EXTERNAL REVIEW PROCESS OPTIONS FOR SELF-FUNDED HEALTH INSURANCE PLANS

David Goldin*

---

* J.D. Candidate 2012, Columbia University School of Law; B.A. Columbia University, 2007. The author would like to thank all those who helped him.

I. INTRODUCTION

Many provisions of the Patient Protection and Affordable Care Act (the "PPACA" or "the Act"), signed into law on March 23, 2010, are highly controversial.[1] Particularly contentious are issues pertaining to the rationing of health care,[2] as illustrated by the recent, highly visible discourse about "death panels."[3] The issue became so heated that President Obama urged five governors with whom he met to avoid using the word "rationing" in discussing health care reform "for fear of evoking the hostile response that sank the Clintons' attempt to achieve reform."[4] Although none of the legislative proposals contained any provisions that would lead to the creation of death panels or any similar body,[5] the Act does have sections that affect decisions about who will receive health care and who will not.

One of these sections is the provision of the PPACA governing external review of denial-of-care decisions by insurance companies. This section generally mandates either that insurers comply with external review processes found in state law, or, if they are not subject to state

[1] David M. Herzenhorn and Robert Pear, *Health Vote Is Done, but Partisan Debate Rages On*, N.Y. TIMES, Mar. 23, 2010, at A19 (describing the ongoing debate and opposition to PPACA).

[2] *See* Peter Singer, *Why We Must Ration Health Care*, N.Y. TIMES, July 19, 2009, Magazine, at 38 (discussing the need for the rationing of health care).

[3] *See* Jim Rutenberg and Jackie Calmes, *False 'Death Panel' Rumor Has Some Familiar Roots*, N.Y. TIMES, Aug. 14, 2009, at A1 (analyzing the reasons for the spread of the "death panel" rumor). While the term death panel does not have a single definition, the general concept is a "technocratic panel" that makes decisions pertaining to end-of-life care. Editorial, *Death Panels Revisited*, WALL ST. J., Dec. 29, 2010, at A12.

[4] Singer, *supra* note 2.

[5] *See* Rutenberg & Calmes, *supra* note 3.

regulation, that they establish an external review process.[6] Insurers in the latter category must implement "effective external review process[es]" that meet "minimum standards established by the Secretary [of Health and Human Services]" and that are "similar" to state-regulated processes.[7] While the framework provided in the Act offers some guidance as to what these processes should look like, it does not dictate a specific review process.

This provision is particularly important because it will lead to the implementation of a review process for claims determinations made by insurers in self-funded plans that are governed by the Employee Retirement Income Security Act ("ERISA").[8] The lack of meaningful review for these claims in the current insurance system has been heavily criticized in the past, and the PPACA provides an excellent opportunity to correct the problem. Section 514 of ERISA provides that ERISA supersedes all state laws that "relate to any employee benefit plan."[9] One consequence of this provision is the shielding of self-funded insurers from liability for negligent utilization review determinations, which limits the remedies available to claimants injured from improper denials of benefits.[10] The external review provision of the PPACA has the potential to provide

[6] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10101(g), 124 Stat. 119, 887–88 (2010).

[7] *Id.*

[8] Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 5 U.S.C., 18 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.).

[9] *See* 29 U.S.C. § 1144(a). ERISA preemption is particularly meaningful because the "U.S. Supreme Court has broadly interpreted this clause to extend ERISA's preemption over virtually every state or local law that has any effect on an employee benefit." Arlene Akiwumi-Assani, Comment, *Four Problems Facing Meaningful State Health Care Reform and Coverage in the United States*, 72 ALB. L. REV. 1077, 1084 (2009).

[10] *See* Patricia Mullen Ochmann, *Managed Care Organizations Manage to Escape Liability: Why Issues of Quantity vs. Quality Lead to ERISA's Inequitable Preemption of Claims*, 34 AKRON L. REV. 571, 588 (2006) (finding that ERISA preemption has served to shield managed care organizations from liability).

claimants insured under self-funded plans with a meaningful forum for review of claims determinations.[11] It thus has the potential to be very powerful.[12]

Five months after the signing of the PPACA, the U.S. Department of Labor issued Technical Release 2010-01, which dictates two interim procedures for external review that, if adopted, would provide insurers with a safe harbor.[13] One option is for plans governed by ERISA to voluntarily submit themselves to state external review processes,[14] among which there is a wide range of variation.[15] Alternatively, states have the option of adopting the process set forth in the Technical Release, which mandates the use of Independent Review Organizations ("IROs").[16] Technical Release 2010-01 is entirely elective; self-funded insurers can choose both whether to comply with the release, and thus whether to benefit from the safe harbor, and which method of external review they will use.

---

[11] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §10101(g), 124 Stat. 119, 887–88 (2010).

[12] *See* Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49, 50–56 (finding that as a result of ERISA preemption, health insurers are completely insulated from liability in a situation in which an improper denial of inpatient alcohol treatment by the insurer set into motion a chain of events that culminated in the alcohol-related death of plaintiff's husband).

[13] *See* DEP'T OF LABOR, TECHNICAL RELEASE NO. 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 (2010), *available at* http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf.

[14] *Id.*

[15] *See* Karen Pollitz et al., *Assessing State External Review Programs and the Effects of Pending Federal Patients' Rights Legislation* (rev. 2002) (report to the Kaiser Family Foundation), *available at* http://www.kff.org/insurance/externalreviewpart2rev.pdf (providing an overview of, and data on, state external review programs).

[16] U.S. DEP'T OF LABOR, EMP. BENEFITS SEC. ADMIN., TECHNICAL RELEASE NO. 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, *available at* http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf.

It is up to the Secretary of the Department of Health and Human Services ("the Secretary") to promulgate minimum standards for the processes that insurers must implement.[17] This Note analyzes a number of potential options for external review processes that can be implemented under the PPACA for self-funded health insurance plans regulated by ERISA. Establishing a viable and efficient external review process is particularly important because few other options for review of claims decisions by self-funded insurance plans exist, in part because of ERISA preemption.[18] If properly structured and operated, this external review mechanism has the potential to help both insurers and insureds.

Part II introduces the review processes and methods that health insurers use to either approve or reject claims, and discusses the implications of these processes for both insurers and insureds. It also examines the legal issues unique to review of claims determinations for self-funded health insurance plans governed by ERISA, which are specifically addressed by Section 10101(g) of the PPACA. Part III discusses the issues that should be considered in promulgating the minimum standards for an external review process. Part IV concludes by analyzing many of the options that might fulfill the external appeals process mandate.

II. BACKGROUND

To best understand the importance of the external review provision of the PPACA, one must have a general understanding of the issues that it addresses. On the one hand, health insurers in the United States often play the role of rationers of health care. In this role, they have the potential to make errors.[19] On the other hand, as a result of

[17] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10101(g), 124 Stat. 119, 887–88 (2010).

[18] See Ochman, *supra* note 10 and accompanying text.

