WHAT'S THE APPEAL? TRYING TO CONTROL MANAGED CARE MEDICAL NECESSITY DECISIONMAKING THROUGH A SYSTEM OF EXTERNAL APPEALS

AARON SETH KESSELHEIM

[Ralph] Benedetto, 44, a disabled Medicaid patient, contracted hepatitis B 10 years ago from a blood transfusion he received after he was struck by a drunken driver. Two years ago, his doctors said his disease had progressed to the point where he could die at any moment without a liver transplant. But his health maintenance organization refused to pay for the treatment.

The H.M.O. . . . cited guidelines issued by the state of Florida recommending against liver transplants to hepatitis B patients . . .

. . .

[But e]xperts say there is now wide agreement that hepatitis B, in and of itself, is no longer a valid reason to deny someone a liver transplant.

. . .

In the end . . . the case had prompted senior agency officials to make an immediate change in the agency's rule on hepatitis B [and the H.M.O. had agreed to move forward with the transplant] . . . [b]ut now Mr. Benedetto may no longer be a viable candidate.1

INTRODUCTION

Armed with Mr. Benedetto's story and similar anecdotes, the United States Senate and House of Representatives each passed land-
mark patient protection legislation during the 106th Congress\(^2\) to support the interests of Americans who receive their health insurance from a managed care organization ("MCO").\(^3\) MCOs had grown in popularity through the 1980s and 1990s due in part to their promise to reduce medical costs by contractually restricting payment to medical treatment that they considered to be "medically necessary."\(^4\) As a centerpiece of their new patient protection efforts, however, federal legislators have granted MCO enrollees the right to appeal such deni-


\(^3\) A managed care organization is:

[A]ny health coverage arrangement in which, for a pre-set fee . . ., a company sells a defined package of benefits to a purchaser, with services furnished to enrolled members through a network of participating providers who operate under written contractual or employment agreements, and whose selection and authority to furnish covered benefits is controlled by the managed care company.

RAND E. ROSENBLATT ET AL., LAW AND THE AMERICAN HEALTH CARE SYSTEM 551-52 (1997) (emphasis omitted). MCOs include health maintenance organizations, preferred payer organizations, and similarly structured forms of managed care medical insurance. See Eric R. Wagner, Types of Managed Care Organizations, in PETER R. KONGSTVEDT, ESSENTIALS OF MANAGED HEALTH CARE 36-48 (2d ed. 1997) [hereinafter ESSENTIALS OF MANAGED HEALTH CARE] (describing the different types of MCOs). The federal patient protection laws proposed in 1999 and 2000 covered the 140 million privately insured Americans in MCOs. See ROSENBLATT ET AL., supra, at 544 (giving the 1995-1996 enrollment statistics for MCOs). A significant percentage of Americans receiving government-sponsored health insurance through Medicaid and Medicare are also enrolled in MCOs, but federal law already provides these enrollees with a meaningful independent appeals process. See Eleanor D. Kinney, Protecting Consumers and Providers Under Health Reform: An Overview of the Major Administrative Law Issues, 5 HEALTH MATRIX 83, 87-109 (1995) (reviewing the federal constitutional and administrative protections available to aggrieved patients enrolled in Medicaid- and Medicare-sponsored MCOs); see also sources cited infra note 44 (discussing further the appeals process open to Medicare- and Medicaid-MCO enrollees).

\(^4\) Infra notes 27-39 and accompanying text (detailing the cost-containment tactics of MCOs).
als of insurance coverage and have established independent review organizations to judge the true necessity of the medical service. Consumer advocates had long endorsed the concept of independent review organizations to which patients could appeal their MCO's medical necessity determinations as a way of ensuring the scientific basis of such determinations. Commentators had envisioned neutral arbitration panels empowered to analyze the relevant objective scientific evidence in order to ensure that MCOs were not violating their enrollee contracts and denying patients medically necessary care. For patients otherwise trapped in the red tape of their MCO—such as Mr. Benedetto—a well delineated, timely appeals procedure and an impartial mediator could help overturn potentially life-threatening decisions.

As evidenced by the specific provisions enacting the external appeal privilege, however, federal legislators were not satisfied simply to grant patients the right to appeal to a neutral, third-party decision-maker. The language of both federal patient protection bills is striking in its departure from the commentators' conception of an appeals body as a neutral, scientific adjunct. Rather, the House and Senate bills expand the right to appeal and secure the superiority of the patients' position in the appeals process through such tactics as explicitly...
assigning burdens of proof for external reviews, listing sources and types of evidence on which the reviewers must rely, and giving independent reviewers wide-ranging authority to overturn MCO coverage determinations. For example, the House Bipartisan Consensus Managed Care Improvement Act of 1999 requires external reviewers to make a "fair and de novo" determination, lists the types of evidence the reviewers should consider, and notes that the reviewers are not bound by the definitions of "medical necessity" included in the health plan's insurance contract. What happened to the modest goals and the neutral, scientific ideal that characterized the movement toward independent review organizations?

This Comment examines the origin and evolution of the laws that permit appeals of MCO determinations to external bodies in order to explain the astonishing adversarial stance seen in the recent legislative efforts. Such historical analysis suggests that Republican and Democratic legislators' implicit goal in creating external appeals systems is to use independent review organizations as proxies for taking medical decisionmaking control away from MCOs and returning it to physicians. This Comment suggests, however, that because of inherent shortcomings in the external appeals system, granting MCO enrollees the right of independent review is not an appropriate means of achieving that end. Part I details the emergence of MCOs and patient advocates' concomitant efforts to promulgate external grievance procedures for MCO enrollees. Part II investigates representative examples of state laws instituting the right to appeal adverse MCO benefit determinations to independent review organizations. While before
1997 only Rhode Island had an official external review process, by 1999 thirty states and the District of Columbia had established rights to external review for private health plan enrollees. This Part reveals how state legislators generally expanded the rhetorical and actual scope of authority of independent review organizations over time. Part III looks at the development of patient protection acts proposed in the United States Congress during the same time frame. Part IV posits an explanation for the trend toward granting independent review organizations more authority to overturn MCO "medically necessary" determinations, characterizing it as an attempt by legislatures to impose a fee-for-service regime onto the managed care health care coverage system. Finally, Part IV also interprets legislative efforts to


12 Patient advocates considered such federal protection necessary to extend the right of independent review of medical necessity determinations to all Americans enrolled in MCOs and to avoid possible federal law preemption of the state legislative efforts. The federal law that patient advocates feared would preempt state legislative efforts was the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 (1994), which spares employer-sponsored MCOs—two-thirds of all MCO enrollees are covered by MCOs through their employers—from regulation by state insurance, contract, tort, and other law. See ROSENBLATT ET AL., supra note 3, at 160-61. The fear of ERISA preemption was realized in Corporate Health Insurance, Inc. v. Texas Department of Insurance, 12 F. Supp. 2d 597 (S.D. Tex. 1998), aff'd in part, rev'd in part, 215 F.3d 526 (5th Cir. 2000) where the court struck down a Texas state law instituting the right of independent review of adverse MCO "medically necessary" determinations because the relevant provision "related to" the services offered by the state's ERISA-covered MCOs. Id. at 611-14. For further discussion of ERISA's influence on the development of MCO enrollees' right of independent review, see sources cited infra note 75.
institute interventionist external appeals processes as a futile attempt at improving health care delivery to the vast majority of people in managed care systems, and explains that the attempt fails because of procedural and theoretical deficiencies in the appeals system.

I. MANAGED CARE ORGANIZATIONS AND THE DEVELOPMENT OF THE APPEALS PROCESS

This Part tracks the development of the external appeals mechanism as it emerged in response to changing American health care reimbursement practices. First, it examines traditional fee-for-service health insurance and the principal justifications for the MCOs that led the managed care revolution in the late 1980s and early 1990s.16 Second, it focuses on one novel MCO practice, prospective and concurrent utilization review, in which MCO officers review prescribed medical services to ensure that enrollees receive only those that are truly "medically necessary." This practice leads many to call for a mechanism by which MCO enrollees could appeal such determinations to independent, neutral experts, thus ensuring that MCOs were not prioritizing cost-containment and profitability over the health of their enrollees.17 Third, this Part analyzes the efforts of legal commentators and champions of patients' rights who suggested certain substantive and procedural features fundamental to an equitable appeals process.18 Ultimately, patient advocates found widespread success, as over thirty states and, most recently, the U.S. Congress, passed legislation setting up the right to external appeal.19

A. The Evolution of Health Care Insurers' Control over Physician Decisionmaking

In the traditional "fee-for-service" design of reimbursement for medical services, health care providers charged a certain fee for each

16 See infra Part I.A (arguing that the pursuit of cost-containment led MCOs to become the dominant payers for health care by the early 1990s).
17 See infra Part I.B (describing consumer advocates' concerns with the tactics used by MCOs to limit expenditures on health care).
18 See infra Part I.C (outlining commentators' and patient advocates' visions for an appeals process that would help curb the perceived cost-containment excesses of managed care).
19 See supra note 14 and accompanying text; infra text accompanying note 76 (giving a brief overview of the degree to which MCO enrollees' right to appeal adverse "medically necessary" benefit determinations to an independent review organization has been codified by state legislatures).
aspect of the medical care they rendered, and patients generally entered into contracts with indemnity insurers to cover their medical costs. The physician prescribed a course of treatment and then undertook to deliver that care, submitting the bill to the insurer after the completion of the medical service. While indemnity insurers reimbursed physicians only for services considered "medically necessary," two features of the fee-for-service system helped avoid disputes over reimbursement and the propriety of physician prescription practices. First, fee-for-service insurers by nature examined the medical necessity of a particular treatment only after the patient had received it. Second, traditional insurers usually abided by the health care provider's judgment as to the proper medical care, rarely denying payment for services. Thus, under the fee-for-service system, providers freely undertook the medical treatments or procedures they thought necessary.

While fee-for-service medicine emphasized the primacy of the provider/patient relationship by not questioning the health care provider's prescribed course of action, the fact that reimbursement for physicians was not limited to those services that were medically necessary undeniably provided an incentive for physicians to overuse medical resources. Partly as a result, by the early 1980s, the health care

---

20 Marc A. Rodwin, Managed Care and Consumer Protection: What Are the Issues?, 26 SETON HALL L. REV. 1007, 1009 n.1 (1996) ("Under traditional indemnity insurance and fee-for-service medical practices, the insurers enter into a contract with the insured party and reimburse the individual for certain medical expenses that are incurred.").

21 See Scott Thornton, Comment, The Texas Health Care Liability Act: Managed Care Organizations Can Say Goodbye to Their Extensive Immunity from Lawsuits—or at Least That Was How It Was Supposed to Work, 30 TEX. TECH L. REV. 1227, 1231 (1999) (describing the fee-for-service system and noting that "[t]he entity receiving the request for payment considered the necessity of the treatment only after the service had been performed").


23 Edward B. Hirshfeld & Gail H. Thomason, Medical Necessity Determinations: The Need for a New Legal Structure, 6 HEALTH MATRIX 3, 5 (1996) (describing the "traditional medico-legal system" as one in which "health care providers were expected to act in the best interests of the patient... [and] [i]nsurers paid for such care without question").

