External Review of Health Plan Decisions

This policy brief is the product of background research and the discussion at the California Health Policy Roundtable on Examining Proposals for Independent (External) Review of Health Plan Decisions held in Sacramento, California on August 3, 1998. The California Health Policy Roundtable is a nonpartisan education and information forum on health policy issues in California. It is directed by Helen Schaffler and staffed by Juliette Cubanski, UC Berkeley School of Public Health, Center for Health and Public Policy Studies; cosponsored by the California Center for Health Improvement in Sacramento; and funded by the Kaiser Family Foundation.

The purpose of this Roundtable was to inform the policy debate in California about the issues, policy options, and public and private sector initiatives in the area of external review of health plan decisions. Speakers at the Roundtable included Kevin Hanley, Director of the State of California Office of the Insurance Advisor, Sacramento, CA; Peter Lee, Director of Consumer Protection Programs at the Center for Health Care Rights, Los Angeles, CA; Karen Pollitz, Project Director at the Institute for Health Care Research and Policy at Georgetown University, Washington, D.C.; David Richardson, President of the Center for Health Dispute Resolution, Pittsford, NY; Michael Shapiro, Staff Director for the California State Senate Committee on Insurance, Sacramento, CA; and Alan Zwerner, Senior Vice President and Chief Medical Officer of Health Net, Woodland Hills, CA.

Eighteen states and the Medicare program have implemented systems for external (or independent, third-party) review of health plan decisions.

National Context for Reform

With approximately 85 percent of California’s insured adults enrolled in managed care plans in 1997, the state’s health care financing and delivery system is dominated by managed care. Managed care plans, such as health maintenance organizations (HMOs), preferred provider organizations (PPOs) and point-of-service (POS) plans, seek to contain health care costs in part by managing the utilization of services by enrollees. Critics of managed care argue that in an effort to lower costs, some managed care plans may inappropriately deny their members necessary health care services.

Establishing consumer protection standards in managed care plans and holding plans accountable for the outcomes of their utilization review decisions has become a primary concern for many federal and state policymakers. Congress considered a number of consumer protection proposals this past year, one of which passed the House. States were also active in this arena; all states except South Dakota have enacted one or more consumer protection laws in recent years focusing on such areas as provider access, continuity of care, and consumer assistance programs.
In their pursuit of patient protection standards and health plan accountability, legislators have considered, and many states have implemented, a system for external (or independent, third-party) review of health plan decisions. External review is currently available to Medicare and Medicaid beneficiaries. Both the President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry and the California Managed Health Care Improvement Task Force recommended an independent system of external review of health plan decisions. External review was also part of every major managed care reform proposal considered by Congress in 1998 and the subject of legislation in the 1998 session of the California Legislature.

Through the process of external review, consumers can appeal beyond their health plan’s internal appeal mechanism to an external, independent review organization (IRO) and/or to medical experts who have no professional, financial or material connection to the parties involved or interest in the outcome of the review. An IRO makes final, generally binding, decisions about the appropriateness of the health care service in dispute.

External review of health plan decisions is seen by many as a significant component of state and federal patient protection proposals because it responds directly to consumer concerns about inappropriate denials of service. According to a 1998 Kaiser Family Foundation/Harvard University survey, 59 percent of Americans are either somewhat or very worried that their health plan would be more concerned about saving money than about what is the best treatment for them if they were sick. According to a survey commissioned by the California Managed Health Care Improvement Task Force in 1997, 42 percent of Californians said they had experienced problems or difficulties with their health plan in the previous twelve months. In the 1998 Kaiser Foundation/Harvard University survey, 81 percent of Americans said they support a law to establish an external review system (though support falls when the possibility of resulting premium increases is mentioned).