[19] *See* Timothy P. Blanchard, *"Medical Necessity" Determinations—A Continuing Healthcare Policy Problem*, 37 J. HEALTH L. 599, 604 (2004) (providing an overview of processes used to determine whether a specific

ERISA preemption, there are limited options for review of these rationing decisions by self-funded insurance plans.[20] Thus, many decisions pertaining to who does and does not receive medical care are subject to only very limited review, something which the external review provision seeks to rectify. This Section discusses how such a situation came to exist.

A. Allocation of Health Care by Insurers

Society cannot provide health care in all cases in which there might be a positive net benefit,[21] as doing so would require devoting an unrealistic amount of resources to health care.[22] As a result, health care must be rationed—meaning that some individuals will not receive care, even if it could benefit them.[23] In the United States, public and private health insurers generally make rationing decisions.[24] The selection of the party that makes these rationing decisions, as well as the development of the decision-making processes, "are fundamental issues affecting the rationality, equity, and effectiveness of our healthcare systems."[25] This Section explores the historical development, structure, and effects of the current decision-making process.

1. Historical Perspective

The health insurance industry has its roots in the 1920s, with the first formal health insurance provider arising in the

health care procedure is medically necessary and describing the misunderstandings surrounding and nebulous nature of the term "medical necessity" itself).

[20] *See* 29 U.S.C. § 1144(a).

[21] *See* Einer Elhauge, *Allocating Health Care Morally*, 82 CALIF. L. REV. 1449, 1454 (1994) (discussing the moral issues surrounding allocation of scarce health care resources).

[22] *See id.*

[23] *See id.*

[24] *See* Blanchard, *supra* note 19, at 599–600.

[25] *Id.* at 604. While the merits of having insurers perform the rationing function are debatable, a full discussion of this is not within the scope of this Note.

1930s.[26] In the early years, financial conflicts of interest threatened the integrity and sustainability of the industry. There were no checks on the incentives for physicians to provide unnecessary medical services in order to increase revenue, such that physicians' medical judgment was often compromised.[27] Patients lacked the information required to make decisions regarding services, and because they were insured, they often did not bear the financial brunt of the unnecessary and costly care they received.[28]

Partially as a result of these problems, health care costs ballooned, and, in 1969, President Nixon declared a "health cost crisis."[29] Subsequently, steps were taken to restrict unfettered access to health care. Congress passed the Health Maintenance Organization Act (the "HMO Act") in 1973, which attempted to control health care usage by promoting managed care, including the use of health maintenance organizations ("HMOs").[30] "Managed care" entails the use of processes to "control or influence the quality, accessibility, utilization, costs and prices" of health care.[31] Implementation of a managed care regime could thus enable payors to closely control access to health care and

---

[26] *See* Ann Maltz, *Health Insurance Fundamentals*, in UNDERSTANDING INS. L., 2253 (PLI 2008).

[27] *See* Marc A. Rodwin, *The Metamorphosis of Managed Care: Implications for Health Reform Internationally*, 38 J.L. MED. & ETHICS 352, 353 (2010) (discussing the history and development of the system of managed care and the impact on health care reform).

[28] *See id.*

[29] *See id.* at 356.

[30] *See* Benjamin Saunier, Note, *The Devil Is in the Details: Managed Care and the Unforeseen Costs of Utilization Review as a Cost Containment Mechanism*, 35 OKLA. CITY U. L. REV. 483, 490 (2010) (discussing the implications of usage of utilization review mechanisms to control costs).

[31] *See id.* at 491 *quoting* Am. Med. Ass'n, Principles of Managed Care 2 (5th ed. 2004), http://www.ama-assn.org/ama1/pub/upload/mm/363/principlesmanagecare.pdf. ("The American Medical Association (AMA) defines 'managed care' as processes or techniques used by any entity that delivers, administers and/or assumes risk for health services in order to control or influence the quality, accessibility, utilization, costs and prices, or outcomes of such services provided to a defined population.").

utilization of health care resources and, as a result, would lower their health care expenditures.

Patients' largely negative reactions to the movement towards HMOs and managed care, and the resulting restrictions in access to certain services, spurred patient protection laws, many of which contain common provisions including required disclosure of physician incentives and minimum covered hospital stays for certain procedures like birthing.[32] While these laws provided for review of insurance claims decisions, they restricted the ability of consumers to accomplish system-wide change because internal reviews of decisions were treated as individual cases without binding precedential effect on HMOs.[33] Nonetheless, opposition to HMOs and managed care remained strong, and many managed care organizations responded by broadening networks and adopting other methods to achieve the overall cost reduction goals.[34] Despite its negative image, however, managed care is still a prevalent feature of health insurance plans offered today.[35]

2. Utilization Review, Exclusions, and Medical Necessity

As discussed above, one of the ways that health insurers have sought to manage costs is through restricting access to

[32] *See* Rodwin, *supra* note 27, at 359. Consumers used political processes to express their dissatisfaction with managed care and to obtain change. They had some success at doing so—forty-seven states passed legislation regulating managed care between 1995 and 2001. *See id.* at 358.

[33] *See id.* at 359. This is largely because each appeal is treated independently, as opposed to as a part of a larger policy. Moreover, each appeal is decided by different reviewers. *See Id.*

[34] *See id.* Some of these methods include focusing utilization review on high cost items and increased oversight of drugs. *See Id.*

[35] *See id.* at 360. This may be the case, even if the term "managed care" is not used, as other terms with less negative connotations, like "health plan" are used. *See Id.*

services.[36] A number of methods and systems have been developed to facilitate the making of rationing decisions, and these methods have changed over time.[37] One way this is done is by excluding certain care from being covered by plans. Government programs, like Medicare, provide lists of both covered services and categories of medical care that will always be excluded.[38] Private insurers often apply bright-line rules—many, for example, will not pay for experimental treatments.[39] Even the use of lists and bright line rules does not make all utilization review decisions easy—health care procedures are constantly changing, and it is often debatable whether a given procedure is experimental or fits within a category of care covered by a policy.[40]

Another way insurers perform the rationing function and restrict access to health care is through a process called utilization review.[41] Utilization review aims to ensure that services are used only when appropriate and necessary.[42] It is performed by reducing unnecessary medical care.[43] The basic idea is that less utilization of medical care will lead to lower overall expenditures for insurers and lower premiums for consumers. While the mechanics of utilization review

---

[36] *See* Saunier, *supra* note 30, at 490 (addressing methods taken to control health care costs, including the use of HMOs and managed care, which led to restricted access to health care services).

[37] *See* Rodwin, *supra* note 27, at 352 (discussing the history of managed care and different methods used by actors providing managed care).

[38] *See* Blanchard, *supra* note 19, at 600 (discussing the use of lists of care excluded from coverage by Medicare and Medicaid).

[39] *See* Denise S. Wolf, *Who Should Pay for "Experimental" Treatments? Breast Cancer Patients v. Their Insurers*, 44 AM. U. L. REV. 2029, 2033 (1995) (noting that insurers have exclusionary provisions in policies which exclude experimental treatments from coverage).

[40] *See id.* at 2036.

[41] *See* Saunier, *supra* note 30, at 492.

[42] *See* Thomas M. Wickizer, *The Effects of Utilization Review on Hospital Use and Expenditures: A Covariance Analysis*, 27 HEALTH SERVS. RES. 103, 104 (1992) (discussing the growth of utilization review and the reasons for its use).

