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Hope or Hype?: Why the Affordable Care Act's New External Review Rules for Denied ERISA Healthcare Claims Need More Reform

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The discouraged participant with a meritorious claim represents pure savings to the managed care entity.¹

Justice too long delayed is justice denied.²

INTRODUCTION

Almost 173 million Americans count on private health insurance for their healthcare.³ The correct processing of these Americans's healthcare claims is important—without proper processing and payment of claims, plan participants can lose significant amounts of money or even fall into

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1. *Healthcare Quality: Grievance Procedures: Hearing of the Senate Committee on Labor and Human Resources*, 105th Cong. 12 (1998) [hereinafter Olena Berg] (statement of Olena Berg, Assistant Secretary, Pension and Welfare Benefits Admin. U.S. Dep't of Labor).

2. DR. MARTIN LUTHER KING, JR., LETTER FROM A BIRMINGHAM CITY JAIL (1963), reprinted in *POLITICAL PHILOSOPHY: THE ESSENTIAL TEXTS* 576, 578 (Steven M. Cahn ed., 2005).

3. See, e.g., U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-11-268, PRIVATE HEALTH INSURANCE: DATA ON APPLICATION AND COVERAGE DENIALS 1,5 (2011) [hereinafter GAO] (noting that as of 2009, 64% of Americans had private health insurance and that most of this insurance is obtained through employment).

medical bankruptcy.⁴ Without proper claims processing, participants stand to lose confidence in the system's fairness⁵ and discount the value of healthcare benefits in employment negotiations.⁶

The overall error rate in claims processing is high—perhaps as many as 20% of claims are processed erroneously.⁷ No one knows this error rate with certainty because comprehensive data are not collected nationally on this issue.⁸ In addition, plan administrators may decide that certain therapies are experimental or not medically necessary and deny them on those grounds. Since many

4. See David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 743 (2009), http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf (noting also that about 75% of medically-related bankruptcy debtors had health insurance when they fell ill).

5. See Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41,726, 41,733 (July 19, 2010) (codified at 29 C.F.R. § 2590 (2011) [hereinafter Interim Final Rules].

6. See *id.* at 43,341 (noting that “[i]f workers perceive that there is the potential for inappropriate denial of benefits or handling of appeals, they will discount the value of these benefits and adjust for this risk”).

7. The American Medical Association (“AMA”) indicates that the overall error rate in commercial health insurers’ claims processing was 19.3%, which was even less accurate than in 2010. There is no comprehensive, nationwide data on the number or proportion of claims that are improperly denied—the AMA estimates that this level of inaccuracy adds \$1.5 billion in unnecessary administrative costs. Press Release, Am. Med. Ass’n., New AMA Health Insurer Report Card Finds Increasing Inaccuracy in Claims Payment (June 20, 2011), available at <http://www.ama-assn.org/ama/pub/news/news/ama-health-insurer-report-card.page#> (reporting that approximately 20% of claims are processed incorrectly and advocating a uniform, national set of standards for processing healthcare claims; also noting that the study was based on “random sampling of approximately 2.4 million electronic claims for approximately 4 million medical services submitted in February and March of 2011 to Aetna, Anthem Blue Cross Blue Shield, CIGNA, Healthcare Service Corporation, Humana, The Regence Group, UnitedHealthcare and Medicare. Claims were accumulated from more than 400 physician practices in 80 medical specialties providing care in 42 states.”); see also Press Release, Cal. Nurses Ass’n/Nat’l Nurses Org. Comm., California’s Real Death Panels: Insurers Deny 21% of Claims (Sept. 2, 2009), available at <http://www.reuters.com/article/2009/09/02/idUS202570+02-Sep-2009+PRN20090902> (estimating the denial rate at 21%).

8. GAO, *supra* note 3, at 1.

claims are processed incorrectly or otherwise denied, plan participants must be able to access effective mechanisms for correcting errors and reversing improper denials. These mechanisms play an important role in obtaining the benefits due.

As part of the recent Patient Protection and Affordable Care Act (“PPACA”),⁹ Congress authorized new rules that expand consumer access to external review of denied healthcare claims.¹⁰ External review comes only after a plan participant has appealed a claim within the plan to plan personnel. External review allows plan participants to obtain review of denied claims by an independent body outside the plan or company providing the healthcare plan.¹¹ Even before the PPACA, almost all states had adopted some form of external review, but these rules did not apply to self-funded plans subject to ERISA.¹² Now, however, both insured and ERISA-governed plans must establish an external review process.¹³

The new external review rules have been heralded as a boon to consumers that will ease the appeal process.¹⁴ The Department of Labor (“DOL”) asserted that the new rules

9. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 42 U.S.C. (Supp. 2011)).

10. See *infra* notes 56-57 (outlining the changes Congress authorized with PPACA).

11. See *Has Your Health Insurer Denied Payment for a Medical Service? You Have a Right to Appeal*, HEALTHCARE.GOV (June 15, 2012), <http://www.healthcare.gov/news/factsheets/2012/06/appeals06152012a.html>.

12. Interim Final Rules, *supra* note 5, at 43,335 (codified at 29 C.F.R. § 2590 (2011)). The regulations’ preamble explains that ERISA preemption prevents a State external review process from applying to self-insured plans, and that those plans are now subject to the Federal external review process. *Id.* at 43,334-37.

13. See *infra* note 58 (providing an explanation of the ERISA changes under PPACA).

14. Candy Sagon, *New Tools Help Fight Health Claim Denials*, AARP BULL., Sept. 2010, at 4 (“Fighting back when your health insurance company denies a claim just got a little easier, thanks to federal rules recently issued under the healthcare overhaul law.”); Alison Young, *Rules to Ease Consumer Appeals in Health Coverage*, USA TODAY, July 23-25, 2010 at 3A.

would “help support and protect consumers and help end some of the worst insurance company abuses.”¹⁵ But how much does the average plan participant stand to benefit from the new rules? As a practical matter, is a further level of review—usually available only after exhaustion of internal levels of review—the kind of reform that will make a difference to most plan participants?

One indication that external review may not be purely beneficial to consumers is that health insurance companies and plan sponsors also welcomed the external review requirements.¹⁶ As explained below, the external review rules help payors—as plan participants drop out of the appeal process at each level, external review will act as an extra winnowing level before a participant resorts to litigation. In fact, all but a few plan participants fail to complete the arduous appeal process available to them even before this new, external level of review.¹⁷

This Article posits that the new external review procedures are a positive step, but ultimately an imperfect substitute, for more extensive ERISA claims reform that would incentivize payors to make correct initial decisions on the claims that they process. The external review procedures are helpful with regard to certain classes of claims, namely high-stakes claims such as those for organ transplants, surgeries, bariatric surgery,¹⁸ or other

15. Press Release, U.S. Dep't of Labor Press Office, Administration Announces New Affordable Care Act Measures to Protect Consumers and Put Patients Back in Charge of Their Care: New Regulations Give Patients Right to Appeal Health Plan Decisions; New Grants Program Strengthens State and Territory Consumer Assistance Programs (July 22, 2010), *available at* <http://www.dol.gov/ebsa/newsroom/2010/ebsa072210.html>.

16. *See* Young, *supra* note 14, at 3A (quoting Robert Zirkelbach, spokesman for the trade group America's Health Insurance Plans, as stating that “health plans have a long track record of supporting third-party review to give patients greater peace of mind”); Letter from Am.'s Health Ins. Plans to the Office of Consumer Info. & Ins. Oversight 8 (Sept. 21, 2010), *available at* <http://www.dol.gov/ebsa/pdf/1210-AB45-0063.pdf> (stating that “our members strongly support the right of consumers to participate in internal appeals and external review processes”).

17. *See infra* note 131 and accompanying text.

18. Bariatric surgery includes gastric bypass surgery and other surgeries designed to promote weight loss by changing the digestive system's anatomy.

expensive or cutting-edge treatments. But for most plan participants, the new external review rules simply add to plan participants' paperwork and procedural burden. The problem is not that there are too few levels of review, but instead, that too many claimants drop out of the appeal process, never questioning their denied claims at all.¹⁹ The addition of yet another layer of review does not solve this problem.

Furthermore, the external review rules do not address another major failing of the ERISA claims process, namely that there is no direct, negative, and substantial consequence of payors' incorrect denial of legitimate healthcare claims.²⁰ For the external review rules to be meaningful and effective, they should be revised so that payors are exposed to the negative effects of incorrect decisions. That is, as the regulations stand, it is the participant with a meritorious but denied claim who bears the burden of completing the multiple levels of appeal in order to have the incorrect denial overturned. If payors had to internalize the costs of their incorrect decisions, they would be incentivized to make more accurate initial decisions.

Payors would be exposed to the cost of their incorrect decisions if a participant's success on external appeal resulted in an award of not just the face value of the claim, but also interest on the delayed payment and an additional penalty payment to compensate the participant for the necessary time and trouble expended in pursuing the monies that he or she was owed. In other areas of law, correct decisions are incentivized through such penalties. In tax cases, for example, taxpayers who miscalculate their taxes are assessed a 20% percent penalty.²¹ Without a disincentive, those payors who are inclined to decline

Farlex, *Medical Dictionary*, THE FREE DICTIONARY, <http://medical-dictionary.thefreedictionary.com/bariatric+surgery> (last visited June 12, 2012).

19. See *infra* note 131 and accompanying text.

20. See *infra* notes 89 and 97 and accompanying text.

21. I.R.C. § 6662(a) (2006).

payment frivolously can continue to do so without consequence.

In addition, the regulations should be revised to increase consumer participation. Participation could be encouraged, for example, through a broad campaign to inform consumers about their rights and obligations under healthcare regulations. Participation would also increase if twice-appealed claims were automatically referred to external review; this system is already in place for denials under Medicare Part C.²²

The new external review rules are a positive first step, but to affect substantive reform that would assist plan participants, payors rather than participants should bear the cost of incorrect denials. Part I of this Article explains the claims processing rules and sets out why external review is so important to participants in ERISA plans; Part II explains why so few plan participants ever use external review; Part III proposes changes to the external review rules that would both encourage accurate initial claims decisions and place the consequences of improper decision making on payors rather than participants.

I. BACKGROUND: THE APPEALS PROCESS AND WHY ROBUST EXTERNAL REVIEW IS CRUCIAL TO ERISA PLAN PARTICIPANTS

The processing and appeal of a healthcare claim is a lengthy and complicated process—to appeal a claim to external review, a participant must stay the course through multiple levels of review. For participants in ERISA plans, the claims adjudication process and its culmination in external review are particularly important: unlike

22. 42 C.F.R. § 422.592(a) (2011) (“When the [Medicare Advantage] organization affirms, in whole or in part, its adverse organization determination, the issues that remain in dispute must be reviewed and resolved by an independent, outside entity that contracts with [Centers for Medicare and Medicaid Services].”); see KAREN POLLITZ, GERALDINE DALLEK & NICOLE TOPAY, INST. FOR HEALTHCARE RESEARCH AND POLICY, EXTERNAL REVIEW OF HEALTH PLAN DECISIONS: AN OVERVIEW OF KEY PROGRAM FEATURES IN THE STATES AND MEDICARE 18 (1998), <http://www.kff.org/insurance/loader.cfm?url=/commons/spot/security/getfile.cfm&PageID=14659>.

participants in other plans, ERISA plan participants stand very little chance of relief beyond the claims process. Thus, as explained below, the ERISA plan participant who loses on external review has probably lost a last viable chance at relief.

A. *Overview of the Claims Processing and Appeals Process*

External review of a denied healthcare claim comes at the end of a larger review process. Before external review takes place, the participant must, in most cases, complete the preceding steps in the appeal process. The processing of a claim begins with the payor's initial review, followed by internal review, proceeding then to external review.

The initial review. The first step in processing a claim is the payor's initial assessment of the claim.²³ At this stage, the payor may pay the claim, deny the claim if required by the plan's terms, or seek additional information necessary to assess the claim.²⁴ Plans typically contain a provision stating that benefits are provided for "medically necessary" care, so part of the assessment is to determine whether the care was medically necessary.²⁵

According to the regulations, payors must maintain reasonable claims processing procedures.²⁶ Claims procedures are considered to be unreasonable if they contain any provision unduly inhibiting the processing of claims, such as requiring a person to receive prior authorization when the person is unconscious or requiring

23. Claims processing may occur before, during, or after care is obtained. These reviews are known as precertification, concurrent review, or retrospective review, respectively. See, e.g., *Determining Coverage*, AETNA, <http://www.aetna.com/health-professionals/policies-guidelines/determining-coverage.html> (last visited June 12, 2012).

