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Managed Care Grievance Procedures: The Dilemma And The Cure

By Judge Joyce Krutick Craig¹

INTRODUCTION

As we enter the 21st century, the health care community (providers and policy makers alike) must come to terms with the fact that managed care, in one form or another, is here to stay.² Accepting the fact that health care costs, at present and in the future, will generally be paid for on a capitated basis,³ we must determine how to handle denials of claims in order to adequately protect patients.

Patients and physicians feel equally frustrated and powerless when a managed care organization refuses to pay for treatment.⁴ Managed care organizations ("MCOs") consistently claim they are making payment decisions rather than medical decisions in these situations. But the reality is that, when a denial of coverage is made, it is the equivalent of a

1 The author serves as a United States Administrative Law Judge assigned to the Social Security Administration, and was Chief Judge of the Hartford, Connecticut Hearing Office from September 2000 to September 2001. The opinions expressed in this paper are solely that of the author and do not represent the policy of the Social Security Administration. Judge Craig received her B.A. in history from Long Island University in 1969, her J.D. from Brooklyn Law School in 1969, and is a candidate for an L.L.M. in Health Law and Policy at Seton Hall University School of Law. Judge Craig gratefully acknowledges the assistance of Judge John Mason and Mary Pappas in editing this work.

2. The term "managed care" is generally used to describe plans for payment of health care costs that include mechanisms to control costs while attempting to provide quality service. In most instances, prior authorization for service is required. Often the primary physician is a "gatekeeper." For an excellent discussion of the evolution of the term "managed care," see Harold S. Luft, *Why Are Physicians So Upset about Managed Care?*, 24 J. HEALTH POL., POL'Y & L. 957 (1999).

3. See Eleanor D. Kinney, *Procedural Protections for Patients in Capitated Health Plans*, 22 AM. J. L. & MED. 301, 301 (1996).

4. This has become evident to this author on a daily basis during hearings conducted pursuant to 42 U.S.C. § 1395w-22(g)(5) (1994). Medicare beneficiaries, who are enrolled in health maintenance organizations and their physicians, regularly express their frustration to this author. Most do not understand why the HMO denies treatment and/or testing ordered by the physician.

denial of care.⁵ Physicians feel that their professional judgment has been undermined and patients are angry and frightened because they cannot secure the care that their doctors believe is necessary.⁶ Both patients and physicians want control over medical decisions to be returned to the treating physician. Managed care organizations argue that to do so would undermine the cost saving benefits of managed care.⁷

Scholars have authored many articles concerning the "backlash" in managed care.⁸ This "backlash" is fueled by the numerous horror stories of patient deaths attributed to health care denials. The media routinely reports cases of exacerbated illnesses and death resulting from claims that have been denied by MCOs. For example, *Newsweek* displayed a cover showing a woman in a hospital gown, fist clenched, with an anguished look on her face, and the words "The War Over Patient's Rights HMO HELL."⁹ A study by the Public Advocate of the City of New York found that providers experience significant delays when they attempt to secure pre-certification of services for their patients.¹⁰ Examples of the problem include the need for the physician to make multiple phone calls before a pre-certification is issued. The physician must deal with insurance plan staff who have no medical knowledge and insurer staff physicians whose expertise often lies in unrelated specialties. Scholars suggest, among other things, amending the Employee Retirement Income Security Act ("ERISA")¹¹ to allow lawsuits for negligence, and creating a patients' bill of rights. Congress, in passing ERISA, intended to protect employees who participated in private pension plans by setting uniform standards.¹² Although Congress did not particu-

5. Recently, a bill introduced in the New Jersey Legislature took note of this fact, stating that in order to reduce the costs of care, many carriers have been denying medically necessary treatment for patients. S.B. 1333, 209th Leg. (N.J. 2000).

6. *Id.*

7. See Brief of Amici Curiae Am. Assn. of Health Plans at 3, *Pegram v. Herdrich*, 530 U.S. 211 (2000) (No. 98-1949).

8. See Norman Daniels & James Sabin, *The Ethics of Accountability in Managed Care Reform*, HEALTH AFF. Sept.-Oct. 1998, at 50 (suggesting accountability as a key to reform health care); see also Thomas Rice, *The Mechanics of Backlash: The Microregulation of the Health Care Marketplace*, 24 J. HEALTH POL., POL'Y & L. 967 (1999).

9. *The War Over Patient's Rights HMO HELL*, NEWSWEEK, Nov. 8, 1999, cover.

10. Mark Green, *Obstacle Course: How Managed Care Organizations Manage to Delay and Deny Health Care* (June 1999), at <http://pubadvocate.nyc.gov/padcdetail.cfm?id1=7&id2=81> (last visited Jan. 12, 2002).

11. 29 U.S.C. §§1001-1191(c) (1994).

12. *Id.*

larly focus on health plans, much less managed care,¹³ ERISA has had a significant impact on the relationship between managed care plans and their beneficiaries. The major thrust of ERISA was to pre-empt state law that conflicted with the federal statutory scheme.¹⁴ In 1999, seventy-three percent of workers in the United States had health insurance provided through their employers (as part of an employee benefit plan as defined by ERISA).¹⁵ Therefore, the impact upon patients has been enormous. Patients, injured when their MCO denied care, often sue for negligence. These suits are generally brought in state courts. Such suits are generally dismissed because ERISA limits the remedy; a patient may sue for the cost of the services that have been denied or may sue to force the MCO to provide care, but cannot sue for damages.¹⁶ Thus, patients find themselves without the ability to sue for damages due to negligence.

The New Jersey Legislature adopted a resolution asking Congress to eliminate "certain statutory impediments . . . to medical malpractice actions against ERISA plans maintained to provide health insurance."¹⁷ However, solutions of this nature do not address the crux of the problem, getting the patient the care he or she needs when it is needed. The right to sue for malpractice comes too late for many patients.¹⁸

Remedies of this nature fail to take into account the fact that each claim by a managed care entity involves a legal interpretation of the policy provisions, and application of those standards to medical facts. Because the issue is a mixed question of law and medicine, patients would be best served by having their claims heard by federal administrative law judges, who are skilled in both law and medicine.

At present, the only federal statute dealing with grievance procedures has little value in protecting patients' rights.¹⁹ Some MCOs have an internal review process, which may be required by state law. Some go

13. See Margaret G. Farrell, *ERISA Pre-emption and Regulation of Managed Care: The Case for Managed Federalism*, 23 AM. J.L. & MED. 251, 251 (1997).

14. *Id.* at 252.

15. *Contingent Workers Incomes and Benefits Lag Behind Those of Rest of Workforce*, MEDICAL BENEFITS, Aug. 30, 2000, Vol. 17, No. 6, at 5, available at <http://www.senate.gov/~kennedy/statements/00/07/2000725859.html> (last visited Jan. 9, 2002).

16. This is known as ERISA pre-emption. See discussion *infra* Section I.

17. A.R. 49, 209th Leg. (N.J. 2000).

18. Even a suit under ERISA to force the plan to provide benefits under 29 U.S.C. §1132(a)(1)(B) (1994) is not helpful, as a patient would have to sue the company (most likely with the assistance of an attorney in federal court). Because lawsuits take time, the patient may die in the interim or, at the very least, have their condition worsen.

19. 42 U.S.C. § 300(e) (1994) (commonly known as the Health Maintenance Organization Act of 1973). See also *infra* Part II.

further, providing arbitration and/or other forms of independent review, which also may be required by state law. Many states have enacted procedures that allow a patient to appeal adverse managed care decisions; however, the statutes vary greatly in the protections afforded each patient. Some statutes only require that an MCO maintain grievance procedures. Others go to great lengths to detail review procedures. Such procedures might include a review of the denial by company employees (commonly termed "internal review"), a second review by company employees (commonly termed "reconsideration"), and an independent review by a private independent review organization or a state agency (commonly known as external review).

The President's Advisory Committee also recognized the need for strong grievance procedures,²⁰ but a solution has yet to be proposed that adequately protects patients. The difficulty with allowing each state to formulate its own procedure is the lack of uniformity. Uniformity is necessary to prevent a resident of one state, who suffers from the same condition, requires the same care, and carries the same health insurance as a resident of another state, from being denied the necessary care because one state has mandatory and binding external review, while the other state does not. Moreover, people move from state to state for both work and play. Often, they move to be near quality health care. For example, if health care is provided in New York, but the individual resides in New Jersey and works in Pennsylvania, which grievance procedure controls?²¹ The question has been posed: "Does the state managed care regulation conflict with the effectuation of the acknowledged goals of the federal legislation or unreasonably impede the free flow of commerce in employer provided health services?"²² I believe that such regulation places a chokehold on the ability of patients to secure necessary care.

This paper will focus on the procedures currently available for patients to appeal denials of claims, and will propose a unified federal grievance procedure. The proposed procedure would utilize the talents

20. ADVISORY COMMISSION ON CONSUMER PROTECTION & QUALITY IN THE HEALTH CARE INDUSTRY, CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES: REPORT TO THE PRESIDENT OF THE UNITED STATES 57-62 (1997), available at <http://www.hcqualitycommission.gov/cborr> (last visited Jan. 12, 2002).

21. While traditional rules governing conflict of laws would be applied, court action would be required to ascertain the answer.

22. Farrell, *supra* note 13, at 259.

of the federal administrative judiciary assigned to the Social Security Administration. These judges have expertise in both medicine and utilization review resulting from their work adjudicating disability claims and appeals of adverse Medicare determinations including: Part A hospital benefits; Part B physicians services, home health services, and provision of durable medical equipment; and the newly added Part C Medicare + Choice program.²³ Part I explores the implications of ERISA and pre-emption of state actions for negligence. Part II discusses current federal law and provides a state-by-state analysis of state appeals procedures. Part III discusses the evolution of federalism and its application to health care law. Part IV discusses existing proposals and pending legislation dealing with grievance procedures. Part V proposes a statutory federal due process hearing for appeals of managed care adverse determinations.

I. ERISA

In 1974, Congress passed the Employee Retirement Income Security Act.²⁴ The stated purpose for the passage of the Act, in pertinent part, was:

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities . . . to provide for the general welfare and the free flow of commerce, . . . that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of

23. Title XVIII of the Social Security Act covers Hospital Insurance Benefits for the Aged and Disabled (42 U.S.C. §§ 1395-1395i-5 (1994)), Supplementary Medical Insurance Benefits for the Aged and Disabled (42 U.S.C. §§ 1395j-1395w-4 (1994)), and Medicare + Choice (42 U.S.C. §§ 1395w-21-1395w-28 (1994)).

24. 29 U.S.C. § 1001 (1994).

commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness. . . .

It is hereby further declared to be the policy of this Chapter to protect interstate commerce, the Federal taxing power, and the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such plans by requiring them to vest the accrued benefits of employees with significant periods of service, to meet minimum standards of funding, and by requiring plan termination insurance.²⁵

The movement for federal regulation and uniformity in employee benefits plans in 1978 focused primarily on pension benefits. Health plans were not an issue, as managed care had yet to become an important consideration. As numerous authors have noted,²⁶ the effect ERISA would have on health care law was unanticipated. Professor Farrell stated, "abuses of health benefit plans and a need for national uniformity were not apparent in 1974."²⁷ Quite the opposite, Congress expressly stated in a "savings clause" that health insurance provided to ERISA-protected employees should continue to be state regulated.²⁸ Nonetheless, Congress made it abundantly clear from the definitions it set forth that Congress intended ERISA to regulate health insurance plans. The language states in pertinent part:

(1) The terms "employee welfare benefit plan" and "wel-

25. *Id.*

26. See generally 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 (1999) (arguing that the first step in reforming U.S. health care is reforming ERISA); Peter D. Jacobson & Scott D. Pomfret, *Form, Function, and Managed Care Torts: Achieving Fairness and Equity in ERISA Jurisprudence*, 35 HOUS. L. REV. 985 (1998) (suggesting a clarification of ERISA with a functional analysis); Deborah S. Davidson, *Balancing the Interests of State Health Care Reform and Uniform Employee Benefit Laws Under ERISA: A "Uniform Patient Protection Act,"* 53 WASH. U. J. URB. & CONTEMP. L. 203 (1998) (discussing the absence of comprehensive health care reform and suggesting means to achieve it); Karen A. Jorden, *The Complete Pre-emption Dilemma: A Legal Process Perspective*, 31 WAKE FOREST L. REV. 927 (1996) (exploring complete pre-emption as providing more principled and purposive law); James E. Holloway, *ERISA, Pre-emption and Comprehensive Federal Health Care: A Call for "Cooperative Federalism" To Preserve the States' Role in Formulating Health Care Policy*, 16 CAMPBELL L. REV. 405 (1994) (taking the position that health care is becoming a field of exclusively federal regulation).

27. See Farrell, *supra* note 13, at 257.

28. 29 U.S.C. § 1144(b) (1994).

fare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability. . . .²⁹

The major thrust of ERISA was to pre-empt state laws that conflicted with the federal scheme.³⁰ Congress also limited employee rights.³¹ Specifically, an employee covered by an ERISA plan who has had services denied is limited to a suit for the cost of the services denied, assuming that he or she has paid for the services.³² In the alternative, the employee may seek an injunction to require that the company provide the benefits.³³ A negligence suit is barred because it "relates to" an employee benefit plan. Supreme Court jurisprudence in the area has had a substantial effect, by essentially leaving the health care consumer injured by the denial of health care services without a remedy.

The question of whether a federal law pre-empts a state statute was presented to the Supreme Court in 1983 when it was called upon to determine whether ERISA pre-empted the New York Human Rights Law.³⁴ Ruling that the New York statute did indeed "relate to" an employee benefit plan, the Court concluded that: "a law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan."³⁵ The Court further noted that "Congress used the words 'relate to' in § 514(a) in their broad sense."³⁶

Following the logic of the Court's decision in the 1987 case of *Shaw v. Delta Airlines, Inc.*, the Court decided two cases concerning ERISA pre-emption.³⁷ The Court heard the argument for both cases, and on the

29. 29 U.S.C. § 1002(1) (1994).

30. 29 U.S.C. § 1144(a) (1994) (providing that the statute supersedes a state law that "relates to" an employee benefit plan).

31. 29 U.S.C. § 1132 (1994).

32. *Id.*

33. 29 U.S.C. § 1132(a)(1)(B) (1994).

34. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 88 (1983).

35. *Id.* at 96-97.

36. *Id.* at 98.

37. *Metro. Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

same day, Justice O'Connor delivered both opinions. In *Pilot Life Insurance Co. v. Dedeaux*, an employee and beneficiary covered by a long-term disability policy brought an action in state court for "Tortious Breach of Contract," "Breach of Fiduciary Duties," and "Fraud in the Inducement."³⁸ Noting the "expansive sweep of the pre-emption clause,"³⁹ Justice O'Connor stated that "[t]he common law causes of action raised in Dedeaux's complaint, each based on alleged improper processing of a claim for benefits under an employee benefit plan, undoubtedly meet the criteria for pre-emption under § 514(a)."⁴⁰ Referring specifically to the provisions for civil enforcement in the federal courts, she noted that:

In sum, the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.⁴¹

In the companion case, *Metropolitan Life Insurance Co. v. Taylor*, the Court decided "whether these state common law claims are not only pre-empted by ERISA, but also displaced by ERISA's civil enforcement provision, § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), . . . to the extent that complaints filed in state courts purporting to plead such common law causes of action are removable to federal court under 28 U.S.C. § 1441(b)."⁴² The plaintiff in this case brought an action in state court to enforce an employment contract and to collect damages for "mental anguish caused by breach of this contract, as well as immediate reimplementation of all benefits and insurance coverages . . ."⁴³ The Court had no difficulty concluding that the cause of action "related to" an ERISA plan and was therefore pre-empted.⁴⁴ Holding that the cause of ac-

38. *Dedeaux*, 481 U.S. at 44.

39. *Id.* at 47.

40. *Id.* at 48.

41. *Id.* at 54.

42. *Taylor*, 481 U.S. at 60.

43. *Id.* at 61.

44. *Id.* at 62.

tion was removable to federal court,⁴⁵ Justice O'Connor noted that "pre-emption is ordinarily a federal defense to the plaintiff's suit."⁴⁶ The court also wrote: "Congress may so completely pre-empt a particular area that any civil complaint raising this select group of claims is necessarily federal in character."⁴⁷ Drawing an analogy to § 301 of the Labor-Management Relations Act of 1947,⁴⁸ and quoting Senator Williams⁴⁹ (who was an ERISA sponsor), Justice O'Connor concluded that in enacting ERISA, Congress intended total pre-emption.⁵⁰

How then are these holdings to be applied when the issue involves actions sounding in tort and involving the failure to provide and/or pay for health care benefits? For the most part, courts have held that such suits are pre-empted by ERISA.⁵¹

A seminal case on the issue, and one that is often cited as one of the "horror stories," is *Corcoran v. United Healthcare, Inc.*⁵² Mrs. Corcoran, a pregnant woman, was considered a high risk due to numerous medical problems. An employee of South Central Bell Telephone, she applied for temporary disability benefits but was denied coverage.⁵³ Her treating physician wrote to the company's medical consultant, who continued to deny coverage.⁵⁴ Unilaterally and without notice to Mrs. Corcoran or her doctor, the company physician sought a second opinion. This opinion concluded, "the company would be at considerable risk denying her doctor's recommendation."⁵⁵ Because Mrs. Corcoran had previously experienced problems in pregnancy, her physician ordered that she be hospitalized towards the end of the pregnancy so that "he could monitor the fetus around the clock."⁵⁶ Blue Cross and Blue Shield ("Blue Cross") administered the company's self-funded health insurance

45. *Id.* at 67.

46. *Id.* at 63.

47. *Id.* at 63-64.

48. 29 U.S.C. § 141-185(a) (2001).

49. The senator stated: "It is intended that such actions will be regarded as arising under the laws of the United States, in similar fashion to those brought under section 301 of the Labor Management Relations Act." *Taylor*, 481 U.S. at 66 (quoting 120 CONG. REC. 29933 (1974)).

50. *Id.* at 67.

51. Several courts have refused to find pre-emption in negligence suits against HMOs predicated upon vicarious liability. These cases are discussed *infra* pp. 344-49.

52. 965 F.2d 1321 (5th Cir. 1992).

53. *Id.* at 1326.

54. *Id.*

55. *Id.*

56. *Id.* at 1323.

plan.⁵⁷ However, United HealthCare (“United”) administered pre-certification of hospital admissions.⁵⁸ Pursuant to the plan’s requirements, her treating physician sought approval for her admission.⁵⁹ United refused to pre-certify, finding that an inpatient stay was not medically necessary.⁶⁰ Instead, they authorized home nursing for ten hours a day.⁶¹ Although Mrs. Corcoran entered the hospital, she was forced to return home after nine days.⁶² Thirteen days later, when the nurse was not present, “the fetus went into distress and died.”⁶³ Mrs. Corcoran and her husband brought a wrongful death action against both Blue Cross and United.⁶⁴ The defendants removed the matter to federal court and moved for summary judgment, arguing that the claims “related to” an ERISA plan and were therefore pre-empted.⁶⁵ The district court ruled in the defendants’ favor.⁶⁶ On appeal, the defendants asserted that they were making benefit determinations rather than medical decisions.⁶⁷ Therefore, they argued that the claims should be pre-empted.⁶⁸ The Corcorans on the other hand, asserted that the defendants were making medical decisions.⁶⁹ While neither agreeing with the Corcorans nor the defendants, the court held that “United makes medical decisions - indeed, United gives medical advice - but it does so in the context of making a determination about the availability of benefits under the plan.”⁷⁰ The court held that ERISA pre-empted the action, leaving the Corcorans without a remedy.⁷¹ Reflecting on the result of its decision, the court noted:

The result ERISA compels us to reach means that the Corcorans have no remedy, state or federal, for what may have been a serious mistake. This is troubling for several reasons. First, it eliminates an important check

57. *Id.*

58. *Id.* at 1321.

59. *Id.* at 1324.

60. *Id.*

61. *Id.*

62. *Id.*

63. *Id.*

64. *Id.* at 1324.

65. *Id.* at 1324-25.

66. *Id.* at 1325.

67. *Id.* at 1329.

68. *Id.*

69. *Id.* at 1330.

70. *Id.* at 1331.