As of mid-1998, 18 states had established external review programs. Of the 13 state programs recently examined by Karen Pollitz, Geraldine Dallek, and Nicole Tapay of Georgetown University in a report prepared for the Kaiser Family Foundation, some generalizations can be made:

- **Access**: Twelve states require consumers to exhaust their health plan’s internal appeals process before requesting an external review.
- **Scope**: Six states limit the plan denials subject to external review to those involving medical necessity, while three states subject any consumer grievance not resolved by the plan to external review. The actual cost per review is generally less than $500.
- **Cost**: The cost of external review is paid by the state in four states, by the state through licensing fees in three states, by health plans in five states, and split between the plan and the consumer in one state.
- **Threshold**: No states impose a minimum dollar threshold for the service in dispute to initiate external review.
- **Review Entity**: In nine states, the state insurance regulatory agency selects the external review entity, as opposed to the health plan in three states or the consumer in one state.
- **External Reviewers**: Nine states use only physicians or other health care providers to conduct external review; four states use other/additional types of reviewers, including attorneys and consumers.
- **Conflict of Interest**: Twelve states specifically prohibit conflicts of interest between the external reviewers and the parties involved in the appeal.
- **Process**: External review is conducted on paper in eight states, and through a hearing in four states.
- **Time Line**: Twelve states allow a maximum of 30 days for external review; 11 states specify an expedited time frame for external review in emergency or life-threatening cases, most ranging from 24 to 72 hours.
- **Binding**: External review decisions are binding on health plans in 11 states.
- **Case Disposition**: The percent of external appeals decided for consumers is split fairly evenly in most states, ranging from a low of 33 percent in Vermont to a high of 68 percent in Rhode Island.
- **Utilization**: Use of external review varies among states from a low of 10 cases in one year in New Mexico to a high of 218 cases in one year in Texas. Pennsylvania’s 1997 external review rate was less than 0.04 cases per 1,000 enrollees.
The Medicare External Review Process

The appeals process within Medicare has been suggested by some as a model for states in designing external review systems. All Medicare beneficiaries enrolled in managed care plans who are denied a health care service or who have a coverage dispute with their health plan have a right to external review of their appeal. To initiate the review process, Medicare beneficiaries must first appeal through their plan’s internal appeals mechanism. If a health plan upholds its initial denial, the plan must automatically forward the appeal to the Center for Health Dispute Resolution (CHDR), the external review contractor for Medicare.

CHDR has performed external review for the Medicare program since 1989. In 1997, CHDR reviewed more than 9,000 Medicare appeals, finding in favor of beneficiaries in one-third of cases. Trend data from CHDR show that one to two persons per 1,000 beneficiaries per year seek to use the external review process, at an administrative cost overall of under four cents per member per month.6

Current Status of External Review in California

The Role of the DOC. According to the Knox-Keene Act of 1975, managed care plans in California must establish an internal grievance system, and must inform enrollees of the procedure for processing and resolving grievances. Plans must also notify enrollees of their right to file complaints against plans with the California Department of Corporations (DOC), which is responsible for overseeing the state’s managed care industry. Knox-Keene requires the DOC to provide enrollees with an informal review process for their complaints against plans involving accessibility, benefits/coverage, claims, and quality of care issues. If a health plan does not resolve an enrollee’s complaint within 60 days, an enrollee can file a Request for Assistance (RFA) with the Health Plan Division of the DOC. In 1997, the DOC received 0.98 RFAs per 10,000 enrollees.7 No information is available on the disposition or resolution of these cases, nor on the role of the DOC in the resolution process.

The Friedman-Knowles Act. Under the Friedman-Knowles Experimental Treatment Act of 1996, managed care plans in California are required to provide an external, independent review process as of July 1, 1998 to examine the plan’s coverage decisions regarding experimental or investigational treatment denials for enrollees with terminal conditions.

• When treatment is denied, the plan must provide for external review of the denial if the enrollee requests it. No filing fee is required.
• The plan must contract with one or more accredited IROs to conduct the external review.
• An external review panel has 30 days to make a recommendation to the plan, or seven days when an enrollee’s physician requests an expedited external review because the patient’s condition requires timely treatment.

Implementation of this law is currently behind schedule because as of October 1998, no IROs had been accredited in the state. The DOC has chosen the accrediting agency, but few IROs have applied for accreditation, perhaps due to the detailed accreditation process established by the Friedman-Knowles Act.

Private Sector Effort. In addition to these legally established standards for external review, a voluntary private-sector effort is underway in California. Health Net, one of California’s largest HMOs with 2.3 million enrollees, has had an external review system in place for its commercial HMO enrollees since May 1998.8

• When care is denied at the physician group level, members are notified of Health Net’s internal and external appeals procedure.
• Members can appeal a denial of treatment to their physician group, which has five days to uphold or overturn the denial.
• If the denial is upheld, a Health Net Medical Director reviews the case file within five days and makes a second-level internal decision to uphold or overturn the denial.

