AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

PATIENT APPEALS IN HEALTH CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIFTH CONGRESS

SECOND SESSION

APRIL 23, 1998

Serial 105–100

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE
63–213 CC WASHINGTON : 2000

COMMITTEE ON WAYS AND MEANS

BILL ARCHER, Texas, *Chairman*

PHILIP M. CRANE, Illinois
BILL THOMAS, California
E. CLAY SHAW, JR., Florida
NANCY L. JOHNSON, Connecticut
JIM BUNNING, Kentucky
AMO HOUGHTON, New York
WALLY HERGER, California
JIM MCCRERY, Louisiana
DAVE CAMP, Michigan
JIM RAMSTAD, Minnesota
JIM NUSSLE, Iowa
SAM JOHNSON, Texas
JENNIFER DUNN, Washington
MAC COLLINS, Georgia
ROB PORTMAN, Ohio
PHILIP S. ENGLISH, Pennsylvania
JOHN ENSIGN, Nevada
JON CHRISTENSEN, Nebraska
WES WATKINS, Oklahoma
J.D. HAYWORTH, Arizona
JERRY WELLER, Illinois
KENNY HULSHOF, Missouri

CHARLES B. RANGEL, New York
FORTNEY PETE STARK, California
ROBERT T. MATSUI, California
BARBARA B. KENNELLY, Connecticut
WILLIAM J. COYNE, Pennsylvania
SANDER M. LEVIN, Michigan
BENJAMIN L. CARDIN, Maryland
JIM MCDERMOTT, Washington
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia
RICHARD E. NEAL, Massachusetts
MICHAEL R. MCNULTY, New York
WILLIAM J. JEFFERSON, Louisiana
JOHN S. TANNER, Tennessee
XAVIER BECERRA, California
KAREN L. THURMAN, Florida

A.L. SINGLETON, *Chief of Staff*
JANICE MAYS, *Minority Chief Counsel*

SUBCOMMITTEE ON HEALTH

BILL THOMAS, California, *Chairman*

NANCY L. JOHNSON, Connecticut
JIM MCCRERY, Louisiana
JOHN ENSIGN, Nevada
JON CHRISTENSEN, Nebraska
PHILIP M. CRANE, Illinois
AMO HOUGHTON, New York
SAM JOHNSON, Texas

FORTNEY PETE STARK, California
BENJAMIN L. CARDIN, Maryland
GERALD D. KLECZKA, Wisconsin
JOHN LEWIS, Georgia
XAVIER BECERRA, California

Pursuant to clause 2(e)(4) of Rule XI of the Rules of the House, public hearing records of the Committee on Ways and Means are also published in electronic form. **The printed hearing record remains the official version.** Because electronic submissions are used to prepare both printed and electronic versions of the hearing record, the process of converting between various electronic formats may introduce unintentional errors or omissions. Such occurrences are inherent in the current publication process and should diminish as the process is further refined.

CONTENTS

	Page
Advisory of July 24, 1998, announcing the hearing	2

WITNESSES

Health Care Financing Administration, Michael M. Hash, Deputy Administrator	9
U.S. Office of Personnel Management, William E. Flynn III, Associate Director for Retirement and Insurance	16
Association of Private Pension and Welfare Plans, and GTE Corporation, J. Randall MacDonald	36
AvMed Health Plan, Stephen J. deMontmollin	52
Center for Health Dispute Resolution, David A. Richardson, Jr	70
National Association of Insurance, Colorado Division of Insurance, Jack Ehnes	44

SUBMISSIONS FOR THE RECORD

American Association of Retired Persons, Jim Parkel, statement and attachment	78
Medical Care Management Corporation, Bethesda, MD, Peter G. Goldschmidt M.D., statement	83
National Senior Citizens Law Center, Vicki Gottlich, statement and attachment	91

PATIENT APPEALS IN HEALTH CARE

THURSDAY, APRIL 23, 1998

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:10 a.m., in room 1100, Longworth House Office Building, Hon. Nancy Johnson presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

Subcommittee on Health

FOR IMMEDIATE RELEASE
April 16, 1998
No. HL–21

CONTACT: (202) 225–3943

Thomas Announces Hearing on Patient Appeals in Health Care

Congressman Bill Thomas (R–CA), Chairman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on how patient appeals are processed in various health care settings. The hearing will take place on Thursday, April 23, 1998, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.

Witnesses will include representatives from the Health Care Financing Administration (HCFA), health insurance and managed care organizations, and patient advocacy groups. Any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Due process is a core value of the American legal system and has recently become an important health care issue. Virtually all private and public health organizations provide consumers with some form of complaint resolution, using varied procedures to respond to consumer complaints.

With respect to the Medicare appeals process, a U.S. District Court in Arizona in 1997 found that HCFA (and the Medicare HMOs with which HCFA contracts) denied beneficiaries their right to fair notice and hearings in contesting coverage issues. The court ordered HCFA to provide seniors with detailed information concerning grievances, hearings and appeals.

Many States require health insurers to provide certain complaint procedures. More than thirty States have some specific complaint procedures that health plans must follow. A growing number of States are also requiring expedited appeals for denials of urgently needed care.

In announcing the hearing, Chairman Thomas stated: "Patients should be assured that they have an avenue for appealing health care decisions and that these decisions are made in a timely manner. While concerns have been raised about current regulations, in fact, many insurers and health care organizations are already going beyond the requirements of existing State and Federal law. Patient satisfaction in resolving disputes is a key element for maintaining confidence in the American health care system."

FOCUS OF THE HEARING:

The Subcommittee will examine the different types of appeals procedures used in Medicare and in private markets, and what progress HCFA has made in improving patient appeals. In addition, the Subcommittee will consider lessons learned from States which have traditionally regulated health insurance benefits. A representative of the National Association of Insurance Commissioners (NAIC) will testify re-

garding its model grievance statute which is under consideration in a number of States.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) single-space legal-size copies of their statement, along with an IBM compatible 3.5-inch diskette in ASCII DOS Text or WordPerfect 5.1 format only, with their name, address, and hearing date noted on a label, by the close of business, Thursday, May 7, 1998, to A.L. Singleton, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments. At the same time written statements are submitted to the Committee, witnesses are now requested to submit their statements on an IBM compatible 3.5-inch diskette in ASCII DOS Text or WordPerfect 5.1 format. Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at "HTTP://WWW.HOUSE.GOV/WAYS__MEANS/".

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Mrs. JOHNSON of Connecticut. Welcome. My Chairman, Mr. Thomas, is unexpectedly detained and we're going to move ahead in his absence.

Due process means many things. To legal scholars, it's a term of art meaning the technical process by which legal rights are enforced. In a larger sense, due process means simply the opportunity to be heard, the chance to air grievances. Due process has always been important to our legal system.

Today the concept is gaining significance in health care. The reason for this is simple. Americans are becoming more informed consumers and they are demanding opportunities to be heard. With a wide variety of opportunities to educate themselves through newspapers, journals, television documentaries, and the Internet, the average patient today is much better informed about medical options than the average patient just a decade ago.

In the past, a patient with a rare disease might only have sought a second opinion before selecting a treatment regimen. Today a patient may sit down at their home computer, or stop in at their local library, and enter a world of information—from the National Library of Medicine to chat rooms for patients with a similar condition.

This empowerment of consumers means that they no longer take a coverage denial decision sitting down. When a fee-for-service health plan or a managed care plan denies coverage for service, because it is either not covered by the policy or the service is deemed to be medically unnecessary, patients often feel angered and frustrated.

Insurers and managed care plans could significantly reduce these concerns by, first, providing coverage information in a form that is easily understood by consumers when they enroll in their plan, and two, by making coverage decisions in a timely manner, so that patients are not in limbo for an undefined period of time. Many plans have already taken these steps, and I predict that they will be the winners in the end, as individual consumers and employers walk with their feet to the plans that meet their needs.

Finally, it is inevitable that, no matter how detailed the information provided to consumers, and no matter how elaborate the appeals process concerning coverage decisions, there will be always disputes about what is and is not covered. Our goal should be to minimize these disputes.

Today we will hear from several witnesses representing a wide variety of opinions on the issue of patient appeals.

Our first witness today is Mike Hash, the new Deputy Administrator of the Health Care Financing Administration. Joining him is Mr. William Flynn, who is responsible for managing the Federal Employees Health Benefit Plan, the health program that covers Members of Congress and all Federal employees. I look forward to hearing testimony from these and our other witnesses today, and yield now to Mr. Stark.

Mr. STARK. Thank you, Madam Chairman, and I intend to yield to Mr. Cardin, who has a bill that was referred to this Subcommittee. And, I thank you, Chairman Thomas, for holding this hearing.

I'm sorry to say that I think this is perhaps the most important health issue before the public today. The administration has put forward a lot of bills which will help in some small way to expand insurance to the uninsured, and we have talked a lot about fraud

and abuse, and there is a commission to extend the life of Medicare. But, I think nothing is more in the public's mind now than the almost obscene indifference of the for-profit health care plans to their patients—the idea that they will deny health care at every opportunity in an effort to make increasing profits and pay ever higher executive salaries, and do this by refusing to deliver decent medical care. And, arbitration plans aren't the solution. Health plans will only wake up and do the right thing when they stand close to criminal indictment and/or severe civil penalty. And, it is for that reason, that it is imperative that the Federal Government and the Congress respond to the overwhelming public demand.

I seriously would like to repeat, I know of no other legislative proposal than patient protection that is more in the public's mind today, and that includes cutting taxes. They are more interested in this than they are in having taxes reduced. It is incumbent on this Subcommittee to move ahead and satisfy that or the States will come up with a hodgepodge of different protections which will make life very much more complicated for all Americans.

And, I'd like to yield at this point to Mr. Cardin, who has an excellent bill that has been referred to this Subcommittee.

Mr. CARDIN. Let me thank Mr. Stark for yielding the time, and Madam Chairman, let me thank you and Mr. Thomas for holding this very important hearing on patients' rights.

We really start the debate, and this hearing, on Congress passing a patients' bill of rights bill. It is very important that we provide for an independent, unbiased review of insurance company decisions affecting one's health care.

The President's Advisory Commission on Consumer Protection and Quality last November came out with a series of recommendations to protect the quality of health care in this country. And, they did provide for an external appeal—an independent appeal process. The President took action in February, by Executive order, extending this right to all enrollees of Federal health programs, so that 85 million people are currently covered by an external appeal, thanks to President Clinton's actions.