71. *Id.* at 1334.

on the thousands of medical decisions routinely made in the burgeoning utilization review system. With liability rules generally inapplicable, there is theoretically less deterrence of substandard medical decisionmaking. Moreover, if the cost of compliance with a standard of care (reflected either in the cost of prevention or the cost of paying judgments) need not be factored into utilization review companies' cost of doing business, bad medical judgments will end up being cost-free to the plans that rely on these companies to contain medical costs. ERISA plans, in turn, will have one less incentive to seek out the companies that can deliver both high quality services and reasonable prices.⁷²

Another equally distasteful result occurred when Pamela Danca sued Private Health Care Systems and Phoenix Home Life Mutual Insurance Company.⁷³ Ms. Danca had a long history of mental illness.⁷⁴ In September 1994, her physician recommended hospitalization at McLean Hospital.⁷⁵ In choosing this hospital, he relied on the fact that she had a prior successful treatment in the facility. The defendants⁷⁶ refused to pre-certify the admission, but did pre-certify admission to another facility.⁷⁷ Ms. Danca asserted that she did not receive proper care at the facility chosen by the defendants and, as a result of her inadequate care, "attempted suicide by self-immolation, causing severe burns and permanent disfiguring injuries."⁷⁸ Ms. Danca sued in Massachusetts Superior Court, alleging various causes of action sounding in negligence.⁷⁹ The defendants removed the matter to federal court and moved to dismiss on the grounds that the claims were preempted by ERISA.⁸⁰ The district court granted the motion.⁸¹ Finding that although the "allegedly negligent decision making . . . maybe characterized as medical in nature," the court nonetheless held that "the conduct was indisputably part of the process used to assess a participant's claim for a benefit payment under

72. *Id.* at 1338 (citation omitted).

73. *Danca v. Private Health Care Sys. Inc.*, 185 F.3d 1, 1 (1st Cir. 1999).

74. *Id.* at 3.

75. *Id.* at 2.

76. Defendants are the claimant's insurance company and its utilization review agent.
Id. at 2.

77. *Id.* at 3.

78. *Id.*

79. *Id.* at 3.

80. *Id.*

81. *Id.*

the plan.”⁸² As such, the court held the state law tort claims were “alternative enforcement mechanisms under ERISA,” and therefore were preempted.⁸³ Conversely, the Third Circuit ruled in 1995 that malpractice claims involving quality of benefits were not claims for the recovery of benefits under the ostensible agency theory, nor were they claims to enforce plan rights nor clarify rights to future benefits “as those phrases are used in § 502(a)(1)(B) of ERISA.”⁸⁴ Therefore, the Third Circuit ruled that they were not preempted.⁸⁵ Other courts have since followed the Third Circuit’s reasoning.⁸⁶ In 1999, the Third Circuit revisited this issue.⁸⁷ Discussing the *Dukes* ruling, the court stated that:

Perhaps the most significant contribution made by the *Dukes* opinion was the distinction drawn between (1) state-law claims directed to the quality of benefits provided, which are not completely preempted, and (2) claims “that the plans erroneously withheld benefits due” or that seek “to enforce [plaintiffs’] rights under their respective plans or to clarify their rights to future benefits,” which are subject to complete pre-emption. To reiterate, we embraced a distinction between claims pertaining to the quality of the medical benefits provided to a plan participant and claims that the plan participant was entitled to, but did not receive, a certain quantum of benefits under his or her plan.⁸⁸

The court further held that when the complaint does not allege a “failure to provide or authorize benefits under the plan,”⁸⁹ the cause of action

82. *Id.* at 5-6.

83. *Id.* at 6.

84. *Dukes v. U.S. Health Care, Inc.*, 57 F.3d 350, 351 (3rd Cir. 1995). The ostensible agency theory will find the HMO liable when a patient looks to the HMO rather than the individual physician for care, and the HMO’s conduct leads the patient to reasonably believe he or she is being treated by an employee of the HMO. *Id.* at 352 (quoting *Boyd v. Albert Einstein Med. Ctr.*, 547 A.2d 1229, 1234-35 (Pa. Super. Ct. 1988)).

85. *Dukes*, 57 F.3d at 352.

86. *See, e.g., Lancaster v. Kaiser Found. Health Plan*, 958 F. Supp. 1137, 1145 (E.D. Va. 1997); *Coyne & Delany Co. v. Selman*, 98 F.2d 1457, 1467 (4th Cir. 1996) (holding that “Delany’s malpractice claim is not preempted because it does not ‘relate to’ an employee benefit plan within the meaning of ERISA’s preemption provision”); *Custer v. Sweeney*, 89 F.3d 1156, 1167 (4th Cir. 1996) (holding that “Congress intended ERISA to preempt state law malpractice claims involving professional services to ERISA plans.”).

87. *In re U.S. Healthcare, Inc.*, 193 F.3d 151 (3rd Cir. 1999), *U.S. Healthcare v. Bauman*, *cert. denied*, 530 U.S. 1242 (2000).

88. *Id.* at 161-62 (citations omitted).

89. *Id.* at 162.

should not be completely pre-empted.⁹⁰

For courts following the *Dukes* and *Bauman* reasoning, the question revolves around quality versus quantity.⁹¹ If the complaint alleges state law claims of negligence, the case is one involving the quality of care and will not be pre-empted.⁹² If, on the other hand, the complaint alleges a failure to provide benefits under the terms of an ERISA plan, the claim will be pre-empted.⁹³ Although the United States Supreme Court refused to review this decision,⁹⁴ the Court recently noted that decisions on eligibility under a plan and "treatment decisions" are often "inextricably mixed."⁹⁵ Thus, distinguishing between claims based upon "quality of care" as opposed to "quantity of care" will often be exceedingly difficult.

Regardless of whether the patient is in a jurisdiction that adheres to the *Dukes* and *Bauman* rationale, a negligence or malpractice suit is still an unsatisfactory solution. The very appellation of a suit in "negligence" or "malpractice" infers that the patient has been harmed. Both patients and their doctors need a solution that will prevent the harm from occurring.

Although ERISA was intended to protect employees and their beneficiaries, the net effect as applied to health insurance has left them largely unprotected. A patient who is denied care and resides in a jurisdiction that has adopted *Dukes* and *Bauman* will generally lose in a state court negligence action due to ERISA's pre-emptive effect.⁹⁶ A patient who sues in state court to enforce the terms of the plan will likely find the matter removed to federal court.⁹⁷ Without the ability to sue the managed care entity (clearly not a satisfactory solution), and in the absence of a national policy on grievance procedures, patients are relegated to state statutes. What then does federal law provide? Which states have

90. *Id.* The Fifth Circuit took the same position in *Corporate Health Ins., Inc. v. Tex. Dep't of Ins.*, 215 F.3d 526, 534-35 (5th Cir. 2000), ruling that the portion of the Texas statute which imposes liability upon a managed care organization for failure to exercise ordinary care in decision making was not preempted by ERISA.

91. *In re U.S. Healthcare*, 193 F.3d at 161-62 (construing *Dukes*' important contribution to the quality versus quantity dichotomy).

92. *Id.* at 162.

93. *Id.*

94. *In re U.S. Healthcare, Inc.*, 193 F.3d 151 (3rd Cir. 1999), *cert. denied*, *Bauman v. U.S. Healthcare, Inc.* 530 U.S. 1242 (2000).

95. *Pegram v. Herdrich*, 530 U.S. 211, 229 (2000).

96. *See Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350, 350 (3rd Cir. 1995); *see also In re U.S. Healthcare, Inc.*, 193 F.3d at 151.

97. *See Dukes*, 57 F.3d at 350; *see also In re U.S. Healthcare, Inc.*, 193 F.3d at 151.

mandatory grievance procedures? Which states have mandatory external review? What do the state statutes require? We turn now to an examination of those statutes.

II. CURRENT FEDERAL LAW AND STATE STATUTORY SOLUTIONS

A) Federal provisions

The federal Health Maintenance Act requires HMOs to provide “meaningful procedures for hearing and resolving grievances between the health maintenance organization . . . and the members of the organization.”⁹⁸ This mandate is, unfortunately, meaningless. As one author has noted:

The HMO Act applies only to plans which seek designation as federally qualified HMOs. Even for those plans, there is no provision for individual enrollee appeals. Complaints about a plan’s general failure to meet the requirements of the Act can be sent to HCFA’s Office of Managed Care. However, there is no remedy under the HMO Act for wrongful denial of care to an individual enrollee.⁹⁹

On February 20, 1998, President Clinton signed a memorandum that directed the Secretary of Labor to “propose regulations to strengthen the internal appeals process for all Employee Retirement Income Security Act . . . health plans to ensure that decisions regarding urgent care are resolved within not more than 72 hours and generally resolved within 15 days for non-urgent care.”¹⁰⁰ Pursuant to that directive, final regulations were published on November 21, 2000.¹⁰¹ The regulations set standards for “minimum procedural requirements” for ERISA plans with regard to deciding claims.¹⁰² In setting time frames for decision-making, the department concluded that short time frames for group health plans and

98. 42 U.S.C. § 300(e)(c)(5) (2001).

99. Gordon Bonnyman, Jr. & Michele M. Johnson, *Unseen Peril: Inadequate Enrollee Grievance Protections in Public Managed Care Programs*, 65 TENN. L. REV. 359, 370-71 (1998).

100. 29 C.F.R. § 2560 (2000).

101. *Id.*

102. *Id.* These standards apply only to internal review by the carrier and do not deal with the issue of external review. *Id.*

disability plans were "crucial" to protect plan members.¹⁰³ Specific reference is made to pre-emption. The regulation states that "[n]othing in this section shall be construed to supersede any provision of State law that regulates insurance, except to the extent that such law prevents the application of a requirement of this section."¹⁰⁴ The fact that a state's law provides for a grievance procedure will not prevent application of the regulation.¹⁰⁵ It is unclear whether a state procedure containing longer time frames will be considered to "prevent the application of a requirement" of the regulation.¹⁰⁶ There are no provisions concerning enforcement of these regulations. Thus, the patient is relegated to a suit under Section 502(a) of ERISA.¹⁰⁷

B) State Solutions

Most states have statutes requiring managed care entities to maintain some form of internal grievance review. Only five states lack such a provision,¹⁰⁸ whereas several state statutes apply only to health maintenance organizations, not other forms of managed care.¹⁰⁹ Only twenty-three states require external review of those decisions.¹¹⁰ Of those twenty-three states, decisions of the external review organizations are

103. *Id.* Under the new regulations, all claims decisions must be made within a reasonable period of time, taking into consideration the patient's condition. 29 C.F.R. § 2560.503-1(f)(1) (2000). However, an urgent care determination must be made within seventy-two hours of the filing of the claim. 29 C.F.R. § 2560.503-1(f)(2)(i). A claim involving services yet to be provided must be determined within fifteen days of the receipt of the claim. 29 C.F.R. § 2560.503-1(f)(2)(iii)(A). Where services have already been provided the plan has up to thirty days to make a decision. 29 C.F.R. § 2560.503-1(f)(2)(iii)(B).

104. 29 C.F.R. § 2560.503-1(k)(1).

105. 29 C.F.R. § 2560.503-1(k)(2)(i).

106. *See* 29 C.F.R. § 2560-503-1(k).

107. 29 U.S.C. § 1144(a) (1994).

108. The states that lack this type of provision are Arkansas, Delaware, Massachusetts, New Mexico and South Carolina. *See infra* "State Solutions Chart" at p. 351-52.

109. The states that apply this type of provision are Iowa, Louisiana, North Dakota, Tennessee, Utah, Vermont, Washington, and West Virginia. *See infra* "State Solutions Chart" at p. 351-52.

110. *See infra* "State Solutions Chart" at p. 351-52. The National Committee for Quality Assurance, a private organization responsible for accreditation of health care carriers, added a requirement in March 1999 for an external review process in order for a plan to qualify for approval. *Quality Assurance: NCQA Adds External Review Requirement to Managed Care Accreditation Standards*, 8 BNA's Health Law Rep. 443 (March 18, 1999). This has, to some extent, been responsible for an increase in the number of plans offering an external appeals process. However, these external appeals processes remain purely private rather than statutorily mandated.

binding in only thirteen states.¹¹¹ The following chart indicates whether a state has mandatory grievance procedures or mandatory external review, and whether such review is binding on the parties. Following the chart is a summary of the provisions of each state's statutes.¹¹²

STATE SOLUTIONS

ST	MAND. GRIEV. PROC.	MAND. EXTERNAL REV.	BINDING
AL	yes	yes	yes
AZ	yes	yes	yes
AR	no	no	no
CT	yes	yes	yes
CO	yes	yes	
DE	no	no	
FL	yes	no	
GA	yes	yes	yes
HI	yes	yes	no
ID	yes	no	
IL	yes	yes	yes
IN	yes	yes	yes
IA	yes (HMOs only)	no	
LA	yes (HMOs only)	no	
KS	yes	no	
KY	yes	no	
MA	no	no	no
MD	yes	yes	no
MI	yes	no	no
MN	yes	yes	yes
MS	yes	no	no
MO	yes	yes	yes
MT	yes (HMOs only)	yes (for all managed care entities)	yes
NE	yes	no	yes ¹¹³
NV	yes	no	no
NH	yes	yes	no
NJ (statute)	yes	yes	no
(adm. code)	yes	yes	no
NM	no	no	no
NY	yes	yes	yes
NC	yes	no	no
ND	yes (HMOs only)	no	no
OH	yes	yes	no
OR	yes	no	no
OK	yes	yes	no
PA	yes	yes	yes
RI	yes	yes	no
SC	no	no	no

111. See *infra* "State Solutions Chart" at 351-52.

112. Virtually all of these statutes have time frames for filing appeals, providing documentation, and decision-making. In most instances these time frames will not be discussed.

113. The carrier's second-level review determination is binding on the carrier. However, since no external binding review is required, a decision adverse to the enrollee leaves the enrollee without a remedy.

SD	yes	no	no
TN	yes (HMOs only)	yes	yes
TX	yes (HMOs only)	yes (all MCO entities)	no
UT	yes (HMOs only)	no	no
VT	yes (HMOs only)	no	no
VA	yes	yes	yes
WA	yes (HMOs only)	no	no
WV	yes (HMOs and prepaid ltd. HSOs) ¹¹⁴	no	no
WI	yes	no	no
WY	yes	no	no

Alaska devotes a title in the state's insurance law to "Regulation of Managed Care Insurance Plans."¹¹⁵ Decisions to deny payment for a service because it is not medically necessary must be made by an agent of the MCO, who is a state licensed health care provider.¹¹⁶ In addition, the statute mandates timely decisions and an internal appeals procedure.¹¹⁷ An MCO may condition external review upon completion of the company's internal review process. The state maintains standards for the qualification of external review agencies.¹¹⁸ The judicial review is *de novo*, and the statute delineates evidence that may be considered in reaching a decision.¹¹⁹ A written decision must be rendered promptly, stating the rationale for the decision and informing enrollees of their right to appeal to the courts.¹²⁰ The decision is binding unless appealed to the superior court.¹²¹

Arizona requires health care insurers to provide, at a minimum, the following four levels of review:¹²² (1) an expedited medical review in situations where delay may negatively impact the patient's condition; (2) an informal reconsideration;¹²³ (3) a formal appeals process; and (4) an

114. HSO means "Health Service Organization."

115. ALASKA STAT. § 21.07 (Michie 2000).

116. ALASKA STAT. § 21.07.020(4)(B) (Michie 2000).

117. ALASKA STAT. § 21.07.020(4)(A). A decision to deny payment must be made within seventy-two hours of the request for pre-approval of health care services. In emergency situations, the decision must be made within twenty-four hours of the request. *Id.*

118. ALASKA STAT. § 21.07.060 (Michie 2000).

119. ALASKA STAT. § 21.07.050 (Michie 2000).

120. *Id.* A decision is required within twenty-one working days from the filing of the request for review. In the event of an expedited appeal, the decision must be reached within seventy-two hours. ALASKA STAT. § 21.07.050(d)(8).

121. ALASKA STAT. § 21.07.050(d)(8). The statute appears to allow either the MCO or the patient to appeal the decision, and a request for appeal must be filed within six months of the date of the decision. ALASKA STAT. § 21.07.050(f).

122. ARIZ. REV. STAT. ANN. § 20-2533 (West Supp. 2000).

123. ARIZ. REV. STAT. ANN. § 20-2535 (West Supp. 2000). However, this is not required where the carrier's utilization review process applies only to the review of claims for services already provided. ARIZ. REV. STAT. ANN. § 20-2535.

independent external review process.¹²⁴ Informal reconsideration allows a patient up to two years from the date of the initial denial to file an appeal.¹²⁵ The utilization review agent may request that the state's insurance director commence an independent external review.¹²⁶ If the decision is adverse to the patient, it must contain supporting documentation including the clinical criteria used, information concerning the formal appeals process, and external review.¹²⁷ However, if the service is found to qualify for coverage, the insurer is bound by this decision.¹²⁸ An aggrieved party must file a timely request for a formal appeal if the issue involves a service that has yet to be provided.¹²⁹ However, if the service has already been provided, the time limit extends to two years from the notice of denial.¹³⁰ The statute requires a review of an issue of medical necessity to be performed by a physician licensed either in Arizona or another state and qualified in the medical specialty relating to the service at issue.¹³¹ The statute sets time frames within which a decision must be rendered.¹³² At this level as well, the reviewer may initiate external independent review.¹³³ If the plan member does not initiate external independent review after a denial decision is issued, the utilization review agent must advise the plan member of the right to do so.¹³⁴ As in the reconsideration stage, if the decision is made that the service should be covered, the carrier is bound by this decision.¹³⁵ The utilization review agent must choose one or more independent reviewers who are licensed physicians, and have neither a direct financial interest, nor previous knowledge of the case.¹³⁶ A decision by the independent reviewer is considered a final administrative decision and is subject to judicial review.¹³⁷ Thus, both the carrier and the plan member may appeal the decision.

124. ARIZ. REV. STAT. ANN. § 20-2537 (West Supp. 2000).

125. ARIZ. REV. STAT. ANN. § 20-2535(A).

126. ARIZ. REV. STAT. ANN. § 20-2535(E).

127. ARIZ. REV. STAT. ANN. § 20-2535(F).

128. ARIZ. REV. STAT. ANN. § 20-2535(G).

129. ARIZ. REV. STAT. ANN. § 20-2536(A) (West Supp. 2000).

130. *Id.*

131. ARIZ. REV. STAT. ANN. § 20-2536(D).

132. ARIZ. REV. STAT. ANN. § 20-2536(E).

133. ARIZ. REV. STAT. ANN. § 20-2536(F).

134. ARIZ. REV. STAT. ANN. § 20-2536(G).

135. ARIZ. REV. STAT. ANN. § 20-2536(H).

136. ARIZ. REV. STAT. ANN. § 20-2538 (West Supp. 2000).

137. ARIZ. REV. STAT. ANN. § 20-2537(H).

However, the health care insurer must provide care that is determined to be medically necessary, whether or not judicial review is requested.¹³⁸ Arkansas merely requires carriers to provide “meaningful review on the issue of denial.”¹³⁹ What constitutes “meaningful review” is not defined.

In California, health plans must maintain a grievance procedure and provide aggrieved enrollees with forms for filing a written grievance.¹⁴⁰ The statute has two versions, one effective until January 1, 2001 and one effective beginning January 1, 2001.¹⁴¹ The major difference is the availability of independent medical review enacted in the second version.¹⁴² The enrollee may submit the grievance for departmental determination¹⁴³ after completing the internal grievance procedure, or within thirty days after filing the grievance.¹⁴⁴ The enrollee is also entitled to request mediation. If this method is chosen, the enrollee retains the right to submit the grievance to the department after mediation is complete.¹⁴⁵ Expenses of the mediation process are borne by the parties equally.¹⁴⁶ The first version of the statute does not mandate compliance with the department’s decision upon review. However, after January 1, 2001, the department may order the plan to “promptly offer and provide” the denied services.¹⁴⁷ In the alternative, it may order the plan to reimburse the enrollee for the costs of the services for which he or she paid outside the plan if the department determines that it was reasonable to do so.¹⁴⁸ The decision of the department is binding on the parties.¹⁴⁹

A department known as the “Independent Medical Review System” is

138. ARIZ. REV. STAT. ANN. § 20-2537(C)(1).

139. ARK. CODE ANN. § 23-99-410 (Michie 1999).

140. CAL. HEALTH & SAFETY CODE § 1368(a)(1)-(3) (West 2000).

141. CAL. HEALTH & SAFETY CODE § 1368.

142. CAL. HEALTH & SAFETY CODE §§ 1368(b)(3)-(5), 1368.03-04.

143. The statute fails to identify the department of state government to which it refers. However, earlier sections of the same part refer to the insurance commissioner. Thus, it is reasonable to conclude that this section refers to the Department of Insurance. In discussing these provisions, wherever a reference is made to “the department” one can therefore reasonably infer that it is the Department of Insurance. See CAL. HEALTH & SAFETY CODE §§ 444.23 (West 2000), 1342.5 (West 2000), 1343 (West 2000), 1317.2(a) (West 2000), 1349 (West 2000), 1357.17 (West 2000), & 1342.3 (West 2000)).