24 See Peter R. Kongstvedt, Compensation of Primary Care Physicians in Open Panel Plans, in ESSENTIALS OF MANAGED HEALTH CARE, supra note 3, at 130 (noting that "[i]n a system where economic reward is predicated on how much one does... it is only human nature to do more, especially when it pays more"). Other features of the American health care system also contributed to the over-prescription of medical services. For example, many commentators point to the rise of medical malpractice lawsuits from the 1960s to the 1980s that led many physicians toward "defensive medi-
system generated massive costs-reaching 13.5% of America's total gross domestic product—that threatened the continued availability of health insurance to Americans. Consequently, in the late 1980s, managed care organizations grew in popularity among purchasers of health insurance because of the managed care industry's promise to rein in the costly excesses of the fee-for-service insurance system.

MCOs offered enrollees lower cost health insurance by exerting more control than their indemnity insurance competitors over the delivery of medical services. MCOs restrained "the kind, volume, and manner in which services are provided" either directly through rules and organizational controls limiting the options available to health care providers or indirectly by modifying health care providers' behavior through financial incentives. MCOs implemented cost-saving strategies across the entire spectrum of health care delivery, including fixing payments for services and limiting access to more expensive medical specialists. Most significantly, however, MCOs worked to eliminate excessive services through a stronger commitment to reviewing care recommended by physicians and refusing to authorize treat-
ments deemed unnecessary. The next section focuses on the controversy created by the strategy MCOs used to limit medical services to those that are "medically necessary"—a process known as "utilization review"—and then describes the subsequent support for an external appeals system to guard against potential abuses of the utilization review process.

B. MCO Utilization Review and the Call for Independent Review Mechanisms

Utilization review refers to the practice of analyzing the medical procedures, treatments, or services prescribed by health care providers to ensure that they are neither improper nor frivolous under the circumstances. Akin to those of indemnity insurers, MCO contracts typically covered only benefits that they considered "medically neces-

2 ROSENBLATT ET AL., supra note 3, at 212 (explaining that MCOs' "use[] [of] the medical necessity... criteri[on] to question the treating physician's judgment" first arose in the late 1970s, while previously "[m]any insurance policies did not even contain language excluding medically unnecessary... care"). The rise of the MCOs' medical necessity criterion has been explained as follows:

Several factors have combined to [promote the use of a medical necessity criterion by MCOs]. The most obvious has been the sharp health care cost increases from 1965 to the present, and consequent pressure on employers and government to use more aggressive techniques to deny claims. Second, medical technology has developed a number of highly expensive and hazardous treatments for severe illness—such as organ and bone marrow transplants—whose efficacy in some circumstances is open to question. Third, research comparing geographical differences in the rates at which doctors use certain procedures has found large differentials without clear justification in patient demographics or outcomes.

Id. at 212-13. In addition to studies showing disparate provision of medical care in different geographic areas, other research indicated that nearly 12,000 Americans died in one year from unnecessary surgeries. SUBCOMM. ON OVERSIGHT AND INVESTIGATIONS, HOUSE COMM. ON INTERSTATE AND FOREIGN COMMERCE, 94TH CONG., COST AND QUALITY OF HEALTH CARE: UNNECESSARY SURGERY (Comm. Print 1976) (finding that 11,900 deaths occurred from unnecessary surgeries in 1975); see also Richard I. Smith, Pro & Con: In Search of Fairness in Patient Care, N.Y. TIMES, Mar. 9, 1999, at F7 (supporting MCOs' utilization review tactics in the context of arguing that patients should not be able to sue their health plans). These studies indicated that health care providers, when given autonomy in making determinations about medical necessity, were not using scientific principles in their decisionmaking. Through utilization review, health plans intended to "improv[e] the medical knowledge... available to practicing physicians." Hirshfeld & Thomason, supra note 23, at 20.

2 ROSENBLATT ET AL., supra note 3, at 377-78 (explaining that the function of a utilization review committee was "to review the medical necessity of hospitalization, length of stay, and professional services"); see also Jack K. Kilcullen, Gropping for the Reins: ERISA, HMO Malpractice, and Enterprise Liability, 22 AM. J.L. & MED. 7, 22-25 (1996) (describing private utilization review as a cost-cutting tool).
sary"—excluding, for example, experimental care, nonstandard treatments, treatments without any known benefits, and cosmetic surgery—and, like traditional insurers, MCOs reviewed physician treatment plans to enforce the "medically necessary" standard. Whereas the utilization review process employed by indemnity insurers was retrospective and largely dormant in practice, MCOs expanded the role of utilization review in determining health care coverage. MCOs continued to engage in retrospective review by examining providers' medical decisionmaking for overuse of services, such as referrals to specialists. Yet MCOs went further, establishing systems of prospective and concurrent utilization review for most medical services. The system of prospective utilization review mandated that health care providers approve the initiation—or, in the case of concurrent review, the continuation—of medical treatment for individual enrollees. Providers were required to contact the MCO, whose utilization reviewers analyzed the propriety of the suggested regimen for the particular patient's circumstances based on a set of predetermined criteria. Thus, through the prospective and concurrent methodologies, the MCO's review and subsequent refusal of authorization could lead to the prompt end or complete prevention of a treatment regimen deemed unnecessary.

35 See supra text accompanying notes 22-23 (describing the two key features of indemnity insurers' review of physician decisionmaking regarding treatment alternatives).
38 For a detailed description of the prospective utilization review process, see INSTITUTE OF MEDICINE, CONTROLLING COSTS AND CHANGING PATIENT CARE? THE ROLE OF UTILIZATION MANAGEMENT 17-18 (Bradford H. Gray & Marilyn J. Field eds., 1989). See generally Thornton, supra note 21, at 1232 (discussing utilization review and noting that "through utilization review, MCOs evaluate the medical appropriateness of care prescribed").
39 For an example of a denial under prospective utilization review, see Corcoran v. United Healthcare, Inc., 965 F.2d 1321, 1324 (5th Cir. 1992) (denying precertification for a physician's recommended hospitalization of a woman with a high-risk pregnancy). For an example of a denial under concurrent utilization review, see McEvoy v. Group Health Cooperative of Eau Claire, 570 N.W.2d 397, 400 (Wis. 1997) (discontinuing coverage for the hospitalization of a patient with anorexia nervosa).
In those cases where an MCO denied preauthorization for a particular service, but the enrollee, through her health care provider, disputed the MCO's characterization of the service as "not medically necessary," MCOs offered reconsideration through an internal appeal process.\textsuperscript{10} MCOs' internal procedures varied somewhat, but most retained the same basic features. After the initial adverse determination,\textsuperscript{11} most health plans empowered a physician, a more senior medical director, or a committee to hear patient grievances.\textsuperscript{42} In "McGraw v. Prudential Insurance Co. of America," the Tenth Circuit outlined Prudential's three-tiered review process for exclusion of services: "At the first level, the local medical director decides whether the claim is covered by the policy. A challenge of that decision then goes to Prudential's regional medical director. At the third level, an appeals committee ... may confirm or reverse the ... decision."\textsuperscript{43}

Once enrollees in MCOs exhausted the internal appeals process, enrollees who still believed in the necessity of the services sought by their provider's medical plan found their options limited.\textsuperscript{44} If ag-


\textsuperscript{44}Limitations on options after the internal appeals process applied only to enrollees in private, personal, or employer-sponsored MCOs. MCO enrollees who received their health insurance through the government or the federally mandated Medicare or Medicaid health insurance programs had the statutory right to appeal adverse MCO medical necessity determinations beyond the internal process to administrative law
grieved enrollees tried to challenge their MCO’s final decision in court, the courts applied a deferential standard to the decisionmaking body because the standard terms of health plan contracts gave administrators the power to make discretionary decisions regarding treatment coverage.45 Furthermore, the courts have interpreted the Employee Retirement Income Security Act of 197446 ("ERISA") to make employer-sponsored MCOs ineligible for legal liability for any negative consequences that later arose from omission of medical treatment due to an adverse benefit determination.47

MCOs' interventionist utilization review processes and internal appeals systems proved more effective than the retrospective review employed by traditional indemnity insurers in reducing the overutilization of medical services that contributed to the high cost of health care.48 Despite MCOs' success in applying utilization review to cut costs, however, consumer advocates soon charged MCOs with abusing their own system by denying "medically necessary" services in certain instances due to financial considerations instead of the medi-judges. See Gordon Bonnyman, Jr. & Michele M. Johnson, Unseen Peril: Inadequate Enrollee Grievance Protections in Public Managed Care Programs, 65 TENN. L. REV. 359, 370, 374-75 (1998) (noting that Medicaid recipients receive the same due process notice and appeals protections for denials of recommended services as for other revocations of means-tested government aid); Maria A. Morrison, The Impact of Grijalva v. Shalala on the Medicare HMO Appeal Process and the Importance of Enforcing Appeal Process Regulations, 103 DICK. L. REV. 735, 737-41 (1999) (describing the recourse available to Medicare recipients when appealing adverse MCO benefit determinations under the Medicare Act and the Health Care Financing Administration's regulation of the Medicare appeals process).

45 See Bernstein v. CapitalCare, Inc., 70 F.3d 783, 787 (4th Cir. 1995) ("If the administrator or fiduciary is given discretionary powers under the plan, his decisions are reviewed for abuse of discretion and will not be disturbed if they are reasonable."); Mark A. Kadzielski et al., Managed Care Contracting: Pitfalls and Promises, 20 WHITTIER L. REV. 385, 390 (1998) (noting that "generally, when disputes arise regarding coverage, the standard of review under ERISA is 'abuse of discretion' where the plan has vested the administrator with discretion to interpret and apply the terms of the plan"). Weighing in favorably to the patient, the Fourth Circuit noted that if the administrator has a conflict of monetary interest, then that conflict is weighed into the "abuse of discretion" analysis. Bernstein, 70 F.3d at 787.


47 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 [injured parties] have no remedy, state or federal, for what may have been a serious mistake"). In that case, after an HMO authorized home nursing rather than hospitalization for a woman with a high-risk pregnancy, the fetus went into distress and died while the nurse was off duty. Id. at 1321-22.

cal need of their beneficiaries. Reports indicated frustration from MCO enrollees and health care providers alike, and the perception of abuse became more widespread. Horror stories, such as Mr. Benedetto's, followed in the media, recounting the adverse health consequences of MCO enrollees resulting from red tape and seemingly capricious coverage denials. Patient advocates criticized the internal grievance mechanisms for authorization denials as "slow and one-sided," and looked skeptically upon the notion that MCO appeal procedures offered a true reconsideration of the beneficiary's claim. To empower patients in, and reinforce the objectivity of, the medical necessity determination process, many advocates supported establishing a right for MCO enrollees to take appeals of MCOs' adverse determinations to independent, external bodies of medical experts.

---

59 See Hall & Anderson, supra note 6, at 1666 (pointing out that insurers' conflicts of interest cast doubt on their ability to make unbiased "medical necessity" determinations).

60 See David Nather, Protecting the Patient: How Independent Review Could Force HMOs to Behave, WASH. MONTHLY, July-Aug. 1998, at 28, 28 (reporting a Kaiser Family Foundation study that 48% of enrollees said they have either had problems with their health plan or know someone who has); Robin Toner, Many Doctors Tell of Denial of Coverage by H.M.O.'s, N.Y. TIMES, July 29, 1999, at A18 (reporting a Kaiser Family Foundation study of physicians, in which one- to two-thirds of surveyed physicians reported recently having had a denial of a proposed treatment regimen, leading to adverse health consequences for the patient).