24. See U.S. Dep't of Labor, *Understanding Your Fiduciary Responsibilities Under a Group Health Plan* (Aug. 2011), <http://www.dol.gov/ebsa/publications/ghpfiduciaryresponsibilities.html>.

25. Aaron Seth Kesselheim, *What's the Appeal? Trying to Control Managed Care Medical Necessity Decisionmaking Through a System of External Appeals*, 149 U. PA. L. REV. 873, 881 (2001).

26. 29 C.F.R. § 2560.503-1(b) (2011).

that a person pay a fee to appeal a claim denial.²⁷ Claims processing procedures must contain “administrative processes and safeguards” such that plan provisions are interpreted and applied consistently and that decisions are made according to plan documents.²⁸

The regulations do not, however, require any particular processes or safeguards to ensure that decision making is consistent—the means of accomplishing consistent decision making are left to the payors.²⁹ Notably, the regulations revise the conflict of interest rules so that compensation of claims processing personnel cannot be directly tied to the proportion of claims denied.³⁰

Claims for benefits must be processed within thirty days after the plan’s receipt of the claim, unless the plan administrator determines that a fifteen-day extension is necessary and sends written notice to that effect to the participant.³¹ The statute does not require payors to pay interest on late-paid claims.³²

If a claim is denied, a written denial must set out the basis for the denial, reference the specific plan provision upon which the decision was based, and give a description of any additional material or information needed to pursue the claim.³³ If an internal rule, guideline, protocol, or similar criterion was relied upon in the denial, that rule or criterion must be disclosed to the claimant upon request.³⁴ In

27. *Id.* § 2560.5030-1(b)(3).

28. *Id.* § 2560.503-1(b)(5).

29. See U.S. DEP’T OF LABOR, *FAQs About the Benefit Claims Procedure Regulation*, DOL.GOV, http://www.dol.gov/ebsa/faqs/faq_claims_proc_reg.html (last visited June 28, 2012).

30. See Interim Final Rules, *supra* note 5, at 43,330, 43,344 (codified at 29 C.F.R. § 2590 (2011)).

31. 29 C.F.R. § 2560.503-1(f)(2)(iii)(B).

32. See, e.g., *Skredtvedt v. E.I. DuPont De Nemours*, 372 F.3d 193, 205-06 (3d Cir. 2004) (noting that the ERISA does not require payment of interest on late-paid claims and stating that any award of interest is discretionary with the court).

33. 29 C.F.R. § 2560.503-1(g)(1).

34. *Id.* §§ 2560.503-1(g)(v)(A), 2560.503-1(j)(5)(i); see U.S. Dep’t of Labor, *FAQs About the Benefit Claims Procedure Regulation*, *supra* note 29 (stating

addition, the notice must be written “in a manner calculated to be understood by the claimant.”³⁵ The notice is required to inform the participants as to the steps required in order to submit the claim for review.³⁶

Internal appeal. If the initial decision on a healthcare claim is adverse to the participant, the participant can opt to appeal.³⁷ Plans are required to afford participants the opportunity for “a full and fair review.”³⁸ Quite often, plan documents call for participants to complete two levels of internal appeal before a participant can seek external review or judicial remedies.³⁹ No more than two levels of appeal are allowed.⁴⁰

At the internal appeal levels, the plan employs or retains the person deciding the appeal.⁴¹ Typically, the appeal is decided by a committee, a medical director, or a physician.⁴² At this stage, the participant can submit additional documentation in order to support the

that “[t]he [Department of Labor] also has taken the position that internal rules, guidelines, protocols, or similar criteria would constitute instruments under which a plan is established or operated within the meaning of section 104(b)(4) of ERISA and, as such, must be disclosed to participants and beneficiaries.”).

35. 29 C.F.R. § 2560.503-1(g), (j).

36. Under the regulations applicable to this section, the denial notice must contain: (1) The specific reason or reasons for the denial; (2) specific reference to the pertinent plan provisions on which the denial is based; (3) “a description of any additional material or information necessary for claimant to perfect the claim and an explanation of why such information is necessary;” and (4) appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review. *Id.* § 2560.503-1(g)(1)(i)-(iii),(vi).

37. U.S. Dep’t of Labor, *FAQs About the Benefit Claims Procedure Regulation*, *supra* note 29.

38. 29 C.F.R. § 2560.503-1(h).

39. *Id.* § 2560.503-1(c)(2); *see also Cigna Healthcare Appeals & Grievances*, CIGNA, <http://www.cigna.com/appeals> (explaining process for two-level internal appeal).

40. U.S. DEP’T OF LABOR, *FAQs About the Benefit Claims Procedure Regulation*, *supra* note 29.

41. *See* 29 C.F.R. § 2560.503-1(h)(3)(ii).

42. Kesselheim, *supra* note 25, at 883.

participant's position that the care is covered under the plan's terms.⁴³

Internal review has long been the target of criticism for issues such as processing delays,⁴⁴ suspicion of pro-payor bias, or reports that those deciding internal appeals prefer to decide in favor of their employer whenever possible.⁴⁵ In addition, participants often have difficulty appealing their claims because the basis for the initial denial may be unclear.⁴⁶ These various complaints about internal review served, in part, as the impetus for external review to be developed and implemented.⁴⁷

External review and the new rules. External review is an additional and separate review of a denied claim by an outside entity after the levels of internal plan review are completed.⁴⁸ Typically, to promote the reviewer's independence, the reviewer is not connected with the plan.⁴⁹ By the time a participant seeks external review, the claim has usually been twice denied by the plan itself. External review of denied healthcare claims is the final review without resort to legal action.

External review was featured in some health insurance plans as early as 1978.⁵⁰ At the state level, external review

43. See 29 C.F.R. § 2560.503-1(h)(2)(ii).

44. Internal appeals at one time reached an average processing time of twenty-eight months. George J. Annas, *Patients' Rights in Managed Care—Exit, Voice, and Choice*, 337 NEW ENG. J. MED. 210, 214 (1997).

45. See Kesselheim, *supra* note 25, at 884-85.

46. Dustin D. Berger, *The Management of Healthcare Costs: Independent Medical Review After "ObamaCare"*, 42 U. MEM. L. REV. 255, 275 (2011) (citing Annas, *supra* note 44, at 211 (explaining that in one review of denial notices "74 percent of the notices provided vague or ambiguous reasons for denial of services")).

47. See Berger, *supra* note 46, at 279-80.

48. TRUDY LIEBERMAN ET AL., A CONSUMER GUIDE TO HANDLING DISPUTES WITH YOUR PRIVATE OR EMPLOYER HEALTH PLAN, 2005 UPDATE, KAISER FAMILY FOUND. 1, 2 (Aug. 4, 2005), http://www.kff.org/consumerguide/upload/7350ConsumerGuidev4_080805.pdf.

49. *Id.*

50. GERALDINE DALLEK & KAREN POLLITZ, EXTERNAL REVIEW OF HEALTH PLAN DECISIONS: AN UPDATE, KAISER FAMILY FOUND. 3 (May 2000), *available at*

of healthcare claims has existed for years, with the number of states requiring external review increasing steadily over the past decade.⁵¹ In 2010, forty-four states and the District of Columbia developed external review programs.⁵² State external review programs are usually operated by each state's department of insurance, and the state typically uses an independent review organization ("IRO") to assess claims.⁵³ State external review programs generally require each reviewer to be a healthcare professional who is board certified and qualified in the particular specialty at issue in the claim.⁵⁴ In making a decision on external review, the reviewer can uphold the plan reviewer's decision, reverse the decision, or modify or partially reverse the earlier decision.⁵⁵

The PPACA⁵⁶ added the following external review requirement:

(b) External review.—A group health plan and a health insurance issuer offering group or individual health insurance coverage—

(1) shall comply with the applicable State external review process for such plans and issuers that, at a minimum, includes the

<http://www.kff.org/insurance/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=13505>.

51. See AHIP CTR. FOR RES. & POL'Y, UPDATE ON STATE EXTERNAL REVIEW PLANS 1 (Jan. 2006), www.ahip.org/External-Review-2006/.

52. *Id.* at 2; see also *Appealing Health Plan Decisions*, HEALTHCARE.GOV, <http://www.healthcare.gov/news/factsheets/2010/09/appealing-health-plan-decisions.html> (last visited June 29, 2012) (noting that forty-four states provide external review programs).

53. See LIEBERMAN ET AL., *supra* note 48, at 2.

54. AHIP CTR. FOR RES. AND POL'Y, *supra* note 51, at 2.

55. *Id.* at 3.

56. The Patient Protection and Affordable Care Act ("PPACA"), Public Law 111-148, was enacted on March 23, 2010; the Healthcare and Education Reconciliation Act ("HCERA"), Public Law 111-152, was enacted on March 30, 2010. The PPACA and the HCERA "reorganize, amend, and add to the provisions of part A of title XXVII of the Public Health Service Act (PHS Act) relating to group health plans and health insurance issuers in the group and individual markets. The term 'group health plan' includes both insured and self-insured group health plans." Interim Final Rules, *supra* note 5, at 43,331 (codified at 29 C.F.R. § 2590).

consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners and is binding on such plans; or

(2) shall implement an effective external review process that meets minimum standards established by the Secretary through guidance and that is similar to the process described under paragraph (1)—

(A) if the applicable State has not established an external review process that meets the requirements of paragraph (1); or

(B) if the plan is a self-insured plan that is not subject to State insurance regulation (including a State law that establishes an external review process described in paragraph (1)).⁵⁷

The PPACA also amended ERISA to make clear that ERISA plans are also bound by the new external review requirement.⁵⁸

The new external review requirement is implemented through agency regulations.⁵⁹ The new regulations affect an estimated “72,000 large and 2.8 million small ERISA-covered group health plans with” about “97 million participants in large group plans.”⁶⁰ The regulations do not apply to “grandfathered” plans,⁶¹ which are those that

57. PPACA, Pub. L. No. 111-148, § 2719A(b), 124 Stat. 119, 888 (2010).

58. The amendment to ERISA states that “the provisions of part A of title XXVII of the Public Health Service Act [42 U.S.C. §§ 300gg et seq.] (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, as if included in this subpart; and (2) to the extent that any provision of this part conflicts with a provision of such part A with respect to group health plans, or health insurance issuers providing health insurance coverage in connection with group health plans, the provisions of such part A shall apply.” 29 U.S.C. § 1185d(a) (2012).

59. On July 23, 2010, EBSA and the Department of Health and Human Services (“HHS”) agencies jointly published their interim final rules with a request for public comment. The interim final regulations are published at 26 C.F.R. § 54.9815-2719T (IRS), 29 C.F.R. § 2590.715-2719 (EBSA), and 45 C.F.R. § 147.136 (HHS). Citations herein will be to the EBSA version of the regulations. The rules were effective September 21, 2010, applying to group health plans and group health insurance issuers for plan years beginning September 23, 2010. Interim Final Rules, *supra* note 5, at 43,330.

60. Interim Final Rules, *supra* note 5, at 43,339-40.

61. *Id.* at 43,332.

existed on March 23, 2010; such plans can retain this status provided they adhere to the specific regulatory requirements.⁶²

Under the new rules, plans are subject to either a state or federal external review process;⁶³ the final interim rule gives guidance as to which process applies.⁶⁴ Plans and issuers not presently subject to a state external review process are now subject to a federal process, beginning with plan years on or after September 23, 2010.⁶⁵

The new regulations' stated purpose is to increase the uniformity and consistency of external review, while promoting confidence in the claims processing system.⁶⁶ Increased uniformity is necessary due to the patchwork of laws that previously governed external review.⁶⁷ Under these inconsistent standards, participants' rights varied considerably because external review laws differed from state to state, and self-insured plans were not subject to state external review laws at all.⁶⁸ These differences had

62. 29 C.F.R. § 2590.715-1251(a)(1)(i), (a)(2)(i) (2011). Under the regulations, a plan maintains grandfathered status provided it has covered at least one person without interruption since March 23, 2010. *Id.* § 2590.715-1251(a)(1)(i). This is the case even if the other enrolled individuals leave the plan. *Id.* According to the regulations, a plan wishing to maintain its grandfathered status must fulfill other requirements. It (1) must include a statement with the materials given to participants or beneficiaries setting out the benefits provided under the plan in question, that the plan believes that it is a grandfathered plan and (2) must provide contact information for questions and complaints. *Id.* § 2590.715-1251(a)(2)(i).