144. CAL. HEALTH & SAFETY CODE § 1368(b)(1).

145. CAL. HEALTH & SAFETY CODE § 1368(b)(9).

146. *Id.*

147. CAL. HEALTH & SAFETY CODE § 1368(b)(6)(B).

148. CAL. HEALTH & SAFETY CODE § 1368(6).

149. *Id.*

created under the statute delineating external review (which became effective January 1, 2001).¹⁵⁰ A distinction is made between a "disputed health care service" (a service which is eligible for coverage pursuant to the plan but which has been denied) and a "coverage decision" (which is a decision to deny coverage on the basis that the service is "included or excluded" under the terms of the plan).¹⁵¹ Only grievances relating to "disputed health care services"¹⁵² are eligible for processing under the Independent Medical Review System.¹⁵³ A determination as to the nature of the grievance is left to the department and will ultimately determine whether this procedure or that delineated in section 1368 applies.¹⁵⁴ Provisions have been made for: expedited review in cases of "imminent threat to health";¹⁵⁵ the method of analysis;¹⁵⁶ avoidance of conflicts of interest by reviewers;¹⁵⁷ prompt and timely effectuation of the decision by the health care plan;¹⁵⁸ assessment of costs (to be borne by the health care plan);¹⁵⁹ and a report to the legislature concerning implementation due by March 1, 2002.¹⁶⁰

In Colorado, Medicaid MCOs must provide a process for expedited review including two levels of review for denials of care.¹⁶¹ All other managed care organizations are covered by consumer protection standards enacted in 1997.¹⁶² All plans must maintain grievance procedures that comply with administrative rules concerning prompt investigation of health claims involving utilization review and grievance procedures.¹⁶³ External review is provided by regulation.¹⁶⁴

Connecticut requires an internal grievance procedure, but does not

150. CAL. HEALTH & SAFETY CODE § 1374.30(a) (West 2000).

151. CAL. HEALTH & SAFETY CODE § 1374.30(b)-(c).

152. *Id.*

153. CAL. HEALTH & SAFETY CODE § 1374.30(d)(1).

154. CAL. HEALTH & SAFETY CODE § 1374.30(d)(2)-(3).

155. CAL. HEALTH & SAFETY CODE § 1374.31 (West 2000).

156. CAL. HEALTH & SAFETY CODE § 1374.33 (West 2000).

157. CAL. HEALTH & SAFETY CODE § 1374.32 (West 2000).

158. CAL. HEALTH & SAFETY CODE § 1374.34 (West 2000).

159. CAL. HEALTH & SAFETY CODE § 1374.35(b) (West 2000).

160. CAL. HEALTH & SAFETY CODE § 1374.36(a) (West 2000).

161. COLO. REV. STAT. ANN. § 26-4-117 (West 2000).

162. *Id.*

163. COLO. REV. STAT. ANN. § 10-16-704(9)(g)(I) (West 2000). The word "division" refers to the Division of Insurance of the Department of Regulatory Agencies. *See infra* note 161.

164. 3 COLO. CODE REGS. §§ 702-2, 702-4 (2000); 3 COLO. CODE REGS. §§ 4-2-17, 4-2-21 (2001).

specify standards for the review.¹⁶⁵ In the event of a denial pursuant to the company's internal review process, an enrollee or the provider (with the consent of the enrollee) may appeal the denial to the Commissioner of Insurance.¹⁶⁶ A filing fee of twenty-five dollars (waived for an indigent enrollee) is required.¹⁶⁷ Review is conducted on behalf of the Commissioner by an independent review organization (often referred to as an "IRO").¹⁶⁸ The determination of the IRO must be accepted by the Commissioner and is binding on the parties.¹⁶⁹ As an additional protection for consumers, in the 1999 session, the legislature established the Office of Managed Care Ombudsman.¹⁷⁰ Among the duties imposed upon the ombudsman is the duty to "[p]ursue administrative remedies on behalf of and with the consent of any health insurance consumers."¹⁷¹

Delaware requires a health care insurer to maintain an internal review process; an aggrieved individual may submit a request for arbitration or mediation to the state's insurance commissioner.¹⁷² Parties to such arbitration retain the right to petition for *de novo* review by the state's Superior Court.¹⁷³ If the result is adverse to the patient, the statute merely requires a written decision that contains a summary of the facts; refers to the language of the policy; provides a rationale for the denial; and identifies the evidence relied upon to reach the decision.¹⁷⁴

Although Florida requires HMOs to provide both formal and informal internal grievance procedures, the state does not require external review.¹⁷⁵ Florida recently passed legislation providing that the Agency for Health Care Administration publish annual report cards for HMOs.¹⁷⁶ Additionally, the new legislation regulates other non-HMO health care providers, requiring that they charge reasonable fees and

165. CONN. GEN. STAT. § 38a-478m (2001).

166. CONN. GEN. STAT. § 38a-478n.

167. CONN. GEN. STAT. § 38a-478n(b)(2).

168. CONN. GEN. STAT. § 38a-478n(c). Standards for utilization review companies acting in the state are contained in CONN. GEN. STAT. § 38a-226c (2001).

169. CONN. GEN. STAT. § 38a-478n(d).

170. CONN. GEN. STAT. § 38a-1041 (2001).

171. *Id.*

172. DEL. CODE ANN. tit. 18, § 332 (2001).

173. *Id.* *De novo* review is subject to the rules of pre-emption established by ERISA, citing to *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 101 (1989). See *supra* note 30.

174. *Id.*

175. FLA. STAT. ch. 641.22(9) (2001).

176. FLA. STAT. ch. 99-393 (2001).

costs to the insured.¹⁷⁷ Like Connecticut, Florida has an ombudsman for managed care.¹⁷⁸

The Georgia legislature has made it clear that "it is a vital government function to protect patients from managed care practices which have the effect of denying or limiting appropriate care."¹⁷⁹ Moreover, it is the avowed public policy of the state that providers of health care advocate on behalf of their patients.¹⁸⁰ In keeping with this statement of policy, managed care plans *must* include provisions that allow the patient to seek required emergency care without fear that the claim will be denied retrospectively.¹⁸¹ Managed care organizations must notify enrollees of their rights and explain their grievance procedure (which is mandated by statute).¹⁸² Each MCO must have a grievance procedure providing for a hearing by a panel of at least three individuals.¹⁸³ At least one panel member must be a physician¹⁸⁴ (and cannot be the medical director of the plan), and at least one panel member must be a provider trained and licensed to provide the treatment or procedure in question.¹⁸⁵ Although no time limit is specified for the issuance of a decision, "prompt notice" of the outcome is mandated.¹⁸⁶ If the determination is favorable, the treatment or procedure must be authorized "without delay."¹⁸⁷ If it is unfavorable, notice to the enrollee must contain specific findings as to why the care requested cannot be authorized.¹⁸⁸ The notice must also state the policies relied upon to reach a decision, any recommendations for alternative care, and information concerning a reconsideration determination (if available).¹⁸⁹ An appeal to an IRO is available when an unfavorable determination is issued pursuant to the plan's grievance procedure, or where the MCO has not complied with the statutory re-

177. *Id.*

178. FLA. STAT. ch. 641.60 (2001) (providing for a statewide managed care ombudsman committee).

179. GA. CODE ANN. § 33-20A-2 (2000).

180. *Id.*

181. GA. CODE ANN. § 33-20A-9 (emphasis added).

182. GA. CODE ANN. § 33-20A-5.

183. GA. CODE ANN. § 33-20A-5(3)(B)(ii).

184. *Id.* The physician may be a plan member or may also be a shareholder of the plan. See *infra* note 142.

185. GA. CODE ANN. § 33-20A-5(3)(B)(ii) (2000).

186. *Id.*

187. *Id.*

188. *Id.*

189. *Id.*

quirements.¹⁹⁰ Special provisions exist for those suffering from terminal conditions where the treatment prescribed is excluded as experimental.¹⁹¹ In the event independent review is requested, a state agency assigns the matter to an IRO.¹⁹² Costs of the IRO are the responsibility of the managed care organization.¹⁹³ Although the IRO has a short time frame for the issuance of a decision, this time limit may be extended or shortened by agreement of the parties.¹⁹⁴ Expedited review is available where delay would jeopardize the health of the enrollee.¹⁹⁵ A decision favorable to the patient is binding on the MCO.¹⁹⁶ In what appears to be a concession to the insurance industry, the statute provides that a determination favorable to the MCO creates a rebuttable presumption in any subsequent litigation that the decision was appropriate.¹⁹⁷ Moreover, lawsuits against MCOs are barred unless the affected party or his or her designated representative exhausts all administrative remedies.¹⁹⁸

In 1998, Hawaii enacted a patients' bill of rights.¹⁹⁹ Managed care plans operating in the state must establish and maintain a complaint resolution procedure.²⁰⁰ There are, however, separate procedures for claims involving mental health, drug or alcohol treatment.²⁰¹ An enrollee who has exhausted all the company's internal complaint procedures may appeal a denial of care to a three-member panel appointed by the Commissioner of Insurance.²⁰² The panel is comprised of a representative of the enrollee's health plan (who is not involved in the dispute), a provider licensed and practicing medicine in Hawaii (also an individual who is not involved in the dispute), and either the Commissioner or a designee.²⁰³ A majority vote of the panel is required for a decision.²⁰⁴ There is no provision to make the panel's decision binding on the man-

190. GA. CODE ANN. § 33-20A-32 (2000).

191. *Id.*

192. GA. CODE ANN. § 33-20A-35 (2000).

193. *Id.*

194. GA. CODE ANN. § 33-20A-36 (2000). A decision must issue within fifteen days.

195. *Id.*

196. GA. CODE ANN. § 33-20A-37 (2000).

197. *Id.*

198. GA. CODE ANN. § 51-1-49 (2000).

199. HAW. REV. STAT. § 432E (2000).

200. HAW. REV. STAT. § 432E-5 (2000).

201. HAW. REV. STAT. § 334B (2000).

202. HAW. REV. STAT. § 432E-6 (2000).

203. *Id.*

204. *Id.*

aged care entity.²⁰⁵

Idaho requires MCOs to establish a grievance procedure and submit it to the director of the Department of Insurance for approval.²⁰⁶ Records must be maintained delineating the grounds for the grievances filed, and the total number processed.²⁰⁷ There are no provisions for external review.²⁰⁸

On August 18, 1999, Illinois enacted comprehensive managed care reform.²⁰⁹ Among the rights enunciated is the patient's right to "care consistent with professional standards of practice to assure quality nursing and medical practices"²¹⁰ To assure that this is not just a hollow affirmation, the statute prohibits retaliation against physicians and other providers who advocate on behalf of their patients,²¹¹ mandates external review of adverse determinations,²¹² and establishes an "Office of Consumer Health Insurance" to assist consumers in understanding their plans and their rights.²¹³ Health care plans must establish a grievance procedure, notify enrollees of the process, and render a prompt decision on any appeal.²¹⁴ Appeals must be reviewed by "an appropriate health care professional" (presumably a physician trained in the field of medicine under consideration) and decisions must be provided to the enrollee, his or her primary care physician and the provider who prescribed the service under review.²¹⁵ If a determination adverse to the enrollee is rendered, the enrollee is entitled to an external review.²¹⁶ The statute requires that the health care plan provide a method for "joint selection of an external independent reviewer by the enrollee, the enrollee's physician or other health care provider, and the health care plan"²¹⁷ The state affords a very short time to render the decision.²¹⁸ That decision is

205. *Id.*

206. IDAHO CODE § 41-3918 (Michie 2000).

207. *Id.*

208. *Id.*

209. 215 ILL. COMP. STAT. ANN. 134/1 (West 2001).

210. 215 ILL. COMP. STAT. ANN. 134/5(a)(1) (West 2001).

211. 215 ILL. COMP. STAT. ANN. 134/35(a) (West 2001).

212. 215 ILL. COMP. STAT. ANN. 134/45 (West 2001).

213. 215 ILL. COMP. STAT. ANN. 134/90 (West 2001).

214. 215 ILL. COMP. STAT. ANN. 134/45(c) (requiring a decision within fifteen days).

215. 215 ILL. COMP. STAT. ANN. 134/45(b), (d).

216. 215 ILL. COMP. STAT. ANN. 134/45(e).

217. 215 ILL. COMP. STAT. ANN. 134/45(f)(3)(A).

218. 215 ILL. COMP. STAT. ANN. 134/45(f)(4) (requiring a decision five days from the filing).

final and binding on the plan.²¹⁹ If the decision favors the enrollee, the health care plan must pay for the service.²²⁰ Costs of the independent external review are borne by the plan.²²¹ The impartiality of the peer reviewer is assured by provisions requiring that the reviewer have no direct financial interest in the matter and not be informed of the specific identity of the enrollee.²²² He or she is immunized from liability whether civil, criminal, or professional²²³ thus providing further assurance of independence and impartiality. Administrative complaints are handled under a separate process.²²⁴ The Department of Insurance must maintain records of all complaints filed²²⁵ and must classify the complaints under categories contained in the statute.²²⁶ Utilization review agents must be accredited and registered with the Department of Insurance.²²⁷ In addition to these provisions, the Illinois Health Maintenance Organization Act²²⁸ requires an "independent second opinion"²²⁹ when there is a dispute between a patient's primary care physician and the HMO as to the medical necessity of a "covered service."²³⁰ If the independent physician determines that the service is medically necessary, the HMO must provide the service.²³¹

Indiana mandates an external grievance procedure to review adverse

219. *Id.*

220. *Id.*

221. 215 ILL. COMP. STAT. ANN. 134/45(f)(5).

222. 215 ILL. COMP. STAT. ANN. 134/45(f)(8)(A), (B), (C).

223. 215 ILL. COMP. STAT. ANN. 134/45(f)(6).

224. 215 ILL. COMP. STAT. ANN. 134/50 (West 2001).

225. 215 ILL. COMP. STAT. ANN. 134/55 (West 2001).

226. 215 ILL. COMP. STAT. ANN. 134/55(d)(1)-(10).

227. 215 ILL. COMP. STAT. ANN. 134/85 (West 2001).

228. 215 ILL. COMP. STAT. ANN. 125/4-10 (West 2001).

229. *Id.*

230. *Id.*

231. *Id.* In reviewing the statute, the Seventh Circuit noted that under "Illinois law, laws are automatically incorporated into all contracts of insurance in that state." It further held that claims under the statute were properly recharacterized as a claim for benefits under section 502(a)(1)(B) of ERISA, and removal from the state court to the federal court was proper. The court further held that in the case under consideration, although a suit under the Illinois statute was a suit to enforce rights under an ERISA plan, the statute did not conflict with the provisions of ERISA. Holding that the act "simply establishes an additional internal mechanism for making decisions about medical necessity," it allowed the plan participant to recover reimbursement from the HMO. *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959, 971 (7th Cir. 2000). This decision conflicts with the Fifth Circuit's decision in *Corcoran v. United Healthcare, Inc.*, 956 F.2d 1321 (5th Cir. 1992). A petition for certiorari was granted by the Supreme Court on June 29, 2001. *Rush Prudential HMO, Inc. v. Moran*, 331 U.S. 948 (2001).

utilization review decisions, adverse medical necessity decisions and determinations that a proposed service is experimental.²³² However, when an individual is entitled to external review under Medicare these rules do not apply.²³³ The format for the grievance procedure specified in the statute must allow for an expedited appeal when delay would seriously jeopardize the enrollee's health or life.²³⁴ The statute mandates rotation of the independent review organizations selected in each appeal.²³⁵ Conflicts of interest among the medical review professionals are prohibited and enrollees may be required to pay a fee of up to twenty-five dollars toward the cost of the review.²³⁶ An enrollee has the right to submit any relevant information.²³⁷ If the matter is before an IRO when the new evidence is submitted, the IRO must cease all action until the HMO reconsiders the matter.²³⁸ Accordingly, IROs must be certified by the Department of Insurance²³⁹ and their decision is binding on the HMO.²⁴⁰

Both Iowa²⁴¹ and Louisiana²⁴² merely require HMOs (but not other forms of managed care) to maintain a complaint system to resolve written complaints.²⁴³ These states do not provide for external review. Kansas, while not explicitly mandating an internal grievance procedure, does so by implication.²⁴⁴ Like Iowa and Louisiana, Kentucky requires only that a plan have a "satisfactory grievance procedure and the ability to respond to enrollee's inquiries and complaints."²⁴⁵ However, unlike Iowa and Louisiana, this statute applies to all health plans in the state.²⁴⁶

232. IND. CODE ANN. § 27-13-10.1-1 (Michie 2001).

233. IND. CODE ANN. § 27-13-10.1-11.

234. IND. CODE ANN. § 27-13-10.1-2.

235. *Id.*

236. *Id.*

237. IND. CODE ANN. § 27-13-10.1-6.

238. *Id.*

239. IND. CODE ANN. § 27-13-10.1-8.

240. IND. CODE ANN. § 27-13-10.1-5.

241. IOWA CODE § 514B.14 (2000).

242. LA. REV. STAT. ANN. § 22:2022 (West 2000).

243. Although lacking a requirement for a mandatory complaint system for other types of managed care entities, Louisiana does provide mandatory time lines for a managed care entity to render a decision on a request to authorize treatment or testing. LA. REV. STAT. ANN. § 22:2021 (West 2000).

244. The statute delineating requirements for a certificate of authority provides that certain items, including a statement describing the internal grievance procedure, shall accompany applications. KAN. STAT. ANN. § 40-3203(b)(5) (2000).

245. KY. REV. STAT. ANN. §§ 304.17A-300 (Michie 2000).

246. *Id.*

Maine requires all carriers offering managed care plans to provide grievance procedures that notify enrollees of a denial in a timely manner.²⁴⁷ The notice must contain a rationale for the denial, information about the right to file a grievance, the procedure for filing and time limit within which to file.²⁴⁸ In the event that a medical opinion is "a material issue in the dispute," the enrollee is entitled to a second opinion.²⁴⁹ Once authorization for a procedure or treatment is given, a carrier may not retroactively deny coverage.²⁵⁰

Maryland requires an internal grievance procedure that includes an expedited decision in cases of emergency.²⁵¹ A written decision is mandated, and in non-emergency cases, must be provided quickly.²⁵² Separate procedures exist for contesting decisions regarding addiction disorders and mental impairment cases.²⁵³ In the event of a retrospective denial, the MCO may take more time to render its decision.²⁵⁴ After exhausting the carrier's internal procedure, an enrollee may file a complaint with the Commissioner of Insurance.²⁵⁵ Within the Office of the Commissioner, a Health Advocacy Unit will assist the enrollee with the filing of an internal grievance, but may not accompany or represent the member in the proceeding.²⁵⁶ A carrier may delegate the internal grievance process to a private review organization, but if it does so, the decision of the reviewing agent is binding on the carrier.²⁵⁷ Independent review by the Commissioner of Insurance is available upon request by the enrollee or the health care provider.²⁵⁸ The burden of proof lies with the carrier to establish that its determination was correct.²⁵⁹ However, the statute fails to make the Commissioner's decision binding on the carrier.

Massachusetts does not appear to require a grievance procedure for

247. ME. REV. STAT. ANN. tit. 24, § 4303 (West 2001).

248. *Id.*

249. *Id.*

250. ME. REV. STAT. ANN. tit. 24, § 4304 (West 2001).

251. MD. CODE ANN., INS. § 15-10A-02 (2001).

252. *Id.* (requiring a decision within thirty days of the filing of the grievance).

253. MD. CODE ANN., INS. § 15-10B-06 (2001).

254. MD. CODE ANN., INS. § 15-10A-02 (allowing the MCO up to forty-five days).

255. Exhaustion is not required where the enrollee or his designee files sufficient supporting evidence to establish a "compelling" reason. MD. CODE ANN., INS. § 15-10A-02(d)(1)(i).