61 See supra text accompanying note 1 (describing a patient's efforts to get his MCO to approve a liver transplant, where scientific research had established the medical necessity of the procedure).

62 See, e.g., David S. Hilzenrath, Final Say: One Patient's Ordeal, WASH. POST, June 24, 1998, at A1 (recounting the story of a patient whose MCO did not approve his liver transplant surgery until his condition had become inoperable); Laurie McGinley, HMO Fracas Moves to Who Makes Medical Decisions, WALL ST. J., Feb. 18, 1999, at A24 (recounting the case of a child with cerebral palsy whose physical therapy program was denied by his MCO as not "medically necessary" because one study showed it would not lead to marked improvement in his muscular deterioration); Joseph P. Shapiro, Seeking a Second Opinion: A New Law for Patients When an HMO Says No to Care, U.S. NEWS & WORLD REP., Mar. 8, 1999, at 26 (describing an HMO's refusal to pay for nursing care for a child with a respiratory ailment).

63 George J. Annas, Patients' Rights in Managed Care—Exit, Voice, and Choice, 337 NEW ENG. J. MED. 210, 214 (1997) (reporting that such appeals took an average of twenty-eight months); see Hilzenrath, supra note 52, (quoting A. G. Newmyer III, head of the Fair Care Foundation, a patient advocacy group, charging that MCO internal appeals procedures "are structurally designed to take forever, to be as inconvenient as possible, and to achieve the precise result that the insurers want—that is, to get the policyholders to simply give up").

64 See Rodwin, supra note 29, at 1342-43 (noting that "internal reviews are not likely to question standards established by the organization").

65 See, e.g., THE PRESIDENT'S ADVISORY COMM'N ON CONSUMER PROTECTION & QUALITY IN THE HEALTH CARE INDUS., QUALITY FIRST: BETTER HEALTH CARE FOR ALL
C. The Emergence of Independent Review Organizations

Health care experts have defined external review as "a formal dispute resolution process, established by a state or federal agency to be independent of disputing parties, that has the capacity to evaluate and resolve at least those disputes involving medical issues." For many patients’ rights advocates, external review for MCO adverse medical necessity determinations held promise for both preserving access to treatment in the medical marketplace and eliminating the perceived implicit financial bias in MCO medical necessity decisionmaking. In addition to legitimating the internal appeal process by offering neutral expertise, external review, because of its perceived ability to provide for the delivery of needed medical care to ill patients in an expeditious fashion, offered further benefits over more traditional means of dispute resolution such as adjudication. As a result, as managed care increasingly dominated the medical marketplace, commentators began calling for legislators to enact an external appeals process to help protect patients’ interests from the potentially biased medical necessity decisionmaking of their MCOs.

Advocates for such independent review organizations listed certain features as critical to the effectiveness of the reformed appeals process. On a substantive level, they noted that the reviewers themselves should be “appropriately credentialed health care professionals

\[\text{AMERICANS 161 [hereinafter PRESIDENT’S ADVISORY COMM’N] (“Implementation of independent external review systems by public and private purchasers of health care services is an essential element in reducing the number of Americans injured by inappropriate coverage denials.”); Nather, supra note 50, at 29 (quoting the Consumers Union as considering external appeals the “linch-pin for all other consumer protections” in health care).}

\[\text{56 KAREN POLLITZ ET AL., THE KAISER FAMILY FOUND., EXTERNAL REVIEW OF HEALTH PLAN DECISIONS: AN OVERVIEW OF KEY PROGRAM FEATURES IN THE STATES AND MEDICARE iii (Nov. 1998), reprinted in Impact of External Review Hearing, supra note 7 (appendix to statement of Geraldine Dallek).}

\[\text{57 See Tracy E. Miller, Center Stage on the Patient Protection Agenda: Grievance and Appeal Rights, 26 J.L. MED. & ETHICS 89, 89 (1998) (commenting that “[g]rievance and appeal rights have been embraced as a way to empower patients, to enhance access to treatment, and to improve the quality of care”).}

\[\text{58 See Rodwin, supra note 20, at 1044-46 (describing the competing interests involved in health plan benefit determinations).}

\[\text{59 See Rhonda L. Rundle, External Review of HMO Decisions Becomes Hot Issue, WALL ST. J., Dec. 3, 1998, at B2 (reporting widespread agreement that external review provides faster relief than a legal battle to critically ill patients who are at odds with their health plan).}

\[\text{60 See, e.g., INSTITUTE OF MEDICINE, supra note 38, at 6 (recommending the institutionalization of external independent review organizations).}
who were not involved in the initial decision" and eligible disputes should be limited to appeals of medical necessity or other clinical determinations, so as not to overload the system and waste resources. Commentators suggested giving the external reviewers enough authority and discretion to "enable the patient to achieve the desired outcome if, on the merits, the decision-maker concludes that the patient should prevail." They also recommended opening general trends and anonymous results of the external appeals process for public consideration to foster patient confidence in the process and responsiveness on the part of the MCO with regard to its general coverage policies. On the issue of the substantive effect of the independent reviewers' decisions, some patient advocates suggested making reviewers' decisions binding on the health plan, but not on the patient, to address the imbalance of power between the two parties.

In addition to the basic substantive features of independent review, consumer advocates emphasized the importance of providing aggrieved MCO enrollees with an equitable procedure to promote satisfaction with the independent reviewers' decision, even if the reviewers ultimately supported the MCO's denial. For example, consumer advocates supported giving enrollee representatives or state officials, rather than the MCO, the authority to appoint the independent re-

61 PRESIDENT'S ADVISORY COMM'N, supra note 55, at 160.

62 For example, treatments judged experimental or investigational are also normally excluded from health plan coverage. See Julia Field Costich, Note, Denial of Coverage for "Experimental" Medical Procedures: The Problem of De Novo Review Under ERISA, 79 Ky. L.J. 801, 807-11 (1991) (describing the rationale for denial of benefits for experimental or investigational therapeutic regimens).


64 See Annas, supra note 53, at 214 (supporting making records available "for the purpose of improvement... in the quality of care"); Gladieux, supra note 22, at 92 (noting that "external reviews open the appeal process to public scrutiny and increase consumer confidence").

65 Annas, supra note 53, at 214 (decrying the "imbalance of power" between patients and health insurers). A decision that is not binding on the patient allows the patient to try to marshal new evidence and reappeal any negative judgments. Still, the requirement that MCOs abide by independent reviewers' ultimate determinations is likely only a theoretical concern because, practically, any health plan noted to have a propensity toward noncompliance doubtlessly will draw unwanted attention from state licensing boards. See Miller, supra note 57, at 93 (noting that in New Jersey, the Department of Health investigates patterns of noncompliance).

66 See Kinney, supra note 63, at 326-27 (outlining the essential elements of a fair grievance and dispute resolution procedure).
viewers to a particular case to ensure the reviewers' neutrality. Professor Eleanor Kinney outlined four key procedural elements to the external appeals process, subsequent to reviewer selection:

First, there should be timely notice that appealable events have occurred and of the procedures for appeal.

Second, there should be prompt decisions by a knowledgeable, unbiased decision-maker.

Third, large areas for exercise of discretion should be accorded to the decision-maker.

Finally and perhaps most importantly, there should be methods for empowering patients in the grievance process [such as an] informal and comprehensible [procedure] [and] the option to be represented by counsel or other types of representative[s].

Kinney considered the provision of notice significant because of information indicating that many managed care enrollees did not even realize that they could appeal adverse decisions internally. Kinney's final recommendation also reflected concern for enrollees who are unaware of their rights, because her proposal authorized patients to use representatives when patients confront their health plan. Kinney's call for expediency in the face of medical need grew out of concern regarding the time delays reported from the internal process. Other patient advocates promoted additional procedural

---

67 See Nather, supra note 50, at 31 (indicating the that Consumers Union's solution for keeping reviewers "honest" includes allowing the consumer or the state to choose reviewers, or at least allowing the consumer to reject the MCO's choices).

68 See id. at 32 (promoting independence as a means of assuring impartiality and promoting consumer confidence).

69 Eleanor D. Kinney, Resolving Consumer Grievances in a Managed Care Environment, 6 HEALTH MATRIX 147, 162 (1996).


71 Professor Kinney's final recommendation raised the issue of the role of health care providers as advocates for the patient in the independent review process, especially considering their financial relationship to the health plan. In response, accompanying restraints have been proposed on health plans, such as preventing retaliation by outlawing "gag rules" imposed by MCOs on physicians and barring "no-cause termination" of physician contracts. Miller, supra note 57, at 94 (noting policies put in place to "promote [the] physician[']s role in informing patients and assisting them in the appeal process"). See generally William M. Sage, Physicians as Advocates, 35 HOUS. L. REV. 1529, 1571-74 (1999) (discussing the ethical conflicts faced by physicians in the role of patient advocates before patients' MCOs).

72 See supra note 53 and accompanying text (pointing to time delays in internal appeal processes as a major contributor to calls for instituting an external appeals proc-
safeguards, such as the continuance of treatment during the time of the appeal and the imposition of all costs on the insurer. 23

In the end, armed with the vision of an external review process structured around the aforementioned substantive and procedural provisions, scholars and patient advocates pressed legislators to enact the right to an external, independent appeal from adverse benefit determinations. 71 By the late 1990s, their advocacy had met with a large measure of success. 72 At the state level, thirty states now have laws

---

23. The Health Care Financing Administration's ("HCFA") external appeals regulation for Medicare beneficiaries enrolled in MCOs served as a model of expediency for many patient advocates, because it invoked a seventy-two hour process if the adverse decision "could jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function." Gladieux, supra note 22, at 77 (internal quotations omitted; emphasis added); see also sources cited supra note 44 (discussing the different legal external appeals options available to Medicare recipients in MCOs as opposed to enrollees in private or employer-sponsored MCOs). HCFA adopted the less stringent "could" standard to compromise with consumer groups who wanted the beneficiary to decide when the expedited process was appropriate. Gladieux, supra note 22, at 79-80.

71. See Annas, supra note 53, at 214 (outlining various provisions he considers indispensable to "quick, easy to use, and fair" dispute resolution mechanisms).

72. This success in promoting the right to external appeal of MCO medical necessity decisionmaking came despite numerous roadblocks. Some government actors and MCOs at first opposed the creation of external review boards, claiming that a new layer of bureaucracy and regulations would further drive up costs and lead back down the road toward unaffordable health insurance. Nather, supra note 50, at 30 (noting MCOs' initial suspicion of legislatively mandated external appeals procedures); Steve Sternberg, Few Consumers Challenge Rulings of Health Plans, USA TODAY, Nov. 23, 1998, at 6D (quoting Gail Wilensky, the former director of HCFA, as saying, "[i]t's easy to legislate when you don't have to pay—Congress is wonderful at doing that"). Initial models, however, indicated that the true costs would be less than expected. See Nather, supra note 50, at 30 (emphasizing the cost-effectiveness of external appeals by pointing out that one consulting firm, Coopers & Lybrand, estimated the cost of the independent appeals process at only ten cents per person per month).