63. See U.S. DEP'T OF LABOR, TECHNICAL RELEASE 2010-01, INTERIM PROCEDURES FOR FEDERAL EXTERNAL REVIEW RELATING TO INTERNAL CLAIMS AND APPEALS AND EXTERNAL REVIEW UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT 1, 1-2 (Aug. 23, 2010), <http://www.dol.gov/ebsa/pdf/ACATEchnicalRelease2010-01.pdf> [hereinafter TECHNICAL RELEASE 2010-01].

64. *Id.*

65. Interim Final Rules, *supra* note 5, at 43,332. The regulations' preamble explains that ERISA preemption prevents a State external review process from applying to self-insured plans, and that those plans are now subject to the Federal external review process. See *id.* at 43,331-32.

66. See Interim Final Rules, *supra* note 5, at 43,341.

67. See *id.* at 43,339.

68. See *id.*

several negative effects on plan participants: with regard to plans operating in more than one state, the differences increased plan administration costs and “created an appearance of unfairness . . . and may have led to confusion among consumers about their rights.”⁶⁹ The new rules are expected to create both efficiencies resulting from greater uniformity in standards and “broader social welfare gains, particularly for consumers.”⁷⁰

The new external review procedures are meant to increase the consistency between plan terms and the actual provision of benefits and result in the provision of benefits to participants that otherwise might have been incorrectly denied.⁷¹

The new rules were also designed to decrease significant secondary effects of incorrect denial of claims, namely that where claims are incorrectly denied, “substantial harm can be suffered by participants, beneficiaries, and enrollees, which can also lead to an associated loss of confidence in the fairness and benefits of the system.”⁷² These effects can even disrupt compensation negotiations because employees who perceive a risk of incorrect denial or claims mishandling may discount the value of healthcare coverage in compensation negotiations.⁷³

To satisfy the new rules, self-insured plans presently can select one of two avenues.⁷⁴ The plans can voluntarily comply with a state external review process if the process includes the consumer protections described in the Uniform Health Carrier External Review Model Act issued by the National Association of Insurance Commissioners (known as the NAIC Uniform Model Act).⁷⁵

69. *Id.*

70. *Id.* at 43,341.

71. *Id.*

72. *See id.*

73. *Id.*

74. TECHNICAL RELEASE 2010-01, *supra* note 63, at 2-3.

75. The protections are set out in paragraph (c)(2) of the July 2010 regulations and include the following, according to a summary provided in the U.S. Department of Labor’s Technical Release 2011-02:

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1. The process must provide for external review of adverse benefit determinations (and final internal adverse benefit determinations) based on medical necessity, appropriateness, healthcare setting, level of care, or effectiveness of a covered benefit.
 2. Issuers (or plans) must be required to provide effective written notice to claimants of their rights to external review.
 3. If exhaustion of internal appeals is required prior to external review, exhaustion must be unnecessary if – (a) the issuer (or plan) waives the exhaustion requirement; (b) the issuer (or plan) is considered to have exhausted the internal appeals process by failing to comply with the requirements of the internal appeals process except those failures that are based on de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant; or (c) the claimant simultaneously requests an expedited internal appeal and an expedited external review.
 4. The cost of an independent review organization (IRO) to conduct an external review must be borne by the issuer (or plan), although the process may require a nominal filing fee from the claimant requesting external review.
 5. There cannot be any restriction on the minimum dollar amount of a claim in order to be eligible for external review.
 6. The process must allow at least four months to file a request for external review after the receipt of the notice of adverse benefit determination or final internal adverse benefit determination.
 7. The IRO must be assigned by the State or an independent entity, on a random basis or another method of assignment that ensures the independence and impartiality of the assignment process (such as rotational assignment), and in no event assigned by the issuer, the plan, or the individual.
 8. The process must provide for the maintenance of a list of approved IROs (only those that are accredited by a nationally recognized private accrediting organization) qualified to conduct the external review based on the nature of the healthcare service that is the subject of the review.
 9. Approved IROs must have no conflicts of interest that will influence their independence.
 10. Claimants must be allowed to submit to the IRO additional information in writing that the IRO must consider when conducting the external review, and the claimant must be notified of the right to submit additional information to the IRO; the IRO must allow the claimant at least 5 business days to submit any additional information and any additional information submitted by the claimant must be forwarded to

Alternatively, self-funded plans can comply with the federal external review process.⁷⁶ This process has been shaped and clarified through a series of technical releases from the Department of Labor.⁷⁷ As the rules have been

the issuer (or plan) within one business day of receipt by the IRO.

11. The IRO decision must be binding on the claimant, as well as the plan or issuer (except to the extent that other remedies are available under State or Federal law).

12. For standard external review, the IRO must provide written notice to the issuer (or plan) and the claimant of its decision to uphold or reverse the adverse benefit determination within no more than 45 days after the receipt of the request for external review.

13. The process must provide for an expedited external review in certain circumstances and, in such cases, provide notice of the decision as expeditiously as possible, but not later than 72 hours after receipt of the request for external review (and if notice of the IRO's decision is not in writing, the IRO must provide written confirmation of its decision within 48 hours after the date of the notice of the decision).

14. Issuers (or plans) must provide a description of the external review process in or attached to the summary plan descriptions, policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to participants, beneficiaries, or enrollees, substantially similar to section 17 of the NAIC Uniform Model Act.

15. The IRO must maintain written records and make them available upon request to the State, substantially similar to section 15 of the NAIC Uniform Model Act.

16. The process must follow procedures for external reviews involving experimental or investigational treatment, substantially similar to section 10 of the NAIC Uniform Model Act.

U.S. DEPT OF LABOR, TECHNICAL RELEASE 2011-02, GUIDANCE ON EXTERNAL REVIEW FOR GROUP HEALTH PLANS AND HEALTH INSURANCE ISSUERS OFFERING GROUP AND INDIVIDUAL HEALTH COVERAGE, AND GUIDANCE FOR STATES ON STATE EXTERNAL REVIEW PROCESSES 1, 2-4 (June 22, 2011), <http://www.dol.gov/ebsa/pdf/tr11-02.pdf> [hereinafter TECHNICAL RELEASE 2011-02].

76. See TECHNICAL RELEASE 2010-01, *supra* note 63, at 2.

77. Center for Consumer Info. & Ins. Oversight, *Regulations and Guidance*, CMS.GOV, <http://cciio.cms.gov/resources/regulations/index.html> (last visited Oct. 4, 2012).

developed and technical releases have been issued, various stakeholders have weighed in on the new rules through the government's public comment periods.⁷⁸

Stakeholder comments have resulted in clarification of the rules in some areas and relaxation of the rules in others.⁷⁹ In particular, the first in this series of rules and technical releases sets out the procedures to be followed for the participant and payor involved in external review, the applicable deadlines, the documents that should be part of the external review, and the accreditation requirement for IROs participating in the process.⁸⁰ The DOL's August 23, 2010 release sets out specifics of an interim safe harbor within the regulatory framework: if followed, the safe harbor's guidelines provide protection against enforcement actions or other adverse actions by the DOL or Internal Revenue Service.⁸¹ Furthermore, the release contains a provision intended to promote the independence of contracting IROs by requiring that plans contract with at least three separate IROs.⁸² The release sets out the standard of review IROs should apply on external review, stating that an IRO should not treat the internal denials with any deference but should address each decision *de novo*.⁸³ The release also sets out the information that IROs must consider in rendering a decision.⁸⁴

As discussed above, the new rules continue to be shaped and refined through an ongoing series of technical releases

78. See Emp. Benefits Sec. Admin., *Internal Claims and External Review Processes*, U.S. DEP'T OF LABOR, <http://www.dol.gov/ebsa/regs/cmt-1210-AB45.html> (last visited June 30, 2012) (listing the public comments to the Department of Labor concerning the Internal and External Review processes).

79. See, e.g., TECHNICAL RELEASE 2010-01, *supra* note 63, at 4 (requiring plans to contract with at least three external reviewers and to rotate among them); TECHNICAL RELEASE 2011-02, *supra* note 75, at 8 (noting that in response to stakeholder comments, the Department relaxed the rule requiring payors to contract with three external reviewers).

80. TECHNICAL RELEASE 2010-01, *supra* note 63, at 3-7.

81. *Id.* at 2.

82. *Id.* at 4.

83. *Id.* at 5.

84. See *id.*

and public comments. These technical releases and debates reflect the strong voice of the healthcare industry—refinements of the rules have tended to favor the industry far more than the consumer. Thus, even these modest rule changes have been eroded in favor of a more industry-friendly version of the rules.

B. *Robust and Fair External Review is Particularly Important to Participants in ERISA Plans*

To any plan participant, external review is important. With regard to ERISA plans in particular, however, the lack of judicial remedies available to participants in these plans makes meaningful external review crucial.

Participants in ERISA plans have fewer rights after external review than participants in non-ERISA plans. As an initial matter, preemption of state-law claims and the lack of other remedies make external review a last viable option for participants.

ERISA preempts state laws that “relate to” ERISA plans,⁸⁵ as well as causes of action that duplicate or supplant a claim under ERISA.⁸⁶ ERISA thus subtracts most state-law claims and remedies. Courts struggle with what, if anything, ERISA provides in their place. In practice, ERISA preemption therefore takes away state-law claims but gives no replacement claim.⁸⁷ Even as it provided this broad preemptive power, Congress expected a federal common law to develop in the federal courts.⁸⁸ Such a common law has yet to develop.

85. See 29 U.S.C. § 1144 (2006).

86. See *id.* § 1132.

87. See *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1338 (5th Cir. 1992) (noting that “[t]he result ERISA compels us to reach means that the Corcorans have no remedy, state or federal, for what may have been a serious mistake.”).

88. Principal sponsor Senator Javits stated upon presenting the Conference Report to the full Senate that “[i]t is also intended that a body of Federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans.” 120 CONG. REC. 29,942 (1974); see also *Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 156

ERISA's remedies are limited,⁸⁹ heightening the need for payors to determine initial claims and appeals accurately and provide meaningful relief on external review. To enforce ERISA's provisions, a claimant must turn to the six provisions found in section 1132(a) of the statute; these are the sole avenues to seek relief in an ERISA-governed plan.⁹⁰ The enforcement provisions are particularly important because ERISA supplants all other state-law claims and remedies.⁹¹ A wronged participant cannot sue immediately in federal court under ERISA section 1132(a)(1)(B), but must first exhaust administrative remedies within the plan.⁹² After exhausting these administrative remedies, the participant is then eligible to file an ERISA lawsuit in federal court.⁹³ Under the basic claim for benefits, a participant brings a cause of action under ERISA section 1131(a)(1) for "benefits due," meaning the value of the benefit.⁹⁴ ERISA contains an attorney's fee

(1985) (Brennan, J., concurring) (discussing Congress's intention that the courts would develop a federal common law of ERISA).

89. *See, e.g.,* DiFelice v. Aetna U.S. Healthcare, 346 F.3d 442, 453 (3d Cir. 2003) (Becker, J., concurring) (noting that "virtually all state law remedies are preempted [by ERISA] but very few federal substitutes are provided.").

90. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 208-09 (2004) (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987)).

91. *See* *Pilot Life Ins. Co.*, 481 U.S. at 54 (noting that "[t]he deliberate care with which ERISA's civil enforcement remedies were drafted and the balancing of policies embodied in its choice of remedies argue strongly for the conclusion that ERISA's civil enforcement remedies were intended to be exclusive."). The exchange of remedies is known as the "ERISA bargain": "Plaintiffs and employees similarly situated receive the many protections of ERISA in exchange for certain rights to sue under previous federal and state law. Congress has decided that they are better off for the bargain. Whatever injustices this scheme may tolerate in isolated instances are more than compensated by the general security provided to pension rights under ERISA—plaintiffs themselves are now enjoying the fruits of rights which Caterpillar could not and cannot divest. If workers deserve further protection, it will be up to Congress to provide it." *Williams v. Caterpillar, Inc.*, 720 F. Supp. 148, 152 (N.D. Cal. 1989), *aff'd*, 944 F.2d 658 (9th Cir. 1991).

92. *LaRue v. DeWolff, Boberg & Assocs.*, 552 U.S. 248, 259 (2008).

93. *Id.*

94. 29 U.S.C. § 1132(a)(1)(B).

provision permitting the award of attorney's fees to either party, within the court's discretion.⁹⁵

Equitable relief is available under ERISA, but only under certain circumstances.⁹⁶ If the participant wins the lawsuit, the participant is generally awarded the value of the benefit and nothing more.⁹⁷ Current case law does not contemplate extracontractual damages for consequential harms, even when the result is that the plan participant is not made whole.⁹⁸ The participant might also receive attorney's fees at the court's discretion.⁹⁹

Thus, even when a claim is improperly and repeatedly denied, a participant who sues in federal court and wins still only receives the value of the benefit. The payor's improper and repeated denials are not separately punished at all. Because ERISA provides so few additional remedies, the rules should incentivize accurate claims processing and robust external review.