256. MD. CODE ANN., INS. § 15-10A-02(f)(2)(v).

257. MD. CODE ANN., INS. § 15-10A-02(1).

258. MD. CODE ANN., INS. § 15-10A-03 (2001). The request must be filed within thirty days of the receipt of the internal grievance process decision.

259. *Id.*

adverse managed care decisions.²⁶⁰ However, in 1999, the Massachusetts Legislature introduced more than twenty bills dealing with patient protection issues.²⁶¹ One bill dealt directly with the issue of external appeals of adverse determinations.²⁶² This bill would require each health insurance plan to establish and maintain an internal appeals process²⁶³ and an external appeals process.²⁶⁴ It would also establish an "Independent Appeal Board"²⁶⁵ and a managed care ombudsman.²⁶⁶ The 1999 session of the legislature closed without passing this bill.²⁶⁷

Michigan requires HMOs to establish formal internal grievance procedures that include written notification of the basis for an adverse determination and the procedures for filing a grievance.²⁶⁸ An appeal of this decision may be made to the Health Department.²⁶⁹

Minnesota enacted statutes to deal separately with grievances requiring a medical determination and those that do not.²⁷⁰ When the issue is whether the care requested is experimental, investigative, or not generally acceptable care, a three-member panel reviews the denial and reports to the Commissioner of Insurance.²⁷¹ In non-emergency cases, patients are required to exhaust internal grievance procedures.²⁷² A denial

260. An extensive search of the LEXIS and Westlaw databases utilizing keywords including "managed care appeals process," "appeals from adverse determinations by managed care," and "external appeals of adverse determinations by managed care" failed to reveal statutes governing such procedures.

261. See, e.g., H.B. 1130, 1999 Leg., 181st Gen. Court. (Mass. 1999); H.B. 3858, 1999 Leg., 181st Gen. Court. (Mass. 1999); H.B. 2887, 1999 Leg., 181st Gen. Court. (Mass. 1999); H.B. 4468, 1999 Leg., 181st Gen. Court. (Mass. 1999); H.B. 3658, 1999 Leg., 181st Gen. Court. (Mass. 1999).

262. S.B. 501, 1999 Leg., 181st Gen. Court. (Mass. 1999).

263. S.B. 501 § 18B(1), 1999 Leg., 181st Gen. Court. (Mass. 1999).

264. S.B. 501 § 18C(1)-(3), 1999 Leg., 181st Gen. Court. (Mass. 1999).

265. S.B. 501 § 18D, 1999 Leg., 181st Gen. Court. (Mass. 1999).

266. *Id.*

267. The last action was taken on June 28, 1999, when a new draft of the legislation was substituted for the original version. See 1999 Bill Tracking MA S.B. 501, available at LEXIS, Massachusetts Bill Tracking StateNet (report on the disposition of S.B. 501, 1999 Leg., 181st Gen. Court. (Mass. 1999), upon the conclusion of the 1999 session).

268. MICH. COMP. LAWS ANN. § 500.2213 (West 2001).

269. *Id.* An extensive search of Westlaw and Lexis databases failed to reveal statutes governing appeals to the Health Department, however, the statute does require the Commissioner to establish a procedure for such appeals. *Id.*

270. MINN. STAT. ANN. § 62Q.68-73 (West Supp. 2001) (providing the requirements for Health Plan Companies complaint Resolutions); MINN. STAT. ANN. § 62M.01-16 (West Supp. 2001) (regarding the Minnesota Utilization Review Act of 1992).

271. MINN. STAT. ANN. §§ 72A.327(a), (c) (West Supp. 2001).

272. MINN. STAT. ANN. § 72A.327(d).

of such care may be further appealed to a state District Court.²⁷³ Appeals concerning other denials of care are processed by a utilization review organization, with an expedited review (over the telephone where necessary) in cases where the patient's medical condition warrants an immediate decision.²⁷⁴ Where an attending physician or other health care professional makes the request, the review must be conducted by an individual in the same specialty that normally manages the condition, procedure, or treatment.²⁷⁵ Notice to the patient must contain information concerning the right to external review and the procedure for commencing such review.²⁷⁶ A request for external review requires payment of a \$25 filing fee that may be waived if there is evidence of financial hardship.²⁷⁷ The statute contains minimum criteria that must be met by the external review agent (including expertise in health law, dispute resolution, and lack of conflict of interest).²⁷⁸ The statute mandates that the plan provide a time line for the filing of information and inform the enrollee of his or her right to representation.²⁷⁹ The decision is not binding on the enrollee who seeks judicial review, but is binding on the health plan.²⁸⁰ The health care plan may only seek judicial review "where the decision was arbitrary and capricious or involved an abuse of discretion."²⁸¹

Mississippi requires that all HMOs maintain a grievance procedure approved by the Insurance Commissioner.²⁸² However, there is no provision for external review. Whether these provisions apply to other managed care entities is questionable as the Mississippi Code specifically defines managed care entities.²⁸³ The definition includes HMOs and other types of managed care entities, but the statute mandating grievance procedures refers only to HMOs.²⁸⁴

273. MINN. STAT. ANN. § 72A.327 (stating that if the matter is taken to the state court a trial *de novo* is held).

274. MINN. STAT. ANN. § 62M.06 (West Supp. 2001) (declaring that a decision must be rendered within thirty days of the receipt of the notice of appeal).

275. MINN. STAT. ANN. § 62M.06.3(f).

276. MINN. STAT. ANN. § 62M.06.2(g).

277. MINN. STAT. ANN. § 62M.73.3(a) (West Supp. 2001).

278. MINN. STAT. ANN. § 62Q.73.5(g).

279. MISS. CODE ANN. § 62Q.73.6 (providing that a decision must be rendered within forty days of the receipt of the request for review).

280. MISS. CODE ANN. § 62Q.73.8 (West Supp. 2001).

281. *Id.*

282. MISS. CODE ANN. § 83-41-321 (West Supp. 1996).

283. MISS. CODE ANN. § 83-41-403 (West Supp. 1996).

284. *Id.*

Missouri statutes enumerate a three-tiered review of adverse determinations.²⁸⁵ All health insurers that offer a managed care plan must provide a first and second level review of adverse determinations.²⁸⁶ Receipt of a request for review must be acknowledged in writing.²⁸⁷ An impartial decision-maker must make a prompt decision.²⁸⁸ If the decision affirms the denial of care, notice must be provided advising the enrollee of the right to a second level review.²⁸⁹ The statute requires "clear and specific"²⁹⁰ notice to be sent to the individual who filed the grievance.²⁹¹ Second level grievances are submitted to a panel that consists of other enrollees and representatives of the carrier (who were not involved in the facts and circumstances of the grievance).²⁹² When the issue is one regarding a denial of medical care, members of the panel must include a physician in the same specialty of medicine that is under review.²⁹³ In addition to the statutory provisions, the director of the Department of Insurance is given rulemaking authority.²⁹⁴ Rules promulgated may be neither more nor less stringent than those governing such procedures for Medicare enrollees.²⁹⁵ The time frames for investigation, determination, and notice of decision are those that apply to the first level review (except where an expedited review is required).²⁹⁶ The panel's decision must provide notice of the right to file an appeal to the director of the department of insurance, the address of the director, and the toll-free telephone number.²⁹⁷ In those circumstances where delay would "seriously jeopardize the life or health of an enrollee or would jeopardize the enrollee's ability to regain maximum function," an expe-

285. MO. ANN. STAT. §§ 376.1350-1389 (West Supp. 2001).

286. MO. ANN. STAT. §§ 376.1353, 376.1359, 376.1361, 376.1363 (West Supp. 2001) (declaring that carriers that maintain utilization review procedures must have an approved plan filed with the Director of Insurance, must use documented clinical review criteria and must follow procedures set by statute for making determinations and notifying enrollees).

287. MO. ANN. STAT. § 376.1382.2(1) (West 2000).

288. MO. ANN. STAT. § 376.1382.2(2) (declaring that the decision must be made within five days of completing the investigation).

289. MO. ANN. STAT. § 376.1382.2(3).

290. *Id.*

291. MO. ANN. STAT. § 376.1382.2(4) (declaring that notice must be sent within fifteen working days after the completion of the investigation).

292. MO. ANN. STAT. § 376.1385.1 (West 2000).

293. *Id.*

294. MO. ANN. STAT. § 354.562 (West 2000).

295. *Id.*

296. MO. ANN. STAT. § 376.1385.2 (West 2000).

297. *Id.*

dited review is available.²⁹⁸ The director of the Department of Insurance must resolve the grievance “through any means not specifically prohibited by law”²⁹⁹ If the director is unable to resolve the grievance, then it must be referred to an IRO.³⁰⁰ A register of certified IROs is maintained and assignment to an IRO is on a rotational basis.³⁰¹ The decision of the IRO is considered a final agency decision and is binding on both the carrier and the enrollee.³⁰² Judicial review is available for those instances where the appellant argues that the action of the director is arbitrary, capricious, unreasonable, unlawful, unconstitutional, or is an abuse of discretion.³⁰³

The Montana statute requires any HMO petitioning for a certificate of authority to establish a complaint system³⁰⁴ that must be approved by the Commissioner of Insurance.³⁰⁵ An enrollee is entitled to notice of the denial of a claim. Notice must contain information on the right to file a complaint as well as the requisite procedures.³⁰⁶ Adverse determinations involving issues regarding provided or proposed care, whether made by an HMO or any other managed care entity, is subject to independent review.³⁰⁷ The carrier is responsible for the cost of peer review and the determination is binding on the managed care entity.³⁰⁸

Nebraska has adopted the “Health Carrier Grievance Procedure Act.”³⁰⁹ The Act’s stated purpose is “to provide standards for the establishment and maintenance of procedures by health carriers to assure that covered persons have the opportunity for the appropriate resolution of their grievances as defined in the act.”³¹⁰ A two level grievance procedure is established that binds the carrier.³¹¹ A reviewer with “appropriate

298. MO. ANN. STAT. § 376.1389 (West 2000) (stating that a decision must be made within seventy-two hours of the receipt of the request for review (oral or written) and written confirmation of the decision must be given within three working days).

299. MO. ANN. STAT. § 376.1387.1 (West 2000).

300. *Id.*

301. *Id.*

302. *Id.*

303. *Id.*

304. MONT. CODE ANN. § 33-31-201(3)(d)(xi) (1999).

305. MONT. CODE ANN. § 33-31-303(1)(a) (1999).

306. MONT. CODE ANN. § 33-31-201(1)(b).

307. MONT. CODE ANN. § 33-37-102(1) (1999).

308. MONT. CODE ANN. § 33-37-102(3)-(4).

309. NEB. REV. STAT. §§ 44-7301 to -7315 (1998).

310. NEB. REV. STAT. § 44-7302 (1998).

311. NEB. REV. STAT. § 44-7309(1)-(2)(a) (1998).

expertise" must handle first level review.³¹² A written decision containing the medical rationale in clear terms is mandated; however, the statute fails to provide a time frame for the issuance of the decision.³¹³ In the event of an adverse determination, the notice must provide information concerning the right to a second-level review and the procedures applicable.³¹⁴ The notice must also inform the enrollee of his or her right to contact the office of the Director of Insurance and must contain the telephone number and address of the director's office.³¹⁵ At the second-level review, the enrollee has the right to appear before a grievance review panel.³¹⁶ The panel members are appointed by the carrier, must have appropriate expertise, and must have no connection to the facts and circumstances of the grievance (including all prior determinations).³¹⁷ The enrollee has the right to attend the meeting, present the case to the panel, submit new evidence, question the carrier's representative, and be represented by an individual of his or her choice.³¹⁸ The written decision is binding on the carrier.³¹⁹ Expedited review procedures are available where delay would seriously impair the health of the enrollee.³²⁰ Violations of the statute are punishable by fines and suspension or revocation of the carrier's certificate of authority.³²¹

Nevada requires HMOs and all managed care entities to establish a system for resolving grievances and must notify enrollees of their rights and the procedures involved in filing a grievance.³²² The managed care entity must provide an employee to assist the enrollee in filing a complaint and/or appealing the decision of the statutorily mandated review board.³²³ The review board is a part of the managed care entity's grievance procedure. A majority of the members of the board must be enrollees of the MCO.³²⁴ In the event that the complaint involves "an immi-

312. NEB. REV. STAT. § 44-7308(1) (1998).

313. NEB. REV. STAT. § 44-7308.

314. NEB. REV. STAT. § 44-7308(3)(e)-(f).

315. NEB. REV. STAT. § 44-7308(3)(g).

316. NEB. REV. STAT. § 44-7309(1) (1998).

317. *Id.*

318. NEB. REV. STAT. § 44-7309(3) (A meeting of the review panel must be held within forty-five working days).

319. NEB. REV. STAT. § 44-7309(2)(a) (The decision must be issued within five working days of the meeting).

320. NEB. REV. STAT. § 44-7311(1) (1998).

321. NEB. REV. STAT. § 44-7312 to -7313 (1998).

322. NEB. REV. STAT. § 695C.265 (1987); NEB. REV. STAT. § 695G.200 (1999).

323. NEB. REV. STAT. § 695G.200 (3)(a) (1999).

324. NEB. REV. STAT. § 695G.210(1) (1999).

nent and serious threat to the health of the insured,"³²⁵ an expedited review and a written decision are required within seventy-two hours of the filing of the complaint.³²⁶ No provision is made for binding external review.

New Hampshire requires all carriers offering managed care plans to provide written procedures for grievance resolution, file copies of the procedures and all relevant materials with the Commissioner of Insurance, maintain written records documenting grievances filed, and provide consumers with a full description of the procedures available.³²⁷ A carrier's written denial of care must contain notice of the right to an internal grievance process.³²⁸ A two level review is available to the enrollee. The first level review decision must be made by someone other than the individual who rendered the initial denial.³²⁹ The written decision must contain the titles and qualifying credentials of those participating in the review, a statement of the nature of the grievance, a clear statement of the contract basis or medical rationale for the decision, a discussion of the documentation, and notice of the process for obtaining second level review along with any time frame for review.³³⁰ Standard review of adverse determinations must be submitted to clinical peers "in the same or similar specialty as would typically manage the case being reviewed."³³¹ A request for review from an adverse standard review determination is treated as a second level grievance.³³² For the second level review, the carrier appoints a review panel for each grievance.³³³ A majority of the panel must not have previous involvement in the grievance and the carrier must provide at least one clinical peer with appropriate expertise in the field under review.³³⁴ A written decision is required.³³⁵ A copy of the decision must be submitted to the insurance department as well as the enrollee.³³⁶ It must contain a statement of the issues, facts, a ration-

325. NEB. REV. STAT. § 695G.210(3) (1999).

326. *Id.* (In non-emergency cases, a determination by the review board must be made within thirty days from the filing of a complaint).

327. N.H. REV. STAT. § 420-J:5(I)-(II) (1998).

328. N.H. REV. STAT. § 420-J:5(II)(c).

329. N.H. REV. STAT. § 420-J:5(III)(a).

330. N.H. REV. STAT. § 420-J:5(III)(b) (The decision must be rendered within twenty days of the receipt of a grievance).

331. N.H. REV. STAT. § 420-J:5(IV)(b).

332. N.H. REV. STAT. § 420-J:5(V)(d).

333. N.H. REV. STAT. § 420-J:5(V)(a)(1).

334. N.H. REV. STAT. § 420-J:5(V)(a)(2).

335. N.H. REV. STAT. § 420-J:5(V)(a)(3).

336. *Id.*

ale for the decision, reference to the supporting documentation, and if the decision is adverse to the enrollee, instructions on requesting an external appeal.³³⁷ An enrollee may request an appearance before the review panel.³³⁸ Expedited procedures are mandated in cases where delay would jeopardize the health of the enrollee.³³⁹ An external review conducted by the insurance department is available for those dissatisfied with the second level decision.³⁴⁰ However, the statute fails to specify procedures, and does not make the external review decision binding on the carrier.³⁴¹

In 1997, New Jersey enacted the "Health Care Quality Act."³⁴² This statute must be read in conjunction with ancillary New Jersey Administrative Code provisions in order to understand the full measure of state requirements for internal and external review of adverse determinations. Although the statute provides for an "Independent Health Care Appeals Program" in the Department of Health,³⁴³ no mention is made of the mandatory internal review process. Those provisions are located in the New Jersey Administrative Code.³⁴⁴ HMOs are required to establish utilization review programs in order to monitor procedures, underutilization and/or over utilization, clinical review criteria, and evaluation of member satisfaction with the complaint and appeals system.³⁴⁵ Decisions to deny care, limit a hospital stay, or deny payment for a procedure, must be made by a physician.³⁴⁶ Such decisions must be "directly communicated by the physician to the provider."³⁴⁷ In the event of urgent or emergency cases, the physician must be available to render a decision "immediately."³⁴⁸ Decisions must be made on a timely basis, and retroactive denials of reimbursement are prohibited.³⁴⁹ A member or his

337. *Id.* (stating that the decision must be made within five business days of the review meeting.)

338. N.H. REV. STAT. § 420-J:5(V)(b)(1) (The meeting must be held within forty-five days of the receipt of the request. Notice to the enrollee must be given at least fifteen days prior to the date set.).

339. N.H. REV. STAT. § 420-J:5(VI).

340. N.H. REV. STAT. § 420-J:5(VIII).

341. *Id.*

342. N.J. STAT. ANN. § 26:2S-1 (West 1996).

343. N.J. STAT. ANN. § 26:2S-11.

344. N.J. ADMIN. CODE tit. 8, § 38-8.1 to -8 (2001).

345. N.J. ADMIN. CODE tit. 8, § 38-8.1(a).

346. N.J. ADMIN. CODE tit. 8, § 38-8.3(b).

347. *Id.*

348. *Id.*

349. N.J. ADMIN. CODE tit. 8, § 38-8.3(c)-(d).

or her agent may appeal an adverse determination.³⁵⁰ A written explanation of the appeals process is required.³⁵¹ The first level appeal is known as an “[i]nformal internal utilization management appeal process (Stage 1).”³⁵² At this point, the member or his or her designated representative is given the opportunity to discuss the determination with the HMO medical director and/or the physician who was responsible for the initial denial.³⁵³ The statute sets a short time frame for decision-making.³⁵⁴ Stage 2 reviews allow the enrollee to appeal to a panel comprised of a physician and/or another health care provider not previously involved in the matter.³⁵⁵ The HMO selects the panel.³⁵⁶ In addition to the physician panel member, consultants who are engaged in practice in the specialty under consideration must be made available and may participate in the panel if requested by the enrollee or his or her health care provider.³⁵⁷ Should the panel issue a decision adverse to the enrollee, it must provide written notification to the enrollee of the right to an independent external review and include appropriate forms.³⁵⁸ The external appeals process is delineated in the statute³⁵⁹ and in the administrative code.³⁶⁰ The statute allows any covered person to appeal a decision to deny, reduce, or terminate benefits upon exhaustion of the carrier’s appeal process.³⁶¹ The individual must pay a twenty-five dollar processing fee, which may be waived upon a showing of hardship.³⁶² The appeal is conducted by an independent utilization review organization (“IURO”) under contract to the commissioner. Findings of the IURO must be stated in writing, and if the IURO determines that the carrier’s denial deprived a covered person of medically necessary covered services, it

350. N.J. ADMIN. CODE tit. 8, § 38-8.3(e).

351. *Id.*

352. N.J. ADMIN. CODE tit. 8, § 38-8.4(a).

353. N.J. ADMIN. CODE tit. 8, § 38-8.5 (Decisions must be rendered within five business days, however in cases of urgent or emergency care, a decision must be rendered no later than seventy-two hours after the request for review is initiated.).