Another major setback occurred when a Texas district court, in Corporate Health Insurance, Inc. v. Texas Department of Insurance, struck down the external appeals provision in Texas's 1997 patient protection legislation as being preempted by ERISA because it improperly "mandate[s] the administration of employee benefits" in imposing a course of conduct on ERISA plans. 12 F. Supp. 2d 597, 625 (S.D. Tex. 1998), aff'd in part, rev'd in part, 215 F.3d 526 (5th Cir. 2000); see also Thornton, supra note 21, at 1247 (explaining that ERISA regulates employee benefit plans—including employer-sponsored health plans administered by MCOs—and preempts all state laws that "relate to any employee benefit plan" (quoting 29 U.S.C. § 1144(a) (1994))]. Since the Texas external appeals law required "an MCO to comply with the decision of the independent reviewer and to pay for the review...the provisions for an independent review improperly mandate the administration of employee benefits and therefore, have
granting MCO enrollees the right to independent review. At the federal level, support came in the form of the Senate Patients' Bill of Rights Plus Act of 1999 and the House of Representatives Bipartisan Consensus Managed Care Improvement Act of 1999.

Following the procedural and substantive recommendations set forth by legal commentators and patient advocates, the state and federal external appeals legislation shared numerous common provisions. The archetypal statute required exhaustion of the MCO's internal appeals process before enrollees were qualified for an external appeal, though some states allowed direct access in life-threatening situations. Once the patient met the eligibility standards, most statutes provided explicit instructions for notifying enrollees of their right to request, at the expense of the MCO, an appeal to a neutral, external body of appropriately licensed medical experts.

In addition, the legislation reflected a widespread desire to make the process available to emergency cases by establishing an expedited time line that patients could invoke, if necessary. To ensure the reviewers' independ-
ence, provisions listing explicit disqualifying conflicts of interest between reviewers and the health plan were prevalent throughout the legislation, and the drafters of the statutes made sure to keep MCOs out of the reviewer selection process. As for the process itself, most external appeals laws provided for a paper review of the patient's medical records and the insurer's written adverse determination. Many laws also allowed the patient to request a personal hearing accompanied by their treating physician or any other representative they might require. The majority of the laws made the ultimate determination binding, but also did not restrict any future judicial review of the particular decision the enrollee might want to pursue. Finally, the external appeals statutes tended to include general provisions protecting the confidentiality of patients, limiting the liability of the reviewers except in cases of gross negligence, and requiring the reporting of statistics describing the number of appeals and their dispositions.

D. Conclusion

Features inherent in the traditional fee-for-service medical care reimbursement system led a new generation of cost-conscious health care insurers—MCOs—to pioneer the use of prospective and concurrent utilization review and attempt to control expenditures by actively limiting payment to "medically necessary" services. Patient advocates and legal commentators were concerned that MCOs' utilization reviews would reflect a bias toward cost-containment over true medical need. In an effort to circumvent this hazard, they conceived of an MCO enrollee's right to appeal adverse medical necessity determinations to independent bodies. They envisioned independent review organizations, armed with certain procedural and substantive safeguards, serving as neutral, third-party arbiters to disputed medical necessity claims. The efforts of patient advocates and legal commentators met with early success, as states passed legislation establishing

---

See id. at 26-27 (sketching the characteristics considered important in the selection of external reviewers).

See id. at 35-36 (discussing general features of external review processes).

See id. at 43 (reviewing the disagreement among the states as to whether to make external review decisions binding).

independent review organizations with most of the recommended procedural and substantive features.

A closer examination of the more recent state and federal external appeals laws, however, reveals an established process different from the patient advocates' original conception. Over a relatively short period, the scope of discretion granted to the independent review organizations changed, as more recent legislative efforts tilted the balance of power in these bodies away from even-handed neutrality and toward the MCO enrollees.

II. THE EVOLUTION OF STATE EXTERNAL APPEALS LAWS

The independent review organizations, statutorily authorized in over thirty jurisdictions to review MCO medical necessity determinations, originated under state laws to aid MCO enrollees with any general grievances they might have against their MCO. After first appearing in Rhode Island in 1992, the state-supported right to external review emerged on a widespread scale in 1996 and 1997. However, independent review organizations were largely limited in the scope of their authority over MCO decisionmaking. By 1998, another group of states had enacted statutes authorizing independent review organizations. Compared to the external appeals laws of their predecessors, however, the second group of states granted enhanced powers and rhetorical importance to the external appeals bodies. State independent review organizations' leverage over MCO decisionmaking progressed further in 1999 and 2000 due to the proliferation of statutory provisions that put the burden of proof on MCOs and even allowed independent reviewers to approve treatment plans that were not strictly "medically necessary."

---

86 See infra Part II.A (analyzing the pertinent provisions of bills passed in Michigan and Florida that enacted the nonspecific MCO grievance panels that served as the predecessors to the current visions of independent review organizations).
87 See infra Part II.B (discussing Rhode Island's Health Care Services-Utilization Review Act, the first statutorily enacted right to external review of MCO medical necessity determinations).
88 See infra Part II.C (analyzing the provisions of state external appeals laws passed in 1996 and 1997 and concluding that states established independent review organizations with a limited scope of review).
89 See infra Part II.D (reviewing the 1998 state external appeals laws and concluding that, on the whole, these laws expanded the authority of independent review organizations at the expense of MCOs in the so-called "neutral" arbitration process).
90 See infra Part II.E (examining the most recent state external appeals laws and noting many instances where state legislators utilized statutory tools to convert supposedly neutral independent review organizations into patient advocating bodies in the
A. The Statutory Progenitors of the External Appeals Movement

In 1978, Michigan lawmakers passed the first state law granting MCO enrollees the right to take health plan grievances to an external body. The Michigan legislators established a health facilities and agencies advisory commission within the department of health and authorized the chairperson to create “task force 3,” a commission subdivision charged with reviewing enrollee “protest[s] or appeal[s].” According to section 333.21088 of the Michigan Code:

1. A health maintenance organization shall establish and maintain reasonable procedures for receiving, processing, and resolving enrollee complaints as to the operations of the organization.

2. An enrollee may file a grievance with task force 3 of the advisory commission after having exhausted the [internal] procedures for resolution of enrollee grievances. The advisory commission shall render a determination as to the validity of the grievance and direct measures it considers appropriate under the circumstances.

Michigan created the earliest incarnation of a body outside and independent of MCOs to hear grievances from MCO enrollees. The panel was not created solely to settle appeals for denials of health benefits because its mandate of “receiving, processing, and resolving enrollee complaints as to the operations of the organization” also encompassed nonmedical concerns, such as customer service issues and outstanding bills.

The Michigan legislators clearly did not foresee a large role for “task force 3” in the health care of Michigan citizens. First, the statute does not outline any procedural guidelines for taking appeals. Additionally, legislators did not vest “task force 3” with any significant authority. They merely granted it the broad and nonspecific ability to “render a determination as to the validity of the grievance.”

Florida passed a similar measure in 1985—its Statewide Subscriber Assistance Program—to create a panel to review all unresolved grievances from enrollees in MCOs. Like the Michigan initiative, Flor-

---

MCO benefit determination process).

1. S. c MICH. COMP. LAWS ANN. § 333.21088 (West 1992) (outlining the procedures for handling grievances and complaints regarding the operations of health plans).

2. Id. § 333.21013.

3. Id. § 333.21088.

4. Id. § 333.21088(1).

5. Id. § 333.21013.

6. Id. § 333.21088(2).

ida's "appeals body" was not an expert organization. In fact, it consisted primarily of government bureaucrats who could "contract with a medical director [of a health plan] and a primary care physician . . . [for] technical expertise" if necessary. Florida legislators established it primarily to reduce red tape in filing complaints with the government against health insurers.

B. Rhode Island's 1992 Health Care Services-Utilization Review Act: The First Statute Granting MCO Enrollees the Right to External Review of Medical Necessity Determinations

In 1992, Rhode Island instituted the first external independent review body specifically for adverse benefit determinations. Rhode Island's Health Care Services-Utilization Review Act required that "the review agent shall provide for an external appeal by an unrelated and objective appeal agency." Rhode Island legislators specifically charged the "appeal agency" with reviewing adverse determinations of medical benefits: "The external appeal review and decision shall be based on the medical necessity for the care, treatment or service, and the appropriateness of service delivery for which authorization has been denied." In addition, Rhode Island legislators mandated that only "neutral physicians or dentists shall be utilized to make" the medical decisions.

Rhode Island legislators structured their state appeal agency with most of the basic procedural protections enumerated by commentators, including independence of the reviewers from the health plan.

---

100 Id. § 23-17.12-10.
101 Id. § 23-17.12-10(b)(1). The Rhode Island legislature amended its independent review provision in 1999 to read: "The external appeal review and decision shall be based on the medical necessity for the health care or service, and the appropriateness of service delivery for which authorization has been denied." R.I. Gen. Laws § 23-17.12-10(b)(1) (Supp. 1999) (emphasis added).
102 R.I. Gen. Laws § 23-17.12-10(b)(2) (1996). The Rhode Island legislature amended the restriction on the credentialing of the independent decisionmakers in 1999 to include "other practitioners" and restrict the specialty of those practitioners chosen to "the same or similar general specialty as typically manages the health care service." R.I. Gen. Laws § 23-17.12-10(b)(2) (Supp. 1999).
and the power to make final determinations binding on MCOs.\textsuperscript{104} Rhode Island specifically authorized its appeal agency to monitor MCO decisionmaking by analyzing the proposed care and making a judgment as to its propriety.\textsuperscript{105} As a result, Rhode Island's Health Care Services-Utilization Review Act was the first statutorily enacted model of the external independent review agency originally envisioned by legal commentators and patient advocates.\textsuperscript{106}

C. External Review Organizations Emerge on a Wider Scale: The Early State External Appeals Processes

It was not until 1996 and 1997 that other states created external review boards to oversee MCO medical necessity determinations.\textsuperscript{107} The pertinent provisions in this wave of post-Rhode Island statutes reveal that the state legislators envisioned a generally limited role for the medical necessity review boards.

Three states—Vermont, Ohio, and California—established external review procedures but expressly restricted their scope to certain specialized areas of decisionmaking. California in 1996\textsuperscript{108} and Ohio in 1997\textsuperscript{109} mandated that MCOs give enrollees the right to appeal coverage denials to expedited independent review, but only in cases involving experimental or investigational therapies. California's and Ohio's provisions also limited eligibility for appeal of adverse benefit decisions to patients with a terminal condition and a life expectancy of under two years for whom standard therapies were not effective.\textsuperscript{110} Thus, the laws excluded pure medical necessity determinations from the scope of the review board's authority. Vermont's 1997 statute

\textsuperscript{104} Id. § 23-17.12-10(b)(5) (providing aggrieved enrollees the right to further judicial review of the decision).

\textsuperscript{105} Id. § 23-17.12-10(b)(1) (stating the bases for external appeal review).

\textsuperscript{106} See supra notes 61-73 and accompanying text (outlining the basic substantive and procedural requirements that legal commentators and other patient advocates considered crucial to the establishment of an equitable external appeals process).

