficiary. See Humiston et al., supra note 383, at 3, 7 and n.13.

389. Moran, 536 U.S. at 386.
390. Zaremski, supra note 387.
394. Moran, 536 U.S. at 395 n.5.
395. 215 ILL. COMP. STAT. § 125/4-10 (2000).
contracts. The dissent noted *Fort Halifax Parking Company v. Coyne*, 482 U.S. 1, 16 (1987), in which the Court held that a state cannot avoid ERISA preemption by mandating a benefit. The Court ignored the "interlocking, interrelated, and interdependent" nature of the ERISA remedial scheme and announced that the relevant inquiry is whether a state regulatory scheme provides a new cause of action or new form of relief. In a conciliatory manner, Justice Thomas ultimately acknowledged that there might be advantages to allowing states to implement IMR as a supplement to ERISA remedies, but that this decision was to be made by Congress.

Given this backdrop, how firm is the Court’s support for IMR, and what, if anything, would tip members of the majority over to the dissent? The Court noted in *Moran* that "[a] state might provide for a type of review that would so resemble an adjudication as to fall within *Pilot Life*’s categorical bar." Therefore, a state would risk preemption by either adding a new cause of action or an additional claim for damages. Further, new state remedies or procedural requirements would have to effect substantive, not merely procedural, change.

In fact, few of the suggestions offered by the critics above seem to conflict with the Court’s essential framework that damages in an action against an ERISA health plan are limited to the cost of the benefit denied. The five-member majority in *Moran* would probably remain firm if additional remedies, including state-based judicial claims built carefully around the frame of IMR, carried remedies exclusively allowed under ERISA and specifically excluded extra-contractual damages.

Accordingly, it is unlikely that the Court would allow ERISA to preempt a state-based regimen that allowed any of the following elements: 1) external review coupled with a pre-litigation ADR mechanism, such as

---

398. *Id.*
399. *Id.*
400. *Id.* at 402.
401. *Id.* at 378-381. See generally *Pilot Life Ins. Co. v. Dedœaux*, 481 U.S. 41 (1987) (holding that an ERISA plan participant seeking punitive damages under Mississippi common law due to an insurer’s alleged bad faith in processing a claim was preempted because the bad faith cause of action was not saved as a law directly related to insurance and because tortious breach of contract provided an alternative remedy (a legal remedy) in conflict with ERISA remedies, which are meant to be exclusive for plan participants asserting improper processing of benefits). See also Donald T. Bogan, *ERISA: The Savings Clause, § 502 Implied Preemption, Complete Preemption, and State Law Remedies*, 42 *Santa Clara L. Rev.* 105, 126-27 (2001).
402. See Interview with Mark Rust, *supra* note 329.
403. Humiston et al., *supra* note 383, at 8.
mediation; 2) non-binding determinations on the beneficiary; 3) ERISA-like remedies exclusively; 4) limited evidentiary functions, such as limited discovery or testimony of parties or experts where reviewers/adjudicators are devoid of judicial-like power over the disputing parities; 5) professional, discipline-based judgments made by reviewers in addition to physicians; and 6) subsequent suit in federal or state court that focused on quality of care, medical treatment, or claims where these issues were inextricably bound with coverage and benefits issues. These elements, among the many dispute resolution ideas gathered herein from critics, might fit into the framework handed down by the Court.

VI. HARMONIZING STATE AND FEDERAL LAW

Concurrent with the rush to institute state systems of external review and the judiciary’s attempts to clarify the scope of ERISA preemption, the federal executive and legislative branches have been busy instituting their own response to managed care and ERISA. Congress has tried to pass patient protection legislation, albeit unsuccessfully. The Department of Labor (“DOL”) successfully promulgated new rules governing ERISA health plans and added important claims review, notice, and timeliness measures to improve appeal procedures for ERISA health plan beneficiaries. However, although changes in ERISA rules are welcome, the DOL is unable to add a comparable IMR scheme to ERISA. Implementation of IMR is beyond the DOL’s authority because external review represents a substantive change demanding Congressional action.

Therefore, the interrelated problems of IMR dissemination, limitations in ERISA’s civil enforcement scheme for harms incurred, difficulties in mounting challenges to ERISA preemption, and the inequities created among similarly situated patients continue to beg for Congressional action. In response, Congress should either directly amend ERISA or pass broader patient protection legislation to do the same.