Madam Chairman, it is interesting to point out that some of these plans already had an external appeal for many years. And, as the testimony today will point out, there have been none of the problems that some of the opponents of external appeal have said would happen in those programs in our Federal Government that have had an external appeal process.

But, it is important now that we deal with Americans who are not covered by the President's Executive order. Their claims are being denied as not medically necessary, or not a medical emergency, and the internal review process within these plans has not worked.

Let me give you just one example that maybe will underscore the problem that we have with the internal review process that most managed care plans use. A person from my State happened to be hiking in the State of Virginia. She fell from a 40-foot cliff, and fractured her arm, pelvis, and skull. She was airlifted to a hospital and was admitted as an inpatient. The HMO denied coverage, and, to this day, has still denied the inpatient services. The internal review process has not worked.

Let me quote from the executive of that managed care program as to how that plan is saving money. I'm quoting, "Perhaps the brightest spot in our operations is the improvement of our claims auditing ability. We have taken advantage of significant opportunities to reduce current and future medical expenses by more closely challenging the contractual and medical appropriateness of claims."

Now, in this managed care program, the annual compensation package for the company's top executives in 1996 was $1.8 million. I think we can figure out ways in which this managed care program can save money. It shouldn't be by denying claims that are appropriate, in order that there be higher bonuses for the corporate executives. And that's what is happening, and without an external appeal process, we are in danger that that will just be exaggerated.

The States have tried to respond. One-third of our States have passed laws that guarantee to their citizens an external review process. My own State of Maryland enacted a review process in their last legislative session that will become effective on January 1, 1999—the NIAC model, where the State legislature contains an external appeal process. But, currently, there are 125 million Americans who are enrolled in programs that are covered under the ERISA statute. Even if every State in this Nation passes an external review process, 125 million Americans won't be covered under those laws, because of the Federal preemption under ERISA.

It is important that we in Congress pass this basic protection for those individuals. I have introduced H.R. 3469, The Patient's Right to Independent Appeal Act, which provides that an external review of cases must be determined within 72 hours for emergency cases, and 60 days for all other decisions. This bill has been endorsed by the American Federation of State, County, and Municipal Employees; the National Senior Citizens Law Center, and Families USA. A comparable, similar provision is provided in the Democratic caucus bill, Patient Bill of Rights Act, H.R. 3605, that I am an original cosponsor of.

Let me just point out one additional fact. Proponents of external appeal say it would add to the cost of health care in this country. I disagree with that. There are two independent studies that have been done. One, by the Lewin Group, that said the cost will range from three-tenths of $.01, to $0.07 per month, per person, and Coopers and Lybrand recently came in with a review that shows it will cost $1.20 per year, or $0.10 per month, for an external review process.

I think that those estimates are wrong. I think it will save money. If we adopt national standards for external review, managed care programs will develop a much stronger internal review process. And managed plans will be handled more efficiently. It will also reduce the amount of litigation that has taken place in health care.

For all these reasons, I urge this Congress to act quickly on an external review process, so that we can provide this protection to all people in our country, and, Madam Chairman, I ask you now to consent that my entire statement be included in the record.

Mrs. JOHNSON of Connecticut. So ordered.

[The opening statement follows:]

Opening Statement of the Hon. Benjamin L. Cardin, a Representative in Congress from the State of Mayland

Good morning, Mr. Chairman, Members of the Subcommittee. I want to commend Chairman Thomas for holding this hearing on the most fundamental of patient rights-

to obtain an independent, unbiased review of insurance company decisions affecting one's health care.

I also want to applaud you for beginning with a discussion of the Medicare program. Since its creation more than 30 years ago, Medicare has led the way in setting high standards for health care quality.

In the years since Medicare was enacted, America's over–65 population has increased rapidly due to technological advances and increased awareness of healthful lifestyles. At the same time, health care costs have increased, and Congress has been challenged to keep its promise to beneficiaries-guaranteeing them comprehensive medical care while keeping the program solvent.

One of the ways we have kept that promise is by providing access to an external appeals process where denied claims can be reviewed by an independent entity and beneficiaries can trust that their cases are being considered fairly. I hope that by examining Medicare's external appeals system, we can both improve it for seniors and appreciate the value of guaranteeing this process for all Americans.

The President's Advisory Commission on Consumer Protection and Quality recognized the importance of external review and included it in its Patients Bill of Rights last November. In February, the President issued an Executive Order extending this right to all enrollees of Federal Health Programs-more than 85 million Americans.

When that Executive Order was signed, Americans in private health plans looked to Congress for reassurance that they, too, would be guaranteed this right. They are looking to us because there is a crisis of confidence in managed care. Every week, I receive letters and phone calls from people in my district who are frustrated with their health care companies. They follow the rules, and still they are unable to receive services that are covered by their insurance policies. Claims are denied as "not medically necessary," or "not a medical emergency." They find it difficult to register complaints or obtain reconsideration of their decisions, and they experience lengthy delays in getting their cases reviewed. They are concerned that these delays will put their health or life in jeopardy while they fight a health plan's red tape.

Last July, a Maryland woman was hiking in Virginia when she fell off a 40-foot cliff, sustaining arm, pelvis and skull fractures. After being air-lifted to a hospital, she was admitted as an inpatient. Her HMO denied reimbursement for the ER, air-lift and inpatient treatment charges because she did not obtain pre-authorization. The patient says that she was so heavily medicated during and after the hospitalization that she was unable to provide notification. Although the HMO has now approved reimbursement for the ER and air-lift charges, inpatient expenses are still denied. Clearly, the *internal* review process did not provide adequate patient protection in this case.

Because of scenarios like this, which are widespread, people do not believe that their health plans are providing them a fair and impartial review of their cases. A majority of all Americans are worried that their health plan would be more concerned about saving money than about providing the best medical treatment for them.

And they have good reason to worry. The Chief Financial Officer of the health plan that denied the air-lift and hospitalization told Wall Street Journal analysts that "perhaps the brightest spot in our operations is the improvement in our claims-auditing capability. We have...taken advantage of significant opportunities to reduce current and future medical expenses by more closely challenging the contractual and medical appropriateness of claims."

The average annual compensation package for this company's top executives in 1996 was $1.8 million.

In response to these types of cases, one-third of our state legislatures have enacted laws to guarantee their citizens the right to an external appeal, and bills have been introduced in many others. My own state of Maryland recently enacted external appeals legislation that will go into effect on January 1, 1999.

And yet, because we have an illogical system of health care laws, even if every state legislature in the nation were to pass an external appeals law, millions would still be denied this right. Approximately 125 million Americans are enrolled in ERISA plans, which are not subject to state insurance laws on grievances and appeals.

ERISA requires plans to give its beneficiaries notice and opportunity for a full and fair review of denied claims within 60 days, but if the internal review results in an

adverse determination, the only recourse is to sue the benefit plan to recover the cost of treatment. Because most managed care denials occur during the pre-authorization process, that is, before treatment is rendered, the consequences for a patient's life or health are far more serious than with a fee-for-service denial. Yet, patients are not able to receive compensation for pain and suffering that result from the denial, nor are they eligible to receive punitive damages.

The tremendous disparities between states and between state-regulated and ERISA plans have led me to conclude that federal legislation is imperative.

I have introduced HR 3469, the Patient Right to Independent Appeal Act. This bill provides external review for cases that are not resolved through an internal process or when the plan does not complete the internal process in a timely manner. External review is mandated when services are denied as not medically necessary and the amount exceeds a significant threshold, when the treatment is denied as experimental or investigational, or when the patient's life or health is jeopardized. The procedure may vary depending upon whether it is for ERISA self-insured plans or traditional insurance plans. In either case, the applicable state or federal authority (U.S. Department of Labor) can choose to establish its own external review entity, or certify an independent entity. Each plan will contract with an entity and will pay for the direct costs of the appeal process. This system will allow multi-state plans the opportunity to obtain nationally consistent interpretations of coverage, and is compatible with ERISA's requirement that plans administer their benefits in a consistent manner.

All participants have the opportunity to submit evidence and make an oral presentation. The plan is also required to provide timely access to all information. This external review must be made within 72 hours for emergency cases and within 60 days for all other decisions, and the decision of the review panel is binding on the health plan.

HR 3469 has been endorsed by the American Federation of State, County and Municipal Employees, the National Senior Citizens Law Center, and Families USA.

This provision is also included in the Democratic Caucus Patient Bill of Rights Act,

HR 3605, which I have co-sponsored.

Some groups claim that costs associated with a guaranteed external appeals process are prohibitive. I want to refute that. Last November, the Lewin Group estimated the cost of an appeals process for national implementation. Researchers considered data from Florida, Rhode Island, Texas, and New Jersey. The state of Florida, which implemented its external review system in 1985, is the longest standing appeals process among all the states. Florida's Statewide Assistance Panel, a state agency, performs the appeals at an average cost of $867 per appeal. In the other states, appeals are contracted out to a private company and costs range from $288 to $600 per appeal. Using the low figure of 1 appeal per 10,000 enrollees (Florida) and the high of 2.5 appeals per 1,000 enrollees (Medicare), Lewin determined that the costs would range from three-tenths of one cent to seven cents per person per month. Patients will tell you that is a small price to pay for the peace of mind that comes from knowing that when you require life-saving treatment, the final decision will not be made by someone who stands to profit if appropriate care is denied.

A separate report released yesterday by Coopers & Lybrand for the Kaiser Family Foundation estimates the cost of external appeals at $1.20 per year, or ten cents per per month.

Employers are beginning to acknowledge that consumer protections for ERISA plans are inadequate. The Corporate Health Care Coalition is an alliance of 26 large, multi-state self-insured companies focused on national health care policy. On Monday, one of its largest members, IBM, testified before the Senate Labor Committee that "in one area, the revision of ERISA requirements for internal reviews and creation of a new external, independent review of benefit denials, we believe it is appropriate for Congress to legislate."

There are additional benefits to enacting a federal external appeals law. If health plans are so opposed to external review, perhaps they will strengthen their internal review systems to respond promptly and responsibly to patient concerns so that further appeals will not be needed.

Second, an adequate external appeals system will result in fewer lawsuits. The existence of an independent review process will reduce the need for liability claims against health plans and will eventually result in reduced overall health care expenditures.

Mr. Chairman, thank you for providing a forum for this issue. I look forward to hearing from our witnesses, and to a productive discussion of existing appeals systems and how this Congress can act to improve the health care system for all Americans.