\textsuperscript{107} See CONSUMER GRIEVANCE PROCEDURES, supra note 85, at 5-18 (reviewing the legislative efforts of Arizona, California, Connecticut, Missouri, New Jersey, North Carolina, Ohio, Texas, and Vermont).

\textsuperscript{108} CAL. HEALTH & SAFETY CODE § 1370.4 (West Supp. 2000) (providing for an external review process for health plan decisions regarding experimental or investigational therapies).

\textsuperscript{109} OHIO REV. CODE ANN. § 1753.24 (Anderson Supp. 1999) (establishing an external appeals process for coverage decisions relating to MCO enrollees with a terminal condition who are no longer responding to standard therapies).

\textsuperscript{110} See, e.g., CAL. HEALTH & SAFETY CODE § 1370.4(a) (West Supp. 2000) (setting eligibility criteria for the review process).
similarly restricted the scope of its independent review panel, author-
izing it to deal solely with mental health-related coverage decisions.\textsuperscript{111}

Of the states that passed comprehensive legislation, most confined the board’s decisionmaking discretion. Arizona’s 1997 Health Care Appeals Act noted: “For cases involving an issue of medical necessity, the independent reviewer or reviewers shall evaluate and analyze the case and render a decision that is based upon the utilization review plan on whether or not the service or claim for the service is medically necessary.”\textsuperscript{112} With this language, the Arizona legislature limited independent reviewers to analyzing the course of action that the MCO—or its utilization review agent—ordered, rather than asking reviewers to undertake their own evaluation of the situation at hand. Likewise, Missouri’s 1997 statute charged independent review organizations with making a “decision as to the resolution of the grievance . . . based upon a review of the written record before it.”\textsuperscript{113} As in Arizona, Missouri legislators circumscribed reviewers’ independence; instead of having the appeals board reach its own conclusion, Missouri’s statute merely requested a third party review of the propriety of the adverse benefit determination.

The statutes’ rhetorical language also reflected the restricted scope of these early external review boards. North Carolina’s law called for the independent panel to make a “recommendation” to the insurer.\textsuperscript{114} Texas’s law instituted a “complaint appeal panel, which [advised] the health maintenance organization on the resolution of the dispute.”\textsuperscript{115} Neither statute envisioned an appeals panel doing anything more than acting as an adjunct to the MCO decisionmaking process.

As time progressed, state laws expanded reviewers’ actual and rhetor-ical authority. States began vesting appeals panels with more inde-pendence in their decisionmaking abilities and with tools by which to overturn MCO adverse benefit determinations.

\textsuperscript{111} VT. STAT. ANN. tit. 8, § 4089a (Supp. 2000) (providing for external appeals for health plan coverage decisions regarding mental health care services).
\textsuperscript{112} ARIZ. REV. STAT. § 20-2537(F) (Supp. 2000) (emphasis added).
\textsuperscript{113} MO. REV. STAT. § 376.1387(1) (Supp. 1999).
\textsuperscript{115} TEX. INS. CODE ANN. § 20A.12(i) (Vernon Supp. 2000).

In 1998, eight more states and the District of Columbia passed external appeals legislation creating independent review organizations. This second collection of legislative efforts revealed a distinct progression both in the language used to describe the external appeals process and in the substantive powers granted to the independent review organizations. Slowly, independent review organizations evolved from neutral, expert bodies into patient advocates with the authority to participate actively in the MCO benefit determination process.

The District of Columbia’s Health Benefits Plan Members Bill of Rights Act of 1998 created independent review bodies and outlined their authority by noting: “Upon acceptance of the appeal for processing, the independent review organization shall conduct a full review to determine whether, as a result of the insurer’s decision, the member was deprived of any service covered by the health benefits plan.” Both the emphasis on MCOs’ “deprivation” of health care services and the novel, critical attitude attributed to the independent review organization are significant. No longer was independent review intended to provide a passive, neutral justification or negation of MCO practices, but rather reviewers had been assigned the mission of conducting a “full review” of MCOs’ decisions.

This language facilitated the emergence of a courtroom-style adversarial relationship between the independent external review body and the MCO. Maryland’s 1998 updating of its health insurance legislation echoed that tone. The Maryland legislature specifically allocated the burden of persuasion in all appeals, charging: “During the review of a complaint... a carrier shall have the burden of persuasion that its adverse decision or grievance decision, as applicable, is correct.” The Maryland legislature thus shifted the external review process away from a neutral inquiry and explicitly placed the MCO decisionmakers on the defensive.

During this second major wave of independent review organiza-
tion legislation in 1998, states also gave the reviewers more tools to use in the adversarial process. The District of Columbia, for example, listed the sources to which independent reviewers by law must turn in order to find support for a proposed health care service previously denied by an MCO:

In reaching a determination, the independent review organization shall take into consideration all pertinent medical records, consulting physician reports, and other documents submitted by the parties, any applicable generally accepted practice guidelines developed by the federal government, national or professional medical societies, boards and associations, any applicable clinical protocols or practice guidelines developed by the insurer, and may consult with such other professionals as appropriate and necessary.120

Through the provision, which specifically required the independent review board to make use of certain resources, the legislature afforded the reviewers a great deal of leeway in finding a basis to overturn an adverse determination.

Other state laws integrated similar measures to give their external reviewers more discretion in finding erroneous MCO decisions regarding disputed physicians’ treatment plans. The New York legislature’s 1998 formulation of its independent review law instructed the external appeals agent to “review the utilization review agent’s final adverse determination and ... make a determination as to whether the health care plan acted reasonably and with sound medical judgment and in the best interest of the patient.”121 As a result, the independent reviewer could overturn MCO determinations on the basis of three different categories—reasonable action, “sound medical judgment,” and the patient’s “best interest”—rather than simply considering whether the care was medically necessary.122

E. The Third Wave of State Legislation: Pushing the Envelope on the Discretion and Authority of External Review Boards

In 1999 and 2000, the trend toward granting the right of external appeal for adverse MCO medical necessity determinations continued, as at least eleven states enacted new laws setting up independent review organizations,123 and California and Ohio expanded the previ-

120 See D.C. CODE ANN. § 32-571.7(j) (Supp. 2000) (emphasis added).
122 Id.
123 See CONSUMER GRIEVANCE PROCEDURES, supra note 85, at 5-19 (giving an overview of state requirements for external appeals laws passed in 1999 by Colorado, Geor-
ously restricted discretion of the boards in their states to include medical necessity determinations. Generally, the legislative provisions built on their statutory progenitors, augmenting external reviewers’ rhetorical independence as well as their actual authority to overturn adverse MCO benefit determinations.

Stronger language gave the independent review the rhetorical authority of an actual court adjudication. When Iowa amended its statutory insurance regulations governing MCOs in 1999 to include an external appeal system, it included an entire section devoted to independent reviewers’ “standard of review” for making their determinations, noting: “Review by the independent review entity is de novo.” Hawaii’s independent appeals provision, also passed in 1999, even allowed the independent reviewer to award “attorney’s fees and reasonable costs of a suit” to a patient bringing an appeal. Clearly, Hawaiian legislators wanted the independent reviewers to consider themselves akin to a court of law.

More states also explicitly listed the sources reviewers should use in investigating the propriety of an MCO’s adverse determination. The California legislature even expanded the range of the sources:

Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically necessary based on the specific medical needs of the enrollee and any of the following:

1. Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.
2. Nationally recognized professional standards.
3. Expert opinion.
4. Generally accepted standards of medical practice.
5. Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.
In augmenting the sources of available evidence beyond national standards and clinical practice guidelines, the California law included two very subjective categories—"generally accepted standards" and "treatments that are likely to provide a benefit." As indicated in Part II, MCOs became popular in part by cutting costs through standardizing variances in medical practice that did not affect different patient populations' health care. Yet, California appealed to the vague notion of "generally accepted" practices in evaluating MCOs' attempts to deny a medical service as medically unnecessary. In addition, asking the independent reviewers to determine if a treatment was "likely to provide a benefit" required the reviewers to undertake a case-specific analysis of a proposed health service. Instead of encouraging neutrality and independence on the part of the external appeal agents, California legislators seemed to search for alternatives by which to allow the agents to overturn an MCO denial.

As a symbolic final step, Illinois's amendments to its Health Maintenance Organization Act instituted an external independent review program, authorizing the reviewer to "render a decision that is based on whether or not the health care service or claim for the health care service is medically appropriate." That the statute omitted all mention of "necessity" is ironic because patients' advocates originally conceived of independent reviewers as neutral third-party arbiters of MCO medical necessity determinations.

F. Conclusion

Within a relatively short time frame, a number of states established a right to external appeal of adverse MCO medical necessity determinations and instituted external review boards to mediate those appeals. With each passing year, states developed increasingly interventionist tactics to place the reviewers at odds with MCOs and concomitantly to enhance reviewers' ability to overturn adverse MCO determinations. Eventually, independent review organizations evolved from neutral, third-party expert arbiters into powerful institutional patient advocates that aggrieved MCO enrollees could enlist to help them by finding their physician-recommended treatment plans "medically necessary" under the terms of their MCO contracts.

---

129 Id.
130 See Hirshfeld & Thomason, supra note 23, at 18-21 (discussing the variations in health care provider practices).
Part III investigates how the legislative history of the federal bills granting the right of external appeal mirrored that evolution.

III. NATIONAL LEGISLATIVE EFFORTS AT ESTABLISHING INDEPENDENT EXTERNAL REVIEW BOARDS

The road to the passage of national legislation granting MCO enrollees the right to external appeal of MCO medical necessity determinations—the Senate Patients' Bill of Rights Plus Act of 1999 and the House of Representatives Bipartisan Consensus Managed Care Improvement Act of 1999—followed a similar course. The early legislative efforts of 1997 tended to follow patient advocates' and legal commentators' visions of a neutral, third-party arbiter and enumerated independent review organizations with restricted authority. Over the next two years, however, legislators drafted bills envisioning an activist independent review organization with the authority and sanction to intercede in MCO decisionmaking. The inclination to favor an independent review organization that implicitly and explicitly favored patients over MCOs culminated with the passage of the Patients' Bill of Rights Plus Act of 1999 and the Bipartisan Consensus Managed Care Improvement Act of 1999.

A. Setting the Scene: Prior National Attempts To Pass “Patients’ Rights” Legislation and the Legislative History of the 1999 Bills

In 1997, as independent external appeal agencies were growing in popularity at the state level, Representative John D. Dingell and Sena-
tor Edward G. Kennedy concurrently introduced into the United States House of Representatives and Senate the first patients' rights legislation, the Health Insurance Bill of Rights Act of 1997.\textsuperscript{138} In presenting the bill, Dingell echoed the widely held conviction that the managed care system had evolved to the point where financial concerns overshadowed patient care. He noted: "We've gone from cost being no consideration to cost being the only consideration in providing health care . . . . According to surveys, [eighty] percent of American people agree that quality care is often compromised to save money."\textsuperscript{139} He proposed to improve MCOs' perceived overemphasis on cost-containment by creating "an appeals process that works."\textsuperscript{140} Such an appeals process would include "a real, fair, dispute resolution process which takes account of the views of the patient and provider as well as a third party . . . who can look at the situation from a new perspective."\textsuperscript{141}

The bill set down two different categories of appealable events: denial of coverage for "[e]xperimental [t]reatment[s]"\textsuperscript{142} and a residual classification for denial of "claim[s] for benefits involving costs over a significant threshold, or assuring access to care for a serious condition."\textsuperscript{143} Thus, akin to some early state legislative efforts, the Health Insurance Bill of Rights Act of 1997 did not apply to all categories of medical necessity coverage denials.\textsuperscript{144} In addition, the bill did not specify the external independent reviewers' role in reviewing claims, and granted no special discretion or weight to its reviewing process. The first incarnation of an external review process was ultimately characterized by both the cautious rhetoric surrounding its establishment—Dingell's remarks to the House emphasized "look[ing] at the situation from a new perspective"\textsuperscript{145}—and the limited authority granted to it.