404. Hearings, supra note 351, at 82-85 (statement of Sara Rosenbaum, Professor of Health Law and Policy, George Washington Univ. School of Public Health and Health Servs.). See also Pegram, 530 U.S. at 228-37.
405. See infra text accompanying notes 413-425.
407. Hearings, supra note 351, at 68 (statement of Jane F. Greenman, Deputy General Counsel, Honeywell, on behalf of the ERISA Industry Committee).
408. Id.
To directly amend ERISA, Congress should either craft a uniform federal regime for all ERISA plans, comparable to the IMR prototype, utilizing existing-state based external review systems or pass legislation that precludes preemption of state laws addressing mixed eligibility and treatment decisions made by managed care entities. Such amendments could be broad enough not only to end preemption of state laws mandating external review but also laws providing additional liability protection using new causes of action. These amendments could replace ERISA’s current claims appeals process and also allow additional remedies that go beyond ERISA’s current scheme.

Suspending ERISA preemption for managed care accountability mechanisms would exchange uniformity in the regulation of ERISA plans for uniformity in the handling of grievances for patients regardless of plan sponsor. These are reasonable public policy tradeoffs. Furthermore, health plans and their sponsors are already attuned to existing state differences in licensure, oversight, reporting, coverage mandates, and other patient protections. Congress and health plans have surely contemplated such variation across the states. Even federal patient rights legislation promotes only a common federal floor.

The second, and perhaps less likely way to harmonize state and federal regulation, is to provide similar remedies for all health plan beneficiaries with a federal patient protection act. Both the House and the Senate in the 107th Congress passed versions of this legislation; however, a law was never enacted. Congress was to appoint a conference committee to meet

409. Congress could create a federal external review system, but this would be duplicative and costly. Although Justice Joyce Craig would like to see a federal appeals process using the ALJ for all health plan members, ERISA or not, this goes too far in institutionalizing the IMR approach. No one has suggested that the Departments of Labor or HHS would ever develop a federal system to handle exclusively ERISA claims (and none of the patient protection bills have suggested that approach).

410. Representative Charles Norwood, a Georgia Republican, introduced a direct amendment in the ERISA Clarification Act of 2003, H.R. 596, 108th Cong. (2003). This bill excludes from preemption:

*Any State cause of action to enforce a determination under a group health plan... regarding the existence or extent of coverage of any item or service under the plan to the extent that the determination is of whether or not the item or service is medically necessary or appropriate or is based on the application of substantially equivalent terms.*

*Id.* (emphasis added). This bill complements the introduction of a new version of Representative Norwood’s Patient Protection Act, H.R. 597, 108th Cong. (2003).

411. *See generally* Agrawal & Hall, *supra* note 46 (discussing the evolution of ERISA toward allowing state tort liability actions and damage suits).

412. *See supra* Part II and III.

413. Bi-Partisan Patient Protection Act, S. 1052, 107th Cong. (2001); Bi-Partisan Patient
in the fall of 2001, but the events of September 11th turned Congress’ attention toward matters of national security. Additionally, Congress never finished appointing its conferees and controversy remained between the executive and legislative branch around several politically hot issues, principally involving a patient’s right to sue health plans.

Despite differences between the House and Senate bills, their respective legislation was quite similar. Both bills negated ERISA preemption of state causes of action involving medically reviewable health plan determinations, although the bills differed on whether claims would be governed by federal or state law. Both the House and Senate had similar monetary penalties should health plans fail to follow the determinations of an external review. Both bills embraced rights under a new federal cause of action—breach of duty of “ordinary care”—to sue health plans for coverage, eligibility, or reimbursement decisions that resulted in personal injury or wrongful death, even though the bills had different damage caps.

The core provisions of the bills—protecting patient access and establishing external and internal review—were virtually identical. There was widespread agreement that there should be a uniform federal standard for independent, external review. Specifically, both bills amended ERISA Protection Act, H.R. 2563, 107th Cong. (2001).


415. Both the Senate and House bills require patients to exhaust external and internal appeals before they go to court unless they can prove irreparable harm if they wait. Jared Wolf, Senate Passes Patients’ Bill of Rights by 59-36 Vote, NATION’S CITIES WKLY., July 2001. Punitive damages are prohibited in federal court, but civil penalties are allowed up to $5 million dollars in the Senate version with no limit on economic and non-economic damages. Id.; McMillion, supra note 414. In a last minute compromise with the White House, Representative Norwood successfully amended the House version to ensure that state court actions could proceed but under federal remedies with a cap on non-economic damages of $1.5 million and punitive damages at $1.5 million. H.R. 2563 § 402(a) (2001). Nevertheless, the Senate bill passed with a statutory damage clause that set forth a civil assessment of up to $5,000,000 payable to a claimant in an action for bad faith and flagrant disregard for the rights of a beneficiary. S. 1052 § 402(a) (2001).