354. *Id.*

355. N.J. ADMIN. CODE tit. 8, § 38-8.6(a).

356. *Id.*

357. N.J. ADMIN. CODE tit. 8, § 38-8.6(b). Stage 2 reviews must be completed within twenty days of receipt, except in the case of urgent or emergency care, which requires a decision within seventy-two hours. *Id.*

358. N.J. ADMIN. CODE tit. 8, § 38-8.6(f).

359. N.J. STAT. ANN. § 26:2S-11 (West Supp. 2001).

360. N.J. ADMIN. CODE tit. 8, § 38-8.7 (2001).

361. N.J. STAT. ANN. § 26:2S-11(a) (West Supp. 2001).

362. N.J. STAT. ANN. § 26:2S-11(c) (West Supp. 2001) (A notice of appeal must be filed within sixty days of the date of the decision.).

makes a recommendation to the carrier regarding what services the person should receive.³⁶³ The carrier will then decide whether to accept or reject the recommendation and notify the enrollee.³⁶⁴ The IURO's determination is not binding on the carrier.³⁶⁵ The statute makes it abundantly clear that, should the enrollee seek the health services in question outside the health plan, the enrollee is responsible for the cost.³⁶⁶ However, the carrier cannot routinely reject the IURO's recommendations without consequences. In the event the commissioner sees a pattern of noncompliance, the commissioner may impose sanctions and penalties.³⁶⁷ The administrative code provisions are similar and require the IURO to decide whether to accept the appeal.³⁶⁸ As with the statute, if the IURO determines that the enrollee was deprived of medically necessary care, it makes a recommendation to the carrier.³⁶⁹ The HMO must then submit a written report to the IURO and the Department of Health.³⁷⁰ The report must state whether the HMO will accept the IURO's recommendation or reject them.³⁷¹ If the recommendation is rejected, the HMO must provide the enrollee and the Department of Health with a written explanation containing the basis for rejection.³⁷² While the administrative code provisions apply only to HMOs, it is not entirely clear whether the statute applies only to HMOs or to all managed care entities. The legislature has provided that the "Health Care Quality Act" applies to HMOs³⁷³ and has also provided that no policy or contract may be delivered, executed, or renewed after the effective date of the "Health Care Quality Act," unless it complies with the Act.³⁷⁴ However, neither this statute nor the Act specifies that other managed care entities must follow the "Independent Health Care Appeals Pro-

363. N.J. STAT. ANN. § 26:2S-12(a).

364. N.J. STAT. ANN. § 26:2S-12(c) (The external review must be completed and a determination rendered within ninety days of the receipt of the application for appeal).

365. *Id.*

366. N.J. STAT. ANN. § 26:2S-12(h).

367. N.J. STAT. ANN. § 26:2S-12(d).

368. N.J. ADMIN. CODE tit. 8, § 38-8.7(d)-(e) (2001).

369. N.J. ADMIN. CODE tit. 8, § 38-8.7(i)-(j).

370. N.J. ADMIN. CODE tit. 8, § 38-8.7(k).

371. *Id.*

372. N.J. ADMIN. CODE tit. 8, § 38-8.7(k)(1) (2002). (Once accepted, review must be completed within thirty days from receipt of all documentation; extensions of time are available in certain circumstances.).

373. N.J. STAT. ANN. § 26:2J-4.16 (West Supp. 2001).

374. N.J. STAT. ANN. § 17B:2A-7.3 (2002).

gram.”³⁷⁵ The specific language of the enabling statute uses the words “review of final decisions by carriers”³⁷⁶ It remains to be seen as to how the courts will construe these statutes.

In 1998, New Mexico enacted the “Patient Protection Act.”³⁷⁷ Its stated purpose is to “ensure that managed health care plans treat patients fairly and arrange for the delivery of good quality services.”³⁷⁸ Yet, notwithstanding its stated purpose, a mandatory and binding grievance procedure for patients is not created.³⁷⁹ However, a private right of action is created giving enrollees rights as third party beneficiaries to enforce the provisions of a managed care contract.³⁸⁰ The enrollee may sue to recover “actual damages” as long as they exceed one hundred dollars.³⁸¹ Given ERISA pre-emption,³⁸² it is questionable whether this right of action will withstand scrutiny. Interestingly, the physician/provider is given specific rights. Health care plans must implement a process that allows providers to question the quality and access to health care services, the choice of providers, and the adequacy of the plan’s network of providers.

New York has enacted an extensive statutory scheme of grievance procedures. Corollary procedures are contained in Article 49 of the Insurance Law³⁸³ and Article 49 of the Public Health Law,³⁸⁴ both entitled “Utilization Review and External Appeal.” HMOs are directed to establish and maintain internal grievance procedures and provide enrollees with written notice of the procedures.³⁸⁵ Grievances may be filed either orally or in writing.³⁸⁶ Enrollees may file a written appeal of an adverse

375. N.J. STAT. ANN. § 26:2S-11 (2002).

376. N.J. STAT. ANN. § 26:2S-11(a).

377. N.M. STAT. ANN. §§ 59A-57-1 to 59A-57-11.B (Michie 1978).

378. N.M. STAT. ANN. § 59A-57-2 (Michie 2001).

379. Even the statute delineating requirements for a certificate of authority for HMOs fails in this regard. It merely provides that the HMO must supply a description of the internal grievance procedures used to resolve patient disputes. It does not require the plan to establish and maintain such procedures. N.M. STAT. ANN. § 59A-46-3 (Michie 2001).

380. N.M. STAT. ANN. § 59A-57-9.A (Michie 2001).

381. N.M. STAT. ANN. § 59A-57-9 (Michie 2001).

382. See *supra* Part I.

383. N.Y. INS. LAW §§ 4900-4916 (McKinney 2000).

384. N.Y. PUB. HEALTH LAW § 4900-4916 (McKinney Supp. 2001).

385. N.Y. PUB. HEALTH LAW § 4408-a (McKinney Supp. 2000) (stating that an acknowledgement of the receipt must be provided within five business days). A thirty-day time frame for resolution is mandated. *Id.* However, in cases where delay would cause significant risk to the enrollee’s health, a decision must be provided within forty-eight hours after all information is received. *Id.*

386. N.Y. PUB. HEALTH LAW § 4408-a(3)(a)-(b) (McKinney 2001).

initial determination.³⁸⁷ "Qualified personnel," including licensed health care professionals, must review issues surrounding medical matters.³⁸⁸ Accommodations are required to make the process accessible for non-English speaking people.³⁸⁹ Other managed care entities are directed to establish grievance procedures in the same manner and format.³⁹⁰ Utilization review ("UR") agents acting in New York must register and report biennially to both the superintendent of the Department of Insurance³⁹¹ and the Commissioner of Health.³⁹² There must be a medical director who is a licensed physician.³⁹³ Written policies and procedures based upon clinical review criteria are mandated.³⁹⁴ All notices of adverse determination must include the clinical basis for the decision and instructions on how to file a request for standard and expedited appeal as well as external appeal.³⁹⁵ Appropriate UR personnel must be "reasonably accessible by toll-free telephone."³⁹⁶ Emergency services may not be subject to a prior authorization requirement and may not be retroactively denied.³⁹⁷ Expedited appeals must be decided within two business days of the receipt of all pertinent information.³⁹⁸ Enrollees have a right to an external appeal of final adverse determinations by their health plan.³⁹⁹ A filing fee of up to fifty dollars may be charged by the health care plan (not required for recipients of public medical assistance). In the event the decision is favorable to the enrollee, the fee must be refunded.⁴⁰⁰ In the event of an adverse determina-

387. N.Y. PUB. HEALTH LAW § 4408-a(8) (McKinney 2001) (declaring that the case must be filed within sixty days and that the time frame for resolution is identical to the initial appeal).

388. N.Y. PUB. HEALTH LAW § 4408-a(10) (McKinney 2001).

389. N.Y. PUB. HEALTH LAW § 4408-a(2)(c).

390. N.Y. INS. LAW § 4802 (McKinney 2000).

391. N.Y. INS. LAW § 4901(a) (McKinney 2000).

392. N.Y. INS. LAW § 4901; N.Y. PUB. HEALTH LAW § 4901(1) (McKinney Supp. 2001).

393. N.Y. INS. LAW § 4902 (McKinney 2000); N.Y. PUB. HEALTH LAW § 4902(1)(a) (McKinney Supp. 2001).

394. N.Y. INS. LAW § 4902(a)(2); N.Y. PUB. HEALTH LAW § 4902(1)(b).

395. N.Y. INS. LAW § 4902(a)(5); N.Y. PUB. HEALTH LAW § 4902(1)(e).

396. N.Y. INS. LAW § 4902(a)(6); N.Y. PUB. HEALTH LAW § 4902(1)(f).

397. N.Y. INS. LAW § 4902(a)(8); N.Y. PUB. HEALTH LAW § 4902(1)(h).

398. N.Y. INS. LAW § 4904(b) (McKinney 2000); N.Y. PUB. HEALTH LAW § 4904(2)(b) (McKinney Supp. 2001).

399. N.Y. INS. LAW § 4910(c) (McKinney 2000); N.Y. PUB. HEALTH LAW § 4910(1)-(2) (McKinney Supp. 2001).

400. N.Y. INS. LAW § 4910(c); N.Y. PUB. HEALTH LAW § 4910(3).

tion, the enrollee may request an external appeal.⁴⁰¹ The final determination is binding on both the plan and the enrollee and is admissible in court proceedings.⁴⁰² Specifically exempted from coverage are “self-insured employee welfare benefit” plans as defined by ERISA.⁴⁰³

North Carolina employs a two-tiered approach to the problem.⁴⁰⁴ The statute requires every insurer to maintain a grievance procedure.⁴⁰⁵ In the event that the insurer does not provide for an informal process, a two-stage process is required.⁴⁰⁶ A “First-Level” grievance may be determined without an appearance by the enrollee.⁴⁰⁷ The carrier must advise the enrollee of the name and telephone number of a coordinator selected to handle the matter. The enrollee has the right to submit written information.⁴⁰⁸ A written decision must contain the name and professional qualifications of the reviewer, the medical rationale for the decision, a citation to the evidence supporting the decision, and a statement concerning the right to request “Second-Level” review.⁴⁰⁹ “Second-Level” review includes the right to attend and present the case to the grievance panel. This includes the right to submit evidence and question the review panel, as well as the right to representation.⁴¹⁰ The review panel is comprised of individuals who were not involved in prior determinations, have appropriate expertise, and must include one clinical peer.⁴¹¹ As in “First-Level” review, the decision must include the professional qualifications of the panel, a statement of facts, and the medical rationale for the panel’s recommendation with a citation to the support-

401. N.Y. INS. LAW § 4914(b) (McKinney 2000); N.Y. PUB. HEALTH LAW § 4914(2) (McKinney Supp. 2001) (declaring that a request must be filed within forty-five days of the receipt of the adverse determination and a decision must be rendered within thirty days of the request for review).

402. N.Y. INS. LAW § 4914(b)(4)(b)(iv)-(v); N.Y. PUB. HEALTH LAW § 4914 (2)(d)(A) (iv)-(v).

403. N.Y. INS. LAW § 4908 (McKinney 2000); N.Y. PUB. HEALTH LAW § 4908 (McKinney Supp. 2001).

404. N.C. GEN. STAT. § 58-50-61 (1999).

405. N.C. GEN. STAT. § 58-50-62(b) (1999).

406. *Id.*

407. N.C. GEN. STAT. § 58-50-62(e)(1).

408. *Id.*

409. N.C. GEN. STAT. § 58-50-62(e)(2) (stating that notice containing the name of the coordinator handling the matter must be given to the enrollee within three days of the filing of the first-level grievance and the decision must be rendered within thirty days of the receipt of the grievance).

410. N.C. GEN. STAT. § 58-50-62 (f)(1)(b).

411. N.C. GEN. STAT. § 58-50-62 (f)(2).

ing documentation.⁴¹² The insurer may disagree with the panel's recommendation.⁴¹³ In that event, the decision must state the rationale for the insurer's decision and contain a statement that it is the final decision of the carrier.⁴¹⁴ Expedited review is available if medically justified,⁴¹⁵ however, no provision is made for external review.

North Dakota requires only that HMOs establish and maintain a grievance procedure that is approved by the Department of Insurance Commissioner.⁴¹⁶ Although there are statutory minimum requirements for utilization review agents, including the provision for an expedited appeals process in emergency or life-threatening situations, there is nothing in the statute to indicate that use of a utilization review agent is required or that decisions made by a UR agent are binding.⁴¹⁷

In Ohio, the term "grievance procedure" is not used in its statutory scheme. Rather, all companies offering health insurance must have written procedures to evaluate whether a requested service is covered by the policy.⁴¹⁸ They must also maintain written procedures for utilization review, providing notice of its decisions to enrollees and providers.⁴¹⁹ In comparison to other states' statutes, unusually short time frames for notice are required.⁴²⁰ When an adverse determination is made, the carrier must notify the provider by telephone within three business days.⁴²¹ Written notification must be sent to both the provider and the enrollee within a day after the telephone notice.⁴²² Reviews relating to present care require a decision within one business day after all information is provided.⁴²³ On the other hand, retrospective reviews carry a thirty-day time frame for determination.⁴²⁴ The notice must provide rationale for the decision and information on seeking reconsideration.⁴²⁵ In the event

412. N.C. GEN. STAT. § 58-50-62(g)-(h) (stating that the review meeting must be held within forty-five days of the request for review and notice of the meeting must be given at least fifteen days in advance).

413. N.C. GEN. STAT. § 58-50-62(h)(6) (1991).

414. N.C. GEN. STAT. § 58-50-62(h)(5), (7).

415. N.C. GEN. STAT. § 58-50-62(i).

416. N.D. CENT. CODE §§ 6.1-18.1-10 (1995).

417. N.D. CENT. CODE §§ 26.1-26.4-04 (Supp. 1999).

418. OHIO REV. CODE ANN. § 1751.81(B) (Anderson Supp. 2000).

419. *Id.*

420. OHIO REV. CODE ANN. § 1751.81(C)-(F).

421. OHIO REV. CODE ANN. § 1751.81(C)(2).

422. *Id.*

423. OHIO REV. CODE ANN. § 1751.81(D).

424. OHIO REV. CODE ANN. § 1751.81(E).

425. OHIO REV. CODE ANN. § 1751.81(G).

the time frames are not adhered to, the enrollee or his or her designee has a right to an internal review.⁴²⁶ Reconsideration must take place within three business days after the carrier's receipt of the request, but it is not a prerequisite to internal or external review.⁴²⁷ Internal review requests must be acknowledged and decided within seven days of receipt in cases requiring expedited review. For other matters, the carrier has up to sixty days to reach a decision.⁴²⁸ External review is afforded to the enrollee in cases where the cost of the services in question exceeds \$500 and the carrier has determined that the services are covered but not medically necessary.⁴²⁹ Exceptions include instances where the superintendent of insurance determines that the service is not a covered service, the enrollee fails to exhaust the carrier's internal review process, or the enrollee has previously had external review on the same issue and no new evidence has been submitted.⁴³⁰ Expedited review is available where immediate medical treatment is required to prevent "serious impairment to bodily functions" and "serious dysfunction of any bodily organ or part."⁴³¹ The superintendent of insurance is responsible for selecting an independent review organization, but if the cost of the review is the responsibility of the carrier.⁴³² Expedited review matters must be decided within seven days, whereas standard review allows for thirty days.⁴³³ Separate provisions exist for enrollees with terminal conditions.⁴³⁴ An IRO decision is admissible into evidence in civil proceedings that relate to the coverage decision subject to review.⁴³⁵ There is no indication that the decision is binding on the carrier.

Oregon requires health benefit plans to maintain a grievance procedure for resolving disputes that includes a two-tiered review. There is no provision for external review.⁴³⁶

The "Oklahoma Managed Care External Review Act"⁴³⁷ ("Act") became effective February 1, 2000. Every managed care organization sub-

426. OHIO REV. CODE ANN. § 1751.81(F)(2).

427. OHIO REV. CODE ANN. § 1751.82 (A), (C) (Anderson Supp. 2000).

428. OHIO REV. CODE ANN. § 1751.83 (Anderson Supp. 2000).

429. OHIO REV. CODE ANN. § 1751.84(A) (Anderson Supp. 2000).

430. OHIO REV. CODE ANN. § 1751.84(B).

431. OHIO REV. CODE ANN. § 1751.84(C)(3).

432. OHIO REV. CODE ANN. § 1751.84(D)(1), (5).

433. OHIO REV. CODE ANN. § 1751.84(D)(9)(a).

434. OHIO REV. CODE ANN. § 1751.85(A)(1) (Anderson Supp. 2000).

435. OHIO REV. CODE ANN. § 1751.88 (Anderson Supp. 2000).

436. OR. REV. STAT. § 743.804 (2001).

437. OKLA. STAT. tit. 63, §§ 2528.1-.10 (2001).

ject to the Act must establish internal review procedures.⁴³⁸ The state board of health and the insurance commissioner are directed to establish rules for these internal reviews.⁴³⁹ Once an enrollee has exhausted all internal appeals available under the plan of coverage, an adverse determination relating to medical necessity, medically appropriate or medically effective treatment involving a fee in excess of \$1000.00 is subject to external review.⁴⁴⁰ A request for review must be accompanied by a filing fee of \$50.00, with the balance of the costs to be paid by the health care plan.⁴⁴¹ If the enrollee prevails, the \$50.00 fee must be refunded.⁴⁴² The health benefit plan may reconsider its determination. If a favorable decision is rendered, the external review terminates.⁴⁴³ Once a request for external review is received by the health benefit plan, it is their responsibility to select an IRO from a list certified by the state department of health. However, the enrollee may object. If the enrollee objects, the Department of Health may select another IRO.⁴⁴⁴ If the IRO determines that the individual is insured, has notified the plan of their decision to appeal and their request for an external review, and that the service requested is a covered service, the IRO will proceed to a full review.⁴⁴⁵ The decision must be predicated upon the contract of coverage and a consideration of the medical reports, the medical and scientific evidence, and any other documentation submitted.⁴⁴⁶ Although no explicit statement is made that the IRO's determination is binding, a decision by the IRO that the health plan appropriately denied a claim for reimbursement in whole or in part creates a rebuttable presumption in any subsequent legal action in favor of the carrier.⁴⁴⁷

Managed care plans in Pennsylvania must provide a complaint and grievance process specified by statute.⁴⁴⁸ The complaint process is a two-tiered review. At stage one, a committee of "one or more employ-

438. OKLA. STAT. tit. 63, § 2528.4(A) (2001).

439. OKLA. STAT. tit. 63, § 2528.4(B).

440. OKLA. STAT. tit. 63, § 2528.3(3) (2001).

441. OKLA. STAT. tit. 63, § 2528.5(A)(1)(a) (2001). The request for review must be filed within thirty days of the receipt of a written denial from the health care plan. OKLA. STAT. tit. 63, § 2528.6 (2001).

442. OKLA. STAT. tit. 63, § 2528.5(A)(1)(b).

443. *Id.*

444. OKLA. STAT. tit. 63, § 2528.6(B)(4)(2001).

445. OKLA. STAT. tit. 63, § 2528.6(D).

446. OKLA. STAT. tit. 63, § 2528.8(B) (2001). A decision on the merits must be rendered within thirty days after the appeal is accepted for review. *Id.*

447. OKLA. STAT. tit. 63, § 2528.5.

448. 40 PA. CONS. STAT. ANN. § 991.2111 (West Supp. 2001).

ees of the managed care plan” conducts an investigation of the complaint.⁴⁴⁹ At stage two, a review must be conducted by at least three people who did not participate in the initial determination. Although the carrier’s employees may be members of the panel, at least one third of the panel must be independent of the carrier. The notification to the enrollee must contain a rationale for the decision and information concerning appeal to the insurance department.⁴⁵⁰ An adverse second tier decision may be appealed to the Department of Insurance. The enrollee has the right to be represented.⁴⁵¹ The grievance procedure mirrors the complaint procedure.⁴⁵²

The statutes fail to delineate the reason for these duplicative procedures. Additionally, the statutes do not indicate which procedure is appropriate in a particular case. External review is only available for the appeal of an adverse grievance process determination and not for an adverse complaint determination.⁴⁵³ A utilization review entity assigned randomly from a state maintained list conducts the review.⁴⁵⁴ A physician or psychologist licensed in the same specialty that normally manages treatment for the disputed service is responsible for the decision-making.⁴⁵⁵ The standard of review is “medical necessity” under the terms of the plan.⁴⁵⁶ An adverse decision may be appealed to “a court of competent jurisdiction.” However, there is a rebuttable presumption in favor of the IRO decision.⁴⁵⁷ In the event of a decision that a service is medically necessary, the carrier must authorize the service or pay the claim.⁴⁵⁸ Costs are the responsibility of the losing party if the health care provider filed the request for external review. Alternatively, costs

449. 40 PA. CONS. STAT. ANN. § 991.2141(a) (West Supp. 2001). The investigation must be completed within thirty days of its receipt.