The 1997 bill did not receive enough votes to pass out of committee, so the next year Dingell again brought the issue of patient protection under managed care to the floor of the House with the Patients'
Bill of Rights Act of 1998. Dingell’s 1998 bill revealed an increasingly aggressive vision of independent review organizations. The rhetoric was more inflammatory, as the provision allowing appeals in order to “assur[e] access to care for a serious condition” was changed to allow appeals when “the patient’s life or health is jeopardized as a consequence of the decision.” The bill also imported legal terminology, requiring that the external appeal process “provide for a fair, de novo determination.”

At the same time, a number of competing legislative initiatives arose that also provided for external review of MCO adverse medical necessity determinations. Representative Benjamin L. Cardin introduced the Patient Right to Independent Appeal Act of 1998, with the hope of providing “immediate access to needed health services” and “reestablish[ing] the primacy of doctor-patient decisions.” Cardin’s Patient Right to Independent Appeal Act of 1998 proposed granting the independent external review entity the explicit power to review MCO medical necessity determinations. On the Senate side, a small bipartisan group of senators introduced the Promoting Responsible Managed Care Act of 1998, a bill that expressly allowed many considerations to serve as “[a]dmissible evidence” during independent reviews, including “personal health and medical information,” “the opinion of the individual’s treating physician,” and:

---

147 See H.R. 3605, 105th Cong. § 133(a)(2) (1998) (defining more broadly the criteria for appealability).
148 Id. § 133(a)(2)(B).
149 Id. § 133(b)(2)(A).
150 Notably, in 1997, provisions establishing independent external review boards were not as common. For example, the Patient Access to Responsible Care Act of 1997 set out guidelines for MCO internal appeal procedures but did not explicitly mandate outside review. See H.R. 1415, 105th Cong. § 2776(b) (1997) (describing the due process safeguards for MCO enrollees in their internal appeals process). In the end, none of these competing health care reform bills passed in 1997.
155 Id. § 106(b)(3). The use of the term “admissible evidence” is another example of legislators’ importation of adjudicatory—and thus inherently adversarial—terminology into the independent appeals process.
The results of studies that meet professionally recognized standards of validity and replicability or that have been published in peer-reviewed journals.

The results of professional consensus conferences conducted or financed in whole or in part by one or more government agencies.

Practice and treatment guidelines prepared or financed in whole or in part by government agencies.

Government-issued coverage and treatment policies.

To the extent that the entity determines it to be free of any conflict of interest—

(i) the opinions of individuals who are qualified as experts in one or more fields of health care which are directly related to the matters under appeal, and

(ii) the results of peer reviews conducted by the plan or issuer involved. 156

Thus, as provisions listing the sources upon which independent reviewers could base their decisions grew in popularity in the states, these same provisions also surfaced in federal legislative efforts.

No patient protection bill made it through both chambers of Congress in 1998. In the 106th Congress, however, a combination of past failures and ever-increasing popular demand primed legislators from across the political spectrum to reconsider patient protection legislation. The bills promulgated by the Senate and House envisioned a powerful, independent appeals agency with the discretion and the numerous resources to monitor and overturn adverse MCO benefit determinations.

B. The Senate Patients' Bill of Rights Plus Act

On July 15, 1999, the Senate passed the Patients' Bill of Rights Plus Act. 157 Though the bill notably omitted the much-debated right to sue health insurance plans, 158 senators hailed the external independent appeals process as "the lynchpin of any successful consumer

156 Id. § 106(b) (3) (A)-(E).
protection effort” for its ability to “get patients’ claims decided when the patient needs the care.”

The Act authorized the external review board to “make an independent determination based on the valid, relevant, scientific and clinical evidence to determine the medical necessity, appropriateness, experimental or investigational nature of the proposed treatment.” It required the independent reviewers, in making their determination, to “take into consideration appropriate and available information.” The bill then defined such information to include the MCOs’ clinical practice guidelines, the medical record and other information submitted by patients and their health care providers, “expert consensus including both generally accepted medical practice and recognized best practice,” medical literature, standard reference compendia, and findings from studies conducted under the auspices of federal agencies, federally recognized research institutions, or national boards that evaluate “the medical value of health services.”

The Patients’ Bill of Rights Plus Act of 1999 thus incorporated the more progressive elements of earlier patient protection legislation into its final conception of the external review process. It covered appeals of any medical necessity determinations and included express reference to medical “appropriateness” as an alternative standard to “necessity.” It mandated an “independent” determination on the evidence, unbound by any plan definition of “medical necessity.” Finally, it provided an extensive list of resources that the reviewers had to take into consideration when ruling on a particular prescribed health service. Yet, the resource list elaborated further on the ear-

---

2 Id. at S8541 (remarks of Sen. Grassley).
4 Id. § 503(e)(4)(A)(ii).
5 Id. The Patients’ Bill of Rights Plus Act explicitly names the appropriate compendia: “The American Hospital Formulary Service-Drug Information, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information.” Id.
7 Id.
8 Id. § 503(e)(4)(A)(i).
9 Id.
10 See id. § 503(e)(4)(A)(ii) (naming an array of reference compendia and research institutes where the independent reviewers could look to find support for a particular disputed health service).
lier legislation by including, for example, "generally accepted medical practice," a quasi-subjective category that recognizes health care providers' regular reliance on time-honored care modalities whose efficacy has not yet been proven by evidence-based criteria.

In the end, the Patients' Bill of Rights Plus Act of 1999 formulated an external review procedure that granted a large measure of decisionmaking autonomy to its independent reviewers. On a procedural level, independent reviewers, under the bill's provisions, were not required to consider the MCO's express rationales for each particular adverse decision. Whereas previous federal legislative efforts empowered reviewers to decide "whether such decision[s] were in accordance with the terms of the plan," the Patients' Bill of Rights Plus Act of 1999 omitted consideration of MCOs' prior decisionmaking and deemed the reviewers' decision to be free of any implicitly suspect MCO analysis. In addition to this procedural autonomy, the Senate delineated a comprehensive list of resources that reviewers must canvass in making their substantive determinations. By including quasi-subjective elements and instructing the independent reviewers to judge the medical "appropriateness" of a proposed health treatment plan in addition to its "necessity," the Patients' Bill of Rights Plus Act of 1999 lowered the standard for upholding a particular health service below purely evidence-based necessity. Thus, from a procedural and substantive point of view, Senate legislators armed the independent review process with the authority to cast a critical eye—more than an independent one—on MCO adverse medical necessity determinations.

C. The House of Representatives Bipartisan Consensus Managed Care Improvement Act of 1999

A few months later, the House advanced its patient protection legislation. Rather than using the Senate blueprint, the House formulated the Bipartisan Consensus Managed Care Improvement Act of

\[169\] *Id.*

\[170\] *See id.* § 503(e)(4)(A)(i) (setting forth the standard for independent reviewers but notably omitting reference to prior MCO determinations).


\[173\] *Id.* § 503(e)(4)(A)(i).
MEDICAL NECESSITY DECISIONMAKING

1999. Though it differed from the Patients' Bill of Rights Plus Act of 1999 on such aspects as the right to sue health plans, the Bipartisan Consensus Managed Care Improvement Act of 1999 outlined an external review process with similar interventionist features and responsibilities.17

First, the Bipartisan Consensus Managed Care Improvement Act of 1999 established that the external appeal procedure "shall provide for a fair, de novo determination."176 It granted reviewers the ability to "determine whether the plan's or issuer's decision is in accordance with the medical needs of the patient involved."177 The bill, however, quickly discounted the importance of the "plan's or issuer's decision" by noting in the very next clause: "In making such determination, the external appeal entity shall consider (but not be bound by) any language in the plan or coverage document relating to the definitions of the terms medical necessity, medically necessary or appropriate, or experimental, investigational, or related terms."178

On a substantive level, the Bipartisan Consensus Managed Care Improvement Act of 1999 took care to spell out the "evidence"179 on which the independent reviewers are to rely in making their determinations. It divided such evidence into two categories: resources that the independent review organization must take into consideration—the basis of the health plan's adverse determination, "personal health and medical information supplied with respect to" the patient, and the opinion of the patient's health care professional180—and resources that the independent review organization may take into consideration if applicable.181 In the latter category, the Bipartisan Consensus Managed Care Improvement Act of 1999 included the quasi-subjective "[c]ommunity standard of care and generally accepted principles of medical practice" as well as the opinions of experts in the specific medical field at issue and results of "peer reviews conducted by the plan or issuer involved" to the extent that they are "free of any conflict of interest."182

---

172 See id. § 103 (outlining the external appeals process).
173 Id. § 103(b)(2)(A).
174 Id. § 103(b)(2)(B).
175 Id. § 103(b)(2)(C).
176 Id. § 103(b)(2)(D).
177 Id. § 103(b)(2)(D)(I)-(III).
178 Id. § 103(b)(2)(D)(ii)(I)-(VII).
179 Id. § 103(b)(2)(D)(ii)(V)-(VII).
Therefore, from both a procedural and substantive point of view, the Bipartisan Consensus Managed Care Improvement Act of 1999 built upon the earlier incarnations of federal patient protection legislation. Mandating the “de novo” feature of the reviewers’ work reiterated the adversarial language increasingly associated with the independent appeals process’s consideration of the health plan’s decision. While the decision of the MCO played a more prominent role in the language of the House bill than in the Senate version, House legislators nevertheless made explicit efforts to ensure that the independent reviewers were “not bound by” any decisions the health plan made or by provisions, such as definitions of “medically necessary,” found in the health insurance contract. Finally, the Bipartisan Consensus Managed Care Improvement Act of 1999 listed resources that, while surrounded by less imperious rhetoric, included quasi-subjective aspects such as general medical standards and opinions of experts on the topic that may not have been exposed to the scientific rigors of peer review.

What are the practical consequences of the House bill’s enabling provisions? Representative J. Greg Ganske envisioned an activist independent appeals process coming to the aid of enrollees whose MCOs limited their medical treatment options:

[I]f at the end of their utilization review or their internal appeal within their plan and the plan is still saying, no, we are not going to give you this care and everything you have read about it and your own physician is telling you this is prevailing standards of care and you can be harmed without it, then an individual ought to have access to an external, independent body with the capability and authority to resolve disputes for cases involving medical judgment by the plan.

The provision that the independent reviewers may take into consideration “results of peer reviews conducted by the plan or issuer involved” only if they were “free of any conflict of interest”—implying that scientific studies conducted by health plans are inherently suspect—further demonstrated the legislators’ critical attitude toward the

\[183\] See id. § 103(b)(2)(A) (mandating that the process shall provide “for a fair, de novo determination”).

\[184\] Id. § 103(b)(2)(C).

\[185\] See id. § 103(b)(2)(D) (i)-(ii) (listing both mandatory and optional resources that independent reviewers take into consideration during their analysis of MCO decisionmaking).