[43] Saunier, *supra* note 32, at 496.

programs vary,[44] all plans employ the concept of "medical necessity" in making decisions.[45] However, the concept of "medical necessity" opens the door to a number of problems, as there is no one general definition of "medical necessity" that can be applied to all utilization review decisions, which can make it quite difficult to make these determinations.[46]

Both the American Medical Association and the National Health Law Program have established definitions of medical necessity for the purpose of cost-effective health care decisions.[47] While definitions can give good guidance, given the wide range of procedures and services to which they must apply, they are necessarily broad and thus often cannot be applied to specific situations to make definitive determinations. As a result, there is room for both error and disagreement in determinations of medical necessity.[48] This opens the door to bias in utilization review decisions, and a resulting inefficient allocation of scarce resources.

This is not to imply that a large portion of utilization review decisions will necessarily be "wrong." One way to picture the scenario that reviewers face is to visualize a spectrum: at one end there are services and procedures that are certainly medically necessary, while on the other, there are those that are clearly not. Exclusions and utilization review procedures can do a good job of determining whether claims at both the ends of this spectrum should be approved or denied. Procedures towards the middle of the spectrum are likely to be those for which definitions of medical necessity are going to be the least useful, and for which there is the greatest chance of a disagreement over necessity.

3. Impact of Utilization Review Decisions

Poorly made utilization review decisions can have serious consequences, both for insurers and for insureds. On the

[44] *Id.* at 496–97.

[45] Blanchard, *supra* note 19, at 600.

[46] *See id.* at 604.

[47] *See id.* at 601–02.

[48] *See* Saunier, *supra* note 30, at 498.

side of insurers, many procedures, especially newer ones whose medical necessity is most contentious, can be incredibly costly.[49] Erroneous approval of large numbers of costly treatments that are not medically necessary could have a significant impact on the insurance system, and could lead to higher rates for all. On the other hand, improper denials of necessary care can lead to serious—and occasionally tragic—results for the insured.[50] Thus, erroneous medical necessity decisions in the context of utilization review, which are considered "solely administrative in nature" and not medical,[51] can have a significant impact on all involved.

In discussing utilization review, it is important to consider the broader issues and policy debates surrounding its use. As discussed above, as a society, we must ration healthcare.[52] Therefore, some method to restrict access to healthcare must be used. Utilization review is just one of a number of potential options through which to make these decisions, and there are multiple ways that utilization review can be conducted.[53] Although there are benefits to using utilization review, it is costly to engage in, and there may be more efficient ways to reduce expenditures.[54] A full

[49] *See* Wolf, *supra* note 39, at 2038.

[50] *See* Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49, 50–53 (D. Mass. 1997).

[51] David L. Trueman, *The Liability of Medical Directors for Utilization Review Decisions*, 35 J. HEALTH L. 105, 105 (2002) (discussing the fact that utilization review determinations are treated by managed care companies as administrative decisions that do not entail a physician-patient relationship).

[52] *See* Elhauge, *supra* note 21, at 1454.

[53] *See* Saunier, *supra* note 30, at 497. ("There are three different processes in which utilization review may be conducted: 'prospectively, concurrently, or retrospectively.'").

[54] *See* Wickizer, *supra* note 42, at 117. Utilization review has been found to have "reduced admissions by approximately 12 percent, hospital routine expenditures by 14 percent, hospital ancillary expenditures by 10 percent, and total medical expenditures by 6 percent, even after controlling for a large number of external factors." *Id.* Utilization review appears to "reduce expenditures mainly by reducing admissions through preadmission authorization." *Id.* While the data indicate a reduction in

debate on the benefits and drawbacks of utilization review is beyond the scope of this Note. However, it is important to understand that there is potential for error in the utilization review process and that these mistakes can have serious consequences for those affected.

B. Self-funded Health Insurance and ERISA Preemption

1. Types of Insurance Plans

The term "health insurance" can be used to refer to a broad range of different programs, both private and public. Under the McCarran-Ferguson Act, the states have the primary regulatory authority over insurance sold to state residents.[55] Many individuals, however, are insured through self-funded insurance plans ("self-funded plans")[56] to which state regulations do not apply. Self-funded plans have been defined as "insurance arrangement[s] in which the employer assumes direct financial responsibility for the costs of enrollees' medical claims."[57] An employer who offers a self-funded plan will usually contract with an insurer or a third-party administrator, who agrees to provide administrative services for the plan.[58] Although the employer assumes financial responsibility for the costs of the claims, in some cases, employers will purchase stop-loss coverage from an insurance company to cover the employer in case it is faced with very large claims.[59]

---

costs "even after controlling for a large number of external factors," given that the main source of the reduction has been identified, it is not clear that large utilization review programs are the most efficient way of achieving the desired results. *See id.*

[55] *See* David A. Hyman, *Health Insurance: Market Failure or Government Failure?*, 14 CONN. INS. L.J. 307, 310 (2008).

[56] Eighty-seven million Americans obtain coverage through an employer's self funded plan. *Id.*

[57] *Employer Health Benefits: 2007 Annual Survey*, *supra* note 58, at 148.

[58] *See id.*

[59] *See id.*

One advantage to employers of offering self-funded insurance plans is that these plans are not subject to state insurance regulations—which are often quite extensive—that bind non-self-funded plans.[60] They are instead considered employee benefits plans, and, as such, are governed by ERISA.[61] There are a number of reasons that this can benefit employers. First, many employers operate in several states, and offering self-funded plans frees employers from having to comply with multiple sets of insurance regulations.[62] As a result, employers are able to implement a single coverage arrangement for employees across multiple states and the District of Columbia.[63] Further, unlike state law, ERISA imposes very few substantive regulations, such that employers offering self-funded plans have "virtually complete freedom" to tailor the health care offered to their desired spending levels.[64]

2. ERISA Preemption

Part of the reason that there are almost no regulations for self-funded plans is that ERISA preempts state law.[65] The implications of this are broad. First, employers have flexibility in designing their insurance plans. Further, ERISA preemption limits the availability of state-law remedies for those who claim to have been injured by the decisions of a self-funded health insurer.[66] Specifically, the majority of tort claims pertaining to insurance claim denials are preempted by ERISA's remedial scheme because they

---

[60] *See* Hyman, *supra* note 55, at 310.

[61] *See* Robert W. Miller, *The Effect of the Health Reform Act on Self-Insured Employer Health Plans*, 4 J. HEALTH & LIFE SCI. 59, 59 (2010).

[62] *See* Hyman, *supra* note 55, at 311.

[63] *See id.*

[64] *Id.*

[65] *See* 29 U.S.C. § 1144(a).

[66] *See* Laura D. Hermer, *Private Health Insurance in the United States: A Proposal for a More Functional System*, 6 HOUS. J. HEALTH L. & POL'Y 1, 31 (2005) (discussing the way in which ERISA's provisions block access to state-law remedies for persons receiving insurance through self-funded health insurance plans).