Mrs. JOHNSON of Connecticut. We will now proceed with Mr. Hash and Mr. Flynn to come forward.

STATEMENT OF MIKE HASH, DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. HASH. Good morning, Madam Chair, Subcommittee Members. I want to thank you for inviting the Health Care Financing Administration to testify today about the appeals process available to our beneficiaries. Effective and efficient appeals processes are essential to ensure access to the benefits, to protect our beneficiaries, and to promote improvements in our overall programs. We welcome any insights that you, or the other witnesses today, may share with us about how to improve our processes.

Clearly, Medicare beneficiaries must have the right to speedy remedies in cases where time may be crucial, as Mr. Cardin has just discussed. Beneficiaries must know that they have prompt recourse if they feel they are denied needed care. It is important to note, I think from the perspective of the Medicare Program, that most of our beneficiaries never file an appeal. In fiscal year 1997, less than 1 percent of claims in Medicare were appealed, and less than 5 percent of all beneficiaries have reported through surveys that they have ever filed an appeal. But when there is a dispute, we want our systems to help assure that the rights of patients come first.

Beneficiaries can appeal virtually any issue under the Medicare system. Beneficiaries are regularly reminded of their appeal rights through a variety of sources: Our Medicare Handbook, which we distribute to new Medicare beneficiaries; explanation of Medicare benefits, and Medicare summary notices, which we periodically send to beneficiaries. With respect to patients who are admitted to hospitals, we provide notice of their appeal rights as hospital patients, and, finally, information about our appeal process is included in the enrollment materials with respect to our managed care plans. And at each time a denial is made by one of our contracting private plans, enrollees are advised of their appeal rights.

We think this hearing today is especially timely because we are now considering further improvements in our managed care appeals process. Last year, as I know many of you know, the Clinton administration published the regulations that guarantee appeal rights to Medicare beneficiaries that are among the strongest in the country.

I'd like to call your attention to a chart that we included in our testimony today, which I think illustrates our appeals process, both on the managed care side for our enrollees, and in the traditional fee-for-service program. We are strengthening our managed care appeals because the incentives in the managed care system are so different from the incentives in the traditional fee-for-service system. Beneficiaries must be confident that managed care incentives to reduce unnecessary care won't limit appropriate care. That's why we now require our managed care partners to respond within 72 hours when Medicare beneficiaries appeal a denial of care decision

by a managed care plan that could result in jeopardizing life, health, or the ability to regain maximum function.

As I mentioned, we are considering additional improvements to address continuation of care during appeals in managed care, notification of beneficiaries when services are reduced or terminated, and tighter standards for review in routine appeals in managed care. For example, we believe that the turnaround time for non-urgent appeals should be reduced from the current 60-day period, and we would welcome any comments from the Subcommittee, or other interested parties, on what those timeliness standards should be.

We do guarantee expedited appeals for both managed care and fee-for-service when it comes to a hospital discharge. A Medicare beneficiary or a physician may decide that such a discharge is inappropriate. In this circumstance, there are very short time periods for resolution of that dispute. This is essential to make sure that incentives for hospitals to be efficient do not result in the denial of appropriate care.

Generally, in the fee-for-service part of Medicare, the process works somewhat differently, because the incentives are different there. And, this is an important distinction. Claims denials in the fee-for-service system generally come after services have been delivered and there is not the potential medical urgency issue that arises in the context of managed care when there is a denial before services are actually rendered. Under part B of the Medicare Program, providers have the same right to appeal as beneficiaries if they accept assignment. As you know, accepting assignment means the provider will accept our payment as payment in full, and agree not to bill the beneficiary more than the 20 percent coinsurance.

Most of the delays, that you see from our information included in my longer statement, in our appeals process, occur at the administrative law judge level, where cases can be appealed that are not resolved in favor of the beneficiary at our contractor level. It takes, on average, about 45 days for our contractors to process part A appeals, but the average time for administrative law judge decisions on part A appeals averages over 300 days. It takes, on average, less than 34 days for our contractor to process and review part B claims, but for those that are appealed to ALJs it takes an average of 664 days to resolve those cases.

Now, the administrative law judge system remained within the Social Security Administration when HCFA became an independent agency a number of years ago. Only 5 percent of the ALJs case load is from Medicare appeals. As a result, the judges tend to be far more expert in the Social Security rules and regulations than in Medicare regulations. ALJs are not bound, in addition, by HCFA local review policies that our contractors may apply, and Medicare officials are not automatically included in the discussion of cases at the ALJ level. And, finally, providers can introduce new information, new documentation, at the ALJ level, which has not been available to our contractors in their review process.

To address these problems, we are adding new requirements for our contractors in the appeals area, to ensure that case files that go forward to ALJs are complete and comprehensive. Also, thanks to the Social Security Administration, they have now dedicated

about 30 of the administrative law judges to be Medicare-only specialists. We are working to educate those designated ALJs about Medicare policies. We look forward to continuing to work with the Social Security Administration on further improvements that might be made in reducing the time lags associated with ALJ reviews.

So, while there is room for improvement in our appeals process, especially at the ALJ level, we believe our appeal system is working. We have the strongest appeal rights in the country for our managed care beneficiaries, where appeal rights are so essential because of the incentives in a capitated delivery system. We are working to bolster these managed care appeal rights further for nonurgent appeal cases.

We very much appreciate this opportunity to be with you and participate in this discussion. We, of course, look forward to working with you, Madam Chair, and the Members of the Subcommittee, as you continue to refine the appeals process, and, of course, at the appropriate time, I'd be happy to respond to any questions that you, or other Members of the panel, may have for me. Thank you very much.

[The prepared statement follows:]

Statement of Michael Hash, Deputy Administrator, Health Care Financing Administration

Chairman Thomas, Subcommittee members, thank you for inviting HCFA to testify today about the appeals processes available to our beneficiaries. Effective and efficient systems for beneficiaries to appeal Medicare's coverage and payment decisions are essential. We appreciate any ideas or insights on improving these systems that you and your witnesses might share.

Clearly, Medicare beneficiaries must have the right to a speedy ruling in cases where time may be crucial. Beneficiaries must know that they have a prompt recourse if they feel that they are denied needed care. Most beneficiaries never file appeals, and in Fiscal 1997 less than 1 percent of claims were appealed, and less than 5 percent of beneficiaries report having ever filed appeals. But when there is a dispute, our objective is to have an appeal system that helps to assure that the rights of patients come first.

Beneficiaries can appeal virtually any issue regarding provision or payment of services, and beneficiaries are regularly reminded of their appeal rights. These rights are discussed in the Medicare handbook. They are listed on every Explanation of Medical Benefits and Medicare Summary Notice sent to beneficiaries. They are included on notices to patients when they are admitted to hospitals. And they are described on every denial made by a Medicare managed care plan. (A chart outlining the various appeal levels that are available is attached to this testimony.)

This hearing is timely because we are currently considering options for further improvements in our appeals process. Just last year the Clinton administration published final regulations guaranteeing appeal rights to Medicare managed care beneficiaries that are among the strongest available to any managed care enrollees in the country.

MANAGED CARE APPEALS

Appeal rights are important in both managed care and fee-for-service. We are strengthening regulations for managed care appeals because the incentives are so very different from fee-for-service Medicare. Beneficiaries must be assured that managed care incentives to reduce unnecessary care will not be allowed to limit appropriate care.

That is why we require plans to respond within 72 hours when Medicare beneficiaries appeal a denial-of-care decision by a managed care plan that could jeopardize life, health or ability to regain maximum function. The rule also covers termination of care, such as discharge from a skilled nursing facility.

In expedited appeals, health plans must notify Medicare enrollees within 72 hours of receiving an enrollee's request for services that they are denying the service. The plan at that time must state the reasons for the denial, inform the beneficiary of their appeal rights, use denial notice forms that describe the expedited appeal right,

accept oral requests for appeals, follow up verbal notifications in writing within two working days, automatically grant all physician requests, and maintain logs and periodically report on requests for expedited appeals. The beneficiary has 60 days to file an appeal, and the plan generally has 72 hours to rule on expedited cases, and 60 days on standard cases.

If a plan upholds its original decision to deny the service, the case must automatically be forwarded to our independent reviewer. This contractor runs what we call the Center for Health Dispute Resolution, also known by the acronym CHDR. The CHDR contractor generally acts on expedited appeals within 10 working days, and managed care plans have up to three days from the date an expedited appeal request is made to the CHDR to submit additional information. For appeals that are not medically urgent, the CHDR generally has 30 working days to make a ruling.

Beneficiaries have up to 60 days to request a review of an ALJ's decision by the Department of Health and Human Services Appeals Council. After that level of appeal, beneficiaries have up to 60 days to request a Federal District Court review of any decision involving at least $1,000.

Beneficiaries have up to 60 days to request a review of ALJ rulings in cases involving at least $100 by an Appeals Council. After that, beneficiaries have up to 60 days to request a review by the Department of Health and Human Services Appeals Council. After that level of appeal, beneficiaries have up to 60 days to request a federal district court review of any decision involving at least $1000.

Since the federal government is the largest purchaser of managed care, our expedited appeals regulation for urgent care cases helps set a new, higher standard for the entire managed care industry.

As I mentioned, we are now considering additional improvements to the regulations to address continuation of care during the managed care appeals process, notification of beneficiaries when services are reduced or terminated, and tighter standards for appeals involving situations that are not urgent. We believe the turnaround time for non-urgent appeals should be reduced from the current 60 days, and welcome comments from your committee and other interested parties on what the standards should be.

As we did with our expedited appeals regulation last year, we are consulting with beneficiary advocates, provider groups and the managed care industry in developing these further improvements.

FY 1997 Managed Care Appeals Statistics

In Fiscal Year 1997 there were 5,458,109 Medicare beneficiaries enrolled in managed care plans. We do not currently receive information on the number of appeals filed with managed care plans, which is the first level of appeal for managed care disputes.

Cases not resolved by plans are automatically forwarded to our independent CHDR appeals contractor, and 9,024 appeals were sent to CHDR in FY 1997. About 24 percent of CHDR rulings are in favor of the beneficiary. About 6 percent of CHDR ruling are appealed on for Administrative Law Judge review.

FEE-FOR-SERVICE APPEALS

In fee-for-service Medicare, the appeals process works somewhat differently because incentives are different. Payment denials generally come after care is delivered, and there is not the potential medical urgency that could occur because of a managed care denial before care is delivered.