MCO medical necessity determinations. The "de novo" standard of review enabled the independent reviewers to provide a critical look at the appealed situation, rather than being limited by the health plan's decision. In the end, the House Bipartisan Consensus Managed Care Improvement Act of 1999, like the Senate Patients' Bill of Rights Plus Act of 1999 before it, endeavored to set up an external appeals process with sharply demarcated autonomy and real authority to make its own determinations on disputed medical necessity issues.

D. Conclusion

The progression of patient protection legislative efforts at the federal level, leading to the ultimate passage of two bills instituting patients' rights to independent external appeals of adverse MCO benefit determinations, in many ways corresponded to the statutory development seen at the state level. In Congress, as in the states, legislators vested the independent reviewers with greater discretion in their decisionmaking by increasing their autonomy and expanding the resources available to them. Thus, over time, the predominant vision of the independent review process moved from a neutral, third-party ar-

---

184 Id. § 103(b)(2)(A).
185 Due to differences between the Senate and House bills unrelated to the independent appeals provisions, no patient protection legislation made it to the President's desk by the end of the 106th Congress. In the summer of 2000, the House Bipartisan Consensus Managed Care Improvement Act of 1999 came to the floor of the Senate, but it lost by a vote of 51-48. Major Garrett, Clinton Urges Congress to Pass Patients' Bill of Rights After Supreme Court Ruling (June 13, 2000) (describing the failure of the House-passed patients' rights bill in the Senate), http://www.cnn.com/2000/ALLPOLITICS/stories/06/13/clinton.hmos. Senate Republicans made some concessions on issues such as bringing suit against MCOs and the extent of the coverage of the Act and attached a "Patients' Bill of Rights" to a standard appropriations bill. Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations Act, 2001, H.R. 4577, 106th Cong. tit. XXII (2000). While this Appropriations Act passed, staunch opposition to the patients' rights provision in the House ultimately led to the demise of that section. See Bash, supra note 2 (noting that aides to the sponsoring Senate Republican "acknowledge[d] they lack[ed] support in the House for this measure"). The section of the Act establishing the independent review process was consistent with the earlier Senate Patients' Bill of Rights Plus Act and House Bipartisan Consensus Managed Care Improvement Act of 1999 in its broad implicit and explicit grant of authority to independent reviewers to overturn MCO decisionmaking. See Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations Act, 2001, H.R. 4577, 106th Cong. tit. XXII, § 503B(d)(3)(E) (2000) (mandating, inter alia, that the independent reviewers determine medical necessity without regard for the MCO definitions of medical necessity, unless such definitions comport with those established by state or federal governmental bodies).
biter with limited scope to an advocate for MCO enrollees attempting to obtain authorization for health services disputed by the MCO as not "medically necessary." The next Part analyzes the significance of the legislative evolution of external appeals laws and what that evolution suggests regarding legislators' conception of the role of the independent appeals process in the modern medical marketplace.

IV. THE NATURE AND IMPLICATIONS OF THE LEGISLATIVE DEVELOPMENT OF THE EXTERNAL APPEALS PROCESS

As Parts II and III indicate, the construction of legislation enacting external, independent appeals boards charged with reviewing MCOs' medical necessity determinations changed over time. Legislators directly increased the authority of independent review organizations by divorcing reviewers' analysis from MCOs' decisionmaking processes, diminishing the standard of necessity for the disputed services, and expanding the range of sources on which reviewers could justify their determinations. Legislators also indirectly shifted the balance of power in appeals from MCO decisionmakers to independent reviewers through various rhetorical devices, including envisioning the independent review process as an adjudicatory forum in which health plans must defend their adverse determinations. This Part suggests the legislators' possible motivations, with respect to the remarkable evolution of external appeals laws, and analyzes whether progressively expanding the authority of independent reviewers vis-à-vis MCO utilization review decisionmaking is likely to achieve legislators' goals.

A. Interpreting the Legislative Construction of More Activist Independent Review Organizations

On one level, constructing external appeals laws that grant external reviewers enhanced decisionmaking authority represents the introduction of another incremental safeguard for MCO enrollees in the appeals process. After all, some of the more recent external appeals laws contain more stringent procedural protections than were characteristic of earlier versions, such as listing qualification criteria for the independent experts and certain specifically prohibited con-

---

190 See, e.g., GA. CODE ANN. § 33-20A-39(a)(1)-(C) (2000) (requiring external reviewers, at a minimum, to be experts in the treatment of the medical condition at issue, hold nonrestricted licenses, and have no history of disciplinary action).
flicts of interest. In addition, Professor Kinney, among others, considered granting reviewers enough discretion to make the appropriate determination one of the key procedural elements in a successful appeals process. Therefore, one can interpret provisions expanding the scope of independent reviewer decisionmaking authority as a means of protecting enrollee interests in the external appeals process by ensuring that the reviewers are acting as more than just rubber stamps for MCO decisionmaking.

Interpreting legislatively sanctioned expansions of the authority of independent reviewers as merely another consumer protection, however, underestimates the rhetorical significance that legal commentators and legislators have placed on the external appeals process. Representative Cardin, in his remarks supporting the Patient Right to Independent Appeal Act of 1998 before the Senate Labor and Human Resources Committee, said, "[W]hat patients want most is immediate access to needed health services . . . [and o]nly an external appeals process can provide this access." The exaggerated import many patient advocates bestowed on these legislative efforts suggests a more fundamental characterization of the expanding control of external reviewers over MCO medical necessity decisionmaking. Rather than merely supporting aggrieved MCO enrollees' rights, legislators may be empowering external reviewers at the expense of MCO decisionmaking as a proxy for returning the American health care marketplace to the traditional decisionmaking paradigm.

As noted in Part I, under the traditional health care reimbursement system, the indemnity insurers tended not to interfere with physicians' provision of medical services. Instead, physicians controlled the prescription of health services—and thus set the standard for "medically necessary" services—through their ethical obligations to their patients not to prescribe improper or unnecessary treatments.

---

191 See, e.g., id. § 33-20A-39(b) (listing entities to which reviewers cannot have "any material professional, familial, or financial conflict of interest").
192 Supra text accompanying note 69 (setting down Professor Kinney's four key procedural elements to a fair independent review process).
194 Grievance Procedures, supra note 152, at 134.
195 See supra notes 21-23 and accompanying text (describing the peripheral place of indemnity insurers in the traditional fee-for-service design of the health care reimbursement system).
196 See DENNIS A. ROBBINS, INTEGRATING MANAGED CARE AND ETHICS: TRANSFORMING CHALLENGES INTO POSITIVE OUTCOMES 11-13 (1998) (describing the changes in providers' ethical responsibilities arising from the differences between fee-for-service and managed care health care delivery systems).
With the movement to managed care, however, MCO health plan contracts limited physician reimbursement to "medically necessary" services and, through tools such as prospective and concurrent utilization review, health plans more actively enforced the contractual limitations. Exerting control over physician prescription practices made MCOs the new arbiters of medical necessity, as their own internal standards supplanted the medical decisionmaking of the treating physicians. In essence, under managed care, physicians judged what was medically necessary for their patients and then submitted their determinations to the utilization reviewers at the patients' MCOs. After the MCOs conducted their utilization reviews, they either agreed with the treating physicians, or in the case of adverse benefit determinations, rejected the physicians' judgments of medical necessity and replaced them with their own.

Patient advocates originally conceived of the external appeals process to ensure that financial incentives to limit the provision of medical services would not lead MCOs improperly to deny medically necessary care. In granting ever-widening discretion and making more resources available to the external reviewers, however, legislators made it increasingly difficult for MCOs to maintain their own definitions of what is "medically necessary." To understand this change, it is important to realize that the external appeals entity only reviews decisions where the MCO medical necessity standard is more limited than that of the treating physician. That is, when a particular treatment modality is available to a patient, the physician either can: (a) determine that the service is not medically necessary and not offer it to the patient; or (b) prescribe the service. In fee-for-service health care, the decisionmaking process ends at this point. Under managed care, however, the health plan then reviews only the services prescribed by the physician, and either can: (a) authorize the prescribed service; or (b) deny it. If the MCO authorizes the service, there is no debate, because the physician and health plan agree on the medical necessity of the treatment, and the physician's recommendation is implemented, just as it would be under fee-for-service decisionmaking.

While authorizations pass unchecked, patient advocates have successfully lobbied legislators to grant patients the right to appeal health

197 See Hall & Anderson, supra note 6, at 1651-54 (discussing the insurers' use of prospective utilization review to determine the proper medical treatment).
198 See Peter R. Kongstvedt, Elements of Management Control and Governance Structure, in ESSENTIALS OF MANAGED HEALTH CARE, supra note 3, at 75 (describing the role of the utilization review committee).
plan denials to an independent review organization. Under their original conception, independent review entities functioned to review the scientific evidence and ensure that the MCO was not arbitrarily refusing the prescribed service. The more recent external appeals laws, however, feature various mechanisms that impose a greater burden on health plans in justifying their medical necessity determinations. These mechanisms include expanding the resources that external reviewers can use and placing the burden of persuasion on the MCO. With the MCO decisionmakers on the defensive and the independent reviewers acting more like patient advocates in the process, patients and their physicians now find it correspondingly easier to overturn an MCO denial. As independent reviewers increasingly impose their own, patient-biased interpretation of what is "medically necessary," the MCO's definition of medical necessity becomes less significant. This process continues until the MCO implicitly agrees with providers when they consider a proposed treatment unnecessary and agrees with providers when they consider a proposed treatment necessary. Medical necessity decisionmaking has returned to rules inherent in the traditional fee-for-service model.

The evidence surrounding the enactment of these various external appeals laws reveals the legislators' tacit goals regarding the transformation of independent review organizations from neutral arbiters to active patient advocates. Senator Kennedy, for example, has expressed his aversion to health plans having the “final say” in medical treatment decisions. Language in some of the more recent iterations of the federal patient protection bills prohibits arbitrarily interfering with or altering decisions of physicians regarding which services are delivered or whether they are medically necessary. By constructing an external appeals process rhetorically and in substance more hostile to MCO determinations, these policymakers hope to force health plans to approve more proposed treatment plans by threatening them with a legitimate—and ultimately public—reexamination of their internal decisionmaking processes.

---


*See Patients' Bill of Rights Plus Act, S. 1344, 106th Cong. § 151 (a)(1) (1999); Promoting Responsible Managed Care Act of 1998, S. 2416, 105th Cong. § 102(b)(1). See also McGinley, *supra* note 52 (quoting Sen. Chafee's remark that health plans may not arbitrarily alter the decisions of physicians).

*See Nather, *supra* note 50, at 32 ("[S]upporters say external appeals will put the fear of God into managed care plans. The plans will be more likely to approve appro-
Thus, inspired by stories such as Mr. Benedetto's, legislators at the state and federal levels have rejected MCOs' abilities to make their own scientifically based medical necessity determinations. They have passed numerous patient protection bills embracing external appeals of adverse benefit determinations, relying on these bills as vehicles for returning to the traditional health care delivery system in order to improve patients' access to medical services recommended by their physicians. Yet, the inherent characteristics of managed care and the weaknesses of the external appeals process make it unlikely that these widespread legislative efforts will effectively ensure that all patients receive truly "medically necessary" health services.