"relate to" an employee benefit plan.[67] Plaintiffs who claim they suffered harm as a result of a utilization review decision by a self-funded plan have very few remedies.[68] ERISA grants individuals the right to bring a civil action to recover benefits due or to enforce rights under the plan.[69] However, this option has little utility due to the delay in obtaining relief and the highly deferential standard applied.[70]

Consequently, parties injured as a result of improper denials of care often do not have a meaningful remedy if they receive coverage through self-funded plans.[71] This likely reduces incentives for insurers to grant access to medical care for persons covered by self-funded plans, exacerbating the conflict issue. If an insurer does not approve the care, it averts a potentially significant expense. Even if refusal to approve the care leads to negative results, injured parties will not have a state law remedy.[72] Overall, the confluence of these factors suggests the need for an effective review mechanism for self-funded plans that is not governed by state law. Properly constructed external review processes will be able to serve this role.[73]

Some scholars have called for changes to ERISA in the context of improving access to health care.[74] A change to

---

[67] *Id.* (addressing the way in which ERISA precludes many plaintiffs from bringing common-law tort claims).

[68] *Id.* at 31–32 (discussing the limited remedies available to plaintiffs injured by denials of care).

[69] *See* 29 U.S.C. § 1132(a)(1)(B).

[70] *See infra* Section II.B.3.

[71] *See* Hermer, *supra* note 66, at 31–32 (citing Corcoran v. United Health Care, Inc., 965 F.2d 1321 (5th Cir. 1992)); *see also* Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49, 64 (D. Mass. 1997) (stating that there is "*de facto* immunity that the law now confers upon insurers and utilization review providers associated with such plans").

[72] On the other hand, there is a positive side to this: without the specter of tort suits hanging over insurers, there is a significant chance they will be less likely to approve unnecessary care just to reduce liability risk.

[73] *See* Hermer, *supra* note 66, at 31.

[74] *See, e.g.*, Mary Ann Chirba-Martin, *Drawing Lines in Shifting Sands: The U.S. Supreme Court's Mixed Messages on ERISA Preemption*

ERISA, and, more specifically, waivers from or repeal of its preemption clause, might reduce the need for the external review provision of the PPACA. Specifically, because all insurance plans would be subject to more regulation, and because more options for review would be available to those suffering an injury as a result of improper utilization review decisions,[75] additional review options would be less important.

Nonetheless, overt ERISA reform is unlikely to take place given the significant problems facing the United States both domestically and abroad as well as the fundamental divide on how to reform the health care system at the federal level.[76] Moreover, ERISA "provide[s] a uniform regulatory regime over employee benefit plans,"[77] and repealing it could subject large employers operating in multiple states and the District of Columbia to a large number of separate sets of regulations in provision of employee benefits. Additionally, many different groups have an interest in maintaining ERISA as it is.[78] Thus, while the option of repealing specific sections of ERISA as a way of increasing options for review for individuals insured under self-insured plans is currently under discussion, there are a significant number of hurdles that would need to be cleared for repeal to be realized.

3. Provisions for Review Outside the PPACA

In addition to facing fewer regulations and not being subject to state law remedies, insurers providing self-funded

Imperil Health Care Reform, 36 J. LEGIS. 91, 93, 136 (2010) (stating that Congress should reform ERISA preemption or make more state ERISA waivers available in the context of health care reform); Paul M. Secunda, *Sorry, No Remedy: Intersectionality and the Grand Irony of ERISA*, 61 HASTINGS L.J. 131, 135 (2009) (calling on Congress to amend ERISA to expand access to remedies for employees who have been wronged).

[75] *See* Hermer, *supra* note 66, at 31.

[76] *See* Chirba-Martin, *supra* note 74, at 137.

[77] Aetna Health Inc. v. Davila, 542 U.S. 200, 208 (2004).

[78] *See* Chirba-Martin, *supra* note 74, at 132 (discussing steps taken by advocates for the interests of large employers to preserve ERISA preemption).

plans governed by ERISA have the "enormous advantage of deferential review whenever plan members and beneficiaries have challenged benefit denials by plan fiduciaries."[79] As shown in *Firestone Tire & Rubber Co. v. Bruch*,[80] this is a significant impediment for plan beneficiaries seeking judicial review of a benefit denial.[81] A claimant must establish that the decision by the plan administrator was "arbitrary and capricious, or unreasonable" to have a denial of benefits overturned.[82] The Supreme Court reaffirmed the *Firestone* standard in *Metropolitan Life Insurance Co. v. Glenn*,[83] in which it rejected *de novo* review and instead decided to continue to apply a deferential standard, thereby further entrenching the approach taken in *Firestone*.[84] As a result of these decisions and of the entrenchment of the *Firestone* standard, "an unfairly denied claim may leave a member without benefits for an expensive and urgently needed medical procedure."[85]

The review options available to individuals who receive insurance coverage from their employers through non-self-funded plans that are subject to ERISA differ.[86] Section 502(a) applies to these plans as well.[87] Once in federal court, the highly deferential *Firestone* standard of review, as affirmed by *Glenn,* is applied. Nonetheless, because these plans are subject to state regulation, members of these plans have another option: they may rely on state external review

[79] Beverly Cohen, *Divided Loyalties: How the Metlife v. Glenn Standard Discounts ERISA Fiduciaries' Conflicts of Interest*, 2009 UTAH L. REV. 955, 956 (2009) (discussing the significant edge that employer health and disability plans regulated under ERISA have when claims denial cases are brought in federal court).

[80] 489 U.S. 101 (1989).

[81] Cohen, *supra* note 78, at 956.

[82] *Id.*

[83] 554 U.S. 105 (2008).

[84] Cohen, *supra* note 78, at 956.

[85] *Id.*

[86] *See* Hyman, *supra* note 55, at 310.

[87] 29 U.S.C. § 1132(a)(1)(B).

provisions, providing a level of review that, pre-PPACA, was not available to members of self-funded insurance plans.[88]

Overall, claims decisions made by insurers in the context of ERISA-governed health insurance plans and self-insured plans for which there was no external review provision before the PPACA are largely free from review. Like the lack of state law remedies for injuries caused by claim denials, the dearth of review options has both positive and negative implications. If the standard of review were to be overly-deferential to the insured, it could lead to approval of unnecessary medical procedures for fear of lawsuits and resulting liability. On the other hand, with the knowledge that their decisions will be reviewed under the highly deferential standard,[89] insurers might be more likely to deny costly procedures in borderline cases in order to avoid expenses, or to devote a less-than-optimal level of resources to review claims.

III. PROVIDING EFFECTIVE, BALANCED REVIEW UNDER THE PPACA

By mandating an external review process for claims denials and giving the Secretary the power to set minimum guidelines,[90] the PPACA has the potential to give individuals who receive their health insurance from self-funded plans a stronger position with regard to disputes over benefits that were denied. Although ERISA preemption remains intact, the insured will have access to another layer of review.

Given the broad language of the provision,[91] however, it is unclear exactly what results this will lead to. If, despite the statute's language, the external review provided for by the PPACA ends up being ineffective, or if insurers are granted a

---

[88] *See* Cohen, *supra* note 78, at 956.

[89] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10101(g), 124 Stat. 119, 887–88 (2010).