Part A Appeals

Because of incentives in the Medicare payment system for hospitals, expedited appeals are guaranteed for cases in which a hospital wants to discharge a Medicare beneficiary and the beneficiary's physician considers discharge to be inappropriate. Providing expedited appeal rights for inpatients facing hospital discharge against their physician's advice is an essential check to make sure incentives for hospitals to be efficient do not result in denial of appropriate care.

For Part A disputes other than hospital discharges that concern hospital, skilled nursing and home health claims, appellants must request review within 60 days of receiving notice—called the "initial determination" that the claim is being denied. Our contractors must complete 75 percent of appeals within 60 days, and 90 percent within 90 days.

Part A disputes not resolved at the contractor level can be taken to Administrative Law Judges (ALJs), where there are no time limits for decisions that can be enforced, and where backlogs and delays are occurring. Appeals to ALJs must be

requested within 60 days of receiving a decision on the appeal from the contractor level. Issues for ALJ appeals must be for claims of at least $100, and claims can be added together to meet the $100 requirement.

Part A disputes can be appealed beyond the ALJ level to an Appeals Council. These appeals must be requested within 60 days of the ALJ decision, and unlike other prior appeal levels, the Appeals Council can turn down the request. The Appeals Council can also choose to review an ALJ decision on its own, without a request from a beneficiary or provider.

Part A disputes can be appealed past the Appeals Council to judicial review. These requests must be made within 60 days of the Appeals Council decision, and must involve matters of at least $1000.

PART B APPEALS

For disputes about Part B physician, equipment, and lab service claims, beneficiaries must request an appeal within six months of receiving notice that the claim is being denied. Our contractor must complete 95 percent of reviews within 45 days.

Part B disputes can be appealed past the contractor review level to contractor Hearing Officers, who must complete 90 percent of hearings within 120 days. Requests for hearing officer hearings must be made within six months of the initial contractor review decision, and must be for disputes of at least $100. Claims can be added together to meet the $100 requirement.

Part B disputes can be appealed beyond the Hearing Officers to Administrative Law Judges (ALJs). These appeals must be requested within 60 days of the Hearing Officer decision, and must involve disputes of at least $100 for home health claims and $500 for all other Part B claims. Again, claims can be added together to meet the dollar amount threshold.

Part B disputes can be appealed beyond the ALJs to the Appeals Council. The request must be made within 60 days of receipt of an ALJ decision. And, as with Part A disputes, the Appeals Council can decide to turn down a case, and it can decide to take up an ALJ case on its own, without a request from a beneficiary or provider.

And again, as with Part A disputes, Part B disputes can be appealed beyond the Appeals Council level to the courts. These requests must be made within 60 days of the Appeals Council decision, and must involve matters of at least $1000.

FY 1997 FEE-FOR-SERVICE APPEALS STATISTICS

In Fiscal Year 1997, we processed 843,859,934 claims. Appeals were filed involving 6,091,313, or 0.72 percent.

Part A Appeals:

Our contractors received 58,030 Part A cases in fiscal 1997. They completed 59,689 cases involving 81,432 claims, and ruled in favor of the appellant in 30 percent of cases.

The ALJs were sent 15,937 Part A appeal requests involving 25,422 claims. They completed 12,465 and ruled in favor of the appellant in 72 percent of cases.

Part B Appeals Related to Services such as Hospital Outpatient and Home Health Care:

Our contractors received 152,251 cases. They completed 160,082 cases involving 198,141 claims, and ruled in favor of the appellant in 44 percent of cases.

Hearing Officers received 20,514 cases, completed 14,988 involving 21,694 claims, and ruled in favor of the appellant in 40 percent of cases.

ALJs were sent 3,120 cases involving 4,685 claims. They completed 1,321 cases, and ruled in favor of the appellant in 59 percent of cases.

For Part B Appeals Related to Physician and Other Services:

Our contractors received 3,868,160 cases. They completed 3,337,592 cases involving 5,811,740 claims, and ruled in favor of the appellant in 70 percent of cases.

Hearing Officers received 86,746 cases. They completed 86,898 cases involving 539,040 claims, and ruled in favor of the appellant in 45 percent of cases.

ALJs were sent 8,412 cases involving 123,791 claims. They completed 4,701 cases, and ruled in favor of the appellant in 51 percent of cases.

PROVIDER, PHYSICIAN AND SUPPLIER APPEAL RIGHTS

Providers, physicians and suppliers, as well as beneficiaries have appeal rights, and all can appeal on behalf of beneficiaries if they become the beneficiary's appointed representative.

Under Part A, providers can only appeal denials based on medical necessity. Under Part B, physicians and suppliers have the same right to appeal as beneficiaries if they accept "assignment" on a claim. Assignment, in Medicare jargon, means that they accept what Medicare pays as payment in full without billing the beneficiary for more than the standard 20 percent copayment.

Physicians and other Part B suppliers who do not accept assignment do not have the same appeal rights as the beneficiary. They may, however, appeal medical necessity denials where they are required by statute to make a refund to the beneficiary.

ADMINISTRATIVE LAW JUDGE APPEALS

One area where we would like to make improvements is in the Administrative Law Judge appeals system, and in the coming year, we will work with our partners in the Social Security Administration on this. As I explained earlier, the Administrative Law Judge level is where delays can occur in our appeals process. On average, ALJs process Part A appeals in 301 days and Part B appeals in 664 days. Also, since the vast majority of the judges' workload is Social Security cases, the judges, as a whole, tend to be far more expert in Social Security rules than in Medicare regulations. Furthermore, ALJs are not bound by HCFA local policy or manuals, though they are bound by Medicare law and regulation.

These issues point to a need for some improvement. HCFA is performing an analysis of the ALJ process and will be in discussions with officials of the Social Security Administration about future steps that may be taken.

For now, we are adding new requirements for our contractors to ensure that case files that go to ALJs are complete and comprehensive. Also, about 30 ALJs are being dedicated as Medicare-only specialist who will handle the most complicated Medicare cases. Finally, we are working to educate ALJs about how Medicare local policy is created and the underlying reasons for the policy.

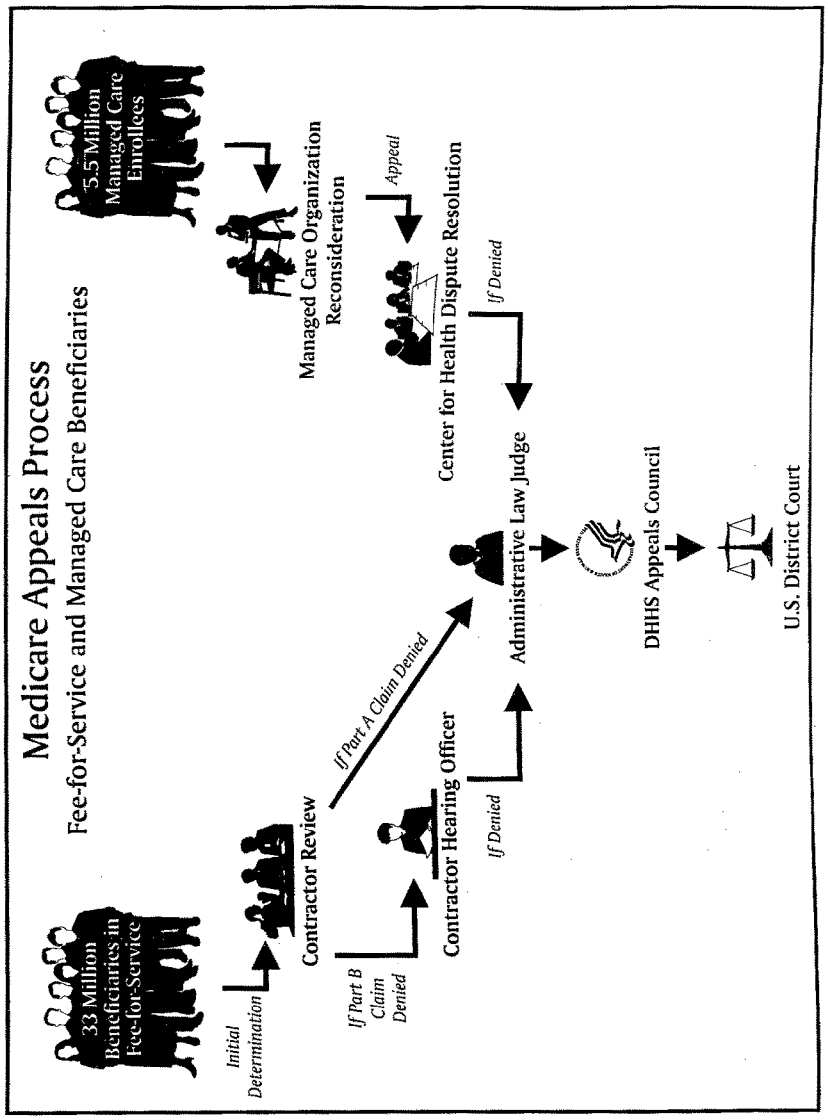
CONCLUSION

There is room for improvement in our appeals process, especially at the Administrative Law Judge level.

We have the strongest appeals rights in the country for our managed care beneficiaries, where appeals rights are so essential because of the incentives that exist in managed care. We are currently working to bolster these managed care appeals rights further for non-urgent cases, and will keep you abreast of our progress.

We also have sufficient appeal rights for our fee-for-service beneficiaries and providers, with prompt turnaround on cases up until they reach the ALJ level, where Medicare has no control.

We appreciate your interest in this issue, and look forward to working with you as we monitor and continue to refine the appeals process. I'd be happy to answer any questions you might have.



Mrs. JOHNSON of Connecticut. Thank you, Mr. Hash.
Mr. Flynn.

STATEMENT OF WILLIAM E. FLYNN III, ASSOCIATE DIRECTOR FOR RETIREMENT AND INSURANCE, OFFICE OF PERSONNEL MANAGEMENT

Mr. FLYNN. Thank you, Mrs. Johnson. I've submitted a statement for the record. I might highlight just for the Subcommittee perhaps 5 points from that.

First, I'd like to thank you for your invitation here today. The Federal Employee Health Benefits Program is the largest employer-sponsored health benefits program in the United States. It consists of over 350 plans, providing health care benefits to over 9 million Federal employees, Federal retirees, and Members of their families.