416. Both bills include additional monetary penalties: up to $1000 per day for each day from the date of a determination until a benefit deemed required is provided; $10,000 for failing to follow timelines in any case in which treatment is not commenced in accordance with the determination of an IMR; authority to obtain a cease and desist order and order attorney’s fees for refusal to provide a benefit as determined; additional penalties against a person acting in the capacity of authorizing (or rather not authorizing) benefits for a plan. H.R. 2563 § 104(f), 107th Cong. (2001); S. 1052 § 104(f), 107th Cong. (2001). Moreover, patterns of repeated refusal to authorize benefits, violate requirements of the internal and external appeal and the act would translate to monetary penalties of the lesser of twenty-five percent of the aggregate value of benefits shown to have not been provided, or unlawfully delayed by a plan or $500,000. H.R. 2563 § 104(f); S. 1052 § 104(f).

417. H.R. 2563 § 402; S. 1052 § 402.
and created mirror-image internal and external review provisions for claims involving medical necessity and appropriateness, E/I treatment, and other coverage decisions that require a review of medical facts. Both bills contemplated one level of internal health plan review. Furthermore, the bills created a process, directed by health plans, by which plans would use federally qualified, certified IROs to determine both eligibility of a claim for review and would conduct and oversee the review.\(^\text{418}\)

Nevertheless, there is lingering concern about removing ERISA preemption, and adding new causes of action and monetary penalties.\(^\text{419}\) Similarly, there is general concern regarding whether federal law would or should preempt state law in the patient protection area, with respect to external and internal review, patient access, choice and provider protections. This is true even though both bills establish clear certification processes for state laws and would allow states to retain state regulatory systems that are substantially equivalent to federal standards.\(^\text{420}\) Should patient protection legislation pass, most states with prototype IMR systems will likely retain their traditional role of determining eligibility of a claim for review, overseeing the external review process, and developing essential, supportive consumer services.\(^\text{421}\)

Finally, both bills would protect employers who were not direct-decision makers from specific claims of liability and would exempt employer conduct in the normal exercise of fiduciary duties, such as designing benefits and dispute resolution schemes. However, there are lingering concerns in the employer community about employer liability when health plans are sued.\(^\text{422}\)

\(^{418}\) H.R. 2563 §§ 103, 104; S. 1052 §§ 103, 104 (2001).

\(^{419}\) The framework in these congressional bills codifies the “quality versus quantity” or “medical versus plan administration” distinctions which the courts have attempted to make for purposes of ERISA preemption. See, e.g., Dukes v. U.S. Healthcare, Inc., 57 F.3d 350 (3rd Cir. 1995); Pegram, 530 U.S. at 211. These bills allow state-based claims directly against health plans when the plan denies claims for benefits for medically necessary or appropriate care, for E/I care, or for “denials otherwise based on an evaluation of medical facts. The latter category includes a “determination that the item or service or condition is not covered based on grounds that require an evaluation of medical facts by a health care professional in the specific case involved to determine the coverage and extent of coverage of the item or service or condition.” H.R. 2563 §§ 104(d)(2); S. 1052 § 104(d)(2).

\(^{420}\) H.R. 2563 § 152; S. 1052 § 152.

\(^{421}\) H.R. 2563 § 152; S. 1052 § 152.

\(^{422}\) Hearings, supra note 351, at 67-70 (referencing statement of Jane F. Greenman, Deputy General Counsel, Honeywell, on behalf of the ERISA Industry Committee). The bills protect employers from suit in federal court by allowing them to designate decision-makers with respect to medical care treatment versus fiduciary decisions. H.R. 2563 § 402(c)(18); S. 1052 § 402(c)(18). The employer community, as represented by these comments is probably not entirely satisfied with this protection given that there still would
As a result, patient protection legislation recently introduced by Representative Charles Norwood does not include any of the expansive federal civil remedies for private rights of action found in earlier versions of legislation. Expanding tort and contract-based liability protections for patients seems to have been swallowed up by increased controversy over tort and medical malpractice liability reform. Clearly, health plans will do everything they can to avoid the machinations of the tort law system now under fire. Therefore, it is not clear that patient protection legislation or legislation to harmonize federal and state regulatory functions that impinge on managed care will pass in the near future. Harmonizing state and federal law through the passage of federal patient protection legislation seems presently out of reach.