B. The Limitations of Using the Right of External Appeal to Impose a Fee-For-Service Model of Medical Necessity Decisionmaking

Numerous difficulties relating to the adverse benefit determination process and the right of external appeal call into question the ultimate ability of these new external appeals laws to provide patients with better access to "medically necessary" services.

First, commentators such as Professor Marc Rodwin have pointed out the remoteness of the external appeals system to the patients it is meant to serve:

To bring an appeal, the consumer must know that he or she has either been denied a service or received poor quality of care; believe that the MCO has acted improperly; be hopeful that filing a grievance may provide a remedy; have the time and resources to pursue the matter; and think it worth the cost of doing so.\textsuperscript{202}

Rodwin correctly observes that these factors "are often absent for those who are ill, poor, or who lack education."\textsuperscript{203} Even among the population of managed care enrollees as a whole, people have not expressed a desire to go through an appeals process: a Kaiser Family Foundation survey indicated that only seventeen percent of managed care enrollees said they wanted to appeal to an independent reviewer when their plan did not cover a service.\textsuperscript{204} Patient advocates have tried
to argue that appeals decisions can have a "sentinel effect" on the behavior of health plans. The decisions of reviewers, however, do not carry the legal weight of binding precedent, and it is unclear whether the express justifications, if any, for overturning a particular adverse benefit determination offered by the external reviewers can be generalized in practice.

Second, even if these statistics merely reveal the fact that the appeals process is not yet user-friendly or that its benefits have not been well advertised to MCO enrollees, problems still remain. Ultimately, many MCOs deny only a limited number of services recommended by health care providers. By some counts, upwards of ninety-seven percent of provider treatment decisions are authorized by MCOs. Moreover, United Health Group, one of the country's largest HMOs, has recently announced that it will forego prospective review of physician treatment decisions altogether. MCOs' lack of significant reliance on medical service denials indicates that health plans no longer consider prospective or concurrent utilization review to be significant sources of their control over access to medical treatment. Rather, health plans have developed a much wider arsenal of methods to limit costs and influence treatment decisions, including adjusting the reimbursement level for services and retrospectively reviewing provider practices, backed up by the threat of termination of the provider's contract with the plan.

Finally, some commentators have asserted that it is completely legitimate for consumers to enter into contracts with health insurers that use medical necessity standards as determined and enforced by the MCO. As Professor Clark Havighurst argues:

[S]ome health insurance policies are appropriately conceptualized as agreements by which members of the covered group mutually elected to be bound in order that the fund created by their contributions would be

---

1 Rundle, supra note 59 (paraphrasing external appeals advocate Karen Pollitz, who noted that to be effective, external appeals entities may not have to review thousands of cases).
2 See Rodwin, supra note 20, at 1048 (describing concerns about the effectiveness of external appeals on general MCO practices regarding consumers).
3 See Miller, supra note 25, at 60-61 (discussing the HMO debate in Congress).
4 See Milt Freudenheim, Big H.M.O. to Give Decisions on Care Back to Doctors, N.Y. TIMES, Nov. 9, 1999, at A1 (reporting that United Health Group will phase out its prospective utilization review of provider treatment decisions).
5 See supra note 30 and accompanying text (listing fixed payments for medical services as a cost-containment tactic of MCOs).
6 See Freudenheim, supra note 208 (recounting MCOs' varied cost-containment strategies).
sufficient to cover their essential needs and would not be squandered on nonessential, inefficient, or overly costly services demanded by any individual. Under this view, an insurer rationing health care financing by invoking a coverage restriction can be seen as serving consumer interests as well as its own.

By imposing an activist external appeals process on the MCO benefit determination process, the legislative system is undermining validly executed enrollee contracts with health plans. Havighurst warns that such high-minded paternalism stifles further “responsible economizing” in the provision of health services by limiting the amount of risk that health plan subscribers can assume.

Ultimately, then, legislators’ attempts to impose the traditional fee-for-service model of physician decisionmaking on the current managed care health system through an activist external appeals process likely will prove ineffective. Both practical deficiencies in the external appeals process itself, as well as more conceptual problems regarding interference with the health care contracting process, argue against advancing patient rights through an empowered external appeals process. While a more autonomous and activist external appeals process can help in cases such as Mr. Benedetto’s, it may not significantly improve the position of the vast majority of patients with regard to the imbalance of power between them and their MCOs. As a result, the emphasis legislators have placed on delineating an ever-expanding role for external appeals systems simply may result in the diversion of resources from more pertinent patient protection measures. The legislative efforts seem to be based misguidedly on media-friendly anecdotal stories such as Mr. Benedetto’s rather than on the true characteristics of the context of MCO medical necessity determinations.

C. Other Methodologies for Administering Medical Necessity Decisionmaking

While the proponents of the current external appeals movement

---

212 See CLARK C. HAVIGHURST, HEALTH CARE CHOICES 164 n.7 (1995) (criticizing the “elitist” patient rights advocates who want to impose their ideas on validly executed contracts).
213 Id. at 146-47.
might be implicitly pushing for a return to fee-for-service medical necessity decisionmaking, the experience of the crippling costs of the pre-managed care 1970s and 1980s\(^2\) indicate that even they might not want a complete return to a fee-for-service medical regime.\(^3\) Yet, if an activist external appeals process appears ill-suited to the task of overcoming the perceived bias of MCO medical necessity decisionmaking, what is a better solution for making resource allocation determinations?

One solution, discussed by Professor Hall, suggests the promulgation of general standards of medical practice. These standards would be composed by groups of experts to provide a more scientifically based guide for physicians in making treatment decisions.\(^4\) As Professor Hall notes: “These technocratic experts might be capable of allocating wisely through cost-sensitive rules based on careful empirical research.”\(^5\) This proposal stems from the concerns of medical ethicists who feel that it is morally troublesome to return to fee-for-service medicine in modern, cost-conscious times and require providers or patients to make care-rationing medical necessity decisions at the bedside.\(^6\) The expert panel scheme is superficially appealing. Since fewer than twenty-five percent of so-called standard medical practices actually have been subject to scientific proof,\(^7\) providing physicians with a comprehensive set of guidelines delineating recommended treatment pathways will help allay the tensions between provider and MCO decisionmaking on a more widespread level than the case-by-case adjudication of the external appeals process. On the other hand, Hall is quick to point out that these guidelines, if applied too literally, might stifle the individualized decisionmaking critical to proper medical practice.\(^8\) Also, many of the MCO/physician disagreements over medical necessity arise in the context of novel, expensive thera-

\(^2\) See sources cited supra notes 24-26 (listing some of the factors contributing to the skyrocketing costs of the American healthcare system in the 1980s).

\(^3\) See Sara Rosenbaum et al., Who Should Determine When Health Care is Medically Necessary, 340 NEW ENG. J. MED. 229, 229 (Jan. 21, 1999) (“We [do not] advocate... a return to total autonomy for treating physicians in determining insurance coverage.”).

\(^4\) See MARK A. HALL, MAKING MEDICAL SPENDING DECISIONS 63-64 (1997) (noting the increased use of third party experts to set spending limits for patients and proposing a “hybrid between physician discretion and third-party rules”).

\(^5\) Id. at 74.

\(^6\) Id. at 64 (“[M]any prominent medical ethicists believe that external authority... is at least morally superior to physicians or patients making their own rationing decision at the bedside.”).

\(^7\) See id. at 74 (calling for more widespread medical technology assessment).

\(^8\) Id. at 77-104 (examining the competing merits of rules versus discretion).
peutic options, and the applicability of these guidelines to new technologies remains debatable. Thus, the "technocratic expert" model might be an effective alternative if regulators employ sufficiently pliable expert standards of medical necessity and then place the burden on the physician to justify a large-scale divergence from these standards. Despite these concerns, however, using expert standards rather than MCO-determined standards of medical necessity could serve as the basis for a more palatable process than the current model, in which each patient/provider decision comes under the scrutiny of utilization review.

Another analytical approach, endorsed by Professor Havighurst, involves using contract law to have patients decide for themselves the level of services they wish to purchase: "[I]t should be possible for different health plans, using contractual tools to adjust the intensity level of the care provided, to cover at significantly different prices the full range of medical conditions encompassed in a standardized, comprehensive benefit package." The contract model can allow consumers to "select the plan whose general policy toward risks and benefits best suits individual preferences and willingness to pay the marginal cost of more generous coverage." It also would force health plans to disclose their often arcane procedures for determining coverage decisions. However, while using contract principles would help patients escape the sweeping generalizations of health management by professional guidelines, it raises its own set of concerns, such as the ability of consumers to make the sort of prospective, fine-tuned decisions about their health these elaborate contracting mechanisms require. Still,
the basic features of a contract-based proposal—using restructured contracts to allow consumers to make informed decisions about their level of medical coverage, rather than placing the interpretation of vague language in the hands of their health plan—successfully empowers patients in their attempts to receive the proper level of medical coverage from their health insurance plans.

Common among these alternate proposals for restructuring the troubled managed care medical necessity decisionmaking apparatus is the emphasis on the same basic patient protections sought by the proponents of the strengthened external appeals process. These goals, which include making sure that coverage determinations have a scientific basis and promoting the interests of patients over potentially biased MCOs, are sufficiently important to warrant being addressed through a more wholesale, direct restructuring of the health insurance system. This solution is ultimately what Professors Hall, Havighurst, and others are advocating. As it is, by expanding the authority and discretion of the external appeals process, legislators seem to be trying to impose a back-door fee-for-service decisionmaking system on the current health insurance process. While legislators' efforts are valuable in their basic convictions and may help resolve particular cases such as Mr. Benedetto's, the limitations of the appeals process suggest that current legislative resources being spent on the external appeals paradigm may be better directed toward other suggested solutions to the managed care coverage determination dilemma.

CONCLUSION

In response to the perceived excesses of the managed care industry in making overly restrictive benefit determinations of which medical services are “medically necessary”—due in large part to mediadriven anecdotal stories such as Mr. Benedetto's—state and federal legislators have promoted patient protection acts granting, as one of their main provisions, the right of MCO enrollees to an independent, external appeal of all such decisions. Over the past few years, these statutes and bills have bequeathed an expanding range of authority and discretion to these external reviewers, granting them increasing latitude to cast an ever more critical eye on the presumptively biased number of MCOs to modulate precisely their desired level of health care coverage.

decisionmaking of MCOs. The legislative trend toward enhancing the position of the independent reviewers can be interpreted as an implicit attempt on the part of legislators to impose, indirectly, the rules of traditional medical necessity decisionmaking on health plans.

While a more powerful external appeals process may have aided Mr. Benedetto, inherent practical and theoretical barriers likely will prevent the independent review process, regardless of how much discretion state or federal legislatures cede to it, from affecting most managed care enrollees and the medical services offered to them under normal circumstances. Given these concerns, it would be irresponsible for legislators not to follow these anecdote-driven legislative efforts with more fundamental alterations to the system—alterations that can have a wider impact on the quality of Americans' health care.