I think the first point that I'd like to make with respect to the patient appeals process is that we believe we have a good program. It's been in place for over 20 years, since 1975. It's fully compliant with the broad principles included in the Patient Bill of Rights, and, as Mr. Cardin mentioned earlier today, it includes an external review process independent from the plan and the initial decision that the plan made on a disputed claim or a patient appeal.

The second point that I'd like to make is that our participants understand the process. They have information on how to use it. That information is included in plan brochures that they get from their individual health carriers. It's included in program guides and other materials that the Office of Personnel Management provides participants. It's on the Office of Personnel Management Internet website, and in other places. Generally speaking, we think it's a relatively simple program. It's easy to understand and relatively efficient to administer.

And, that brings me to my third point. We have in the Federal Employees Health Benefits Program three levels of review. Those are laid out pretty clearly.

The first level of review is at the health plan level. We require health plans to issue a decision to a patient within 60 days, and most plans meet that standard. If the individual is still dissatisfied with the decision at the plan level, they can then come to the Office of Personnel Management, and we have a standard to make a decision—to render a decision within 60 days.

This year we're running at about 37.5 days on average to issue a decision. Last year, it was about 42 days. We process about 4,500 cases a year. Last year was 4,500. This year, at this point, it's about 2,300, so it looks about the same. That is a very small proportion of the total number of claims that are processed in the Federal Employees Health Benefits Program. It runs sort of plan by plan from roughly one quarter of 1 percent in some plans to as high seven-tenths of 1 percent in other plans.

And, then, finally, if an individual is still dissatisfied with OPM's decision, they have the ability to take the matter to Federal court where it is reviewed under the Administrative Procedure Act standard. But I will say that very few cases go to court in any given year, fewer than a half dozen. In fact, a half dozen would be unusual for us.

The fourth point that I would like to make is that we do survey the participants in the Federal Employees Health Benefits Program each year. Each year we ask questions of them about their

opinion of their particular plan's claim processing operation, and what we found consistently over the past 4 or 5 years is that our enrollees believe, between 80 and 90 percent, that they're satisfied with the adequacy of claim processing at the plan level. Perhaps a little bit more precisely, in 1995, we specifically asked enrollees about how satisfied they were with OPM's processing of their disputed claims. And I think that will give a little bit more information here. Just about half of the people who had a dispute, that they asked us to review, felt that we handled it fairly. About three-quarters of the people felt that, even if they were dissatisfied with the decision, the decision that we gave them was simple, clear, and easy to understand. Clearly, we've got some room to improve, but I think we have a pretty good track record from which to operate.

The last point I'd make, Madam Chair, is that the disputed claims process is one component in this program that actually helps us improve the program. It's a good early warning system. It helps us detect, in some cases, problems with consistent administration of contract provisions across the program, and my statement contains several recent examples where that has been the case.

I think that concludes my brief opening statement, and I'd be happy to answer any questions the panel may have for me as well.

[The prepared statement follows:]

Statement of William E. Flynn III, Associate Director for Retirement and Insurance, U.S. Office of Personnel Management

Mr. Chairman and Members of the Subcommittee:

Thank You for this Opportunity to Describe Appeal Rights the Federal Employees Health Benefits Program Affords to Individuals When There Is a Dispute with Their Health Plan over the Provision of Service or Payment of a Claim.

As the Agency Responsible for Administration of the Nation's Largest Employer-sponsored Health Insurance Program, Opm Contracts with 350 Health Plans to Provide Comprehensive Health Care to Approximately 9 Million Civilian Federal Employees, Retirees, and Their Eligible Family Members. The Program Has Afforded Enrollees Both an Internal Appeals Process at the Health Plan Level, and an Independent Review Provided by Opm for over 20 Years. Throughout the Program, These Review and Appeal Procedures Are Uniformly Applied No Matter Where the Participant Lives or Which Plan Provides Their Health Care.

The Steps We Use for Resolving Claims Disputes Are in Full Compliance with the Recommendations Made by the President's Advisory Committee on Consumer Protection and Quality in the Health Care Industry in the Patient Bill of Rights. Standard Language in Benefit Brochures, Which All Health Plans must Give Their Enrollees Each Contract Year, Fully Describes the Steps for Seeking Initial Reconsideration of Denied Benefits by the Plan and a Final Decision by Opm. A Summary of These Steps Also Appears on Our Federal Employees Health Benefits Web Page. They Are Also Referenced Inside the Cover of the Guide to Federal Employee Health Benefits Plans, Which Opm Makes Available to Participants Each Year, Where We Pledge to Provide Fair, Understandable, and Prompt Action on Disputed Claims.

If a Health Plan Denies a Benefit Claim, or a Portion of a Claim, the Individual Has 6 Months to Make a Written Request to the Plan for a Review of That Decision. Within 30 Days, a Plan must Do One of Three Things: 1) Affirm the Denial, 2) Provide the Service or Payment, or 3) Request Additional Information. The Plan must Then Make a Final Decision Within 30 Days after Receiving the Added Information. If Additional Information Is Not Supplied to the Plan Within 60 Days, the Plan must Make a Decision Based on Available Evidence.

A Plan must Send a Written Notice of its Decision to the Covered Individual. If it Affirms the Initial Denial, the Plan must Provide Specific and Detailed Reasons for its Decision and Advise the Individual of the Right to Request an Opm Review. If a Health Plan Fails to Respond to a Plan Member Within Applicable Time Limits, the Individual May Bring the Matter Directly to Opm.

These Formal Procedures Do Not Prevent Opm from Initiating an Immediate Review When an Individual Contacts Us about a Life-threatening or Other Urgent Situation for Which a Health Plan Has Refused Benefits and We Conclude the Plan Is Unlikely to Change its Initial Decision on Reconsideration.

If an Individual Asks Opm to Review a Plan's Decision, We Acknowledge These Requests Within 5 Days of Receipt and Will Provide a Final Decision Within 60 Days of Receiving the Request in Non-life-threatening Situations, and as Soon as Possible in Life-threatening Situations, Unless We Need More Information. In Reviewing a Claim, Opm May Request the Individual or the Plan to Submit Additional Information, Obtain an Advisory Opinion from an Independent Physician, or Make a Decision Solely on Evidence Submitted with the Request for Review. Further, We May Reopen a Decision We Made on a Disputed Claim If We Receive Evidence That Was Unavailable at the Time of That Decision.

If Opm Upholds a Health Plan's Denial of Benefits, the Affected Individual Has a Right to Sue Opm in Federal Court under the Administrative Procedure Act. A Lawsuit May Not Be Brought until Opm Has Taken Final Action and the Recovery in Such a Suit Is Limited to the Amount of Benefits in Dispute. Such Lawsuits Have Been Very Rare.

During Fiscal Year 1997, Opm Reviewed Approximately 4,500 Disputed Claims. In about One-third of These Cases, We Overturned the Plan and Provided Coverage for All or a Part of the Matter in Dispute. Thus Far this Fiscal Year, We Have Reviewed Almost 2,300 Disputed Claims with Similar Results. The Majority of Disputed Claims We Receive Involve Issues of Medical Necessity, Preventive Care Services, and Dental Services. We Also Receive Disputes Involving Services Obtained from Non-covered Providers, as Well as Disputes Related to the "Usual, Customary, and Reasonable" Cost Basis for Reimbursement.

Disputes Arise in less than One Percent of the Claims Filed. We Believe the Very Small Number of Disputes That Occurs Reflects the Value of Broad Competition Within the Program and Opm's Commitment to Making the Best Possible Information Available to Enrollees, Combined with the High Customer Standards to Which We Hold Ourselves and Our Health Plan Carriers.

Opm Conducts an Annual Customer Satisfaction Survey in Which Enrollees in the Federal Employees Health Benefits Program Have an Opportunity to Rate Various Aspects of Their Health Plan's Performance. We Report Survey Results to Enrollees in the Annual Guide to Fehb Plans. In Our 1997 Survey, We Found the Following Levels of Satisfaction in Areas Relating to Claims Processing:

- 86 Percent of Respondents Believed Their Claims Were Processed Accurately
- 79 Percent of Respondents Were Satisfied with the Fairness of Claim Payments
- 83 Percent of Respondents Indicated That They Were Satisfied with Their Plan's Explanation of Benefits (Explaining What Amount the Plan Pays and What the Enrollee Owes).

These Results Show Two Things. First, Most Respondents Are Satisfied with the Claims Processing Services They Receive from Their Health Plan. Nonetheless, the Results Also Show Us That There Is Still Room for Improvement in this Area.

Aside from Helping to Ensure That Program Enrollees Receive All of the Benefits Opm Has Contracted For, We Have Found Disputed Claims Reviews to Be an Invaluable Indicator of What Is Happening in the Program, Often Alerting Us to Problems or Issues We Need to Address. Let Me Briefly Cite Two Recent Examples.

In the First Case, We Found Some Plans Were Applying Program Exclusions for Experimental or Investigational Treatments Inconsistently. Despite Accelerated Fda Approval for Some Drugs and Devices, Some Plans Felt That Fda Requirements for Further Tests Rendered These Products Investigational in Nature. We Clarified Our Policy to All Health Plans to Assure Consistent Application of Coverage for These Treatments.

In a Second Situation, We Learned That Benefits Were Being Denied Inappropriately for Some Screening Services Provided to Children Born in Foreign Countries. We Discovered That the American Academy of Pediatrics Had Made Specific Recommendations for More Exhaustive Tests in Such Cases and We Directed That Benefits Be Provided Consistent with Those Recommendations.

In Summary, the Disputed Claim Program in the Federal Employees Health Benefits Program Has Existed for over 20 Years, Fully Meets the Requirements of the Patient Bill of Rights, and Is Regarded as Effective by Our Customers. In Addition, it Helps Us in the Administration of this Program by Highlighting Areas for Improvement or Clarification.

This Concludes My Statement. I Will Be Glad to Answer Questions You May Have at this Time.

Mrs. JOHNSON of Connecticut. Thank you very much. Thank you both for your testimony.

Mr. Hash, I was interested that in 1997 there were 5.4 million Medicare beneficiaries that are in managed care organizations, and there were about 9,000 appeals sent to the Center for Health Dispute Resolutions. This is less than one one-thousandth of the complaints that went to appeals—of the services that went to appeals. About 24 percent of the rulings were in favor of the beneficiary, and about 6 percent were appealed to the administrative law judges.