PART VII. CONCLUSION

IMR is a viable remedy to promote managed care accountability. It is a prudent approach to reducing human suffering and the pain of litigation. It offers an accessible process for beneficiaries to claim that treatment or reimbursement is due, and it has proven to have a positive impact on the delivery of managed health care. Reports from some of the most sophisticated state-based systems, however, suggest that IMR is still cumbersome, overly time consuming, excludes important disputes about coverage and benefits (outside of medical necessity disputes), and requires streamlining to maximize its potential.

State agency leaders who are pleased with IMR overall are focused on providing better consumer education and support, more disclosure on IMR results, and greater engagement of consumers and providers. Critics are split, with those applauding the IMR scheme and others wanting to improve conflict management processes internal to plans. Some commentators want states to broaden or enhance the remedy in order to foster a more open review and adjudicatory process, and to infuse the system with greater procedural justice at every step. However, at the same time, expansion of state remedies cannot further tempt ERISA preemption.

While a cornerstone of managed care reform and due process, IMR is not

be need for discovery on the extent of employers' relationships to health plan and medical decision-making. From the employers' viewpoint, the patient protection legislation introduced, does not adequately shield them from liability exposure or legal costs incurred in defending health plan liability cases. Id. at 69.

425. Blum, supra note 258, at 327.
accessible to everyone. Despite the Moran decision, which was significant in stabilizing and expanding the reach of IMR, it is still unavailable to beneficiaries of purely self-funded employer health plans. The last frontier, therefore, is to harmonize state and federal regimes either through passage of patient protection legislation or through congressional action to amend ERISA. Without this, new state-based reforms and claims\textsuperscript{426} will continue to push against the ERISA shield, and will push open the doors that Moran has left ajar.

\textsuperscript{426} See generally Roark v. Humana, Inc., 307 F.3d 298 (5th Cir. 2002), petition for cert. filed June 3, 2003, pending conference (No. 02-1826), available at http://www.search.access.gpo.gov (raising ERISA preemption with regard to allowing state claims under Texas' new tort-based cause of action to move forward). This new cause of action aims to hold health plans directly liable when in breach of their duties of ordinary care in instances where medical necessity determinations are alleged to have caused patient injury and harm. \textit{Id.}
## APPENDIX A: CHART I

|---------------------------|------------|----------|----------|--------------|

<table>
<thead>
<tr>
<th>Types of Health Plans Subject to Review</th>
<th>California</th>
<th>Michigan</th>
<th>New York</th>
<th>Pennsylvania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed care plans (except M+C) and indemnity-based health insurance companies</td>
<td>All health plans</td>
<td>All health plans</td>
<td>Managed Care only</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Types of Disputes Subject to Review</th>
<th>California</th>
<th>Michigan</th>
<th>New York</th>
<th>Pennsylvania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only denials based on medical necessity and experimental/ investigational treatment</td>
<td>All denials, except for clear and valid coverage exclusions and coverage termination</td>
<td>Only denials based on medical necessity and experimental/ investigational treatment</td>
<td>Only denials based on medical necessity and appropriateness; includes experimental/ investigational treatment</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Is Decision Binding?</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Are Reviewers Bound by Plan’s Definition of Medical Necessity?</th>
<th>No</th>
<th>No</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>State</td>
<td>State</td>
<td>State</td>
<td>State</td>
<td>State</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who Decides if a Dispute is Eligible for External Review?</th>
<th>California</th>
<th>Michigan</th>
<th>New York</th>
<th>Pennsylvania</th>
</tr>
</thead>
<tbody>
<tr>
<td>State</td>
<td>State</td>
<td>State</td>
<td>Plan</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>State</td>
<td>State</td>
<td>State</td>
<td>Plan</td>
<td></td>
</tr>
</tbody>
</table>
### APPENDIX A: CHART I (CONT.)