450. 40 PA. CONS. STAT. ANN. § 991.2141(b)(5). A decision must be rendered within forty-five days of receipt of the request for review.

451. 40 PA. CONS. STAT. ANN. § 991.2142(b) (West Supp. 2001).

452. *See generally* 40 PA. CONS. STAT. ANN. § 991.2161(b) (West Supp. 2001).

453. 40 PA. CONS. STAT. ANN. § 991.2162(a) (West Supp. 2001). The request for review must be filed within fifteen days of the receipt of the adverse determination. 40 PA. CONS. STAT. ANN. § 991.2142(c)(1).

454. 40 PA. CONS. STAT. ANN. § 991.2162(b)(1).

455. 40 PA. CONS. STAT. ANN. § 991.2162(c)(4)(i).

456. *Id.* 40 PA. CONS. STAT. ANN. § 991.2162(c)(5). A written decision is required within sixty days. *Id.*

457. 40 PA. CONS. STAT. ANN. § 991.2162(c)(4)(i), (c)(5). A written decision is required within sixty days. As with similar provisions in other states, such legal action is most likely pre-empted by ERISA. *See supra* Part I.

458. 40 PA. CONS. STAT. ANN. § 991.2162(c)(4)(i), (c)(5), (c)(6).

are the responsibility of the carrier if the enrollee filed the grievance.⁴⁵⁹

Rhode Island has an extensive structure for regulating utilization review. Termed the "Utilization Review Act," ("the URA") it requires carriers to provide a dispute resolution process consistent with the URA, registration of the utilization review agents, provision a two-tiered internal review and external appeal, and provision for penalties in the event of a violation.⁴⁶⁰ Notices involving a decision not to certify a health care service must include the rationale for the decision and instructions on the procedures to initiate an appeal. The decision must be signed by "a licensed practitioner with the same licensure status as the ordering practitioner."⁴⁶¹ In the event the initial appeal decision affirms the adverse determination, a licensed practitioner in the same field as typically manages the medical condition or treatment subject to review, must conduct the next level review.⁴⁶² The statute prohibits a reviewer who has previously been involved in the matter from engaging in subsequent reviews.⁴⁶³ External appeals are conducted by "neutral physicians, dentist [sic], or other practitioners in the same or similar general specialty as typically manages the health care service" in question.⁴⁶⁴ Payment for the services of the "neutral physician" is borne equally by the two parties to the appeal. However, if the utilization review decision is overturned, the utilization review agent must reimburse the appellant this cost.⁴⁶⁵ Although the decision is not binding, anyone who is aggrieved and has exhausted all administrative remedies may seek judicial review of the decision.⁴⁶⁶

South Carolina has no requirement for mandatory grievance procedures. However, policyholders must be afforded an opportunity "to participate in matters of policy and operation," and the HMOs must have a plan to assure that quality health care is provided.⁴⁶⁷

459. 40 PA. CONS. STAT. ANN. § 991.2162(c)(4)(i), (c)(5), (c)(6), (c)(7).

460. R.I. GEN. LAWS §§ 23-17.12-1 to -17 (2000).

461. R.I. GEN. LAWS § 23-17.12-9 (2001). The statute provides a minimum of sixty days within which to file a request to appeal an adverse determination. A decision on the appeal must be rendered no later than fifteen days after receiving the required documentation. *Id.*

462. *Id.*

463. *Id.*

464. R.I. GEN. LAWS § 23-17.12-10(b)(2) (2001).

465. *Id.*

466. R.I. GEN. LAWS § 23-17.12-7. Again, such judicial review is most likely preempted by ERISA. *Id.*; see also *supra* Part I.

467. S.C. CODE ANN. §§ 38-33-60, 38-33-40(A)(5) (Law. Co-op. 2001).

South Dakota has codified its standards for managed care plans, dedicating a chapter in the title covering insurance.⁴⁶⁸ All managed care plans are required to provide for grievance procedures approved by the director of the insurance department, in consultation with the secretary of the department of health.⁴⁶⁹ The director of the Department of Insurance, consulting with the secretary of the Department of Health, is empowered to promulgate rules relating to time frames for the filing and disposition of grievances.⁴⁷⁰ In the event the grievance involves medical issues of someone in the same field of practice as that of the provider who requested review, the service must make the determination.⁴⁷¹ Responsibility for monitoring utilization review activities falls upon the carrier. If utilization review activities are contracted out to a utilization review entity, the carrier must monitor the activities of the utilization review entity.⁴⁷² Standards for utilization review must be in writing, and documented clinical criteria must be used in evaluating cases.⁴⁷³ In cases involving a request for certification of an admission, procedure, or service, an initial decision must be made within two working days of the receipt of all pertinent information.⁴⁷⁴ Written notice of an adverse determination must contain the "principal reason" for the denial, instructions for filing an appeal, a grievance, or initiating reconsideration, and instructions on requesting a written statement of the clinical rationale. Interestingly, the carrier is not required to provide the clinical rationale unless a request utilizing proper procedures is made.⁴⁷⁵ External review is not mandated by statute.

In Tennessee, HMOs (but not other managed care entities) must maintain a complaint system for resolving grievances, with decisions being subject to independent review.⁴⁷⁶ A grievance is defined as a written complaint concerning availability or delivery of health care services,

468. See generally S.D. CODIFIED LAWS § 58-17C-71 (Michie 2001).

469. S.D. CODIFIED LAWS § 58-18-65 (Michie 2001).

470. S.D. CODIFIED LAWS § 58-18-70 (Michie 2000) (repealed 2000).

471. *Id.*

472. S.D. CODIFIED LAWS § 58-17C-35 (Michie 2001).

473. S.D. CODIFIED LAWS § 58-17C-37 (Michie 2001).

474. S.D. CODIFIED LAWS §§ 58-17C-49, 17C-60 (Michie 2001). The statute provides a minimum of sixty days within which to file a request to appeal an adverse determination. A decision on the appeal must be rendered no later than fifteen days after receiving the required documentation. *Id.* However, retrospective reviews allow a thirty-day time frame for the issuance of a decision. S.D. CODIFIED LAWS § 58-17C-51 (Michie 2001).

475. S.D. CODIFIED LAWS § 58-17C-52 (Michie 2001).

476. TENN. CODE ANN. §§ 56-32-203, -210, -227 (West Supp. 2001).

claims for payment of such services, and issues arising out of the contract.⁴⁷⁷ The company's grievance procedure must be filed with the Commissioner of Insurance, and records concerning grievances filed must be reported to the Commissioner on an annual basis.⁴⁷⁸ Upon submission of a grievance, a "grievance review committee" within the HMO reviews the complaint. The HMO must provide the enrollee with the name, address, and telephone number of the review committee coordinator,⁴⁷⁹ and a written decision is required in clear terms, containing the medical rationale for the decision.⁴⁸⁰ The enrollee has a right to request reconsideration by the Commissioner of Insurance.⁴⁸¹ The Commissioner, or their designee, must issue a written decision, but no time-frame is provided.⁴⁸² The statute precludes the decision of the commissioner from being admitted into evidence in any judicial proceeding.⁴⁸³ If the enrollee has complied with all the internal procedures provided by the plan, as well as these statutory provisions, the enrollee may request independent review of a determination that involves medical issues and a monetary amount of at least \$500.00.⁴⁸⁴ The plan must notify the enrollee in writing of the opportunity to have an independent review, and a request for independent review must be filed in writing.⁴⁸⁵ The enrollee, with the filing of the request, must pay a \$50.00 filing fee.⁴⁸⁶ The decision is binding on both the plan and the enrollee.⁴⁸⁷ The statute provides minimum requirements for independent review entities, including provisions concerning conflicts of interest, and requirements for reviewers who are physician's expert in the treatment of the medical

477. TENN. CODE. ANN. § 56-32-210 (West Supp. 2000).

478. TENN. CODE. ANN. § 56-32-210(e)(5). Review must take place within ten working days.

479. TENN. CODE. ANN. § 56-32-210(c)(5).

480. TENN. CODE. ANN. § 56-32-210(c)(7)(B). It must be issued within five working days from the review.

481. TENN. CODE. ANN. § 56-32-210(e)(1). A written request must be made within thirty days of the receipt of the review committee's decision.

482. *Id.*

483. *Id.*

484. TENN. CODE. ANN. § 56-32-227(a)(4) (West Supp. 2000).

485. TENN. CODE. ANN. § 56-32-227(b)(1) (West 2001). It must be requested within sixty days of the receipt of notification of the decision. *Id.*

486. TENN. CODE. ANN. § 56-32-227(b)(2). The IRO has thirty days within which to submit its expert's determination, however, in cases of life-threatening conditions, the determination must be made within five days of receipt of all pertinent information. TENN. CODE. ANN. § 56-32-227(b)(5) (West 2001).

487. TENN. CODE. ANN. § 56-32-227(a)(2) (West 2001).

condition under review.⁴⁸⁸

The Texas statute is unusual in that it creates a duty imposed upon all health insurance organizations to “exercise ordinary care when making health care treatment decisions, and concomitantly provides a cause of action in negligence for damages caused by the failure to exercise ordinary care.”⁴⁸⁹ However, a suit for damages may not be filed unless the enrollee has exhausted all appeals and agrees to submit the claim to statutory independent review procedures.⁴⁹⁰ Although it appears that only HMOs are required to implement and maintain a complaint procedure,⁴⁹¹ the provisions for health care utilization review cover all companies who write health insurance policies.⁴⁹² Enrollees dissatisfied with the decision of a health insurance company may submit the issue for independent review. Review agents must use written, medically acceptable criteria.⁴⁹³ The decision, if adverse, must include the primary reason for the determination, the clinical basis, a description of the screening criteria used, and a description of the procedure for the complaint and appeal process.⁴⁹⁴ Special provisions are made for patients hospitalized at the time of request for review⁴⁹⁵ and for immediate review by an IRO in the case of a life-threatening condition.⁴⁹⁶ All utilization review agents must provide a written description of the procedures for appeal of an adverse determination.⁴⁹⁷ A physician must

488. TENN. CODE. ANN. § 56-32-227(b) (West Supp. 2000).

489. TEX. CIV. PRAC. & REM. CODE ANN. § 88.002(a) (Vernon 2001). As previously noted, this statute was examined by the Court of Appeals for the Fifth Circuit. *Corporate Health Ins., Inc. v. Tex. Dep’t of Ins.*, 215 F.3d 526 (5th Cir. 2000); see also *supra* note 90 and accompanying text. The court ruled that those portions of the statute that provided for liability on the part of the health care plan and for independent review were not preempted under ERISA. *Corporate Health Ins., Inc.*, 215 F.3d at 535. In holding the liability provision not preempted, the court stated, “[w]e see nothing to take the liability provisions from the regulatory reach of the states exercising their traditional police powers in regulating the quality of health care.” *Id.*

490. TEX. CIV. PRAC. & REM. CODE ANN. § 88.003(a).

491. TEX. INS. CODE ANN. § 21.58A (Vernon Supp. 2001).

492. *Id.*

493. TEX. INS. CODE ANN. § 21.58A § 4(i). Notification to both the enrollee and the provider must be “mailed or otherwise transmitted” (thus allowing for electronic forms of transmission) within two working days of the filing of a request and receipt of all pertinent information by the review agent. This is an unusually short period of time compared to the provisions of other states. TEX. INS. CODE ANN. § 21.58A § 5(b).

494. TEX. INS. CODE ANN. § 21.58A § 5(c).

495. TEX. INS. CODE ANN. § 21.58A § 5(d)(1).

496. TEX. INS. CODE ANN. § 21.58A § 5(c)(4)(c).

497. TEX. INS. CODE ANN. § 21.58A § 6(a). If an appeal is filed, the UR agent must acknowledge receipt of the request and provide the enrollee with a list of all documents that

conduct the review, and in the event of a denial and a request made by the enrollee's health care provider, a specialist in the field that typically manages the condition must review the denial.⁴⁹⁸ The utilization review agent must also make provision to expedite appeals in cases of hospitalized patients and those whose conditions require emergency care.⁴⁹⁹ Written notification of the determination must be made "as soon as practical."⁵⁰⁰ Appeal of an adverse determination to an independent review organization is available upon request.⁵⁰¹ The Commissioner of Insurance is granted the authority to adopt rules and regulations in order to adequately implement the statute.⁵⁰² Specifically excluded from coverage are matters involving "terms or benefits of employee welfare benefit plans as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1002(1))."⁵⁰³ There is no provision making the IRO determination binding on the parties.⁵⁰⁴

Utah requires HMOs and "limited health plans" to maintain a process for resolving grievances.⁵⁰⁵ Utah has established an "Office of Consumer Health Assistance" responsible for assisting consumers in issues such as contractual rights, available remedies, and initiating grievance procedures.⁵⁰⁶ Similarly, Vermont created the "Office of Health Care Ombudsman" with similar responsibilities,⁵⁰⁷ requiring HMOs to establish and maintain a grievance procedure that is approved by the Commissioner of Insurance.⁵⁰⁸

must be submitted. TEX. INS. CODE ANN. § 21.58A § 6(b)(2).

498. TEX. INS. CODE ANN. § 21.58A § 6(a)(3). This review must be completed within fifteen working days of the request. *Id.*

499. TEX. INS. CODE ANN. § 21.58A § 6(a)(4).

500. TEX. INS. CODE ANN. § 21.58A § 6(a)(6). The decision must be made no later than "the 30th calendar day after the utilization review agent receives the appeal." TEX. INS. CODE ANN. § 20A.12(h) (Vernon 2001).

501. TEX. INS. CODE ANN. § 21.58A § 6(a). Although the Court of Appeals for the Fifth Circuit ruled the liability provisions of this statute were not preempted, the court held that the independent review provisions were preempted. It was the opinion of the court that the independent review provisions were identical to the "relief offered under § 1132(a)(1)(B) of ERISA." *Corporate Health Ins., Inc.*, 215 F.3d at 539; *see also supra* note 90 and accompanying text.

502. TEX. INS. CODE ANN. § 21.58A § 13 (Vernon & West Supp. 2001).

503. TEX. INS. CODE ANN. § 21.58A § 14(e) (Vernon & West Supp. 2001). Given this exemption, the range of health care decisions subject to the statute is severely limited. *See Id.*

504. *See id.*

505. UTAH CODE ANN. § 31A-8-205(2) (Supp. 2001).

506. UTAH CODE ANN. § 31A-2-216.

507. VT. STAT. ANN. tit. 8, § 4089j(a) (Supp. 2001).

508. VT. STAT. ANN. tit. 8, § 5102a (Supp. 2001).

Although the Virginia statute governing insurance contracts does not explicitly require managed care entities to maintain grievance procedures, it does so by implication.⁵⁰⁹ However, another section of the insurance law mandates the establishment and maintenance of a complaint process.⁵¹⁰ In 1999, the Virginia legislature enacted provisions for independent external review of adverse health care determinations. An enrollee or a treating health care provider in receipt of an adverse determination for a service costing in excess of five hundred dollars may appeal to the Bureau of Insurance.⁵¹¹ A non-refundable \$50.00 filing fee is required, which may be waived where payment would cause undue financial hardship.⁵¹² The Bureau of Insurance is empowered to contract with impartial health entities to perform the required reviews.⁵¹³ The impartial entity may affirm, modify, or reverse the adverse determination.⁵¹⁴ It must submit its written recommendation to the Commissioner of Insurance who then issues a written ruling. The Commissioner must adhere to the recommendation unless there is reason to believe that the impartial health entity exceeded its authority or acted in an arbitrary and capricious manner.⁵¹⁵ The Commissioner's decision is binding on both the enrollee and the health insurance carrier.⁵¹⁶

The state of Washington requires HMOs to provide a meaningful grievance procedure,⁵¹⁷ which is defined as "a procedure for investigation of consumer grievances in a timely manner aimed at mutual agreement for settlement according to procedures approved by the commissioner, and which may include arbitration procedures."⁵¹⁸ Neither a statutory format for the procedure, nor a requirement for external review

509. VA. CODE ANN. § 38.2-305 (Michie 2000). A statute that deals with the contents of insurance policies notes that "[h]ealth maintenance organizations shall add the following: We recommend that you familiarize yourself with our grievance procedure, and make use of it before taking any other action." VA. CODE ANN. § 38.2-305(B).

510. VA. CODE ANN. § 38.2-5901 (Michie Supp. 2000).

511. VA. CODE ANN. § 38.2-5902(a) (Michie 2000). The request must be filed within thirty days of receipt of the decision.

512. *Id.* The appellant has ten days from the date of acceptance of the appeal within which to supply copies of pertinent medical records to the Bureau of Insurance. VA. CODE ANN. § 38.2-5901.

513. VA. CODE ANN. § 38.2-5901(a).

514. *Id.* It must do so within thirty working days of the acceptance of the appeal by the Bureau of Insurance. *Id.*

515. *Id.*

516. *Id.*

517. WASH. REV. CODE ANN. §§ 48.46.100, 48.46.030 (West 2001).

518. WASH. REV. CODE ANN. § 48.46.020 (West 2001).

exists.

West Virginia requires HMOs and prepaid limited health service organizations to maintain and establish a grievance procedure. It must be approved by the Commissioner of Insurance and contain both formal and informal steps.⁵¹⁹ The HMO must have a grievance coordinator and a toll free telephone number must be maintained.⁵²⁰ The grievance procedure must provide that the enrollee has a right to appeal an adverse decision to the Commissioner of Insurance and written notice of this right must be provided upon completion of the grievance procedure.⁵²¹ The enrollee must also be offered the opportunity to meet with the HMO.⁵²² Physician involvement in the review of medical issues is required.⁵²³

Wisconsin requires all managed care plans to have an internal grievance procedure approved by the Commissioner of Insurance that allows enrollees to file written grievances.⁵²⁴ Grievances must be investigated by a panel consisting of at least one enrollee, assuming an enrollee is available, and one person who has authority to take corrective action.⁵²⁵ No provision exists for external review of adverse determinations.

Wyoming mandates the maintenance of a complaint procedure and the keeping of records concerning the total number of complaints and underlying causes.⁵²⁶ There are no statutory requirements concerning the complaint procedures, nor are there requirements for external review.

The federal provisions contain no enforcement mechanism. The various state statutes are cumbersome and difficult for the layperson to understand. The federal circuits are in conflict as to whether state laws

519. W. VA. CODE ANN. § 33-25A-12 (Michie 2000). These statutes are virtually identical. Thus, when referring to an HMO in this section, this term is meant to include the prepaid limited health service organizations. W. VA. CODE ANN. § 33-25D-14(a) (Michie 2000).

520. W. VA. CODE ANN. § 33-25D-14(b)(4) (Michie 2000). The HMO has up to sixty days to render a decision on a written grievance. W. VA. CODE ANN. § 33-25D-14(b)(6). An additional thirty days is available in the event there is a need to collect information from outside the service area. *Id.*

521. W. VA. CODE ANN. § 33-25D-14(a) (Michie 2000). Although this provision exists, this author was unable to find any statutory provision or administrative rule governing appeals to the commissioner of insurance. *Id.*

522. W. VA. CODE ANN. § 33-25D-14(b)(9) (Michie 2000).

523. W. VA. CODE ANN. § 33-25D-14(b)(12) (Michie 2000).

524. WIS. STAT. ANN. § 609.15 (West 2001).

525. *Id.*

526. WYO. STAT. ANN. § 26-34-103, 34-112 (Michie 2001).

mandating external review are pre-empted by ERISA. Until this is resolved by the Supreme Court,⁵²⁷ disparate treatment of patients' claims from state to state is likely to continue. Moreover, while it is apparent that state legislatures have given considerable time and effort to creating solutions to the problem, the greater majority of health care consumers are still left without a remedy when their MCO denies a request for services. The question of whether the federal government can step in to provide a grievance procedure for both ERISA and non-ERISA procedure that preempts state legislation can only be answered by reviewing the history of federalism and discussing federalism in its current format.

III. THE NEW FEDERALISM

From the earliest discussions about a "Union" at the Constitutional Convention, and through the present, scholars, lawyers, and politicians have debated about the roles of the federal government and state government.⁵²⁸ That federalism is an evolving theory of politics and law cannot be questioned. Woodrow Wilson put it well when he stated:

The question of the relation of the states to the federal government is the cardinal question of our constitutional system . . . Indeed, it cannot be settled by . . . one generation, because it is a question of growth, and every new successive stage of our political and economic development gives it a new aspect, makes it a new question.⁵²⁹

During the latter part of the twentieth century, we have seen Presidents Franklin D. Roosevelt, John F. Kennedy, Lyndon B. Johnson, and William J. Clinton expand the role of federal government to legislate in the area of social policy. In contrast, Presidents Nixon and Reagan were proponents of *New Federalism*. How do we define *New Federalism*, and how is it applied in the area of health care?