[90] *Id.*

[91] *Id.* Health plans are required to implement external review procedures that meet "minimum standards" established by the Secretary that are "similar" to state external review provisions. *Id.*

significant amount of deference similar to that provided under *Firestone*,[92] the provision will end up having little actual impact on the insured, as they will continue to suffer from a lack of meaningful review options.

On the other hand, a standard of review that is too favorable to those challenging claims decisions could potentially lead to the approval of medical procedures—some of which are likely to be quite costly—that may be of little benefit, drive up health care expenditures, misallocate scarce resources,[93] and crowd the dockets of federal courts.[94] Given that there is a limit to the amount that any society is able to devote to health care expenditures, it is important to consider the interests of insurers and premium-payers as well.

In order to balance these competing interests, it is important to carefully consider which elements any external review process adopted under the PPACA should possess. A review process that favors the insured—many of whom will likely have highly sympathetic stories—without giving adequate consideration to cost and necessity could end up leading to a significant increase in health care expenditures, and to the misallocation of resources.[95]

---

[92] 489 U.S. 101 (1989).

[93] *See* Elhauge, *supra* note 21, at 1458–59 (addressing the issue of scarcity of resources as it applies to provision of health care and the need to limit use of health care resources).

[94] This is a valid concern, as in 2008 Americans alone spent more than $2.3 trillion on health care. *See* Saunier, *supra* note 30, at 483 (citing Centers for Medicare & Medicaid Services, U.S. Dep't of Health & Human Services, *National Health Expenditures Aggregate, Per Capita Amounts, Percent Distribution, and Average Annual Percent Growth, by Source of Funds: Selected Calendar Years 1960–2008* (2009), *available at* http://www.cms.hhs.gov/NationalHealthExpendData/downloads/tables.pdf). Costly new technologies and an aging population are putting upward pressure on that figure. Saunier, *supra* note 30, at 483.

[95] *See* Cohen, *supra* note 78, at 956.

IV. OPTIONS FOR EXTERNAL REVIEW PROCESS MECHANISMS

Considering the broad language of Section 10101(g) of the PPACA,[96] there are a number of potential options for external review processes that the Secretary could promulgate as the minimum standard. This section analyzes the elements of the different options for review processes, focusing on the effect that they would have on the competing interests of insurers and insureds.

A. Permanent Adoption of the Interim Procedures Outlined in Technical Release 2010-01

1. Description of the Procedures

On August 23, 2010, the Department of Labor issued Technical Release 2010-01 (the "release").[97] The release detailed two options for interim compliance with the external review provision of the PPACA, which, if adopted, would provide a safe harbor from enforcement action by the Department of Labor or the Internal Revenue Service.[98] One option is for self-funded plans that are not subject to a state's external review process to voluntarily adopt one.[99] The other option is for self-funded plans to comply with the specified processes set forth in the release.[100]

The release's external review process option consists of four steps.[101] While there are a number of requirements that come with each step, the basic procedure is relatively

[96] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10101(g), 124 Stat. 119, 887–88 (2010).

[97] U.S. DEP'T OF LABOR, EMP. BENEFITS SEC. ADMIN., TECHNICAL RELEASE NO. 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, *available at* http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf.

[98] *Id.* at 2.

[99] *Id.* at 3.

[100] *Id.* at 2.

[101] *Id.* at 3–6.

straightforward. First, claimants must be allowed to file requests for external review, and are required to do so "within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination."[102] Then, the health plan must complete a preliminary review to determine whether the claim is eligible for external review, and must notify the claimant if it is not.[103] After that, if the claim is eligible for external review, the insurer must send it to an independent review organization ("IRO").[104] Finally, if the IRO decision reverses the adverse benefit determination, the plan must provide coverage or payment.[105]

The process outlined also requires that claimants be allowed to make requests for expedited external review in situations where completion of a standard external review "would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function . . . ."[106] The other requirements for expedited review are similar to those for standard review. For expedited external reviews, the IRO must provide a final determination "as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after" the IRO receives the request.[107]

The process contains a significant number of requirements for the IROs, which must "review the claim de novo and not be bound by any decisions or conclusions reached during the plan's internal claims and appeals process . . . ."[108] Additionally, plans must contract with at least three accredited IROs and rotate among them, and an "IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of

[102] *Id.* at 3.
[103] *Id.*
[104] *Id.* at 4.
[105] *Id.* at 6.
[106] *Id.* at 6–7.
[107] *Id.* at 7.
[108] *Id.* at 5.

benefits."[109] IROs are required to use legal experts where appropriate, adhere to timelines and documentation requirements, provide written determination notices—which are themselves regulated—and maintain files after the final decision has been made.[110] Of particular note is the requirement that the determination notice that the IRO provides must contain "[a] statement that judicial review may be available to the claimant."[111]

2. Analysis of the Processes in the Release

Permanent adoption of this set of processes in the Release to fulfill the external review mandate could potentially level the playing field between the insured and insurers, as well as between individuals receiving health care through plans subject to state law and individuals receiving care through self-funded plans. It is unclear, however, whether it would lead to a proper balancing of interests, or whether it would instead result in reversals of claim denials, even in cases in which the care is unnecessary. The use of IROs for external appeals is not new. California, for example, enacted provisions mandating external review of health insurance decisions by IROs for specific cases in 1996,[112] and a look at its experience is instructive. In California, insurers are required to offer the option of external review by an IRO for "coverage decisions on experimental or investigational therapies."[113] A number of other states have similar provisions, many of which were enacted in the 1990s.[114]

These external review provisions, however, do not seem to be achieving their goals.[115] Overall, they are relatively

---

[109] *Id.* at 4.

[110] *Id.* at 6.

[111] *Id.* at 4–6.

[112] *See* Kathy L. Cerminara, *Dealing with Dying: How Insurers Can Help Patients Seeking Last-Chance Therapies (Even When the Answer is "No")*, 15 HEALTH MATRIX 285, 307 (2005) (citing Cal. Health & Safety Code § 1370.4 (West 2010)).

[113] CAL. HEALTH & SAFETY CODE § 1370.4 (West 2010).

[114] *See* Cerminara, *supra* note 112, at 306.

[115] *See id.* at 310.

lightly used.[116] Moreover, patients continue to "express dissatisfaction with, and distrust of, plan decision-making procedures when coverage is denied."[117] This is understandable, as people who are denied something they think they need are likely to be dissatisfied, regardless of whether the outcome is correct. Nonetheless, a perception of unfairness or dishonesty in the process is not good. Of particular interest in analyzing external review provisions is the reversal rate; external reviews overturn denials in about forty percent of cases in California.[118] A very high or very low reversal rate might suggest bias toward one side, either insurers or the insured. The rate is thus encouraging, although it is unfortunately not possible to draw definitive conclusions from it.

While this data provides some insight, it is important to recognize that Technical Release 2010-01's external review processes are different from the California provisions.[119] First, the California provisions are applicable to "coverage decisions regarding experimental or investigational therapies" while the Technical Release 2010-01 provisions apply more broadly.[120] Moreover, the process that IROs must follow under Technical Release 2010-01 is more regulated, which could potentially lead to different results.[121] Thus, it is difficult to draw meaningful conclusions from California's experience with external review using IROs and apply them to the process provided for in Technical Release 2010-01.