<table>
<thead>
<tr>
<th>Do Consumers Have Limited Time to Request External Review (filing deadline)?</th>
<th>California</th>
<th>Michigan</th>
<th>New York</th>
<th>Pennsylvania</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 months</td>
<td>60 days (from receipt of final adverse determination)</td>
<td>45 days (from receipt of the final adverse determination from the first level of internal appeal within the plan)</td>
<td>15 days (after receipt of final denial letter from plan)</td>
<td></td>
</tr>
</tbody>
</table>

| Total Available Time to Complete Entire Process | 33 days | 26 days | 37 days plus 5 business days | 60 days |

| Time Limit for Review Entity to Reach Decision | 30 days | 14 days | 30 days | 40 days |

| Time Limit for Expedited Review | 3 days (or sooner as determined by medical exigencies of the case. Also allow additional time, with specific time limits, for certain tasks in the process) | 3 days (72 hours) (or sooner as determined by medical exigencies of the case) | 3 days | 2 business days (or sooner as determined by medical exigencies of the case. Also allow additional time, with specific time limits, for certain tasks in the process) |

| Consumer Charged a Fee for Requesting an External Review? | No | No | $50 | $25 |
Annals of Health Law, Vol. 13 [2004], Iss. 1, Art. 8

APPENDIX A: CHART I (CONT.)

<table>
<thead>
<tr>
<th>Cost Per Case (approximate average)</th>
<th>California</th>
<th>Michigan</th>
<th>New York</th>
<th>Pennsylvania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Necessity:</td>
<td>Medical</td>
<td>Medical</td>
<td>Medical</td>
<td>Medical</td>
</tr>
<tr>
<td>Standard: $395</td>
<td>N/A</td>
<td>$600-700</td>
<td>N/A</td>
<td>$750</td>
</tr>
<tr>
<td>Expedited: $500</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
<td>$500</td>
</tr>
<tr>
<td>Experimental/Investigational:</td>
<td>$1750</td>
<td>$2210</td>
<td>$1750</td>
<td>$2210</td>
</tr>
<tr>
<td>Standard: $2500</td>
<td>$2500</td>
<td>$2500</td>
<td>$2500</td>
<td>$2500</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>State (subject to periodic assessments on health plans)</td>
<td>State (with plan regulatory fees)</td>
<td>Health Plan (fees determined by the state)</td>
<td>Plan, but when provider initiates appeal, the non-prevailing party pays</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Department Oversight Mechanism</th>
<th>California</th>
<th>Michigan</th>
<th>New York</th>
<th>Pennsylvania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Director and Clinical Advisory Board</td>
<td>Commissioner</td>
<td>Commissioner OR Superintendent</td>
<td>Secretary</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Jurisdiction of Courts</th>
<th>California</th>
<th>Michigan</th>
<th>New York</th>
<th>Pennsylvania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consumer must exhaust IMR first</td>
<td>Concurrent Jurisdiction</td>
<td>Concurrent Jurisdiction</td>
<td>Consumer must exhaust IMR first</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>New Cause of Action</th>
<th>California</th>
<th>Michigan</th>
<th>New York</th>
<th>Pennsylvania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Rebuttal presumption in favor of the IRO decision</td>
</tr>
</tbody>
</table>

427. New York State reports that costs vary with type of review and circumstances. The 2002 External Appeal Program Annual report excludes cost information. However, an estimate of average cost can be derived by matching reported costs to all health plans for types of external determinations and graphs listing the number of "External Appeal Decisions by Type of Denial found respectively on p. 28 and p. 48 of New York State Department of Insurance and Department of Health, External Appeal Program Annual Report 2001. This report presents cumulative data from July 1, 1999 through June 29, 2001. Calculated average costs of a Medical Necessity Review is $544; Experimental/Investigational $2210.
### APPENDIX B: CHART II

<table>
<thead>
<tr>
<th>Start Date of Program</th>
<th>California</th>
<th>Michigan</th>
<th>New York</th>
<th>Pennsylvania</th>
</tr>
</thead>
</table>

#### PERIOD 1

<table>
<thead>
<tr>
<th>No. of Cases Accepted for Review</th>
<th>2001&lt;sup&gt;429&lt;/sup&gt;</th>
<th>10/00—8/01</th>
<th>2001</th>
<th>1/99—9/01 (2.5 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>723</td>
<td>271</td>
<td>979&lt;sup&gt;430&lt;/sup&gt;</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No. of Cases Determined</th>
<th>601</th>
<th>220</th>
<th>937</th>
<th>245</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>601</td>
<td>220</td>
<td>937</td>
<td>245</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Decision Overturned</th>
<th>38%</th>
<th>50%</th>
<th>40%</th>
<th>44%</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>38%</td>
<td>50%</td>
<td>40%</td>
<td>44%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Decision Modified</th>
<th>N/A</th>
<th>N/A</th>
<th>9%</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>N/A</td>
<td>N/A</td>
<td>9%</td>
<td>N/A</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Decision Upheld</th>
<th>62%</th>
<th>50%</th>
<th>51%</th>
<th>55%</th>
</tr>
</thead>
<tbody>
<tr>
<td>California</td>
<td>62%</td>
<td>50%</td>
<td>51%</td>
<td>55%</td>
</tr>
</tbody>
</table>