In the Medicare fee-for-service program, which, of course, is a lot larger, there were many more claims, but there were 6 million appeals for 0.72 percent. So there was a much higher percentage of appeals in the fee-for-service than in the managed care plans. I wondered if you had any comment on those figures?

Mr. HASH. Madam Chair, I believe that what those figures still reflect is that we have a very low incident of appeals on either managed care, or in the fee-for-service. I mean, as you pointed out, on the fee-for-service, with nearly a billion claims processed for Medicare beneficiaries in a year, we have less than 1 percent that actually are appealed, even at the basic level within our contractors. Now that's not to say that that 1 percent is not a large number, it is. But, in fact, we think in the context of the size of the claims that are being processed, nearly a billion, something on the order of 5 million claims have been appealed at some level.

Mrs. JOHNSON of Connecticut. Well, certainly we need time and experience, but at this point we are having a lower percentage of appeals in the managed care plans than we are in the fee-for-service sector of Medicare. That may indicate that networks are communicating more effectively with patients, and it may not. But I think it is worth noting that at this point we have some, we don't have a big red flag that the appeals process isn't working in the Medicare managed care sector, as we had hoped it would.

Now I just want to go back to this court suit that HCFA has been involved in. In March 1997, the Federal court in Arizona issued a decision requiring HCFA to take steps directed by the problems in its appeals process. The Balanced Budget Act of 1997, which we passed and this Committee wrote, contained a lot of new requirements in part to address that court decision. However, there is some conflict between HCFA—there's a lot of conflict between HCFA's original policies, some of its remaining policies and the balanced budget reforms that were passed through this Committee. And, in 1997, Secretary Shalala filed for a stay of the court order in Arizona, and asked that it not be enforced. The stay was granted and all parties are now waiting a decision on the appeal. Can you give us some better understanding of why HCFA is still insisting on this stay, and what the relationship is between the reforms that Congress adopted in 1997, and the changes that HCFA needs to make, both to comply with the court decision, and to comply with the new law, and, therefore, better meet the needs for access to care of Medicare beneficiaries?

Mr. HASH. That's an important question, and a complicated one. And, at the outset before I go into the answer, I'd like to say we'd like to submit to you much more detail about the specifics of both the court decision, the BBA provisions, and our position relative to those two issues. Because as you, I'm sure, are familiar, the decision of the court in the original case provided an order that was very specific with respect to a number of specific notification requirements and other appeals rights. And, so we are actively working on responding to those and preparing our response to be a part of the regulations that we are publishing on, or about, June 1, which is the required regulation implementing all of the requirements of the Balanced Budget Act related to Medicare Part C, the new Medicare+Choice opportunities for beneficiaries. So, we are in the process of addressing them.

[The following was subsequently received:]

MR. HASH: We strongly agree with the intent of the decision to provide strong appeal rights for Medicare beneficiaries in managed care. However, for practical and legal reasons the Secretary requested and was granted a stay of the Ninth Circuit's order pending the outcome of an appeal. Because we agree with the intent of the decision, we issued a regulation requiring managed care plans to render decisions within 72 hours of a beneficiary's appeal if denial of care could jeopardize the beneficiary's life, health, or ability to regain maximum function. The regulation also clarifies that discontinuations of service are subject to the appeal process. The regulation was being developed before the *Grijalva* decision was issued, and became effective August 28, 1997.

HCFA is continuing its efforts to improve the managed care appeal process, with further revisions to be addressed in HCFA's June 1998 regulation implementing the Medicare+Choice program established by the Balanced Budget Act.

While the ruling was consistent with HCFA policy initiatives that were already underway, we had serious legal concerns about precedents it would establish, as well as practical concerns about detailed requirements spelled out by the court.

Regardless of our agreement with the appeal policies mandated by the court, we are concerned about the court's reliance on the Constitution's due process clause in imposing detailed requirements on Medicare managed care plans. We believe such details should be determined by Congress, the HHS Secretary and HCFA, not by the courts. Designating these policies as constitutional entitlements would tie HCFA's hands in revising the policies, if deemed warranted, and would preclude Congress from acting in these areas through legislation as well. Thus, we believe this issue alone would warrant an appeal.

We are concerned about the court's finding of "governmental action" in coverage decisions by private HMOs, in which the government has no financial stake and has not had an opportunity to review. (HCFA-level review does not occur until the plan's initial reconsideration decision is referred to HCFA's outside contractor for managed care appeals.) This analysis could logically be extended to impute to HCFA actions by HMO physicians, and could have significant implications for agency liability under the Federal Tort Claims Act.

There were practical concerns, as well.

Ways & Means Subcommittee on Health Hearing on Patient Appeals, April 24, 1998

The court would require written notice for all "reductions" in service (which would appear to include changes in frequency), and notice within five days of a written or oral request for services, without regard to the service's urgency. It would also require HMOs to provide evidence to enrollees, or instructions on how to obtain evidence, that would support the enrollee's appeal. We believe these requirements are unreasonable and would unduly increase HMOs' administrative costs.

In expedited review cases, the court would require continued coverage for services until a reconsideration decision was rendered. This would create an incentive for reconsideration requests without regard to merit and, in some cases, would require coverage of services that are not covered by Medicare or by the HMO's contract for supplemental benefits. Since HMOs were not parties to *Grijalva*, they could sue HCFA for requiring coverage of services that they are not legally required to provide.

The court would prohibit HCFA from ever contracting again with an HMO that had substantially failed to comply with appeal requirements, or had retaliated even once against a physician who had supported an appeal. While the Medicare statute authorizes termination or non-renewal of contracts for HMOs that have substantially failed to comply with contract requirements, we do not agree that automatic termination, termination based on a single incident, or a lifetime ban, are appropriate. Such measures would deny the possibility of corrective action by the HMO (e.g. firing officials responsible for the violation), and could permanently deprive beneficiaries of access to managed care in areas where other plans are unavailable.

In the meantime, as my testimony indicated, last April, we actually published the final rules requiring expedited appeals in the case of urgent medical disputes within managed care plans, the so-called "72-hour requirement," which is now imposed upon all of our risk contractors in the Medicare Program. And so we have taken steps to actually begin that process. And now that the BBA provisions are in place, we can actually speak to some of the court's decisions, we are obviously going to be implementing them as a part of our rulemaking on, or about, June 1. There is a lot of detail underneath that and we'd be happy to furnish you a more complete answer for the record.

Mrs. JOHNSON of Connecticut. Two things: First of all, why do you think 72 hours is a sufficient period of time in which to respond to urgent care decisions?

Mr. HASH. Well, I think the judgment there is that's a period of time in which information on the record, and so forth, could be provided to reviewers in health plans in order to make a judgment about coverage. I think the actual practice, hopefully, is much more rapid than 72 hours, but that was—I believe, I don't know this for sure, I believe it might have been, included in the order of the court in the case to which you referred earlier.

Mrs. JOHNSON of Connecticut. Well, Mr. Flynn testified to the fact that on discharge issues, which I think was Mr. Flynn, perhaps it was you, Mr. Hash, testified that in regard to discharge issues you have kind of an expedited process?

Mr. HASH. We do.

Mrs. JOHNSON of Connecticut. And you, too, Mr. Flynn?

Mr. FLYNN. I'm sorry, we don't have, I didn't mention anything about expedited procedures——

Mrs. JOHNSON of Connecticut. All right.

Mr. FLYNN [continuing]. Under discharge. I think that was Mr. Hash.

Mrs. JOHNSON of Connecticut. Well, discharge decisions seems to me something that has to be responded to promptly——

Mr. HASH. We have——

Mrs. JOHNSON of Connecticut [continuing]. In fact, you pointed out Mr. Hash in your testimony, that fee-for-service, in fee-for-service medicine, claims are—the claims denial process takes place after the services are delivered. Now this is not an advantage. This is a disadvantage. People have to know who's going to pay. Everyone needs to know who's going to pay before the service is delivered. So that is one of the really big weaknesses of the fee-for-service system, and I've seen that head-on, as I'm sure every Member has in their office.

So I think trying to deal with the issue of timeliness is one of, certainly, my goals as we write this legislation. And I'd like to know from you, either now or later, whether you have the data, or whether you could develop for us the data, to differentiate between those things that need 6-hour turnaround. I mean, discharge issues can't have 3 days. A lot of medical procedure issues that are urgent can't wait 3 days, and shouldn't wait 3 days. Often a person is, you know, disadvantaged from the point of recovery possibly, pain endurance, and so on and so forth, having to wait 2 days for a decision about urgent care.

With electronics, if you have really a person of equal competence, of specialty training. You know, consultations in the old world used to take place at bedside with knowledgeable people sharing information and making decisions.

So, one of the things I think we have to really look hard at is why is 72 hours a timeframe for urgent decisionmaking. Most of the decisions I would consider urgent, they are 6-hour decisions, they are 8-hour decisions, they are 10-hour decisions. They are not 3-day decisions.

And, likewise, while 45 days may be an improvement, it's not logical that if someone has been diagnosed with a certain illness, and the certain course of treatment has been proposed, that it should take a month and a half to figure out whether this is reasonable or not. So when it takes a month and a half, what that tells you is that you're bureaucratic. That's not medical; that's bureaucracy. So the whole issue of timeliness of appeals, the 60-, 72-day structure is totally inadequate in my estimation. I think that one of the things we have to do is to be more honest about what this issue is. So if you have any comments on that now, or if you can get us information later, please do. Pete Stark would like to make a comment.

Mr. HASH. I would like to follow on that but——

Mrs. JOHNSON of Connecticut OK, let him make a comment now.

Mr. HASH. I would like to comment, Mrs. Johnson. I've failed to make an important distinction here, I think, about the urgency and so forth of appeals and the timeliness of them, and that distinction is clearly our contractors are, in private health plans now, are re-

quired to cover and pay for any emergency service that is required by a patient, whether that's in the network of the plan, or outside the network of the plan, and there is no 72-hour wait associated with that.

Mrs. JOHNSON of Connecticut. Yes, but Mr. Hash, to a certain extent that's simply dishonest. I mean they need to know who's going to pay. I appreciate that, that's good for the patient. I'm not about to change it. But a system ought to be able to say that you are going to get paid.

Mr. HASH. We do, we do.

Mrs. JOHNSON of Connecticut. And we can't—as we try to cut costs and, as there's less margin, and less cushion out there, we cannot put either patients, or physicians, or hospitals in the position of being mandated to provide care that 24 hours later we are going to say, "Oh, we don't agree that was necessary." So, I appreciate that people are getting the care but that is not enough.