• All denials upheld by Health Net are automatically submitted to a third-party, independent review organization, which has five days to uphold or overturn the denial and report its decision to Health Net.

In the system’s first six months of operation, 27 percent of appeals were resolved by Health Net through an alternate treatment plan different from what the enrollee originally sought, 43 percent were preemptively overturned by Health Net prior to going to external review, 3 percent were overturned at the external review level, and 27 percent were upheld at the external review level. From May to October 1998, the rate of appeal has been 3.25 appeals per 1,000 members. The cost of each review, paid by Health Net, has ranged between $250 and $350.

Health Net has said it will collect and analyze appeals data to identify opportunities for administrative practice improvements, referral process improvements, member and physician education, and product improvements.

The Board of Directors of the California Association of Health Plans (CAHP) announced in early December, 1998 that it would urge all member plans to voluntarily implement programs providing their members the right to a binding external, independent review of medical necessity decisions by the end of 1999. CAHP’s resolution—which lays out general guidelines for external review—would permit plans to impose a “reasonable” monetary threshold and/or a copayment paid by consumers filing appeals.

CAHP is a statewide trade association that represents most of the Knox-Keene licensed plans in the state. The 16 plans represented on CAHP’s Board cover more than 90 percent of the 20 million enrollees insured by CAHP, and CAHP expects that most of its other plans (40 in all) will also implement such programs. CAHP has indicated that it prefers that external review be put into law and continues to support the passage of external review legislation in 1999. Many plans may wait until the end of 1999 to begin implementing the program.

California’s External Review Legislation in 1998. In an effort to broaden external appeals standards for California’s managed care plan enrollees beyond experimen-

Issues Regarding the Design and Implementation of External Review

Establishing an external review system in California has raised complicated issues regarding the design and implementation of the program, potential increases in health insurance premiums as a result of the external review process, preemption of external review by ERISA, and the
connection between external review and expanded health plan liability.

**Design and Implementation.** External review programs in many other states can serve as models for California in establishing an effective external review system. The state could enhance the existing responsibilities of the DOC with respect to complaint resolution and expand the authority of the DOC to perform external review or facilitate the process. The state could also expand the nature of the decisions that are subject to external review under the Friedman-Knowles Act to include all treatment decisions, not just decisions involving experimental or investigational treatments.

The details of an external review system can be tailored in many ways to fit a narrow or broad view of which kinds of external appeals should be heard and how many consumers the system should serve. If external review legislation is introduced in 1999, the Legislature will have to revisit such issues as which health plan decisions are subject to external review, how the costs of external review are borne, whether consumers are charged an application fee, whether a claims threshold is imposed, and whether the external review decision is binding on health plans.

If California implements an external review system, whatever its scope, perhaps the most important criterion for ensuring its viability and effectiveness is informing consumers of their appeal rights, both internal and external. Some have argued that existing external review systems are not highly utilized because consumers are unaware that they have appeal rights. States that have external review systems, as well as the Medicare program, require health plans to disseminate information about enrollees’ appeal rights in plan documentation and when they are denied a service. In this way, enrollees who want to appeal a denial, after exhausting their internal appeal rights, are informed that they have further recourse if they wish to pursue their appeal at the external level.

Some appeals programs, such as those of Medicare and Health Net, automatically forward denials upheld at the internal level for consideration at the external review level. This automatic external review avoids the problem of enrollees not utilizing the external review process because they are unaware that it exists, and would likely lead to a greater number of appeals.

**Premium Increases.** Consumers are concerned about premium increases as a result of implementing patient protection laws. Support for patient protection standards is generally high, but erodes when linked to increases in health insurance premiums. In the 1998 Kaiser Foundation/Harvard University survey, the percentage of Americans who favored a law that would provide a variety of consumer protections decreased from 78 percent to 40 percent when this proposal was linked to a $200 annual increase in health insurance premiums.

While a potential increase in premiums is a legitimate concern, the estimated cost effect of establishing an external review system appears to be low. An analysis of the California Managed Health Care Task Force recommendations, prepared by Price Waterhouse for the Kaiser Family Foundation, indicated that the implementation of external review in California would result in a premium increase of three cents per enrollee per month, a .03 percent increase.