---

[116] *See id.*

[117] *Id.*

[118] *See* Pollitz et al., *supra* note 15, at vi.

[119] *See* CAL. HEALTH & SAFETY CODE § 1370.4 (West 2010); U.S. DEP'T OF LABOR, TECHNICAL RELEASE NO. 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 (2010), *available at* http://www.dol.gov/ebsa/pdf/ACATechnical Release2010-01.pdf.

[120] *See supra* note 119.

[121] *See* U.S. DEP'T OF LABOR, *supra* note 119. The technical release contains significantly more procedural requirements, ranging from regulations pertaining to selection of the IRO to information that must be contained in the decision notice. *Id.*

Nonetheless, the process provided for in Technical Release 2010-01 contains a number of provisions that have the potential to provide for a balanced review of claim denials. The requirement that insurers utilize multiple IROs, the ban on compensation based on likelihood of denials, and the accreditation requirement, are likely to help ensure that IROs are actually, and not just formally, independent.[122] Additionally, the detailed regulations on timing and documentation will likely provide both a level of consistency among the decisions and data for regulators and legislators reviewing programs.[123] In a broader sense, the use of accredited IROs will probably mean that knowledgeable decisionmakers, rather than inexperienced ones, are considering the claims denials.

Overall, however, given the recent release of this process, predicting how effective it would be in providing a balanced review is difficult at best. While a forty percent reversal rate in California is encouraging evidence that IROs are not exhibiting a strong bias to either the insurers or the insureds, it is difficult to draw additional inferences given current data limitations.

B. Review by State-Appointed Panel

1. Description of the Procedures

In three states—Florida, Hawaii, and New Mexico—external review is done by a panel of state-appointed committee members, who may consult with outside medical experts on a case-by-case basis.[124] Unlike in the process in Technical Release 2010-01, where accredited IROs that are not state entities are hired by insurers to conduct external review, in these states the reviewing committee is state-appointed.[125]

---

[122] *See id.*

[123] *See id.* For example, IROs are required to provide a decision notice containing seven specific items. *Id.*

[124] *See* Pollitz et al., *supra* note 15, at 15.

[125] *See id.*

New Mexico's process provides a baseline model that could potentially be modified if the Secretary decides to adopt this form of external review. The provisions are highly detailed—much more so than those in Technical Release 2010-01.[126] The key difference between the New Mexico external review provisions and the IRO process, however, pertains to the role of the state. First, the Superintendent of Insurance serves as the gatekeeper.[127] Instead of filing a request for external review with the plan, the claimant files with the Superintendent of Insurance, who manages the process and determines whether the requirements for external review have been satisfied.[128]

If external review is granted, the Superintendent of Insurance "may designate a hearing officer who shall be an attorney licensed to practice in New Mexico."[129] In addition, the hearing need not be in person—it may be conducted using a wide range of technologies, including video conferencing, at the insurance division's expense.[130] The Superintendent must "consult with appropriate professional societies, organizations, or associations to identify licensed health care and other professionals who are willing to serve as independent co-hearing officers in external reviews."[131] Thus, the state maintains control over the panel that conducts the external review through the selection of its members. As opposed to outsourcing to IROs, if the federal government were to mandate a substantially similar process, it would maintain control over access to review, the process, and the appointment of officers.

Before analyzing the merits and drawbacks of adopting this provision, it is important to note that the remedies that external review panels may grant are circumscribed by the

---

[126] *See generally* N.M. CODE R. § 13.10.17 (LexisNexis 2010).

[127] *Id.*

[128] *See* N.M. CODE R. § 13.10.17.25 (LexisNexis 2010); N.M. CODE R. § 13.10.17.27 (LexisNexis 2010).

[129] N.M. CODE R. § 13.10.17.30 (LexisNexis 2010).

[130] *See id.* Alternatively, the Superintendent of Insurance may personally regulate the proceedings. *Id.*

[131] N.M. CODE R. § 13.10.17.31(A) (LexisNexis 2010).

principle of ERISA preemption.[132] In *Hawaii Management Alliance Ass'n v. Insurance Commissioner*,[133] Hawaii's external review provision was found to be preempted by ERISA because it contained provisions "allowing for a judicial determination of the claimant's entitlement to benefits" that directly conflicted with ERISA.

2. Analysis of Review by State-Appointed Panel

Like the aforementioned external review provisions involving the use of IROs, external review processes by state-appointed boards are lightly used, which makes it difficult to draw many inferences from the data pertaining to their use.[134] Despite this uncertainty, it is notable that about half of the adverse claim decisions are overturned.[135] This even split may suggest that the state-appointed panels do not exhibit a significant amount of pro-insurer or pro-claimant bias. Another notable feature of the Florida external review process is that the cost per case is on the lower end of the spectrum.[136]

On the other hand, the political appointment of panel members may unduly influence the external review process. If left unchecked, interest group influence over board appointment could upset the balance of interests and create an appearance of impropriety in the eyes of the public. Moreover, managing the process could become burdensome if it is heavily used, an issue that current external review

---

[132] Haw. Mgmt. Alliance Ass'n v. Ins. Comm'r, 100 P.3d 952, 966–67 (Haw. 2004).

[133] *Id.*

[134] *See* Pollitz et al., *supra* note 15, at vi. Unfortunately, the report does not contain cost information for New Mexico or Hawaii. The data provided demonstrates very low numbers of cases handled by external review processes. *Id.* For example, in the year studied, there were only 421 cases accepted in California. *Id.*

[135] *See id.* at 25–27.

[136] *See id.* The cost per case in Florida is listed at $309. For the other states that provided costs per case, the amounts ranged from $280 to $2200.

processes do not face.[137] At the same time, if managed well, increased control could allow for closer monitoring of the independence of reviewers.

Another concern pertains to the design of the plan. A significant amount of care would need to be taken to ensure that review mechanisms and potential remedies do not conflict with ERISA. While the external review provision of the PPACA has the potential to provide for a review of claims determinations that is otherwise unavailable to persons insured by self-funded plans,[138] a poorly designed plan would have little real effect, due to a combination of the effects of ERISA preemption and the decision in *Firestone* granting insurers a highly deferential standard of review.[139] Specifically, an external review process involving a federally appointed board could follow in the footsteps of Hawaii's external review provisions and be struck down with regards to self-funded plans.

Overall, many of the benefits and drawbacks that would result from the adoption of a process similar to the processes of New Mexico, Hawaii, or Florida are the same as those that apply to the process provided in Technical Release 2010-01. A thorough, regulated process presided over by independent medical experts has the potential to provide meaningful review that analyzes the competing interests at stake in these decisions. Unfortunately, at this point, it is not possible to determine how well this would achieve the goal of a balanced external review on a federal level.

---

[137] *See id.*

[138] *See supra* sections II.B.2–3.

[139] Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109 (1989) (holding that a deferential standard of review is applicable when ERISA fiduciaries have discretionary authority to determine eligibility for benefits).