Mr. HASH. I just wanted to underscore that in any emergency situation there is no question about payment.

Mrs. JOHNSON of Connecticut. Well, it's good——

Mr. HASH. Payment is required. And second, I think the other distinction I was going to try to make about the remaining window of 72 hours is the way our language reads for our health plan requirement is that health plans are required to make urgent coverage decisions as expeditiously as possible but in no event no longer than 72 hours.

Mrs. JOHNSON of Connecticut. Thank you. I'm going to yield to Mr. Stark and move on with the Subcommittee's questions. Thank you.

Mr. STARK. I want to follow up on the Chair's line, and maybe I'll bring that up a couple of times today, if you'll just bear with me.

Mr. Hash and Mr. Flynn, the issue appears to be two things. In the cases I'd like to talk about, let's assume that a primary care physician has recommended a parhcular treatment. Leave the emergency room alone for a minute. But the plan may, or may not, agree with the primary care physician's recommendation and it may provide the specialty care or choose not to provide the speciality care.

You've got two issues. The patient may at some point be harmed because of this. If we get rid of the ERISA exemption, and a few other things, the patient, if the patient lives, could sue the plan for denying care. And, in my opinion, that would be fair. The patient may die and then the case isn't very strong. But the issue is whether a plan is denying care.

If they're in the emergency room, we have antidumpting laws, you've got to provide the care.

And then you get the question of, who is going to pay? In other insurance, like homeowners' insurance, if your house burns, you as an individual have a duty, and I don't know what it's called; you've got to protect that house. If the roof burns, you've got to put canvas over it, so the rain doesn't hurt it further. You have a contractual duty, to protect it.

Why shouldn't we, in general, say that if a responsible primary care physician, or whatever the entry mechanism is, recommends

a procedure, that the procedure be performed, and we subsequently argue about who pays? Then at least we eliminate the risk of killing the patient because of care denied. And we can argue later about the dollars.

In the emergency room situation, the public gets stuck with the bill if the patient isn't covered and is indigent. That payment then comes under charity care or bad debt/uncompensated care. Managed care plans don't have that problem and they don't do charity care. So maybe they ought to have to absorb it internally if they lose the decision regarding payment. But it would seem to me we could simplify all this if the rule, in general, became if a responsible physician requests a test or procedure, it gets done, and the appeal is subsequently over the dollars. And you don't keep somebody from getting a transfusion, or an operation, or a blood test because some bean counters are arguing about who's going to pay. I don't know how or what that would do to the entire system.

Now, it's my understanding, Mr. Hash, that that's what HCFA does for hospital care under Medicare. If there's a quarrel over discharge, the patient stays in the hospital as long as the patient can either convince the hospital to let him, or as long as his doctor requires. You subsequently decide whether you're going to pay or not pay. But the patient doesn't get kicked out pending your decision to pay. Is that not correct?

Mr. HASH. Well, I think in the case of hospital discharges, if there's a dispute about the timing of the discharge, it is subject to an appeal through our peer review organization.

Mr. STARK. But they don't kick the patient out?

Mr. HASH. No.

Mr. STARK. In other words——

Mr. HASH. Pending the——

Mr. STARK [continuing]. The patient stays. The only argument later is who's going to pay the bill. What I'm suggesting is, could we not extend that same concept to managed care?

Mr. HASH. Mr. Stark, if I may, I think what you've described is essentially what most of the appeals are about in the traditional fee-for-service part of Medicare. The service has been rendered and the issue whether or not the program is going to pay, or cover, even though the service has already been provided. And we also have special protection to prevent the beneficiary from being liable in the case where they did not know about our policy.

Mr. STARK. And I think there could be reasonable concerns about over utilization from unscrupulous providers. There are always those outliers who game the system. But it would seem to me that Chairman Johnson's and my concerns would be significantly different if we were just arguing about who's paying the bill. Patients would be treated and the provider would know that they would either be paid or, in fact, as some emergency rooms now have to swallow uncompensated care, then they build that into the rest of their fees. But the system would be compensated. The question as to whether the patient has to pay extra or the plan has to pay extra could be decided after the care was provided.

Mrs. JOHNSON of Connecticut. I would just like to make the comment that I do disagree with you, Pete. I think the system we have in Medicare is dishonest. It protects the patient from paying. It lets

the service be provided without deciding the issue of appropriateness. And I don't think that's fair. And more and more we're going to have hospitals being minimally reimbursed and under a lot of economic pressure, and we shouldn't be doing that. Now, in some of the old issues, often it was Medicare who was saying, who decided afterward, "No, you should have discharged sooner," over the doctor's decision that the patient needed to stay. And in that instance the hospital had to eat it.

So what I'm saying is that, as we go forward and build for the future, the current HCFA system of saying, "provide the service, can't let the patient pay but we'll decide later on whether we're going to pay you," is really totally inadequate. There are physicians, there are hospitals who want to keep people longer than they should. There are also patients who want to stay longer than they should. The main goal should be, I think, that we have a system that determines up front, in a timely fashion, whether this is a reimbursable service across, you know, in the eyes of all the payers and the providers. So really I don't think we want to settle for the current HCFA fee-for-service system. I think we have to do better than that.

Mr. STARK. What I was suggesting is if a primary care physician requires something, I presume it's the doctor who would argue about the appropriateness of that benefit, not some accountant.

Mrs. JOHNSON of Connecticut. Right.

Mr. STARK. Let's assume the patient require a blood test, and blood tests are covered by the plan. But, the plan may say, "We don't want to pay the blood test for this person," over the doctor's recommendation. Why should we keep the poor patient sitting in limbo while they argue about who's going to pay? Why shouldn't the doctor be presumed to be correct and then the argument about payment can come later?

Mrs. JOHNSON of Connecticut. Well, I think if we have a very good appeals——

Mr. STARK. Then——

Mrs. JOHNSON of Connecticut [continuing]. Procedure, yes.

Mr. STARK. That's exactly what I'm saying, but within a short period of time.

Mrs. JOHNSON of Connecticut. My goal would be, if we have a very good appeals procedure that's timely, then, as Ben said, and as many, many of you commented, it will create a much better internal process. And we shouldn't have providers out there arguing about whether to cover blood tests.

Mr. STARK. But we do. That's what managed care plans are doing all the time.

Mrs. JOHNSON of Connecticut. But that's why a timely appeals procedure——

Mr. STARK. Could I ask one more question? In the appeals question, the Chair raised the issue that there were far fewer appeals from managed care plans. The appeals process is different for managed care than it is for fee-for-service, is it not, Mr. Hash?

Mr. HASH. Yes, sir.

Mr. STARK. OK. And in managed care they first have to appeal to the managed care plan whereas in fee-for-service they come directly to you?

Mr. HASH. They come to our contractors.

Mr. STARK. Right. And, it is my understanding that you don't know how many people are appealing to their managed care plans because you don't have those records?

Mr. HASH. We do not, Mr. Stark.

Mr. STARK. So it is not correct necessarily to assume that there are fewer appeals in managed care plans? There are fewer appeals that are appealed to a second level. But if you start at the base level, the managed care plan has a two-tier level, and the fee-for-service a direct level. So that there may very well be an equal number, or a larger or smaller number, of managed care plan appeals. We just don't know.

Mr. HASH. The one observation I would make is under our managed care appeal procedures. Any reconsideration by a plan of an appeal that is not in the beneficiary's interest is automatically subject to the external appeals process.

Mr. STARK. I'm just saying, you don't know how many people are appealing?

Mr. HASH. We do not.

Mr. STARK. And, unfortunately, we don't either, which would be a good thing to know.

Thank you, Madam Chairman.

Mrs. JOHNSON of Connecticut. But just before I go on to Mr. McCrery, the point that you just made about the automatic forwarding, at any case in which a patient is dissatisfied with a decision of the managed care plan, it's automatically forwarded?

Mr. HASH. That is my understanding.

Mrs. JOHNSON of Connecticut. Thank you.

Mr. McCrery.

Mr. MCCRERY. Thank you. While Mr. Stark may be correct that it's hard to compare the appeals because of the difference in the nature of the appeals between managed care and fee-for-service, my quick math here, according to these statistics, it's about 700 times as frequent under fee-for-service, the incidence rate so, you know, it might take a lot of, well, from the statistics that we've been provided here.

Mr. STARK. We don't have the number of people who've appealed.

Mr. MCCRERY. No, I'm just saying that if you take the statistics which is .0016 percent complaint rate, under managed care, and .72 percent complaint under fee-for-service——

Mr. STARK. Would the gentleman yield?

Mr. MCCRERY [continuing]. It's about 700 times——

Mr. STARK. Would the gentleman yield?

Mr. MCCRERY. Sure.

Mr. STARK. Those, the managed care appeals to HCFA are only a second level, we don't know how many people——

Mr. MCCRERY. I understand the gentleman's——

Mr. STARK [continuing]. Initially——

Mr. MCCRERY [continuing]. Point. My point is in order to just equal the frequency rate you'd have to have about 700 times as many than are being reported. So——

Mr. STARK. That makes sense to me.

Mr. MCCRERY. Yes, well, it would. But, as evidenced by your opening statement that this is the most pressing problem facing

America, the incidence rate simply does not bear out that statement, nor does it even come close. And I've heard, and I'm sorry, I don't have before me, but I have been told that the incidence rate in private sector plans is also extremely low so I think before we jump to conclusions that this is the "most pressing problem facing America," that we ought to have hearings like this and try to discover the facts. Because it seems to me that, perhaps, this is not the most pressing problem facing Americans.

Mr. Flynn, in the FEHBP plans, do you, or do we, require an external review process?

Mr. FLYNN. Yes, sir, we do. That is, the patient appeals procedure, we call it the "disputed claims process," is required of all plans that participate in the Federal Employees Health Benefits Program. It's the same for fee-for-service and managed care plans. It involves a reconsideration of a plan's initial denial first at the plan level, and if the individual is still dissatisfied with the plan's decision, then it comes to the second level at the Office of Personnel Management for an independent external review.

Mr. MCCRERY. So the independent external review for plans in the FEHBP is OPM?

Mr. FLYNN. As the plan sponsor, OPM, yes, sir.

Mr. MCCRERY. So the OPM is the government, right?

Mr. FLYNN. Yes, sir.

Mr. MCCRERY. OPM is the government. The government is the employer——

Mr. FLYNN. Right.