**ERISA Preemption.** The federal Employee Retirement Income Security Act of 1974 (ERISA) establishes the federal government as the regulator of private-sector employee benefit plans, including health benefit plans, and thus preempts many state laws regarding employer-based health benefits. A recent ruling from a U.S. District Court judge in Texas has relevance for the question of ERISA preemption and state external review laws. Ruling on a lawsuit filed by Aetna U.S. Healthcare against the state of Texas, the court found that Texas’ HMO liability law was not preempted by ERISA, but ERISA does preempt the state’s external review process. The case is currently under appeal, and states will be watching it closely for guidance on the degree of flexibility they have under ERISA in designing external review systems.

**Health Plan Liability.** Some have proposed that managed care plans should be held legally liable for damages that result from decisions to limit or deny services (now...
largely preempted for people in employer-sponsored plans by the federal ERISA law). Establishing the liability of health plans would allow patients to sue their plans, analogous to allowing medical malpractice suits by patients against physicians. Health plan liability has been proposed in many states, but as of 1998 only Texas and Missouri had established the legal right of patients to sue their health plans for malpractice.

Some consumer and health care interest groups argue that establishing external review without also making health plans liable for medical malpractice would result in an insufficient level of accountability that would be less effective in changing plan decision-making behavior than if external review were backed by the threat of a lawsuit. Others see external review and health plan liability on a spectrum of methods to hold health plans accountable for their decisions. According to this view, external review is a preventive measure used before damage to the consumer has arisen from a denial, and liability is a means of redress for consumers who have suffered as a result of the denial of treatment.

Health plan and business organizations have argued that liability would raise premiums significantly because health plans would be less stringent in their utilization review activities to avoid the risk of jury verdicts with large damage awards.

Conclusion

Holding health plans accountable for their utilization review decisions, just as physicians are held accountable for their medical practice decisions, has emerged as a key patient protection issue. Establishing an external review system in California is one component of health care reform that could increase consumer confidence that health plan decision-making is fair, and gives patients a place to go if they encounter problems with their plan. Establishing such a system may create an incentive for health plans to assure that responsible treatment decisions are made and to enhance their existing internal appeals procedures in order to minimize enrollees’ need for external appeal. However, while the cost estimates for establishing an external review program in California are modest, the true effect on premiums cannot be measured in the absence of a working system.

While the HMO industry in California has committed to voluntary adoption of external review and remains supportive of state legislation, many details that have important implications for how an appeals system would work in practice remain unresolved.

Because few health care reform bills were signed into law in the 1998 session of the California Legislature, the 1999 session should be another active year for health policy in the state. The issue of external review as a method of increasing health plan accountability is likely to be raised and debated once again, both in California and in Congress.
Endnotes


2 Families USA. Hit and Miss: State Managed Care Laws. Prepared for the Kaiser Family Foundation; July 1998.


6 Information about the Center for Health Dispute Resolution is from the testimony of David Richardson, President of the Center for Health Dispute Resolution, at the California Health Policy Roundtable on Examining Proposals for Independent Review of Health Plan Decisions; August 3, 1998.


8 Information about Health Net’s appeals process is from the testimony of Dr. Alan Zwerner, Senior Vice President and Chief Medical Officer of Health Net, at the California Health Policy Roundtable on Examining Proposals for Independent Review of Health Plan Decisions; August 3, 1998; and from Dr. Zwerner’s testimony at a briefing on external review sponsored by the Kaiser Family Foundation in Washington D.C. on November 16, 1998.


10 Craig Copeland and Bill Pierron. Implications of ERISA for Health Benefits and the Number of Self-Funded ERISA Plans. EBRI Issue Brief Number 193; January 1998.

For more information about the California Health Policy Roundtable, please contact:

Helen Schauffler, Ph.D., or Juliette Cubanski
University of California, Berkeley – Center for Health and Public Policy Studies
Phone: (510) 643-1675 • Fax: (510) 643-2340

Additional copies of this Policy Brief, the Georgetown University study (External Review of Health Plan Decisions..., document #1443), and other referenced Kaiser Family Foundation papers are available through the Foundation’s publication request line at (800) 656-4533 or can be downloaded from the Internet at www.kff.org.

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