C. Judicial Review

1. Description of Processes

Another potential external review provision would be to expand access to court review for claimants. This has been referred to as a "right to sue."[140] Nine states have external review provisions explicitly outlining or expanding the grounds on which enrollees can bring suit against a managed care organization in state court.[141] There is a significant amount of variation in the rights granted in these states. In right to sue states (excluding Arizona) a claimant must first participate in the external review process.[142] West Virginia requires that the claimant win the external review process.[143]

There is also variance with regard to the relation between the external review process and any subsequent lawsuit. Seven of the nine states treat the external review process as separate from judicial action by excluding evidence considered from the external review process from admission in judicial proceedings.[144] In Maine and Georgia, however, evidence from the external review process is considered admissible in a lawsuit and in Georgia the external review decision creates a rebuttable presumption in favor of the winner.[145] This explicit judicial remedy, whether linked to or separate from the external review process, provides another level of review.

Although ERISA preempts many state court actions against insurers of self-funded plans, claimants may have the option to bring cases pertaining to these plans in federal court.[146] Technical Release 2010-01 recognizes this judicial remedy and contains a provision mandating that IROs give

---

[140] *See* Pollitz et al., *supra* note 15, at 28.

[141] The nine states are Arizona, California, Georgia, Maine, New Jersey, Oklahoma, Texas, West Virginia, and Washington. *Id.*

[142] *See* Pollitz et al., *supra* note 15, at 28.

[143] *Id.*

[144] *Id.*

[145] *Id.*

[146] *See* 29 U.S.C. § 1132.

claimants notice that judicial review may be available.[147] However, *Firestone* requires courts to give deference to insurers and to review their claims under an "arbitrary and capricious" standard, which in many cases has the effect of denying meaningful judicial review to claimants.[148]

In defining the external review process, the Secretary could emulate the "right to sue" states by tying the judicial system to external review provisions and creating an explicit forum for *de novo* review of claim denials in federal court. Specifically, the statute gives the Secretary the authority to establish minimum standards for the process that are similar to state processes,[149] some of which, as discussed above, contain a right to sue.[150] This would most likely be effective if provided in conjunction with one of the aforementioned external review processes. The overall effect would be to create another level of potentially meaningful review for the insured. This option is a highly flexible one, as evidenced by the wide variance in procedures of the nine states that provide an explicit right to sue.

2. Analysis of Judicial Review

Given the broad range of forms that this explicit federal judicial review could take—from two distinct sets of review, as in Arizona, to two linked processes, as in Georgia—it is difficult to make generalizations about its effects.[151] Despite this uncertainty, there are a number of potential results that merit consideration.

---

[147] *See* U.S. DEP'T OF LABOR, EMP. BENEFITS SEC. ADMIN., Technical Release No. 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, at 6 (2010), *available at* http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf.

[148] *See* Cohen, *supra* note 78, at 956. Proving that an insurer's decision was arbitrary and capricious presents "a substantial, often insurmountable hurdle." *Id.*

[149] Patient Protection and Affordable Care Act, § 10101(g), 42 U.S.C. § 300Gg-10 (2010).

[150] *See* Pollitz et al., *supra* note 15, at 28.

[151] *See supra* section IV.C.1.

The first issue is the effect on the federal court system. The deferential standard of *Firestone*[152] and the rejection of *de novo* review in *Glenn*[153] are likely having the current effect of deterring claimants from bringing cases against insurers in federal court. A *de novo* standard would probably lead to more suits, which would impose a potentially significant burden on a federal judicial system that is already being stretched thin.[154] While those who have suffered injury should not be barred from court solely for the convenience of the system, the Secretary should consider the scarcity of judicial resources when promulgating any external review processes.

Another important consideration is the expertise of judges. In the two aforementioned external review processes, IROs or expert panels, independent reviewers who presumably have significant knowledge about medicine and/or insurance are making decisions. In a federal courtroom, however, those in charge of the review will be judges who are likely less fluent in insurance and medical care issues. In light of the complex technological and medical questions involved in these cases, federal judges may not be best suited to make these decisions. Moreover, given the sentimental nature of many of these cases, there is a risk that sympathetic judges will approve procedures that

---

[152] Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 109 (1989).

[153] Metro. Life Ins. Co. v. Glenn, 554 U.S. 105, 116 (2008).

[154] *See* Jon O. Newman, *Restructuring Federal Jurisdiction: Proposals to Preserve the Federal Judicial System*, 56 U. CHI. L. REV. 761, 761 (1989) (arguing that the number of cases in federal courts is growing at too fast a rate, threatening the quality of the federal judiciary and therefore federal jurisdiction should be restructured to route some cases from federal to state courts). Eric H. Holder Jr., Op-Ed., *Now Vacant: A Confirmation Crisis in Our Courts*, WASH. POST, Sept. 28, 2010, at A25 (stating that a vacancy on the Sixth Circuit "had been declared a 'judicial emergency' because the Sixth Circuit does not have enough judges to promptly or effectively handle the court's caseload, leading to serious delays in the administration of justice to people in Tennessee and other parts of the 6th Circuit").

are not medically necessary based on emotional considerations.[155]

On the other hand, there are a number of reasons that *de novo* review of claims might be a viable option. One is that judicial review will create a body of precedent. The external review process proposed in Technical Release 2010-01 requires the use of at least three different IROs[156] while the New Mexico state-appointment system gives the Superintendent of Insurance a significant amount of discretion in appointing review panels.[157] There is a significant risk that these types of appointment systems will lead to inconsistent decisions. Establishing a body of precedent through judicial review could lead to more consistency, and could perhaps even avert litigation in the future, as both sides will know where they stand, especially in situations that arise frequently.

Finally, creating an explicit right to sue with *de novo* review has a somewhat intuitive appeal. One effect of ERISA preemption is that it shuts claimants who suffered injuries as a result of utilization review decisions out of state courtrooms.[158] *Firestone* has all but closed the doors of federal courts as well in the majority of cases.[159] Helping the underdog obtain medical care is appealing. This argument is flawed, however. If taken too far, it will lead to approval of unnecessary care simply because claimants desire it or think

---

[155] Judicial opinions involving review of insurance claims are frequently fraught with sentimental language evidencing partiality to claimants. *See, e.g.*, Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49, 52 (D. Mass. 1997) ("The tragic events set forth in Diane Andrews-Clarke's Complaint cry out for relief . . . . Does anyone care? Do you?"). The use of this charged language and rhetoric evidences the entry of emotion into the decision making process.

[156] DEP'T OF LABOR, TECHNICAL RELEASE NO. 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 (2010), *available at* http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf.

[157] N.M. CODE R. § 13.10.17.30 (2010).

[158] *See* Hermer, *supra* note 66, at 31.

[159] Firestone Tire & Rubber Co. v. Bruch, 489 U.S. at 109 (1989).

it will help and will contribute to the misallocation of scarce medical resources. Despite this, it is important to at least address this argument as it is likely to be raised in debates on the topic.

Overall, there are a number of benefits to creating an explicit right to sue in federal court with *de novo* review, namely, the addition of another level of review, a leveling of the playing field once inside federal courthouses, and the creation of a body of precedent. At the same time, there are also downsides, including the overburdening of courts that are likely not to be as knowledgeable about medicine and the appropriateness of medical technologies as independent external reviewers would be.