2. *The PPACA's new medical loss ratio rules apply differently to ERISA plans.* The PPACA's new medical loss ratio requirements apply differently to ERISA plans, such that ERISA plans and employers need not necessarily rebate excess premium dollars to participants as they otherwise would.¹⁰⁰ The PPACA's medical loss ratio requirements are intended to ensure that payors expend a certain percentage of premium dollars on healthcare.¹⁰¹ The rules were enacted in response to the growing percentages of premium dollars that some issuers spend on

95. *Id.* § 1132(g)(1).

96. *See id.* § 1132(a)(3)(B).

97. *See, e.g.,* *Mass. Mut. Life Ins. v. Russell*, 473 U.S. 134, 148 (1985) (allowing no extracontractual damages for claims processing delays).

98. *See, e.g.,* *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 255 (1993); *Aetna Health Inc. v. Davila*, 542 U.S. 200, 222 (2004) (noting that “[a] series of the Court's decisions has yielded a host of situations in which persons adversely affected by ERISA-proscribed wrongdoing cannot gain make-whole relief.”).

99. 29 U.S.C. § 1132(g)(1).

100. *See infra* notes 107-08 and accompanying text.

101. *See* U.S. Dep't of Health & Human Servs., *Medical Loss Ratio: Getting Your Money's Worth on Health Insurance*, HEALTHCARE.GOV (Nov. 22, 2010), www.healthcare.gov/news/factsheets/2010/11/medical-loss-ratio.html.

administrative costs, such as advertising, executive salaries and bonuses, underwriting, and marketing.¹⁰²

The PPACA requires that a minimum percentage of premium dollars be spent on healthcare, specifically “clinical services provided to enrollees” and “activities that improve healthcare quality.”¹⁰³ After January 1, 2011, health insurance issuers offering group or individual coverage must spend at least 85% of premium dollars on healthcare if the issuer is in the large group market or 80% if the issuer is in the small group market.¹⁰⁴ If the insurer spends less than these percentages on healthcare, then it must rebate to enrollees the amount by which the spending on nonhealthcare items exceeds the prescribed amounts.¹⁰⁵ The excess monies would be returned directly to enrollees.¹⁰⁶

The application of this rule to ERISA-governed plans is, however, less clear. The fate of excess premium dollars depends on the policyholder of the plan.¹⁰⁷ If the plan or its trust is the policy holder, then the determination depends on the specific language of the plan or policy.¹⁰⁸ Absent any plan language stating that the employer would have an interest in rebate monies, the monies would be plan assets subject to ERISA’s fiduciary laws.¹⁰⁹ If, on the other hand, the employer is the policyholder, then the employer may retain the monies itself.¹¹⁰ The DOL explains that the employer might not be able simply to retain the monies, and that decisions as to the monies’ use should depend on “the

102. *Id.*

103. *See* Patient Protection and Affordable Care Act §2718(a)-(b), 124 Stat. at 885-87.

104. *Id.* at 886.

105. *Id.*

106. *Id.*

107. *See* U.S. DEP’T OF LABOR TECHNICAL RELEASE 2011-04, GUIDANCE ON REBATES FOR GROUP HEALTH PLANS PAID PURSUANT TO THE MEDICAL LOSS RATIO REQUIREMENTS OF THE PUBLIC HEALTH SERVICE ACT 1, 1 (Dec. 2, 2011), <http://www.dol.gov/ebsa/pdf/tr11-04.pdf> [hereinafter TECHNICAL RELEASE 2011-04].

108. *See id.* at 2.

109. *Id.*

110. *Id.*

terms of the governing plan documents and the parties' understandings and representations."¹¹¹

In short, while non-ERISA plans must spend a minimum amount of premium monies on healthcare and related activities or refund the monies to participants, ERISA plan monies can be retained by either the plan or the employer—depending on which is the policyholder—and not refunded to the enrollee. This means that non-ERISA plans should have less incentive to deny meritorious claims because excess premium monies will be returned to enrollees anyway; the same is not true of ERISA plans. If employers potentially stand to be enriched when premium dollars exceed monies spent on healthcare and related activities, then the need for proper claims processing and robust external review rules are even more pressing than for other plans.

3. *ERISA's administrative exhaustion requirement may apply to external review.* External review may well develop into another step in the administrative processes that must be exhausted before an ERISA plaintiff can file suit. Faced with a claim denial, participants in ERISA plans must exhaust administrative remedies before filing a lawsuit in federal court.¹¹² This requirement arises out of the statute, which calls for benefit plans to “afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.”¹¹³ This generally means appealing a claim once or twice within the health insurance company or third-party administrator's internal system.¹¹⁴ After exhausting these administrative remedies, the participant is then eligible to file an ERISA lawsuit in federal court.

Judicial decisions to date, however, conflict as to whether external review is a step in the administrative process that must, too, be exhausted before a participant

111. *Id.*

112. *Costantino v. TRW, Inc.*, 13 F.3d 969, 974 (6th Cir. 1994).

113. *Id.* (citing 29 U.S.C. § 1133(2) (2006)).

114. *See infra* note 148 and accompanying text.

can file suit. Courts look first to the plan terms to determine whether the plan itself states that external review is a mandatory step in the plan's administration exhaustion requirements.¹¹⁵ In *Goldman v. BCBSM Foundation*, for example, a plan's external review component was not a required step in the administrative exhaustion process, where the denial letter based on the plan terms described external review as optional rather than mandatory.¹¹⁶ The court explained that external review was presented as an option, "not a mandatory requirement[] of administrative review."¹¹⁷ The court saw nothing in the new federal healthcare law as presented by BCBSM that made external review a necessary prerequisite to the filing of a federal claim.¹¹⁸ Other courts have examined the same or similar language and reached the same conclusion.¹¹⁹

Other courts examine similar language, however, and reach the opposite conclusion. In *Casatelli v. Horizon Blue Cross Blue Shield of New Jersey*, the court examined the particular plan language and found that the plan participant was required to have the claim reviewed externally before filing a claim in federal court.¹²⁰ Although the plan language used terms such as "may" and "can" with

115. See, e.g., *Goldman v. BCBSM Found.*, 841 F. Supp. 2d 1021, 1026 (E.D. Mich. 2012) ("First, the November 23 and November 28, 2011 letters do not state, as BCBSM contends, that review by the Commissioner is mandatory.").

116. *Id.* at 1025-26 ("This is our final determination regarding your grievance. If you, as Mr. Goldman's authorized representative, disagree with our decision, you have the right to request an external review by the Michigan Commissioner of Financial and Insurance Regulation. If you choose to do so, follow the instructions indicated on the enclosed Healthcare-Request for External Review form.").

117. *Id.* at 1026.

118. *Id.*

119. See, e.g., *Potter v. Blue Cross Blue Shield of Mich.*, No. 10-cv-14981, 2011 U.S. Dist. LEXIS 92076, at *7 (E.D. Mich. July 14, 2011) (holding that "[e]xhaustion requires only that claimants complete BCBS's two-level *internal* review procedure. An *external* appeal to the [Commissioner] is voluntary, and claimants may forego such review and instead file an action in federal court.") (emphasis in original).

120. No. 2:09-cv-6101, 2010 U.S. Dist. LEXIS 95928, at *17 (D.N.J. Sept. 13, 2010).

regard to the participant's potential pursuit of external review, the court held that this meant only that the participant could opt not to pursue the matter further at all, not that external review was an optional step in the participant's exhaustion of administrative remedies.¹²¹ Any other interpretation, the court concluded, "would be contrary to the public policy behind the exhaustion requirement."¹²²

Participants may avoid the exhaustion requirement with a "clear and positive" showing that further appeal would be futile.¹²³ This may include evidence, for example, that a plan administrator consistently cited particular plan language to deny every claim of a particular type, to which participants should have been entitled.¹²⁴ Such a showing is difficult to make without specific evidence, which a participant is generally unable to obtain.¹²⁵

Thus, because ERISA plan participants have different—and fewer—rights and remedies than participants in other plans, external review represents a last chance for the claim to be reviewed under a *de novo* standard of review, by a person with appropriate expertise, and without litigation. But as explained below, the pressures on participants make external review effectively unavailable to all but the most sophisticated and stalwart participants. While a payor can simply deny a claim, the participant shoulders the burden of following every denied claim through multiple layers of review and trying to prove the treatment's inclusion within plan terms. And even when participants do submit their claims to external review, serious doubts remain about its independence and effectiveness.

121. *Id.* at *16.

122. *Id.* at **16-17.

123. *Id.* at *18 (quoting *Harrow v. Prudential Ins. Co.*, 279 F.3d 244, 249 (3d Cir. 2002)).

124. *See, e.g., Berger v. Edgewater Steel Co.*, 911 F.2d 911, 917 (3d Cir. 1990) (holding that claimant had exhausted administrative remedies where plan administrator uniformly denied a particular kind of benefit).

125. *See Casatelli*, 2010 U.S. Dist. LEXIS 95928, at *21 (concluding that participant had not shown futility and noting that "there is no 'testimony' of a plan administrator that any administrative appeal would be futile").

II. THE HIGH PARTICIPANT DROPOUT RATE AT EACH LEVEL OF APPEAL MEANS EXTERNAL REVIEW IS RARELY REACHED

About half of all claim denials that are appealed externally are reversed on external review.¹²⁶ But due to structural and informational barriers, the vast majority of denied healthcare claims are not appealed even once.¹²⁷ Thus, a payor denying a claim can be confident that in all likelihood, the denial decision will never be questioned. As explained below, this high dropout rate creates an incentive for payors' decision making to be less careful and informed than it would be if external review were modified so that payors too had a financial interest in making the correct decision.

A. *Participants Drop Out in Droves at Each Successive Level of Appeal Due to Structural and Informational Barriers*

National data is not collected on the number of external reviews undertaken.¹²⁸ But the volume of external appeals is low—consumers simply do not access the process.¹²⁹ This high dropout rate, of course, favors payors; each time a participant decides not to appeal a meritorious but denied claim and drops out of the appeal process, the payor need not pay that claim, instead recognizing pure profit.¹³⁰

Statistics collected by state insurance departments show that when faced with multiple levels of appeal,

126. KAREN POLLITZ, JEFF CROWLEY, KEVIN LUCIA & ELIZA BANGIT, KAISER FAMILY FOUND., ASSESSING STATE EXTERNAL REVIEW PROGRAMS AND THE EFFECTS OF PENDING FEDERAL PATIENTS' RIGHTS LEGISLATION, at v (May 2002), <http://www.kff.org/insurance/externalreviewpart2rev.pdf>.

127. *See id.* at 5.

128. Nan D. Hunter, *Managed Process, Due Care: Structures of Accountability in Healthcare*, 6 YALE J. HEALTH POL'Y, L. & ETHICS 93, 138 (2006).

129. *See* POLLITZ, CROWLEY, LUCIA & BANGIT, *supra* note 126, at 5-7 ("Taken together, these findings suggest that the internal appeals process is too lengthy and difficult for most consumers to complete, and may result in the very low use of external review observed in every state.").

130. *See* Olena Berg, *supra* note 1, at 6.

consumers drop out of the appeal process in significant numbers, at each successive level.¹³¹ By the time consumers conclude the internal levels of appeal and are eligible for external review, their numbers are thin indeed, numbering in the dozens to hundreds in every state.¹³² This is a paltry number in comparison to the millions covered by healthcare plans.¹³³ State officials worry that consumers become discouraged with the extensive layers of appeal and simply give up before an external appeal is ripe.¹³⁴

One study prepared for the Kaiser Family Foundation concluded that “[o]ne notable feature of all external review programs is the low volume of cases, either in absolute numbers, or relative to the number of covered consumers, or both.”¹³⁵ Industry analysts agree: America’s Health Insurance Plans estimated in a 2006 report that the aggregate rate of external appeals was approximately “one appeal per 12,000 eligible individuals.”¹³⁶ This rate was “slightly higher” than that of one per 14,000 eligible consumers that the American Association of Health Plans calculated in 1999 and 2000.¹³⁷ In New York, for example, only 902 consumers filed for external review in the reporting year ending in June 2000, although 8.4 million consumers are covered by the external review law in that state.¹³⁸ The NAIC president and the U.S. General

131. See POLLITZ, CROWLEY, LUCIA & BANGIT, *supra* note 126, at 5 (noting that “[a]t each stage of the process, a substantial proportion of consumers do not challenge adverse decisions by their health plans”; the same study gives the example of consumers in Pennsylvania, where “from January 1999 through September 2000, consumers appealed almost 8,200 health plan denials,” 4,469 of which were upheld; of these 4,469, only 1,062 pursued the second level of appeal. Of those 1,062, 618 were upheld, but only 124 of the persistently denied claims were pursued to external appeal level).