527. See *supra* note 231 and accompanying text (referring to the Supreme Court's review of *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959 (7th Cir. 2000), *cert. granted*, 533 U.S. 948 (2001)).

528. For an excellent analysis of the historical roots of federalism, Harry N. Scheiber, *Redesigning the Architecture of Federalism—An American Tradition: Modern Devolution Policies in Perspective*, 14 YALE J. ON REG. 227 (Mar. 1996).

529. *Id.* (citing ARTHUR S. LINK, *WOODROW WILSON AND THE PROGRESSIVE ERA, 1910-1917* (1954)).

A. The Evolution of Federalism and New Federalism Defined in its Current Format

Most scholars look to the Federalist Papers for clues as to how the founders intended federalism to work. One overlooked source is the cover letter from George Washington to the President of the Congress transmitting the Constitution.⁵³⁰ Dated September 17, 1787, Mr. Washington wrote:

We have now the honor to submit to the consideration of the United States in Congress assembled, that Constitution which has appeared to us the most advisable.

The friends of our country have long seen and desired, that the power of making war, peace, and treaties, that of levying money and regulating commerce, and the correspondent executive and judicial authorities should be fully and effectually vested in the general government of the Union: But the impropriety of delegating such extensive trust to one body of men is evident - Hence results the necessity of a different organization.

It is obviously impracticable in the federal government of these states, to secure all rights of independent sovereignty to each, and yet provide for the interest and safety of all: Individuals entering into society, must give up a share of liberty to preserve the rest. The magnitude of the sacrifice must depend as well on situation and circumstance, as on the object to be obtained. It is at all times difficult to draw with precision the line between those rights which must be surrendered, and those which may be reserved; and on the present occasion this difficulty was increased by a difference among the several states as to their situation, extent, habits, and particular interests.

In all our deliberations on this subject we kept steadily in our view, that which appears to us the greatest interest of every true American, the consolidation of our Union, in which is involved our prosperity, felicity, safety, perhaps our national existence. This important consideration, seriously and deeply impressed on our minds, led each state in the Convention to be less rigid on points of infe-

530. Daniel A. Farber, *The Constitution's Forgotten Cover Letter: an Essay on the New Federalism and the Original Understanding*, 94 MICH. L. REV. 615, 649 (1995).

rior magnitude, than might have been otherwise expected; and thus the Constitution, which we now present, is the result of a spirit of amity, and of that mutual deference and concession which the peculiarity of our political situation rendered indispensable.⁵³¹

Looking at this language, there can be no doubt that the founders intended certain matters of importance to be within the sole province of the federal government, while other matters would rest with the states. It is also apparent that the founders intended this to be an evolving doctrine.⁵³² How then has federalism evolved? Prior to 1861, the concept represented a "dual federalism."⁵³³ States remained dominant in "a host of areas vital to everyday life . . ."⁵³⁴ The reconstruction era was a period of controversy over the powers of the states versus the power of the federal government.⁵³⁵ The end result in the area of social welfare was a period of low wages, little protection for workers, and little expansion of public services.⁵³⁶ Beginning in the 1880's, Woodrow Wilson became an advocate for a strong central government.⁵³⁷ His philosophy shaped the federalism debate through the 1930's.⁵³⁸ Others disagreed, arguing that "any increase in the centralized power . . . is injurious to certain aspects of traditional American democracy . . ."⁵³⁹ The period known as the "Progressive Era" saw a move towards a strong central government and an expansion of federal administrative law.⁵⁴⁰ Although the 1920's saw further expansion of the power of the central government, Chief Justice Taft managed to reign in the expansion, noting that the attempt by Congress to "use . . . a tax measure to get around a constitutional prohibition would 'break down all constitutional limitation of the powers of Congress and completely wipe out the sovereignty of the states.'⁵⁴¹

531. *Id.*

532. *Id.* Note the words "the magnitude of the sacrifice must depend as well on situation and circumstance, as on the object to be obtained." *Id.*

533. Scheiber, *supra* note 528, at 234 (referring to Edward S. Corwin, *The Passing of Dual Federalism*, 36 VA. L. REV. 1 (1950)).

534. *Id.* at 236.

535. *See id.* at 237.

536. *Id.* at 238.

537. *Id.* at 243.

538. *Id.* at 243-45.

539. *Id.* at 247 (citing the words of Herbert Croly).

540. *Id.* at 250-51.

541. *Id.* at 251 (citing Taft's decision in *Baily v. Drexel Furniture Co.*, 259 U.S. 20, 38 (1922)).

During the New Deal era, President Roosevelt and Congress, in a reaction to the problems of the 1920's, systematically expanded the role of the Federal Government.⁵⁴² The Supreme Court engaged in a "fundamental restructuring of our constitutional law . . ." and "eventually found constitutional grounds for broad discretionary authority in the Executive"⁵⁴³

President Eisenhower sought to redefine the role of the states, forming a permanent advisory commission on intergovernmental relations, and attempted to use the "Governors' Conference" to further advance his project for "sorting out" the role of the states.⁵⁴⁴ Interestingly, this stands in stark contrast to the legislation enacted during his administration which greatly expanded the federal government's role in social security, education, the federal highway system, and his "vigorous enforcement of federal courts' civil rights orders"⁵⁴⁵

The next great change in federalism came with the Presidency of Lyndon Baines Johnson. He coined the term "Creative Federalism," stating that the solution for the social problems of the era "does not rest on a massive program in Washington, nor can it rely solely on the strained resources of local authority. They require us to create new concepts of cooperation, a creative federalism, between the National Capital and the leaders of local communities."⁵⁴⁶ Social programs expanded during this period, as did the federal regulatory process.⁵⁴⁷

It was President Nixon who coined the term "New Federalism" as the concept exists today, stating: "It is time for a New Federalism in which power, funds, and responsibility will flow from Washington to the states and to the people."⁵⁴⁸ Although Nixon was the proponent of this "New Federalism," it was President Reagan who refined and expanded it. In his inaugural address he opined that:

It is time to check and reverse the growth of government which shows signs of having grown beyond the consent of the governed.

542. See generally MORTON KELLER ET AL., *THE NEW DEAL – WHAT WAS IT?* (1961); FRANCES PERKINS, *THE ROOSEVELT I KNEW* (1946); DANIEL J. BOORSTEIN, *THE AMERICANS: THE DEMOCRATIC EXPERIENCE* (1973).

543. Scheiber, *supra* note 528, at 260.

544. *Id.* at 267 n.136.

545. *Id.* at 267-68.

546. *Id.* at 271.

547. *Id.* at 270.

548. *Id.* at 288.

It is my intention to curb the size and influence of the Federal establishment and to demand recognition of the distinction between the powers granted to the Federal Government and those reserved to the States or to the people.⁵⁴⁹

It has been said that "New Federalism" has three basic principles. "The first tenet is that the states retain crucial aspects of sovereignty."⁵⁵⁰ "The second tenet derives from the recognition that, under the Supremacy Clause, federal power prevails where federal and state power overlap" and the third "holds that the states are not merely a structural feature of our governmental system but an important affirmative good in need of protection."⁵⁵¹ President Reagan hoped that less action on the part of the federal government would ultimately result in a total reduction of governmental action because the states would "be less proactive than federal government."⁵⁵² In its present incarnation, we have witnessed an expansion of the use of federal standards while allowing the states the freedom to apply those standards.⁵⁵³ This it seems is a return to the "dual federalism" concept. With the election of George W. Bush as President, we will in all likelihood see a return to Reagan-style federalism.

B. New Federalism and its Application to the Health Law Arena

As we have observed, Congress has made it abundantly clear that providing health insurance benefits is a national interest.⁵⁵⁴ One author has suggested that pre-emption of this area by Congress has severely restricted the ability of the states to enact health care reform.⁵⁵⁵ Yet, the same author cites any number of state initiatives in health care legislation.⁵⁵⁶ Although ERISA has limited to some extent the areas in which

549. Robert F. Rich & William D. White, *Federalism and Health Care Policy*, 1998 U. ILL. L. REV. 861, 862 n.3 (1998).

550. Farber, *supra* note 530, at 625.

551. *Id.* at 626.

552. Rich & White, *supra* note 549, at 867-69.

553. See, e.g., The Health Insurance Portability and Accountability Act of 1996, 29 U.S.C. § 1181 (1996); Newborn's and Mothers, Health Protection Act of 1996, 29 U.S.C. § 1185 (1996); Mental Health Parity Act of 1996, 29 U.S.C. § 1185a (1996).

554. See discussion *supra* Part I.

555. James E. Holloway, *ERISA, Preemption and Comprehensive Federal Health Care: A Call For "Cooperative Federalism" To Preserve the States' Role In Formulating Health Care Policy*, 16 CAMPBELL L. REV. 405, 439 (1994).

556. *Id.* at 415-16.

states may legislate, there is no dearth of state action in the field of health care.

We have reached a point in the evolution of federalism where the federal government must continue to take a strong role in setting policy for health care and other areas of social welfare. Devolution of regulation to the states in the welfare arena, by granting funds directly to the states without specific direction as to their application, has resulted in the use of those federal funds to pay for programs that have traditionally been the responsibility of the states.⁵⁵⁷ This, it seems, is a sign that states lack an ability to use federal funds responsibly. From this, one can reasonably conclude that if Congress simply mandated minimum requirements for grievance procedures without federal administration, the program would fail.⁵⁵⁸ Attempts by the states to legislate by creating statutory grievance procedures in managed care have failed to produce effective protections for the average citizen in the delivery of health care.⁵⁵⁹ It is this lack of effective relief that establishes that the time has come to return to the "Creative Federalism" proposed by President Johnson and his administration. A case-by-case approach is needed. Certain areas of legislation are best left to the states. On the other hand, where experience demonstrates that attempts by the states to protect national interests have failed, Congress needs to retain the power to act.⁵⁶⁰ In this context, we must next examine the existing proposals for a solution to the problem of grievance resolution in managed care.

IV. EXISTING PROPOSALS AND PENDING LEGISLATION

In 1994, one author suggested that the Federal HMO Act⁵⁶¹ be amended to provide for a federal grievance procedure modeled on the

557. Raymond Hernandez, *Federal Welfare Overhaul Allows Albany to Shift Money Elsewhere*, N.Y. TIMES, April 23, 2000, at A1.

558. The regulations issued by the Department of Labor, setting minimum procedural requirements for ERISA plans are as yet untested. See *supra* note 102 and accompanying text.

559. See discussion *supra* Part III.

560. President Bush has indicated that he is in favor of independent review of claims. See Robert Pear, *Bush Set to Back State Laws to Extend H.M.O. Patients' Rights*, N.Y. TIMES, Jan. 14, 2001, at A20. See also *The President's Budget; Transcript of President Bush's Message & Congress on His Budget Proposal*, N.Y. TIMES, Feb. 28, 2001, at A12. If the Supreme Court rules in *Moran* that external review is preempted by ERISA, President Bush and the nation will have to look at other alternatives. See discussion *supra* note 231 and accompanying text.

561. See Green, *supra* note 10.

Medicare appeals process.⁵⁶² This author discusses at length the statutory basis for Medicare appeals, but falls short of outlining what a federal grievance procedure should contain.⁵⁶³ Another author has suggested enacting a "Uniform Patient Protection Act" which would require disclosure of such material as physician qualifications, plan coverage, benefits, satisfaction statistics, and loss ratios.⁵⁶⁴ It would prohibit gag clauses that prevent physicians from open discourse with patients, and provide procedures for appeals.⁵⁶⁵ Again, no specific recommendations as to the format for appeals were made. In 1997, Representative Stark proposed the Managed Care Plan Accountability Act of 1997.⁵⁶⁶ In the 103rd Congress, Representative Berman introduced the "Health Insurance Claims Fairness Act."⁵⁶⁷ The bill would have amended ERISA to create an "Early Resolution Program," but did not create a binding grievance procedure for health care service denials.⁵⁶⁸

The 105th Congress spent considerable time dealing with the issue but failed to reach a solution. In his opening statement in a hearing conducted by the Senate Committee on Labor and Human Resources, Senator Jeffords noted:

First, the denial for care comes before the treatment. If the denial was because the service was not a covered benefit, the patient finds out too late. If the denial was because the service was covered, but considered not medically necessary, the patient may suffer if the treatment really was medically necessary.

Second, long delays on the part of the health plan in granting authorization can endanger the patient's life or health.

Finally, patients currently have little understanding of how or even if these health plan decisions can be ap-

562. See Susan J. Stayn, *Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures*, 94 COLUM. L. REV. 1674, 1711 (1994).

563. *Id.* at 1709-11.

564. Deborah S. Davidson, *Balancing The Interests of State Health Care Reform and Uniform Employee Benefit Laws Under ERISA: A Uniform Patient Protection Act*, 53 WASH. U. J. URB. & CONTEMP. L. 203, 237-41 (1998).

565. *Id.* at 236.

566. H.R. 1749, 105th Cong. (1997).

567. H.R. 1881, 103rd Cong. (1993).

568. *Id.*

pealed.⁵⁶⁹

During that hearing, Olena Berg, Assistant Secretary of the Pension and Welfare Benefits Administration of the U.S. Department of Labor, opined:

As our system is currently constituted there is no disincentive to applying harsh and arbitrary guidelines for the initial denial of care. To litigate a claim's denial requires significant resources, and some percentage of claimants can be counted on to give up without pursuing their claim. The current system lacks incentives to assure that the initial claims determination is fair, since the wrongly denied claimant who is injured can never seek compensation for injury while his case is pending, and the discouraged participant with a meritorious claim presents pure savings to the managed care entity. A system which delays justice until an internal appeal or even a threat of litigation saves the managed care entity money. Thus, under our current system, there is a strong financial incentive to delay providing medical treatment because . . . the only remedy that plan will have to provide is the benefit that was denied.⁵⁷⁰

At the same hearing, Margaret A. Hamburg, Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services, emphasized that federal legislation was required to adequately protect consumers.⁵⁷¹ The insurance industry and representatives of the states' departments of insurance, on the other hand, opined that state regulation was adequate and appropriate.⁵⁷²

Several bills were introduced during the 105th Congress. The "Patient Protection Act of 1998" was introduced in the House on July 24, 1998.⁵⁷³ The proposal dealt with access to care, medical savings accounts, and protecting patients' right to choose point of service cover-

569. *Health Care Quality: Grievance Procedures, 1998: Hearings Before the Senate Committee on Labor and Human Resources*, 105th Cong. 2 (1998) (statement of Chairman Jim Jeffords) [hereinafter "Hearings"].

570. *Id.* at 12 (statement of Olena Berg, Assistant Secretary, Pension and Welfare Benefits Adm. U.S. Department of Labor).

571. *Id.* at 13-14 (statement of Margaret A. Hamburg, Assistant Secretary for Planning and Evaluation of the U.S. Department of Health and Human Services).

572. *Id.* (statement of David Randall, Deputy Director Department of Insurance State of Ohio; statement of Kathleen Sebelius, Commissioner of Insurance, State of Kansas; statement of Jack Ehnes, Commissioner of Insurance, State of Colorado).

573. H.R. 4250, 105th Cong. (1998).

age.⁵⁷⁴ The Act would have required group health plans to provide written notice of adverse coverage decisions containing rationale for the decision, written in easily understood language, and within set time limits.⁵⁷⁵ Review of initial adverse determinations would be permitted.⁵⁷⁶ External review is not mandatory, but rather is elective.⁵⁷⁷ Overall, the language is cumbersome; the procedures create multiple layers of review, and ultimately leave the patient without a quick and binding process.

On January 19, 1999, Senators Kennedy and Daschle introduced a bill aimed at consumer protection in the managed care arena.⁵⁷⁸ In addition to providing federal grants to the states to establish a health insurance ombudsmen,⁵⁷⁹ the bill guaranteed the right of an enrollee to appeal a denial of coverage,⁵⁸⁰ mandated an internal appeal with a review by a physician (or another health care professional with appropriate experience) who has not previously been involved in the decision making for the claim,⁵⁸¹ a seventy-two hour time frame for expedited reviews and thirty days for other reviews,⁵⁸² and an external appeals process⁵⁸³ that permitted the insurer to require the patient to exhaust all internal appeals.⁵⁸⁴ The process itself would provide *de novo* review by a qualified external review organization, with similar time frames, and the opportunity for the patient to submit additional evidence.⁵⁸⁵ The review would be binding on the insurer.⁵⁸⁶ Although this bill appeared to provide adequate protection to the patient, it failed to provide an enforcement mechanism, and seemed to allow existing state laws to take precedence.⁵⁸⁷

The 106th Congress saw the introduction of at least ten bills relating

574. *Id.*

575. H.R. 4250, 105th Cong. § 1201(a)(3)(B) (1998).

576. H.R. 4250, 105th Cong. § 1201(a)(3)(C).

577. H.R. 4250, 105th Cong. § 1201(a)(4).

578. S. 240, 105th Cong. (1999).

579. S. 240, 105th Cong. § 123 (1998).

580. S. 240, 105th Cong. § 132(a) (1998).

581. S. 240, 105th Cong. § 132(b).

582. S. 240, 105th Cong. § 132(b)(3).

583. S. 240, 105th Cong. § 133 (1998).

584. S. 240, 105th Cong. § 133(a)(3).

585. S. 240, 105th Cong. § 133.

586. S. 240, 105th Cong. § 133(2)(E)(ii).

587. S. 240, 105th Cong. § 192 (1998).

to the provision of health insurance.⁵⁸⁸ Congressman Dingell's bill⁵⁸⁹ mirrored the Kennedy-Daschle bill introduced in the 105th Congress.⁵⁹⁰

Senate Bill Proposal 300, introduced by Senator Lott, provides for a multi-layered internal and external appeals process.⁵⁹¹ External review would be conducted by a review entity selected by the insurer that is either a state agency, a state licensed or credentialed entity, one under contract to the federal government, or one accredited and recognized by "the Secretary for such purpose."⁵⁹² Time frames are provided,⁵⁹³ and the determination of the external reviewer is binding on the insurer.⁵⁹⁴ Penalties for violation of the act include a civil penalty of up to \$500.00 per violation.⁵⁹⁵ However, a maximum of \$5,000.00 is set for multiple violations.⁵⁹⁶ The language is unclear as to whether this applies to individual claims and/or multiple beneficiaries, and over what period the provision covers. As written, it could reasonably be inferred that a plan's total liability for multiple violations is \$5,000.00, and once that amount is reached, no civil money penalties may be imposed. This is problematic, giving less than optimal protection to the public.

House Proposed Legislation, introduced by Congressman Bilirakis (for himself, Mr. Hastert, Mr. Upton, Mr. Talent, Mr. Goodling, Mr. Gillmor, Mr. Cunningham, Mr. English, Mr. Goss, Ms. Pryce, Mr. Hill, Mr. Armey, and Mr. Oxley),⁵⁹⁷ also provides time frames for making initial coverage determinations, decision making by physicians, reconsideration determinations, and external review by an independent medical expert.⁵⁹⁸ Unlike some of the other proposals, alternatives to internal review and external review are allowed.⁵⁹⁹ An enrollee may elect an alternative dispute resolution procedure.⁶⁰⁰ With respect to the alternative

588. See, e.g., H.R. 197, 106th Cong. (1999); S. 374, 106th Cong. (1999); S. 6, 106th Cong. (1999); S. 240, 106th Cong. (1999); S. 326, 106th Cong. (1999); H.R. 216, 106th Cong. (1999); S. 24, 106th Cong. (1999); H.R. 448, 106th Cong. (1999).