D. Other Options

There are many other options that the Secretary could consider that differ more significantly from currently available state external review processes. While it would be impossible to discuss them all, this Section touches briefly upon a few, and discusses their costs and benefits. As a threshold consideration, however, it is important to briefly revisit the language of the PPACA—specifically, the use of the word "similar" with respect to state external review processes.[160] Although broad, this provides a boundary. Thus, this Note will not consider processes without any relation to current state processes. As these state processes change in the future, however, this may need to be revisited.

In looking at these options, this Note will focus on elements that are likely to be effective at achieving an efficient review process that balances the provision of care to those whom it would benefit and at averting unnecessary health care expenditures. One such option is the use of arbitration to handle disputes over claims denials between insurers and individuals receiving healthcare through self-funded plans.

[160] Patient Protection and Affordable Care Act, § 10101(g), 42 U.S.C. § 300Gg-10 (2010).

1. Arbitration

Arbitration has a number of recognized benefits, including "confidentiality, speed, and party autonomy."[161] Moreover, it is highly flexible and controlled by the users, who "can customize a process suited to their own needs, including the selection of an expert adjudicator."[162] It has also been recognized as a method of easing the aforementioned burden on the courts.[163] Overall, it represents a highly adaptable, often speedy, and broadly used dispute resolution mechanism.

Given the high level of variability among arbitration processes, any analysis of specific strengths and weaknesses of arbitration as an external review process will necessarily be lacking. Despite this, it is possible to address broader themes. If arbitration is performed in a timely fashion by knowledgeable, neutral, and consistent arbitrators, it could be a very good method for resolving disputes between insurers and the insured. On the other hand, it is easy to imagine sub-optimal outcomes where ill-prepared arbitrators resolve disputes over claim determinations using a process that is biased in favor of either the claimant or the insurer. Thus, while arbitration has a significant number of potential benefits, it is difficult to assess its potential efficacy as a review process given the many uncertain factors. Nonetheless, it is an option with much potential.

2. Health Courts

The use of a system of health courts to resolve disputes may also be considered. The term "health courts" is commonly used to refer to special court systems created to

---

[161] Shelley McGill, *Consumer Arbitration Clause Enforcement: A Balanced Legislative Response*, 47 AM. BUS. L.J. 361, 364 (2010) (discussing approaches taken by courts to enforcement, or refusal to enforce, of pre-dispute arbitration clauses).

[162] *Id.*

[163] *See id.* at 365.

resolve medical malpractice claims.[164] Proponents of health courts cite a number of benefits, including decreased litigation costs compared to the general court system, knowledgeable adjudicators, consistency, and efficiency.[165] Applying this model and using it for external review of claims determinations, instead of medical malpractice cases, is a potential option.

Of course, it is important to consider that health courts might not be "similar" to existing state processes, as required by the PPACA.[166] States use a combination of IROs, panels, and courts for external review processes, not a separate health court system.[167] Setting this aside for the purpose of considering the use of these courts, however, the adoption and creation of a health court system does have a number of potential upsides. It provides many of the benefits that come from the use of a judicial system, including the creation of a body of precedent and the extensive procedural mechanisms afforded to litigants. At the same time, it will likely not add significantly to the burden of the general court system, and will employ knowledgeable adjudicators.

The use of health care courts, however, also has its drawbacks. Litigation is notoriously expensive and slow, and may continue to be so even in specialized courts.[168] One of the benefits of a number of the aforementioned options is speed.[169] Even in dedicated courts, it would be hard to

---

[164] *See* Freeman L. Farrow, *The Anti-Patient Psychology of Health Courts: Prescriptions from a Lawyer-Physician*, 36 AM. J.L. & MED. 188, 188–89 (2010) (discussing the way in which health courts will lead to a pro-industry bias).

[165] *See id.* at 189.

[166] Patient Protection and Affordable Care Act § 10101(g), 42 U.S.C. § 300Gg-10 (2010).

[167] *See* Pollitz et al., *supra* note 15, at v.

[168] *See* Harry T. Edwards, *Alternative Dispute Resolution: Panacea or Anathema?*, 99 HARV. L. REV. 668, 669 (1986) (discussing some of the benefits and drawbacks of alternative dispute resolution and mentioning some of the issues currently facing litigation, including costs and burdens on judicial resources).

[169] *See* DEP'T OF LABOR, TECHNICAL RELEASE NO. 2010-01, INTERIM PROCEDURES FOR FEDERAL EXTERNAL REVIEW RELATING TO INTERNAL

replicate this. Moreover, the issue of biased adjudicators, as discussed above, could be problematic in a health court system as well. Thus, while creating a separate system of "health courts" to handle external reviews has a number of potential merits, a cursory analysis reveals several potential problems that would need to be addressed in implementation of any "health court" system.

V. CONCLUSION

Given the difficult nature of the decisions that must be made when reviewing the denial of a health insurance claim, and the significant number of factors that must be taken into account, it is hard to imagine that there is a single "perfect" external review process that could be implemented by the Secretary as a minimum standard to fulfill the external review mandate of the PPACA. Every process has at least some drawbacks and numerous uncertainties. Nonetheless, analysis demonstrates that each process has the potential to provide for balanced review. Specifically, the process outlined in Technical Release 2010-01 is a particularly good option, because it contains multiple mechanisms that will enable it to play a role in optimizing the distribution of scarce health care resources—namely, independent reviewers, provisions to ensure this independence is not lost, and a relatively clear and explicit process.

Regardless of which option the Secretary promulgates, however, it is imperative that the Secretary analyze the external review process options in terms of the ability to provide a balanced review that will achieve as optimal an allocation of health care resources as possible. This is particularly urgent given the consistent development of expensive new medical technologies and the rapid graying of

CLAIMS AND APPEALS AND EXTERNAL REVIEW UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (2010), *available at* http://www.dol.gov/ebsa/pdf/ACATechnicalRelease2010-01.pdf; McGill, *supra* note 162, at 364 (listing speed as one of the benefits of arbitration).

the American population,[170] which is likely to lead to increased demand for health care. Specific elements of external review processes have the potential to lead to structural biases in favor of either insurers or the insured.

From a visceral standpoint, it is understandable that many individuals will favor claimants because many have sympathetic stories.[171] Because of ERISA preemption, these claimants are precluded from many forms of review and remedies. Moreover, insurers offering self-funded plans have incentives to deny care to keep costs down, and are shielded from several types of liability by ERISA. Despite this, there is a limit to the resources that can be devoted to health care. It is imperative that the Secretary be cognizant of and account for both of these forces in establishing the minimum standard for the external review process that the PPACA mandates be made available to individuals covered by self-funded plans.

[170] Natasha Singer, *In a Graying Population, Business Opportunity,* N.Y. TIMES, Feb. 6, 2011, at BU1, *available at* http://www.nytimes.com/2011/02/06/business/06aging.html (discussing business opportunities created by the aging population of the US). In 2010, there were over 41 million individuals over the age of 65 in the United States, representing 13% of the population of the United States. By 2050, this number is expected to grow to over 87 million persons, or 21.6% of the population of the United States.

[171] *See, e.g.*, Andrews-Clarke v. Travelers Ins. Co., 984 F. Supp. 49 (D. Mass. 1997).