132. *Id.*

133. See, e.g., *id.* at v-vi (providing the small number of claims for each state, including the disparity between the number of people insured and external appeals).

134. *Id.* at 5.

135. See POLLITZ, DALLEK, & TOPAY, *supra* note 22, at 17.

136. AHIP CENTER FOR RES. AND POL’Y, *supra* note 51, at 1.

137. *Id.*

138. POLLITZ, CROWLEY, LUCIA & BANGIT, *supra* note 126, at v, vii.

Accountability Office agree that appeals processes are under used.¹³⁹

Plan participants' inaction applies not just to external appeals, but to any questioning at all of denied claims. Faced with adverse claim experiences, participants tend to remain completely passive, not approaching their health plans even informally or taking any other steps.¹⁴⁰ Very few consumers appeal their denied claims, even at the initial, internal levels of appeal.¹⁴¹

The reasons for this lack of participation are not clear-cut, but likely result from the many pressures including the following that people with serious illnesses face:

1. *The participant may suffer from illness, intimidation, and lack of familiarity with the healthcare appeals system.* The average explanation of benefits ("EOB") document that sets out a claim and the payor's decision, is full of numbers, codes, and acronyms—the language is dense, if not

139. See John K. Iglehart, *Interview: State Regulation of Managed Care: NAIC President Josephine Musser*, HEALTH AFF., Nov.-Dec. 1997, at 37; cf. U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-98-119, HMO COMPLAINT AND APPEALS: MOST KEY PROCEDURES IN PLACE, BUT OTHERS VALUED BY CONSUMERS LARGELY ABSENT 26 (1998) (finding that many consumers "may not know of their right to appeal or may not understand how to exercise that right").

140. See, e.g., Press Release, Kaiser Family Found., *New Survey Offers Insight into Experiences of Managed Care Consumers* (Nov. 19, 1997), available at <http://www.kff.org/insurance/1344-sierra.cfm?RenderForPrint=1>. A study of consumers in Sacramento, California found that when consumers experienced a problem with their health plan, fewer than one half of them contacted the health plan at all. *Id.* The consumers who took no steps in response to an adverse experience stated that they did not think they would receive a result from contacting the plan (26%), it was not worth the time to contact the plan (24%), or they did not know what to do (14%). *Id.*

141. *Between You and Your Doctor: The Private Health Insurance Bureaucracy: Hearing Before the Subcomm. on Domestic Policy*, 111th Cong. 46 (2009) (statement of Patricia Farrell, Senior Vice President, Aetna Inc.) ("In 2008 only a small percentage of claims generated an appeal or a complaint."); Advocacy for Patients with Chronic Illness, Inc., *How to File Insurance Appeals*, http://www.advocacyforpatients.org/hi_file.html (last visited Aug. 18, 2012) (stating that 94% of denials are never appealed); see, e.g., Caroline E. Mayer, *The Claim Game: Here's How to Fight Back When Your Insurance Company Denies a Claim*, AARP THE MAG., Nov. 2009, at 30 (citing Connecticut's healthcare advocate Kevin Lembo as stating that 96% of denials are not appealed).

impenetrable.¹⁴² The following are examples of codes that appear on actual Explanation of Benefit Documents:

- 608 Negotiated Payment Is Less Than Inpatient And Submitted Charges—No FEP Payment—Member And PPO Facilities;
- 083 Non-Covered Services For Shift Differentials Services Incurred On Or After January 1, 2010.¹⁴³

It is not clear how a plan participant is supposed to decipher these terms. The recipient of this document may be severely ill, may receive several EOBs in the same envelope, and may have little time or energy to delve into the intricacies of three levels of internal and external appeals challenging these reason codes.¹⁴⁴ Those who lack education or sophistication may not even realize that they should appeal.¹⁴⁵ They may not have the ability and the resources to see an appeal through to the end.¹⁴⁶

And, when the plan participant and plan personnel square off to debate the plan terms and how they apply to any individual situation, the knowledge gap between participant and plan personnel is wide: as a representative of the American Association of Retired People (“AARP”) wrote, “the plan or the issuer holds all the cards. They are knowledgeable about all of the plan’s provisions as well as the claims and appeals process; in contrast, most individuals do not regularly deal with the claims process.”¹⁴⁷

142. See, e.g., *Federal Employee Program (FEP) Explanation of Benefit (EOB) Message Codes*, PREMERA BLUE CROSS, <https://www.premera.com/stellent/groups/public/documents/xcpproject/018137.xls> [hereinafter *EOB Codes*] (last visited June 22, 2012); *How to Read an Explanation of Benefits*, PREMERA BLUE CROSS, <https://www.premera.com/stellent/groups/public/documents/pdfs/016548.pdf> [hereinafter *How to Read an EOB*] (last visited Sept. 15, 2012).

143. *EOB Codes*, *supra* note 142.

144. See Marc A. Rodwin, *Managed Care and Consumer Protection: What Are the Issues?*, 26 SETON HALL L. REV. 1007, 1047 (1996).

145. One commentator observes those “who are ill, poor, or who lack education” may not realize that they need to appeal. *Id.*

146. *Id.*

147. David Certner, AARP, comment on the *Amendment to Interim Final Rule—Internal Claims and Appeals and External Review Processes*, U.S. DEPT OF LABOR (July 25, 2011), <http://www.dol.gov/ebsa/pdf/76-2719-IFR.pdf>.

As an analysis of external review processes prepared for the Kaiser Family Foundation notes, “[i]n assessing any external review program, it helps to consider the kinds of consumers who might need to appeal a claims denial—including, for example, patients undergoing chemotherapy, extensive surgery, or severe mental illness, or terminally ill patients seeking experimental therapies.”¹⁴⁸ Obstacles that may be overcome by people in good health may overwhelm people who are ill.¹⁴⁹ Thus, the very illness that results in the claims in the first place can also prevent a person from handling those claims.

2. *The participant may well be facing numerous claims.* One reason participants may not appeal denied claims is the sheer number of claims resulting from a given illness. That is, a single illness or visit to a hospital frequently results in multiple claims because each provider generally bills independently.¹⁵⁰ A single illness or surgery may result in multiple visits with multiple providers, quickly multiplying the number of claims involved.¹⁵¹ Thus, although external review may well be worthwhile for consumers seeking expensive treatment, such as an organ transplant, consumers with adverse decisions on multiple claims from various providers, such as lab treatments or routine tests, may well decide not to spend time on multiple levels of appeal.

3. *The complexity of the appeals discourages participants and rewards payors.* When consumers who did not take

148. DALLEK & POLLITZ, *supra* note 50, at 4.

149. *Id.*

150. See, e.g., *About Your Hospital Bill*, INDIAN RIVER MED. CTR., <http://www.irmc.cc/gui/content.asp?w=pages&r=203&pid=216> (last visited Aug. 18, 2012) (“Why am I getting so many bills from different providers? During your hospital visit, other professionals were involved with your care and they have their own billing office. These other professionals may include, but are not limited to, emergency physicians, radiologists, pathologists, cardiologists, anesthesiologists, ambulance services, etc. These providers bill separately, and in most cases, the hospital Patient Financial Services Department is not able to assist you with these claims. You are better served by contacting their billing offices directly at the phone numbers provided on their bill to you.”).

151. See *id.* (“During your hospital visit, other professionals were involved with your care and they have their own billing office.”).

action against adverse experiences with their payors were asked why they did not do so, 24% responded that it simply was not worth their time to contact the plan at all.¹⁵² Plan participants tend not to appeal their claims unless the stakes are high.¹⁵³ Issues most commonly addressed on external appeal include inpatient hospital admissions, mental health services, and prescription drug coverage.¹⁵⁴ Thus, consumers appear to believe that the review process is best avoided unless the financial stakes are high.

When plan participants opt to appeal only the most significant claims, however, significant sums of money for the denial of routine claims are likely left in payors' hands. A large proportion of claims submitted to payors are for modest sums of money—in fact, the Centers for Medicaid and Medicare Services (“CMS”) reports that of nineteen common procedures performed in a physician's office, eventual payments by CMS are less than \$200, some significantly so.¹⁵⁵ If plan participants are abandoning the idea of fighting denial of these claims due to the complexity and time-consuming nature of the appeals process, then the process' complexity is itself resulting in pure profit to payors.

152. Kaiser Family Found., *supra* note 140 (noting that the consumers who took no steps in response to an adverse experience stated that they did not think they would receive a result from contacting the plan (26%), it was not worth the time to contact the plan (24%), or they did not know what to do (14%)).

153. See, e.g., Kenneth H. Chuang et al., *Independent Medical Review of Health Plan Coverage Denials: Early Trends*, HEALTH AFF., Nov.-Dec. 2004 at 163, 165 (“Among 1,400 cases submitted in California, the most common areas for dispute were cancer care, endocrine/metabolic care (especially for obesity), orthopedic care, and neurological disorders. Surgery and pharmacy services constituted 52% of cases.”).

154. AHIP CENTER FOR RES. AND POL'Y, *supra* note 43, at 4.

155. *Physician Payments: 19 Other Commonly Performed Services Provided in an Office Setting, CY 2011 Data*, Related link from *Physician CMS Updates Physician Payment Information for Value-Driven Healthcare (9-6-12)*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Sept. 6, 2012), <http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareConinit/Physician.html> (follow “Physician Payments: 19 Other Commonly performed Services Provided in an Office Setting, CY 2011 data” hyperlink).

4. *The participant must complete a two-level internal review process.* Those consumers who opt to question a denial face a formidable journey—indeed, some analysts conclude that the appeals process is simply too complex and arduous for the vast majority of participants to complete.¹⁵⁶ Before pursuing external review of their denied healthcare claims, consumers must first exhaust internal levels of appeal,¹⁵⁷ usually two.¹⁵⁸ Completion of these two levels alone requires focus and determination.¹⁵⁹ Analysts suggest that even after persisting through two levels of review, plan participants become discouraged—participants do not want to expend more time, trouble, and money, only to be denied yet again.¹⁶⁰ The steps of the appeals process can prove “exhausting and ultimately discouraging.”¹⁶¹

Many consumers also drop out of the appeal process because they are too ill to undertake the process.¹⁶² Insurance industry representatives, however, interpret the low numbers of appeals as evidence that disputes are resolved internally.¹⁶³

156. POLLITZ, CROWLEY, LUCIA & BANGIT, *supra* note 126, at 7 (“Taken together, these findings suggest that the internal appeals process is too lengthy and difficult for most consumers to complete, and may result in the very low use of external review observed in every state.”).

157. POLLITZ, DALLEK, & TOPAY, *supra* note 22, at 19 (noting that only the State of Missouri explicitly excludes the requirement that consumers exhaust a plan’s internal appeals before pursuing external appeal).

158. POLLITZ, CROWLEY, LUCIA & BANGIT, *supra* note 126, at 5.

159. See Laura B. Benko, *Upon Further Review: External Review of Medical Claim Denials is Law of the Land Nearly Nationwide. But the System Has its Friends and Foes*, MODERN HEALTHCARE, Feb. 7, 2005, at 28, 29 (explaining that plan participants must be very “tenacious and focused” in order to face another level of appeal).

160. See *id.* at 29.

161. *Id.*

162. POLLITZ, DALLEK, & TOPAY, *supra* note 22, at 18 (noting that “state regulators cited two other key reasons that may explain the apparently low volume of external review cases. First, consumers may not be aware they have the right to external review of adverse health plan decisions. Second, when consumers are ill, disabled, or in pain, they may not be able to take action in response to a health plan denial.”).

163. *Id.* at 19.

These barriers to external review and the problem of attrition in the claims process have been well known for some time:

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.¹⁶⁴

As external review processes now stand, the playing field is tilted toward payors. The consumer seeking external review must persevere through multiple levels of appeal, despite illness.