---


429. Data is taken from STATE OF CALIFORNIA, HMO HELP CENTER, DEP’T OF MANAGED CARE, ANN. REP. 2001, JOHN Q DOESN’T LIVE HERE ANYMORE. Data was also taken from CAL. HEALTH CARE FUND, INDEPENDENT MEDICAL REVIEW, PHASE II, at 3, 71 app.C (Apr. 2003).

430. This estimate is derived from the number of applications received cumulatively in New York from the start date of the IMR program to the close of each fiscal year backing out data from prior year reports. FY 2002 (12 mos.) data was extrapolated from 18 month data reported from July 2001 to December 2002 and added to NY cumulative data (due to the state’s change in reporting period to calendar year). The number of cases accepted for review includes cases reversed by health plans while pending review and excludes number of rejected applications to be consistent with other state reports. See 2002 APPEAL PROGRAM, supra note 428, at 14; N.Y. STATE DEP’T OF INS. & DEPT OF HEALTH, A REPORT ON EXTERNAL APPEALS IN NEW YORK, July 1 1999-JUNE 30, 2001, at 27; N.Y. STATE DEP’T OF INS. & DEPT OF HEALTH, A REPORT ON EXTERNAL APPEALS IN NEW YORK, JULY 1 2000-JUNE 31, 2001, at 29, available at www.nystategov.us.
APPENDIX B: CHART II (CONT.)

<table>
<thead>
<tr>
<th>PERIOD 2</th>
<th>California</th>
<th>Michigan</th>
<th>New York</th>
<th>Pennsylvania</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting Period</td>
<td>2002&lt;sup&gt;431&lt;/sup&gt;</td>
<td>2002</td>
<td>2002</td>
<td>9/01—12/31/02 (18 mos.)</td>
</tr>
<tr>
<td>No. of Cases Accepted for Review (rate of increase from prior period)&lt;sup&gt;432&lt;/sup&gt;</td>
<td>969</td>
<td>418&lt;sup&gt;433&lt;/sup&gt; (63%)</td>
<td>1241&lt;sup&gt;434&lt;/sup&gt; (27%)</td>
<td>N/A</td>
</tr>
<tr>
<td>No. of Cases Determined</td>
<td>707 (18%)</td>
<td>294 (33%)</td>
<td>950&lt;sup&gt;435&lt;/sup&gt; (2%)</td>
<td>283&lt;sup&gt;436&lt;/sup&gt; (200%)</td>
</tr>
<tr>
<td>Decision Overturned</td>
<td>35%</td>
<td>32%</td>
<td>37%</td>
<td>41%</td>
</tr>
<tr>
<td>Decision Modified</td>
<td>N/A</td>
<td>N/A</td>
<td>8%</td>
<td>N/A</td>
</tr>
<tr>
<td>Decision Upheld</td>
<td>65%</td>
<td>68%</td>
<td>55%</td>
<td>59%</td>
</tr>
</tbody>
</table>


432. Rates of increase are approximations based on widely varying time periods for Reporting Period 1; however, these numbers convey an accurate estimate of how IMR requests are either increasing or stabilizing in the states studied.

433. Michigan received 455 requests for dispute resolution; fourteen were withdrawn for various reasons including lack of state jurisdiction, leaving 441 cases accepted for review. Of these, 128 were successfully resolved while pending review; nineteen remained pending at the end of 2002; and 294 were fully adjudicated by staff attorneys or IRO. Of these, 123 health plan decisions were upheld and fifty-seven were overturned. Source: Telephone confirmation of most recent statistics with Paul Duguay, Attorney, Manager of Appeals Division, Office of Fin. & Ins. Servs., Dep’t of Ins., State of Michigan.

434. See supra note 430.


436. Pennsylvania data from both reporting periods updated via phone interview and e-mail correspondence from Stacy Mitchell, Director of Bureau of Managed Care, Pennsylvania Department of Health, April–June 2003; 528 external appeals were completed 1/1/99–12/31/02. The per month rates almost doubled from 8.2 to 15.8 per month.