589. H.R. 358, 106th Cong. (1999) (co-sponsored by 165 Members of Congress).

590. S. 240, 105th Cong. (1999); see also *supra* note 578.

591. S. 300, 106th Cong. § 503 (1999).

592. S. 300, 106th Cong. § 503(c)(3).

593. S. 300, 106th Cong. § 503(c)(5).

594. S. 300, 106th Cong. § 503(c)(6).

595. S. 300, 106th Cong. § 231(a) (1999).

596. *Id.*

597. To Provide New Protections Under Group Health Plans, H.R. 448, 106th Cong. (1999).

598. H.R. 448, 106th Cong. § 1201 (1999).

599. *Id.*

600. H.R. 448, 106th Cong. § 1201(b)(5) (1999).

for external review, an enrollee may elect to use a procedure in which the plan agrees in advance to be bound by the recommendations of an independent medical expert(s) and the participant agrees to waive (in advance) any appeal rights.⁶⁰¹ Civil penalties are provided for failure to implement a plan to effectuate the recommendation.⁶⁰² A maximum of \$500.00 per day (and \$1,000.00 per day where bad faith is involved) may be levied, up to a maximum of \$250,000.00.⁶⁰³ If a plaintiff in a civil action alleges that an individual, acting as a fiduciary, has violated the terms of the plan and that action results in an adverse coverage determination, the court has the power to order the plan to cease and desist from its action or its failure to act. Further, the plan may be ordered to pay costs and reasonable attorney's fees.⁶⁰⁴ This bill, like the others, creates a multi-layered appeals process. Its penalty provisions seem well-reasoned and likely to encourage compliance with a decision favorable to the patient. However, an area of concern relates to the procedure allowing for an alternative to external review that constitutes a binding arbitration clause. One wonders what pressure might be applied to induce a patient to accept binding arbitration. A carrier's customer relations staff could potentially inform a patient that he or she can have a quick answer by accepting arbitration, without apprising the patient that there is no appeal from the decision. Perhaps the same customer-relations staff member would suggest that the arbitration procedure is less formal and more "user-friendly." Or, perhaps an explanation of the choices would be too complicated for a sick person to understand when all he or she really wants is to get coverage for their desired medical care.

On February 6, 2001, the "Bipartisan Patient Protection Act of 2001" was introduced in both the House of Representatives and in the Senate.⁶⁰⁵ It addresses issues including access to emergency care,⁶⁰⁶ the right of patients to seek treatment by specialists,⁶⁰⁷ and prescription by physicians of medications not included in a medical care organization's

601. H.R. 448, 106th Cong. § 1201(b)(6) (1999).

602. *Id.*

603. H.R. 448, 106th Cong. § 1205(b)(1) (1999).

604. *Id.*

605. The Bipartisan Patient Act of 2001, H.R. 526, 107th Cong. (2001) and S. 283-284, 107th Cong. (2001) are identical and numbered identically. The following references relate to both the House and Senate Bills.

606. H.R. 526, 107th Cong. § 113 (2001).

607. H.R. 526, 107th Cong. § 114 (2001).

("MCO") formulary.⁶⁰⁸ Health insurance companies would be required to have a utilization review program.⁶⁰⁹ The bill sets forth criteria for the utilization review program,⁶¹⁰ provides procedures for initial claims,⁶¹¹ a timeline for decision-making,⁶¹² requirements for the contents of the written decisions,⁶¹³ and both an internal and independent external appeals process.⁶¹⁴ The external appeals process includes a referral to a "qualified external review entity"⁶¹⁵ and independent medical review.⁶¹⁶ The decision of the independent medical reviewer is binding on the plan.⁶¹⁷ A patient would be required to exhaust all administrative remedies provided by Section 102 and Section 103 of the bill before commencing any civil action.⁶¹⁸ In an apparent attempt to rectify the problems created by ERISA pre-emption, the bill would amend Section 502 of ERISA,⁶¹⁹ imposing a duty of ordinary care upon any individual who is a fiduciary of a health insurer and permitting suits where the failure to exercise ordinary care is the "proximate cause of personal injury" or death.⁶²⁰ A successful plaintiff would be compensated for both economic and non-economic damages. However, punitive damages would be barred.⁶²¹ It appears that these civil liability provisions solve the ERISA pre-emption problem by permitting civil suits in federal court, and preserving a patient's right to sue in state court for negligence. A careful reading of the bill reveals that federal civil suits are permitted where failure to exercise ordinary care and the resulting injury involves: a decision "whether an item or service is covered under the terms and conditions of the plan,"⁶²² or a decision whether the patient is actually enrolled in the plan (either as a participant or beneficiary);⁶²³ or a decision regarding cost-sharing; or questions dealing with policy limitations

608. H.R. 526, 107th Cong. § 118 (2001).

609. H.R. 526, 107th Cong. § 101 (2001).

610. *Id.*

611. H.R. 526, 107th Cong. § 102 (2001).

612. H.R. 526, 107th Cong. § 102(b).

613. H.R. 526, 107th Cong. § 102(d).

614. H.R. 526, 107th Cong. §§ 103, 104 (2001).

615. H.R. 526, 107th Cong. § 104(c)(e)(B)(ii).

616. H.R. 526, 107th Cong. § 104(d).

617. H.R. 526, 107th Cong. § 104(f).

618. H.R. 526, 107th Cong. § 302 (2001).

619. *See supra* note 11 and accompanying text.

620. H.R. 526, 107th Cong. § 302.

621. *Id.*

622. *Id.* (amending 29 U.S.C. § 1132(n)(1)(a)(i)(I) (1994)).

623. *Id.* (amending 29 U.S.C. § 1132(n)(1)(a)(i)(II) (1994)).

regarding the “amount, duration, or scope of coverage of items or services.”⁶²⁴ Specifically excluded from the civil remedies provision are “medically reviewable decisions.”⁶²⁵ These are the decisions subject to independent external review under the bill.⁶²⁶ The bill preserves the right to sue in state court under theories of negligence and/or wrongful death, but prohibits punitive damages unless there is clear and convincing evidence that the defendant’s actions constitute willful and wanton disregard for the rights of others.⁶²⁷

All of these proposals are well constructed and make a serious attempt at weighing the rights of both the insurance carrier and the patient. However, these proposals are all multi-layered and time consuming. Time is something most patients do not have. Independent review requirements (whether imposed by a state or by the new proposed federal regulation) still fail because a patient in one state covered by an MCO may receive the medical care requested, while another patient in another state requesting the same care and covered by the same MCO may not. Any solution to the problem needs to provide a fast and easy remedy, applied to all patients and insurers in a uniform manner, with due process afforded to both sides.

V. THE SOLUTION: A STATUTORY FEDERAL DUE PROCESS HEARING

Let us hark back to the words of George Washington: “Individuals entering into society, must give up a share of liberty to preserve the rest. The magnitude of the sacrifice must depend as well on situation and circumstance, as on the object to be obtained.”⁶²⁸ Asking the states to relinquish control of the managed care grievance process is a necessary sacrifice given the goal: uniform standards and uniform application of those standards for health care coverage determinations. Although there have been many proposals for a federal appeals procedure for managed care grievances, including one modeled on the Medicare Appeals process, these proposals merely suggest a federal solution without providing details.⁶²⁹

624. *Id.* (amending 29 U.S.C. § 1132(n)(1)(a)(i)(III) (1994)).

625. *Id.* (amending 29 U.S.C. § 1132(n)(2)(B) (1994)).

626. H.R. 526, 107th Cong. § 104(d)(2) (2001).

627. *Id.*

628. Scheiber, *supra* note 528.

629. *See* Hearings, *supra* note 569; *See supra* notes 570, 571, 572 (noting statements

The proposal to model the managed care grievance procedure on the Medicare Appeals process is a good one,⁶³⁰ but this proposal must be taken one step further. A statute mandating a federal appeals process for managed care grievances, that includes a statutory due process hearing before a U.S. Administrative Law Judge, is a potential answer for patients. The statute should mandate the assignment of these appeals to judges serving in the Social Security Administration. These judges are appointed under 5 U.S.C. § 3105 and may be removed only for good cause, thus insuring true judicial independence,⁶³¹ they are the "functional equivalent" of U.S. District Court judges.⁶³² The duties of the Social Security Administrative Law Judge include hearing and deciding disability claims under Titles II and XVI of the Social Security Act and hearing and deciding Medicare appeals under Title XVIII of the Social Security Act.⁶³³ These judges receive extensive training in medicine including the anatomy of the various body systems, the diseases that attack them, and diagnostic procedures and treatments. Training commences upon appointment and continues periodically throughout the judges' tenure.⁶³⁴

While much has been written about the statutory basis for hearings before these judges, little has been put forth concerning the day-to-day work of a Social Security Administrative Law Judge. At the present time there are over 1,100 judges serving in 132 hearing offices across

made at the Hearings).

630. See Stayn, *supra* note 562.

631. 5 U.S.C. § 7521 (1994).

632. Butz v. Economu, 438 U.S. 478, 513 (1978).

633. This discussion of the duties of the SSA ALJ and their training and expertise flow from the personal knowledge of the author who has served in this capacity since 1981.

634. See Videotape: Video Medical Lectures (Social Security Administration Annual Conference, 1999). The Agency makes widespread use of videography and interactive video for training. A full TV studio is maintained in Woodlawn Center, the headquarters of the Social Security Administration in Baltimore. In addition, the Association of Administrative Law Judges, the professional association for those of us serving in the Social Security Administration, holds an annual conference. Medical education plays a central role in these conferences. On April 29, 2000, the Social Security Administration released two video medical lectures recorded at the July 1999 conference (one by Dr. Walter Strausser addressing injuries of the upper extremities, including Carpal Tunnel Syndrome and repetitive motion injuries, rotator cuff surgery, frozen shoulder and Dupuytren's Syndrome, the other by Dr. Marian Martin and Dr. Richard Jones dealing with functional limitations due to psychiatric impairments) and plans on releasing a total of five. See Memorandum from Acting Director, Division of Material Resources, Social Security Administration (Apr. 19, 2000) (unpublished document, on file with the author). This author serves on the curriculum committee for continuing medical and legal education in Region I that covers the New England states.

the nation. Judges hear cases in their permanent hearing office and at remote locations in order to accommodate the needs of the public. Disability hearings generally involve the taking of testimony from an individual claimant and may include testimony from a medical expert and a vocational expert. Depending largely on the location of the hearing office, these cases comprise approximately seventy-five to ninety percent of the caseload. The importance of these cases in contributing to the medical expertise of these judges should not be underestimated. The judge must ultimately choose among varying medical opinions and select the one that best describes the claimant's condition and functional limitations. As a result, the judge needs to keep current on medical diagnosis and treatment of disease. In instances where the record is lacking in evidence, the judge has the authority to order a full range of diagnostic testing, as long as the test ordered is non-invasive.⁶³⁵ Thus, the judge needs to keep current on new diagnostic procedures and their application. It is important to keep this in mind when considering the appropriateness of such judges as adjudicators in managed care grievances. In fact, it is this expertise in general medicine that constitutes the basis for these judges hearing and deciding Medicare appeals. In Medicare appeals, the Social Security Administrative Law Judge is called upon to determine the medical necessity of procedures, the medical necessity for the purchase of durable medical equipment, the medical necessity for acute care, and the medical necessity of skilled nursing services, and home care.⁶³⁶ This caseload comprises ten to twenty-five percent of the full caseload, again depending on the location of the hearing office.⁶³⁷ These hearings generally involve testimony from providers and testimony from medical experts called by the judge, to assist in an independent interpretation of the medical evidence. In some cases, most often those involving durable medical equipment and Medicare managed care claims, individual beneficiaries also appear. In sum, the Social Security Administrative Law Judge routinely makes determinations of medical necessity based upon an application of the law to the medical facts of a specific case. It is this expertise that lends itself perfectly to the determination of managed care adverse determinations. State statutes and the various proposals previously discussed lose sight of the fact that al-

635. 20 C.F.R. § 404.1519a (2001); 20 C.F.R. § 416.919a (2001).

636. Other issues such as overpayments to Medicare providers are not relevant to this discussion.

637. General knowledge of this author predicated on monthly reviews of national statistics distributed to judges.

though a medical determination is essential in all these cases, they are in fact mixed questions of law and medicine. Each claim in an adverse determination by a managed care entity revolves around a legal interpretation of the policy provisions and application of those standards to medical facts. The Social Security Administrative Law Judge makes such determinations on a daily basis. Any solution to the problem of the managed care grievance procedures must take into account the fact that these cases are not exclusively medical decisions, but rather mixed questions of law and medicine.

The statute proposed in this article would simplify the procedures. It would require all managed care plans to maintain a single level grievance procedure requiring patients to exhaust all appropriate remedies before turning to a federal administrative hearing.⁶³⁸ This internal grievance would have to be completed within five days of the submission of all relevant medical information in non-emergency situations involving treatment yet to be provided, and within twenty-four hours in cases of emergencies.⁶³⁹ Communication of the decision to the patient and provider would be required to be communicated immediately, either orally or electronically, and be confirmed in writing within twenty-four hours after a decision is made. In cases involving retrospective review, a thirty day time frame would be set with the same provisions for notification of the decision.

In the event of an adverse determination, the carrier would be required to notify the patient and the provider of the right to appeal to a United States Administrative Law Judge ("ALJ"), provide information on how to appeal in clear and concise language, and advise the patient where the nearest hearing office is located. The notice would contain information advising the patient and provider of the right to an "immediate" hearing in the event of a life-threatening situation.⁶⁴⁰ A monetary

638. This would eliminate the multi-layered approach of many state statutes that require an initial and reconsideration determination before allowing for external appeal, and the current federal proposals that mirror many state statutes.

639. Some might believe that five days is too short a period, but several of the state statutes contain even shorter time frames. This author's own experience in hearing and deciding Medicare appeals has been that once all the documentation is received, very little time is required to reach a decision. Patients awaiting care should not have to wait weeks and months to learn whether the care will be covered.

640. The mechanism for this could include immediate telephone scheduling with the Office of Hearings and Appeals (this is the judicial arm of the Social Security Administration and is known as "OHA") for a hearing within twenty-four hours. As in disability and Medicare appeals, the patient would retain the right to waive an oral hearing and rely on the documents.

threshold would restrict appeals to those matters involving \$100.00 or more. Routine care issues would be scheduled for hearing within thirty days of the receipt of the request for hearing at the Office of Hearings and Appeals.⁶⁴¹ In all cases involving emergencies and/or life threatening situations, a hearing would be held within twenty-four hours of the receipt of the request for hearing at OHA. A filing fee of \$50.00 in each case would be required, but would be waived upon a showing of an inability to pay.

The ALJ would be required to make a finding whether the managed care organization unreasonably refused to provide the service. If the ALJ found that the MCO was unreasonable in refusing care, a fine would be levied against the entity.⁶⁴² The decision of the ALJ would be binding on both parties; however, upon a showing of abuse of discretion by the ALJ, an appeal to the district court would be permitted.⁶⁴³ The managed care entity would be required to provide care in cases of emergency or life threatening medical situations in the event of an appeal, but the patient would be liable for repayment in the event that the ALJ's decision is overturned.

Unlike the disability claims and Medicare appeals, a written decision would not be required but would be permitted in the event the judge deemed it appropriate. The ALJ would be required to state the decision, reciting its rationale on the record at the time of the hearing unless the record is held open for additional evidence. A form order would then be issued. The managed care entity would be required to comply with an order to provide care or services forthwith. Fines and penalties would be levied for failure to comply.⁶⁴⁴

This procedure reduces the number of steps a patient must take. Many states require the patient to pursue four internal steps before proceeding to external review (if available at all). In this proposal only a single internal step is required prior to external review by an ALJ. This procedure would provide a binding decision rendered after a due process hearing. At present only twelve states have binding external review.⁶⁴⁵

641. As with all cases in the federal administrative law system, the patient would have a right to be represented by counsel. However, because the administrative law judge wears three hats, and 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."

642. This money would be used to defray the cost of the appeal.

643. A threshold of \$1000.00 would be appropriate to prevent flooding the district courts with cases.

644. Again, these monies would be used to defray the cost of the appeal.

645. See discussion *supra* Part III.A.

On its surface, this proposal may appear to conflict with the general rule that an ERISA plan administrator is given wide discretion to review, interpret, and apply the terms of the plan.⁶⁴⁶ However, this deference to the plan administrator is not absolute. As Judge Lucero⁶⁴⁷ has noted, the level of deference may decrease under certain circumstances.⁶⁴⁸ Given that the application of the principle of deference is not absolute, and to avoid a conflict with its application, the statute proposed in this article would contain a provision limiting such deference. I suggest that for the purpose of the ALJ hearing, the judge would be required to accord *significant weight* to the decision of the plan administrator. However, where the record, as a whole, establishes that the decision is not adequately supported, the judge would be free to accord it little weight. The same standard would also apply to the opinion of the treating physician.⁶⁴⁹ In either case, the administrative law judge would be required to explain why he or she did not accord *significant weight* to either the opinion of the treating physician or the decision of the plan administrator.

Some of the state statutes controlling grievance procedures allow the decision of the independent reviewer to be used in other civil proceedings involving the same facts and circumstances while others do not.⁶⁵⁰ In fairness to the MCO, and to protect the MCO's right to have a jury trial in negligence actions, I propose that neither party be permitted to use the decision of the ALJ in any civil proceeding arising out of the same facts and circumstances.⁶⁵¹

Some will argue that the volume of cases will be too large for the Social Security ALJ's core to handle. However, the data suggests that, at present, the volume of external review cases is low. As of 1998, the rate of external review in Medicare was two cases per one thousand beneficiaries enrolled in managed care per year,⁶⁵² at a cost of less than

646. See *Siemon v. AT&T Corp.*, 117 F.3d 1173, 1177 (10th Cir. 1997) (discussing this legal theory).

647. Writing for the majority in *Siemon*, 117 F.3d at 1173.

648. *Siemon*, 117 F.3d at 1174.

649. This follows the *treating physician rule* as it is applied in the context of Medicare cases in the second circuit. See generally *Keefe v. Shalala*, 71 F.3d 1060 (2d Cir. 1995).

650. See discussion *supra* Part II.

651. A similar provision exists with respect to the reports of the National Transportation and Safety Administration. 49 C.F.R. § 835.4 (2001).

652. Karen Pollitz, *External Review Of Health Plan Decisions: An Overview Of Key Program Features In The States And Medicare*, 1998 KAISER FAMILY FOUNDATION 18 (document 1443).

four cents per member per month.⁶⁵³ If the statute were to be properly promoted, with good notice to plan participants and the general public, one might expect some increase in numbers over the level of Medicare appeals. However, it is unlikely that the level would be so high that it would be unmanageable. At an approximate cost of four cents per member per month,⁶⁵⁴ it seems a small price to pay for due process.

CONCLUSION

The backlash against managed care has created an environment that requires action to protect patients' rights. Too often patients who have been denied care do not appeal the denial, and frequently the patient is not even aware of what appeal procedures are available. Negligence suits for damages are an unsatisfactory solution as they often come too late to help the patient because the patient has died. Moreover, ERISA has effectively barred most negligence suits, and without an amendment, this is not a readily available remedy. Although many states have mandatory grievance procedures, they often require several levels of appeal (ranging from two to four). This type of process is time consuming and confusing to a patient in need of care. At the present time, only twenty-two states have binding external review of an adverse managed care determination.⁶⁵⁵ Thus, most patients are without a remedy.

Congress has evinced a clear intent to pre-empt the states and regulate the provision of health insurance benefits in the context of an employee welfare benefit plan,⁶⁵⁶ and has the power to enact legislation. Just as ERISA was needed "to create uniformity of administration in order to protect both insurers and beneficiaries from the pitfalls of multiple standards depending on which state is involved," so too a uniform national grievance procedure for adverse managed care decisions is needed.⁶⁵⁷ "[T]he most efficient way to meet" the needs of all patients enrolled in managed care health plans "is to establish a uniform administrative

653. *Nonpartisan Education and Information Forum on Health Policy Issues in California: California Health Policy Roundtable: External Review Of Health Plan Decisions* 1999 KAISER FAMILY FOUNDATION POLICY REPORT (document 1453).

654. *Id.*

655. As previously noted, depending on the outcome of *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959 (7th Cir. 2000), external review may be preempted by ERISA. See *supra* note 231 and accompanying text.

656. 29 U.S.C. § 1002(1) (1994).

657. 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, 58 (1999).

scheme, which provides a set of standard procedures”⁶⁵⁸

A federal appeals process that provides for a statutory due process hearing before a Social Security Administrative Law Judge will give patients a “user friendly” means to appeal adverse determinations. It will provide an impartial judge trained in both law and medicine to hear and decide these often life threatening claims quickly, efficiently, and close to the patient’s home.

Finally, it will assure that patients covered by the same MCO, living in different states, but still seeking the same care, will be treated the same way.

658. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987).