5. *The participant must pay a fee.* In some cases, the consumer must also pay a filing fee to initiate external review proceedings.¹⁶⁵ If one is charged, the filing fee is usually a relatively small amount of money, such as \$25.¹⁶⁶ However, when a participant has multiple claims that may not add up to a significant amount of money, then the participant must choose between spending more money to appeal or simply leaving the denial in place. And, given that medical bills are a significant factor in many bankruptcy filings, even a \$25 fee may well be significant to many would-be appealing participants.¹⁶⁷

164. Olena Berg, *supra* note 1, at 12.

165. Benko, *supra* note 159, at 29; POLLITZ, DALLEK, & TOPAY, *supra* note 22, at 21.

166. Benko, *supra* note 159, at 29.

167. See, e.g., Himmelstein et al., *supra* note 4, at 743 ("Illness or medical bills contributed to 62.1% of all bankruptcies in 2007.")

Expanded external review is a poor substitute for more extensive reform of the ERISA claims process because participants so rarely reach this level of appeal. Given this high dropout rate, payors can be confident that incorrect denials will almost never be reversed.

B. Attrition in the Claims Process is High, but Success Rates are High for Those Who Persist

While external reviews are rare, success rates on external review are high when consumers do stay the course.

Estimates vary, but the American Association of Health Plans found that in 2003 and 2004, independent reviewers reversed the internal reviewer's decision about 40% of the time and affirmed the internal decision about 60% of the time.¹⁶⁸ The Kaiser Family Foundation estimates that denials among the fifty states are overturned on external appeal about half the time.¹⁶⁹ Other studies place the number of denials eventually overturned as high as 81%.¹⁷⁰ Rates of success on external appeal vary significantly from state to state.¹⁷¹ In Maryland, the Insurance Administration's 2009 review of medical necessity appeals indicates that consumers were successful about half the time (54%, or 228 of 417 cases), either because the health plan reversed itself during the investigation (214 cases), or the health plan's decision was reversed by the reviewers (14 cases).¹⁷² The health plan's decision was modified by the

168. AHIP CTR. FOR RES. AND POL'Y, *supra* note 51, at 1.

169. POLLITZ, CROWLEY, LUCIA & BANGIT, *supra* note 126, at Exhibit A.

170. Bonnie B. Blanchfield et al., *Saving Billions of Dollars—and Physicians' Time—by Streamlining Billing Practices*, 29 HEALTH AFF. 1248, 1252 (2010).

171. POLLITZ, CROWLEY, LUCIA & BANGIT, *supra* note 126, at 3 (explaining that the rate at which external reviewers overturned denials ranged from a low of 21% in Arizona and Minnesota, to a high of 72% in Connecticut and had an average of 45% across all fifty states).

172. BETH SAMMIS, MD. INS. ADMIN., 2009 REPORT ON THE HEALTHCARE APPEALS & GRIEVANCE LAW 26 (2010), <http://www.mdinsurance.state.md.us/sa/documents/A&G2009Report-July2010.pdf>.

reviewers in seven cases and the health plan's decision was upheld about half the time (192 cases).¹⁷³

In Maryland, consumers were more likely to win in some types of cases than others.¹⁷⁴ With regard to cosmetic procedures, consumers were less likely to win in certain types of cases.¹⁷⁵ And in five instances, the Maryland Insurance Administration imposed administrative penalties ranging from \$1000 to \$5000 for violations of the Maryland insurance article.¹⁷⁶ The violations generally consisted of failures to include the requisite information in notices or failure to meet required deadlines; the failure to render the correct decision in the first instance was not cause for penalty.¹⁷⁷ Thus, when consumers persist and complete their appeals, their efforts are rewarded.

The question of why external review reversal rates are so high is a troubling one—theories abound as to why the reversal rate is so high, but the high reversal rate perhaps suggests that the initial review is insufficiently complete, and that the initial reviewer may be insufficiently qualified. One further reason why the reversal rate on external review is so high is that, as an initial matter, a significant proportion of claims are simply incorrectly decided in the initial claims processing review—the American Medical Association estimates, for example, that 20% of claims are processed incorrectly.¹⁷⁸

173. *Id.*

174. *Id.* at 26-28.

175. *Id.* at 28.

176. *Id.* at 31-33.

177. *See id.*

178. *New AMA Health Insurer Report Card Finds Increasing Inaccuracy in Claims Payment*, AM. MED. ASS'N (June 20, 2011), <http://www.ama-assn.org/ama/pub/news/news/ama-health-insurer-report-card.page>; *see also* Press Release, Cal. Nurses Ass'n/Nat'l Nurses Org. Comm., California's Real Death Panels: Insurers Deny 21% of Claims (Sept. 2, 2009), *available at* <http://www.reuters.com/article/2009/09/02/idUS202570+02-Sep-2009+PRN20090902> (estimating the denial rate at 21% and quoting the organization's co-president Deborah Burger, R.N., as stating that “[t]he routine denial of care by private insurers is like the elephant in the room no one in the present national healthcare debate seems to want to talk about”).

The high rate of reversal upon external review may be because external review involves a more careful and complete review by a more qualified person.¹⁷⁹ Once incorrectly decided, the erroneous decision may be incorrectly upheld on appeal because internal reviewers are not held to a stringent standard of qualification, as external reviewers are.¹⁸⁰ The National Organization of Independent Review Organizations (“NAIRO”), for example, criticizes the use of “clinicians at the internal level that are not qualified to review the subject matter of the appeal.”¹⁸¹ And, conflicts of interest may also play a role in upholding denials: internal reviewers can be employees of the very entity that stands to pay the claim.¹⁸² In addition, payors have a strong incentive to reduce costs, and in doing so, they may deny treatment that should be covered.¹⁸³

Thus, there are numerous incentives and structural features of today’s health plans that could result in persistent, incorrect claim denials. Some commentators suggest that the high reversal rate indicates bias or an overemphasis on cost containment in the internal appeals process.¹⁸⁴

179. A claims processor often need only have a high school education, while an external reviewer is usually a physician board certified in the field at issue. *Compare Medical Claims Processor—Lincoln, Nebraska*, CAREERS.ORG, <http://jobs.careers.org/job/J3F3K979BNH0TGFJLS2/Medical-Claims-Processor--Lincoln-Nebraska> (requiring only a high school diploma or G.E.D.), with POLLITZ, CROWLEY, LUCIA & BANGIT, *supra* note 126, at 15 (noting that external reviewers are most often physicians who are board certified in the area at issue).

180. NAT’L ASS’N OF INDEP. REV. ORG., NAIRO COMMENTS ON INTERIM FINAL RULES (IFR) RELATED TO INTERNAL CLAIMS & APPEALS CONFLICT OF INTEREST SECTION 2719—PATIENT PROTECTION AND AFFORDABLE CARE ACT 5, http://nairo.org/_pdf/uploads/nairosection2719positionpaper.pdf [hereinafter NAIRO] (last visited Feb. 2, 2011).

181. *Id.* at 4 n.3.

182. *See id.* at 2-3.

183. *See Vernellia R. Randall, Managed Care, Utilization Review, and Financial Risk Shifting: Compensating Patients for Healthcare Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1, 28-29 (1993).

184. *See, e.g., Berger, supra* note 46, at 281-82 (noting that “it would seem that consumer advocates are correct with respect to at least one of the following lines of reasoning: either the MCO utilization review process is prone to the kinds of

NAIRO notes, for example, the lack of protections against conflicts of interest, even under the new Interim Final Rules.¹⁸⁵ While the Interim Final Rules forbid the direct linkage of compensation to the employee's rate of claim denials, the rules remain silent on the use of in-house employees to decide internal appeals, the accreditation of reviewers, and the illness-specific expertise of the internal reviewers.¹⁸⁶

Given the encouraging statistics regarding the end result, why do so many consumers either give up during the process or fail to initiate an appeal at all? The answer appears to be that a number of structural barriers and the consumers' own circumstances conspire to keep the external appeal rate low.

III. RAISING THE STAKES ON EXTERNAL REVIEW

With modest changes, external review could be more than the rarely-used and inaccessible device that it is today. External review could become a means of prompting more careful claim adjudication by payors, if payors and not just participants felt some of the effects of payors' inaccurate decision making. The new external review rules contain no incentive to decide claims correctly the first time—the claims processing rules as currently written place the externalities of incorrect decision making squarely on the participant.¹⁸⁷ As explained below, payors should be incentivized to make the correct decision in the first instance. And, with some further modifications to the rules, a greater number of participants could reach external review and recover the monies due to them.

medical or factual errors that IMR can effectively correct, or the utilization review judgments favor economization more than the judgments of the independent medical reviewers.”).

185. See NAIRO, *supra* note 180, at 2-5.

186. See TECHNICAL RELEASE 2011-02, *supra* note 75, at 2-4.

187. See *supra* Part II.A.

A. *The Real Cost of Incorrect Denials Now Falls on Participants, Not Payors*

As the external review rules now stand, participants, rather than payors, suffer all the external costs of payors' incorrect denials. That is, when a payor denies a meritorious claim, the participant bears the administrative burden of persisting through multiple layers of review, only to receive in the end the same dollar amount that the participant was originally due. The entire burden of the appeal process thus falls squarely on the participant, and the already-burdened participant often gives up.¹⁸⁸ This Article posits that if instead, payors had to internalize some or all of the real costs of payors' incorrect denials, payors would be incentivized to improve the accuracy of their decision-making when claims are initially submitted.

As explained above, estimates suggest that up to 20% of claims are processed incorrectly.¹⁸⁹ Yet at the same time, few participants persist in the appeals process, meaning that most erroneous denials stay in place.¹⁹⁰ Further indicating that many mistaken denials occur, a significant proportion of claim denials that are pursued to external review are in fact reversed on external review.¹⁹¹

The current system charges the consumer, who may well be battling severe illness at the time, with driving the appeal forward at each level. When payors deny meritorious claims, participants, not payors, suffer the costs associated with these incorrect decisions. The most immediate cost is the participant's loss of monies if a participant opts not to appeal the incorrect denial. In that situation, the participant simply opts to forgo any appeal, and the payor keeps the monies it would have had to pay if the correct decision had been made.

Given the lack of national statistics on claims processing accuracy, it is hard to know the amount of money

188. *See id.*

189. *See supra* Part II.B.

190. *See supra* Part II.A.

191. *See supra* Part II.B.

that participants leave on the table in the form of nonappealed, incorrect denials. But given the approximately 20% error rate in claims processing and the high reversal levels on appeal discussed above, participants are likely forgoing considerable sums of money. And, of course, a meritorious but denied claim represents the loss of benefits that were contracted for and that the participant was justly owed.

If a participant does decide to appeal, the participant, rather than the payor, still suffers the costs of having the decision reversed. That is, the appealing participant must expend time and effort to complete the arduous, multilevel appeal process that is required for the eventual reimbursement of each meritorious denied claim. An appealing participant must expend time and effort to gather support for a reversal, observe the proper deadlines, and keep track of claims and outcomes, all in addition to the participant's regular occupation and probable illness.

A further cost of payors' incorrect claim denials is that they affect access to care.¹⁹² If the denial is prospective, the participant knows before obtaining treatment that the treatment will not be covered.¹⁹³ In that situation, the participant can proceed with the treatment and appeal, while paying for the treatment without help from the plan or decide not to undergo treatment.¹⁹⁴ The high cost of many treatments, however, makes a self-pay approach impracticable for all but the wealthiest individuals. If the denial is retrospective, on the other hand, the participant seeks care and faces the risk of denial after the treatment has taken place.¹⁹⁵ The participant must then pay the cost of any denied care and would be discouraged from seeking future care of the same kind unless the participant were willing to pay for the care.

192. See Randall, *supra* note 183, at 38-40. "The patient's only chance of recovering the cost of that recommended treatment, if she can now even obtain it, is in a challenge to the third-party payer's decision." *Id.* at 40.

193. See *id.* at 40.

194. See *id.*

195. See *id.*

The payor, in contrast, suffers no immediate, negative result of an incorrect denial, simply because most participants accept a denial without question.¹⁹⁶ Payors are unlikely to lose customers in the short term over incorrect denials because most participants are locked into their plans for at least one year; and even during open enrollment periods, employees' choices of plan tend to be limited.¹⁹⁷ During negotiations with prospective employees, the prospective employees are unlikely to have detailed information about claims experience with the various health plans, such that prospective employees would adjust their negotiations.¹⁹⁸ It is unsurprising, then, that payors with higher denial rates do tend to profit more than others.¹⁹⁹

In a small minority of cases, a participant does appeal, and then the payor is, of course, required to review the claim.²⁰⁰ Unlike the participant, however, the payor is already familiar with the plan and need not expend time and energy becoming familiar with the appeals process. There are certain costs that the payor bears when a claim goes to external review, such as the fees paid to external reviewers and the cost of personnel to handle the administrative tasks involved in external appeal.²⁰¹

Thus, when payors decide a claim incorrectly, the entire burden is on the participant to either absorb the cost himself or herself or to complete multiple levels of appeal in order to obtain the contracted benefits. The external review rules should therefore be revised so that payors are discouraged from denying meritorious claims and affirming

196. See *supra* Part II.A.

197. See Rodwin, *supra* note 144, at 1048.

198. See John H. Langbein, *Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA*, 101 NW. U. L. REV. 1315, 1328 (2007).

199. See Jeffrey D. Greenberg et al., *Reimbursement Denial and Reversal by Health Plans at a University Hospital*, 117 AMER. J. MED. 629, 633 (2004) (finding a "strong positive correlation" between net profit margin and the adjusted odds that the plan would discount the cost of a day's stay in the hospital).

200. See *supra* Part II.A.

201. See POLLITZ, CROWLEY, LUCIA & BANGIT, *supra* note 126, at 12-13.

the denials up until the denials are reversed on external appeal.

B. *Payors Should Internalize the Real Costs of Incorrect Denials When Denials are Reversed on External Review*

The external review rules as currently written do not attempt to place the costs of an incorrect denial on the payor who made that incorrect decision—but this Article posits that they should. If undesirable corporate behavior, such as incorrect claim denials, is to be discouraged, policymakers should ensure that the potential penalties for such behavior take the potential external costs into account. That is, where undesirable corporate behavior—spilling oil, for example—imposes external costs, corporations should be penalized in order to avoid continuation and expansion of these behaviors.²⁰² This approach is known as “optimal penalty theory,” and its principles can be applied to the payor that denies meritorious claims, thereby imposing costs on society and benefitting its own position.²⁰³

According to optimal penalty theory, if actors are not forced to internalize the costs of their negative behaviors, then society is absorbing those costs, and the actors’ incentive is to increase those behaviors.²⁰⁴ Accordingly, penalties should be set at a level that “fully reflects the costs to society of a prohibited activity engaged in by an economic agent.”²⁰⁵ In this way, penalties can reflect the true costs of behaviors, resulting in efficiencies “in which the allocation of resources maximizes societal wealth.”²⁰⁶

202. See Michael K. Block, *Optimal Penalties, Criminal Law and the Control of Corporate Behavior*, 71 B.U. L. REV. 395, 401 (1991) (explaining that “[s]etting fines below the anticipated external costs of oil spills from transshipment of oil, adjusted for the fact that not all violations of law are detected, will induce firms to take too few precautions, and will thus create an excessively high risk of oil spills, exposing society to their attendant costs.”).

203. *Id.* at 397.

204. *See id.*

205. *Id.*

206. *Id.* at 398.

Optimal penalties are particularly important where the behavior is difficult to detect.²⁰⁷ This is the case with regard to the improper denial of meritorious claims—such denials are unlikely to be detected because most are never appealed.²⁰⁸

Optimal penalty theory—with enhanced penalties for the purpose of deterrence—has been adopted in the Commodity Exchange Act (the “Act”) and the precedent applying and interpreting the Act.²⁰⁹ Section 6(c) of the Act, for example, “authorizes monetary penalties of ‘triple the [respondent’s] monetary gain’ for each violation of the Act.”²¹⁰ As applied to the commodities arena, the optimal penalty approach results in a disgorgement of three times the defendant’s expected gains.²¹¹ The penalty is meant to ensure that the actor is not “indifferent” to the actions that are sought to be discouraged.²¹²

If a similar approach were applied to the processing of healthcare claims, it would result in disgorgement of three times the amount of the denied but meritorious claims.²¹³

207. *See id.* at 397 (noting that to be optimal, a penalty should take into account the difficulty of detecting it).

208. *See supra* Part II.A.

209. *See, e.g.*, In re Grossfeld, [1996-1998 Transfer Binder] Comm. Fut. L. Rep. (CCH) ¶ 26,921 (Dec. 10, 1996), *aff’d sub nom.* Grossfeld v. CFTC, 137 F.3d 1300 (11th Cir. 1998); In re R&W Technical Servs., Lt., CFTC No. 96-3, Comm. Fut. L. Rep. P 29556 2003 WL 21805280, at *1 n.1 (Aug. 6, 2003) (noting that “[t]he Commodity Exchange Act largely conforms to this economic approach as does Commission precedent.”).

210. In re R&W Technical Servs., 2003 WL 21805280, at *1 n.1, *6; *see also* 17 C.F.R. § 143.8 (2011) (noting “triple the monetary gain to such person for each such violation”).

211. *See* 17 C.F.R. § 143.8.

212. Emmett H. Miller III, *Federal Sentencing Guidelines for Organizational Defendants*, 46 VAND. L. REV. 197, 204 (1993). Therefore, the “total monetary sanction should be set such that the expected penalty cost outweighs the expected gain from the offense.” *Id.*

213. The denial of meritorious claims does in fact benefit the payor because the payor can expend those monies in other ways or in some cases, give excess monies to the employer, if the employer is the policy holder of the plan. If the plan or its trust is the policy holder, then the determination of the correct treatment of excess funds depends on the specific language of the plan or policy

But would it be fair to penalize healthcare plan payors for incorrect claim denials (as indicated by reversal on external appeal), when the denial might result from a legitimate difference of opinion over plan interpretation or differing views regarding efficacy of a particular therapy? As an initial matter, optimal penalty theory is not as concerned with the defendant's intent as with the effects of the conduct.²¹⁴ Optimal penalty theory is more concerned with maximizing the societal good.

But penalties can apply in other arenas in which entities miscalculate or misjudge the amounts they must pay.²¹⁵ With regard to underpayment of federal taxes, for example, the entity underpaying the taxes is subject to a range of penalties, depending on the circumstances and the presence or absence of a good faith basis for the entity's position.²¹⁶ A penalty can be zero, if the entity takes a good faith position supported by the regulations. Or, a penalty can be more severe if the underpaying entity miscalculates the amount due. The most severe penalties are reserved for those who take frivolous positions, ignore regulations, or actively defraud the government.²¹⁷

In both the example of the Commodity Exchange Act and that of the penalties for underpayment of federal taxes, penalties can be adjusted depending on the flagrancy of the underpayment. The same nuance is appropriate for denial of healthcare claims that are eventually overturned on

and ERISA's fiduciary laws. See TECHNICAL RELEASE 2011-04, *supra* note 107, at 2-3. If, on the other hand, the employer is the policyholder, then the employer may retain the monies itself. *Id.* at 2.

214. See Gary S. Becker, *Crime and Punishment: An Economic Approach*, 76 J. POL. ECON. 169, 194 (1968) (noting that "economists discussing externalities almost never mention motivation or intent"). In analyzing negative behavior such as crimes, optimal penalty theory assumes that "[s]ome persons become 'criminals,' therefore, not because their basic motivation differs from that of other persons, but because their benefits and costs differ." *Id.* at 176.

215. *Id.* at 170 ("The method used formulates a measure of the societal loss from offenses and finds those expenditures of resources and punishments that minimize this loss.").

216. See *id.*

217. See *id.*

external appeal—that is, the external reviewer could determine whether the payor’s denial was frivolous, or whether it represented a legitimate difference of opinion regarding the medical literature or the participant’s symptoms. For example, was the denial a breach of the payor’s own standards and guidelines that it should have in place to ensure equal treatment of similarly-situated claims?²¹⁸ Does the denial represent a departure from the payor’s previous pattern of payment of similar claims? Does the denial ignore a consensus of treating physicians and treatment notations in the participant’s file? These situations could be flagged as requiring a greater denial penalty because the denial represents a frivolous position that simply attempts to delay payment. If the denial is based, on the other hand, on medical and scientific research, and the payor’s position is a valid interpretation of that research, then a penalty would be less appropriate.

In this way, the payor has an incentive to follow its own guidelines and to reach the most accurate decisions that it can. If it does not, then it must internalize some or all of the costs associated with the denial of a meritorious claim.

C. *Measuring the External Cost of Improper Claim Denials*

Before the external costs of an incorrect denial can be imposed on payors, the costs must in some way be quantified. The costs comprise several components, none of which are easily measured. Similar costs are, however,

218. See U.S. DEP’T OF LABOR, *FAQs About the Benefit Claims Procedure Regulation*, *supra* note 29. The Department of Labor noted that:

The department believes that prudent plan administration requires ensuring that similarly situated claims are, under similar circumstances, decided in a consistent manner. Consistency in the benefit claims determinations might be ensured by applying protocols, guidelines, criteria, rate tables, fee schedules, etc. Consistent decision-making might be ensured and verified by periodic examinations, reviews, or audits of benefit claims to determine whether the appropriate protocols, guidelines, criteria, rate tables, fee schedules, etc. were applied in the claims determination process. See [29 C.F.R.] § 2560.503-1(b)(5).

Id.

regularly approximated for other purposes and can be similarly treated for the purpose of external review.

1. *Cost of administrative burden to participants.* As they progress through the arduous multilevel appeal process, plan participants expend time and energy. At present, this time and energy is not compensated—even if the multiple levels of appeal take place over months and require considerable work in requesting records, presenting evidence, and gathering appeal documents, the participant simply receives the same amount that was originally due.²¹⁹ The participant's time and energy expended on the appeal is difficult to quantify, however, because each person's approach to the appeals process is different, each person's time is monetized at different values, and claims vary in their complexity and in the effort required to appeal. Nevertheless, as explained below, administrative efforts such as these are regularly approximated for other purposes and may be calculated in a number of different ways for the purpose of external appeals.

One approach would be to use the federal government's proposed approach for monetizing the time that households spend on data collection for federal government purposes. When the collection of data is required, the federal government attempts to determine the burden of collecting the data, so it can determine whether the benefit of collecting the data outweighs the burden this collection imposes on society.²²⁰ That burden has, in the past, been expressed in terms of hours.²²¹

Recently, however, the government has proposed monetizing that burden, and the government has set out two possible methods for doing so in the case of hours spent by households in collecting data.²²² One proposal is to use

219. See *supra* notes 94 and 98 and accompanying text (noting that ERISA plaintiffs get a claim for benefits and nothing more in the vast majority of cases).

220. John T. Spotila, *Estimating Paperwork Burden*, OFFICE OF MGMT. & BUDGET (Oct. 4, 1999), http://www.whitehouse.gov/omb/fedreg_5cfr1320.

221. *Id.*

222. This calculation is simpler when performed for those who are employees of the entity gathering data, as the burden can be expressed according to a

the opportunity cost—that is, the cost of the next hour that the person would have spent at his or her employment.²²³ This could be calculated as the person’s average hourly wage or based on the person’s overtime wage, if the person is eligible for overtime.²²⁴

Another possible method of calculation is to determine the burden according to “revealed preference,” which is the amount that people actually pay to those who are employed to perform such work.²²⁵ In the realm of healthcare claims processing and appeals, an entire industry has sprung up to serve those who are unable to handle claims and appeals due to their own illness or family responsibilities.²²⁶ Where participants pay such a representative or expend an equivalent personal effort to have an improper denial reversed, the participant is effectively bearing the cost of the payor’s erroneous denial. According to optimal penalty theory, the entity imposing these costs on society—here, the payor—should bear those costs.²²⁷ Just as payors determine the average cost of a procedure for purposes of out-of-network payments, for example, so could the average cost to appeal a certain kind of claim be determined. This amount or some portion of it could be imposed as a penalty upon an external review reversal. Only if the payor must bear some cost of frivolous denials will payors have an incentive to decide claims more carefully than the high external review reversal rate suggests that they are.

2. *Cost of undiscovered incorrect denials.* As explained above, many improperly-denied claims are never appealed,

fraction of the person’s wages plus benefits. *See id.* This calculation is more difficult for household data collection because people are not normally compensated in dollars for their tasks performed in the household. *See id.*

223. *See id.*

224. *See id.*

225. *Id.*

226. There is a growing industry consisting of individuals who, for \$75 to \$120 per hour, will handle appeals and billing issues for individuals and families who are unable to handle those issues due to their own illness or other responsibilities. *See* Ellen E. Schultz, *Medical Paperwork Syndrome*, WALL ST. J., June 16, 2012, at B9.

227. *See supra* Part III.B.

so incorrect decisions in many cases remain undiscovered. Each undiscovered, incorrect decision represents pure profit to the plan or employer and pure loss to the participant who should have been reimbursed.²²⁸

Optimal penalty theory proposes that the undiscovered violations be accounted for by increasing the penalty by a multiplier.²²⁹ Thus, the penalty should equal the total loss divided by the likelihood that the violation would be discovered.²³⁰ In order to internalize fully the effects of undiscovered, incorrect decisions, the amount paid upon reversal on external appeal should be increased to account for the many that were not discovered.

3. *Cost of interest on claim amount.* When participants must proceed through multiple layers of review to obtain reimbursement for claims, they are deprived of the use of the money that was due to them. At a minimum, payors should be required to pay interest on the claim amount that was incorrectly decided. Payors have already agreed, in the context of claims processing class action settlements, to pay interest on delayed claims.²³¹ Where a claim is paid only after two internal appeals and an external review, the payor has benefitted from the use of the retained funds and should, at a minimum, pay the interest on the monies due.

228. See Olena Berg, *supra* note 1, at 6.

229. See Block, *supra* note 202, at 397.

230. As Block explains, this penalty is expressed as $F=L/P$, where L = loss from the violation and P = the probability of being detected. *Id.* at 397-98. Applied to claim denials, this would mean that if a participant suffered a loss of \$100 and the chance of the error being detected was one in three, or .333, then the amount of the penalty would be \$300.30. This amount would account for the costs actually imposed by the incorrect denial, taking into account the probability of detection.

231. See, e.g., *How the Human Inc. Settlement Agreement Helps the Physician Practice*, AM. MED. ASS'N, 1, 1-2 (2008), <http://www.ama-assn.org/resources/doc/psa/humana-flier.pdf> (noting that under the settlement agreement that arose out of *In Re: Managed Care Litigation*, MDL No.: 00-1334-MD MORENO, Humana would pay 6% interest on delayed claims).

D. *External Review Should Be More Transparent, Independent, Available, and Understandable*

External review would be more effective if further steps were taken to ensure the independence of external reviewers and the transparency of results. To increase participants' use of external review, external review of ERISA claims can borrow from the automatic referral of appeals that now takes place in Medicare Part C.

1. *Increase transparency.* External review calls for independent review of repeatedly denied claims. Consumer advocates remain skeptical that external reviewers' functioning under the current rules will truly be independent.²³²

If external review is truly as independent as plans and issuers claim, why not share details of the claims decided with other plan participants, government regulators, and the public at large? In order to assure participants and regulators that decisions are made according to the proper procedures, external reviewers could release the key facts of each appeal so participants can judge for themselves whether the external reviewer at issue has a pattern of deciding claims that is anomalous or unduly in favor of the plan.

232. A letter from twenty-four consumer and patient advocate organizations submitted as part of the public comment period for the regulations explained that:

[W]hen insurers or plans act as the hub, receiving the appeal, choosing the outside reviewer, receiving the decision of the outside reviewer, and then issuing a decision to the consumer, outcomes are skewed in favor of insurers or plans . . . We also can cite cases in which an IRO ruled in favor of consumers in true external appeals administered by States, but the same so-called IRO ruling on the same treatment for the same condition rule for the plan when the outside reviewer was selected by the plan.

Letter from Advocates for Patients with Chronic Illness to Phyllis Borzi & Karen Pollitz (Jan. 31, 2011), *available at* <http://advocacyforpatients.blogspot.com/2011/01/advocates-letter-on-appeal-regulations.html>.

In the course of the public comment period for the new regulations, advocates such as the American Association of Retired Persons have urged that external reviewers be required to release pertinent details of every claim decided, redacted to remove individually-identifying information.²³³

If participants were armed with information and precedent regarding claims similar to their own, they would be better able to understand their chances of succeeding on appeal and perhaps more likely to pursue such steps.

2. *Ensure external reviewers' independence.* Patient advocates stress that for external review to be worthwhile, it must be truly independent.²³⁴ At the state level, external review entities are often chosen by regulators rather than by payors.²³⁵

States have developed other ways to safeguard the external reviewer's independence, such as permitting the plan to select the external reviewer from a list of approved external reviewers but allowing the participant to object to the payor's choice.²³⁶ Still another approach is to permit the participant, the participant's physician, and the payor to select the external reviewer together.²³⁷ In Tennessee, residents can apply directly to the state for external review, and when residents do so, the regulatory staff selects the

233. AARP urged that external reviewers be required to release the following details:

- (1) cases handled (redacted for privacy); (2) the name of the plan or issuer; (3) description of the issue; (4) approximate cost of the claim; (5) result (favorable to plan or insurer, or to participant); (6) the number of past reviews for each insurer or plan; (7) professional credentials of reviewer(s) used; and (8) compensation paid to each physician reviewer for the year and the two previous calendar years.

Letter from AARP to the Dep't of Health and Human Servs., Emp. Benefits Sec. Admin., and the Internal Revenue Serv. (Sept. 21, 2010), *available at* www.dol.gov/ebsa/pdf/1210-AB45-0059.pdf.

234. *See* Letter from Advocates for Patients with Chronic Illness to Phyllis Borzi & Karen Pollitz, *supra* note 232.

235. *See* POLLITZ, CROWLEY, LUCIA & BANGIT, *supra* note 126, at 16.

236. *See id.* (explaining that Iowa and Oklahoma have adopted this approach).

237. *See id.* (explaining that Illinois uses this approach).

external reviewer with advice from a physician.²³⁸ When a resident elects to appeal directly to the plan, on the other hand, the plan selects the external reviewer.²³⁹

Under the new federal rules, regulators permit plans to contract with as few as three external reviewers and to rotate among those plans.²⁴⁰ Consumer advocates questioned in public comments whether an external reviewer that is one of three contracted to serve a payor can be truly independent.²⁴¹ In response to consumer advocates' concerns, the government reiterated the requirement that plans contract with at least three external reviewers and added only the requirement that plans rotate assignments among them.²⁴²

3. *Refer twice-denied claims to external review automatically.* To increase participation in external review, claims that are initially denied and then denied at two levels of internal appeal should be automatically routed to the external reviewer. Those participants who do not wish to participate could simply opt out of the external review, but the external review could be the default procedure.

Automatic referral to external review already occurs in the Medicare appeals process.²⁴³ Medicare Part C enrollees can opt to appeal a denial internally within the plan.²⁴⁴ If

238. *Id.*

239. *See id.*

240. TECHNICAL RELEASE 2010-01, *supra* note 63, at 4.

241. *See* Letter from Advocates for Patients with Chronic Illness to Phyllis Borzi & Karen Pollitz, *supra* note 232; *see also* Letter from Jennifer C. Jaff, Esq. of Advocacy for Patients with Chronic Illness to Offices of Consumer Info. & Ins. Oversight & Health Plan Standards & Compliance Assistance (Dec. 15, 2010), <http://www.scribd.com/doc/73353491/Self-funded-Plan-IRO-Problems#download>.

242. *See* TECHNICAL RELEASE 2011-02, *supra* note 75, at 3, 8-9.

243. *See* 42 C.F.R. § 422.592(a) (2011) (stating that “[w]hen the [Medicare Advantage] organization affirms, in whole or in part, its adverse organization determination, the issues that remain in dispute must be reviewed and resolved by an independent, outside entity that contracts with CMS.”); *see also* POLLITZ, DALLEK, & TOPAY, *supra* note 22, at iii.

244. *See* CTRS. FOR MEDICARE AND MEDICAID SERVS., MEDICARE MANAGED CARE (PART C-MEDICARE ADVANTAGE), <https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Flow.pdf> (last visited Feb. 29, 2012); *see also* *Medicare Managed Appeals: Medicare Appeals and Your Rights*, MAXIMUS FED.

the denial is upheld, the plan must send the claim on to an Independent Review Entity.²⁴⁵ If the denial continues to be upheld, the participant may then appeal to an administrative law judge, and finally to federal court.²⁴⁶ The administrative law judge and federal court phases of the Medicare Part C appeals process are optional, at the participant's request.²⁴⁷

The Medicare Part C automatic referral process has resulted in a higher rate of external review than takes place in other healthcare plans. In 2009, the Medicare Part C reviewer received 5.54 reconsiderations for each 1000 Medicare enrollees.²⁴⁸ External review of denied claims takes place at a far higher rate within the Medicare context—scholars attribute this difference to a number of factors but principally to Medicare's automatic referral system.²⁴⁹ Consumer advocates in the group healthcare arena urge that members of group plans should benefit from the same automatic escalation of twice-denied claims to external review.²⁵⁰

4. *Early experiences of the appeal rules.* Anecdotal evidence from the field suggests that the new external review rules for self-funded plans are not functioning smoothly. In late 2011, lawyers representing plan participants reported problems; for example, IROs

SERVS., INC.,
<http://www.medicareappeal.com/MedicareEnrollees/MedicareAppealsandYourRights.aspx> (last visited Feb. 29, 2012).

245. See CTRS. FOR MEDICARE AND MEDICAID SERVS., *supra* note 244.

246. See *id.*

247. See *id.*

248. *Id.*

249. See POLLITZ, DALLEK & TOPAY, *supra* note 22, at 18 (noting that Medicare beneficiaries tend to be more elderly and therefore use greater amounts of healthcare, Medicare beneficiaries may not be aware of their plan rules and therefore have a greater number of disputes, Medicare beneficiaries have advocates that other healthcare consumers do not, and that all claim denials upheld in the internal review process must undergo external review).

250. See Letter from the Ctr. for Medicare Advocacy, Inc. to the Office of Consumer Info. and Ins. Oversight 3-4 (Sept. 21, 2010), available at <http://www.dol.gov/ebsa/pdf/1210-AB45-0042.pdf>.

“violate[d] URAC standards, the NAIC Model Act and the intent of the federal regulations.”²⁵¹ Significantly, one well-known attorney who handles many cases on external appeal indicated that external reviewers behave differently when they are contracted by a self-funded plan than they do when contracted by a state.²⁵²

In one instance, the lawyer reported in public comments, the external reviewer “made up an entirely new standard” in order to deny the claim, apparently “straining to do whatever needed to be done to find a reason to deny coverage.”²⁵³ In another instance, the external reviewer denied a treatment for a recurrent sinus infection based on lack of documentation without further explanation, despite over fifty office notes documenting the infections.²⁵⁴ In that case, the file was replete with procedural irregularities, including a delay of nearly three months in providing the external review.²⁵⁵ The lawyer noted that she had worked with the same external reviewer on many past occasions and had never experienced the kind of problems she experienced with them when they were contracted by self-funded plans.²⁵⁶

Of course, ERISA external review is still new. But even these early indications suggest that if adjustments are to be

251. Letter from Jennifer C. Jaff, Esq. of Advocacy for Patients with Chronic Illness to Phyllis Borzi, Assistant Sec’y of Labor, *supra* note 241, at 1.

252. *Id.* (noting that “in every case, [the IRO] has done things that I have never seen them do when they are contracted by a state to conduct independent reviews.”).

253. *Id.* at 2.

254. *See id.*

255. *See id.*

256. Jennifer Jaff noted that:

Since MCMC is one of the largest IROs we have had many external appeals involving fully-funded plans submitted to them over the years. Although I was not always happy with the result, MCMC was professional, it followed the rules, and it was thorough. That most definitely is not the case with respect to the external reviews they are conducting on behalf of self-funded plans.

Id. at 3.

made, they should be made in the direction of increased protections for the participant and increased encouragement for the participant to stay the course and appeal a potentially-meritorious claim to external review.

CONCLUSION

For those plan participants who persist through the appeal process and reach external review, external review of ERISA claims is of doubtless valuable. External review provides one final chance for an improper claim denial to be reversed before litigation.²⁵⁷ Some evidence suggests that the external review process can even shape plans' upstream decision making by giving payors feedback about what is and what is not acceptable under the plan terms.²⁵⁸ In addition, consumers and healthcare providers generally view external review processes as "valuable and fair."²⁵⁹ The PPACA's extension of external review to ERISA plans does provide an avenue for participants that did not exist before.

But as long as participants bear the cost of payors' incorrect decisions and the appeal process is arduous, incorrect denials will go undisturbed and payors will have little reason to improve the quality of their initial decision-making. ERISA plan participants in particular have little other chance of relief. But if, however, payors had to internalize the costs of their incorrect denials, decision-making would improve. External review could thereby become useful to all participants, rather than the few it serves today.

257. See POLLITZ, DALLEK & TOPAY, *supra* note 22, at vi (noting that "[a]t the outset of Pennsylvania's program, for example, a significant portion of reviews involved denial of emergency room care. Over time, the number of such reviews has dwindled and regulators attribute this to HMOs learning and understanding the state's expectations."); see also Benko, *supra* note 159, at 29 (explaining that when claim denials for bariatric procedures such as gastric bypass surgery, were routinely overturned by external review, insurers began to cover the procedure more often in the first instance).

258. See POLLITZ, DALLEK & TOPAY, *supra* note 22, at 51.

259. *Id.* at vi.