Mr. MCCRERY [continuing]. Of these folks that are in these plans. So you are telling us that if they are dissatisfied at the plan level with their appeal, then they appeal that to the employer, OPM?

Mr. FLYNN. Yes, sir, they do.

Mr. MCCRERY. Well now, how is that different from, in the private sector a person who is dissatisfied with a decision in its plan and the individual then has the right to appeal that decision to his employer?

Mr. FLYNN. In that respect, Mr. McCrery, it would be no different whatsoever. We do apply probably the same standards that a typical private employer would apply. What's the contract with the health plan? What's the service that is in dispute? Is it covered under the terms of the contract or not? If a medical judgment is needed, we go to outside physicians, medical consultants, to help us with that. An opinion comes back in and, as an employer, the employer sponsor here, we look at this. We look at it objectively, but we are looking at it as an employer sponsor, and we render a decision.

Mr. MCCRERY. Thank you. I think we will hear, Madam Chairman, in later panels today, that, in fact, that is the norm. That if an individual in a health plan sponsored by his employer, under ERISA, has a complaint, and he's not satisfied with a decision of his plan, he then can appeal that decision to his employer just like in the FEHBP plan. I'm anxious to hear from the employers who will testify.

And, Mr. Flynn, do you have any idea what that procedure costs OPM to provide that service to employees?

Mr. FLYNN. Mr. McCrery, we, at the Office of Personnel Management, to administer the Federal Employee Health Benefits Program, we spend about $25 million a year. The disputed claims process takes up about 5 percent of that, about a little over $1 million a year.

Mr. MCCRERY. And do you pass that cost on to the plans?

Mr. FLYNN. That cost is not passed on to the plans, it's built into the premiums that all Federal employees, all participants in the program, pay for the Program.

Mr. MCCRERY. OK.

Mr. FLYNN. I will say that the $20 million or so that we spend amounts to about seven-tenths of 1 percent of the total program expense, so it's a very small factor. But it is passed on in the form of part of the premium.

Mr. MCCRERY. Yes, and again that cost for the dispute resolution is about 5 percent of your total administrative costs, is that what you said?

Mr. FLYNN. That's correct, Mr. McCrery.

Mr. MCCRERY. OK, thank you very much.

Mr. STARK. Would the gentleman yield to me? I just want to make one correction.

Mr. MCCRERY. OK, sure.

Mr. STARK. I believe that ERISA does not require that a complainant may complain to the employer. He can only complain to the plan. OPM actually is different. After appealing to the plan, a complainant can appeal directly to OPM.

Mr. MCCRERY. No, I understand that, Mr. Stark, but I think we will hear from witnesses today that the norm, that the normal practice in the private sector is for that individual, that employee to have recourse to his employer.

Mr. STARK. Could I ask Mr. Flynn——

Mr. MCCRERY. Sometimes we have to take note of what is actually happening rather than, you know, what's in the black letter of the law.

Mr. STARK. If you'd yield further, just to ask Mr. Flynn one question?

Mr. MCCRERY. Sure.

Mr. STARK. You have some statistics about appeals, as a percentage of your members in your testimony. But you don't separate between fee-for-service and managed care plans. Do you know that, or would you have that information in your records?

Mr. FLYNN. I don't have the information with me. I can tell you, Mr. Stark, that the number of appeals emanating from managed care plans, primarily, health maintenance organizations is very small compared to those which emanate from fee-for-service. And as Mrs. Johnson and yourself both noted earlier, I think a lot of that has to do with the fact that the more plans are managed care, and if you think of it in terms of the staff model health maintenance organization being sort of the end point of that, it's natural to expect that the more familiar a provider, or physician, or whomever is with the particular plan structure, the less likely there is to be some dispute between the provider and the plan over what's an appropriate form of treatment for an individual.

Mr. STARK. Do you think the plan structure itself resolves many disputes just by informing the provider and the patients?

Mr. FLYNN. I think it's a contributing factor, yes, sir.

Mr. STARK. Thank you.

Mr. FLYNN. Thank you.

Mrs. JOHNSON of Connecticut. Mr. Becerra.

Mr. BECERRA. Thank you, Madam Chairman.

Mr. Hash, let me go back to some of the questions that were raised earlier about the appeals process and the difference, in terms of data, that we have for HMO-based care and fee-for-service-based care. It would seem to be that most of these providers, under whatever setting, would collect and store data on grievances filed and, in the case of HMOs, appeals that go beyond just a complaint stage that are internally handled before they get on to some external, or higher level of appeal. HCFA right now does not require that data from the HMO-based providers, correct?

Mr. HASH. That's correct.

Mr. BECERRA. Is there any reason why you don't request that information?

Mr. HASH. I think the answer I can give you that I think is more the other side of this question is that we have under consideration for our rulemaking that I referred to that's coming out in June, amending our reporting requirements. And I believe in some of the provisions that are in the Balanced Budget Act there are requirements for the reporting of this kind of information as a part of measures for performance of our contractors. So I think we're definitely—our plans are to move in that direction.

Mr. BECERRA. Now, when you say you're considering it, does that mean you haven't come to a conclusion if you are going to include that within the rulemaking?

Mr. HASH. Well, we're still in the process of reviewing and clearing our regulation which will be published on or about June 1. So I don't have before me the final resolution, and some of the specifics, but I know that this is an issue that's very much a part of the consideration.

Mr. BECERRA. Is there any reason not to request that information from the HMOs?

Mr. HASH. No, in fact, none that I'm aware of.

Mr. BECERRA. So, while you may not be able to answer the question what will be in the rulemaking, what——

Mr. HASH. Well, I think I should be more precise, and I apologize. It sounds like I'm not trying to answer this directly. I believe the BBA language, in terms of information to be reported by our contracting plans, will, in fact, require this information to be reported and to be disclosed.

Mr. BECERRA. So, today we could say, with some level of confidence, that there's, in whatever rulemaking we have, will be a requirement that HMOs provide that data?

Mr. HASH. I believe that will be the case.

Mr. BECERRA. In regard to the whole issue of the beneficiaries as consumers, some folks complain that, if it were more required, or more known, to the beneficiaries that they had an appeals process, or that they knew what the process, how it worked, that we could probably get some of these things a lot of sooner because some folks

evidently go through the whole process of getting care without knowing what their appeal rights are.

Evidently there have been some investigative reports that have been done to show that in some cases up to one-third, or maybe more, of a plan's enrollees are not familiar with their appeal rights. My understanding is that HCFA has responsibility to ensure that a plan is doing everything it can to inform its enrollees of their rights to appeal. What's HCFA doing at this stage to ensure that there is widespread dissemination of the information of appeal rights to enrollees under HMOs plans?

Mr. HASH. Again, as I think it was included in my written testimony, we, in fact, require that when an individual, one of our beneficiaries enrolls in a private Medicare managed care plan, that, in the enrollment materials that they are furnished, and which we actually preview and certify, that they are informed of their appeal rights in the managed care plan. And then, subsequently, at any time there is a denial of service by a managed care plan, they are required to notice with the denial the appeal rights to the enrollee.

Mr. BECERRA. And I understand that, but your own investigative general report says that what is it with regard to those who are disenrolling, 35 percent of those disenrolling in a March 1998 study, knew not of their appeal rights, or were uninformed of their appeal rights. And 27 percent of those who were enrolling did not know of their appeal rights. So I know what you can do and I know that what you're trying to do, but obviously a good chunk of those who are becoming HMO beneficiaries—or enrollees are not learning what their appeal rights are so what I'm asking is, beyond what the statute, or regulation, may already tell HCFA to do, what are you doing to try to make it more enforceable?

Mr. HASH. But we are, again, as a part of our implementation of the Balanced Budget Act requirements in this area, which is also where these are included as well, we are going to step up our oversight and enforcement with compliance with these. And I——

Mr. BECERRA. What does that mean, step up your enforcement?

Mr. HASH. We have regional office reviews of our managed care contractors which involve site reviews, and we are stepping up the intensity of our investigation of these kind of effects. You're correct in your figures that those surveys by the Inspector General actually, the Department of HHS actually came up with those results. And we need to improve our surveillance and enforcement of these requirements. There's definitely room for improvement.

Mr. BECERRA. So when you say you're stepping up your efforts, I assume that means more research devoted to this?

Mr. HASH. Yes, sir.

Mr. BECERRA. How much more?

Mr. HASH. I don't have that but I can, I'll try to get back to you and give you a more specific answer on that.

Mr. BECERRA. So if you don't know how much more you're devoting research, can you tell how much more you're devoting in staff time to do the investigative work or the enforcement itself?

Mr. HASH. I can get you that. I don't have that with me this morning.

Mr. BECERRA. Has that been determined? Is it that you just don't have it with you but it's been determined, or is still in the process of being determined?

Mr. HASH. I don't know the answer to that. But I will get back to you.

Mr. BECERRA. If you could get back to us, thank you.

[The following was subsequently received:]

MR. HASH: HCFA is taking several steps to improve oversight.

Last year HCFA established the "Performance Review Team" to more aggressively pursue purposeful violators of Medicare managed care regulations. It has taken action against plans for such things as discouraging enrollment by beneficiaries with costly health care needs and for selectively attempting to re-enroll only low cost members who had disenrolled.

The Performance Review Team works with 116 regional office staff who monitor Medicare managed care plans. We intend to increase the number of regional office staff dedicated to this task as needed to deal with the increasing number of plans under the Medicare+Choice program. We will soon release a revised monitoring protocol manual for these regional office staff with new elements to guide them in monitoring expedited appeals.

Also, HCFA's Division of Beneficiary Protections is in the process of hiring additional staff (three full time equivalents) and securing additional funding to fulfill the BBA's requirements for training on beneficiary rights and data collection for managed care appeals.

Other steps to promote better compliance include:

Publication in November 1997, of the "Medicare Managed Care National Marketing Guide," which promotes regulatory efficiency between HCFA and the industry while assuring that beneficiaries have accurate, clear, and complete information.

Publication in July 1997 of model appeal language that plans must use in member materials, including denial notices and notices of noncoverage.

Conducting training sessions in August and September 1997 for health plans on the expedited review processes and new model appeal language in San Francisco, Chicago and New York.

Development, now underway as required under the BBA, of "fair marketing standards"which will combine the best of federal and state regulatory policies plus industry criteria for assuring the integrity of Medicare marketing activity. The standards should be available by this fall.

Work with state managed care regulatory agencies, the National Association of Insurance Commissioners and the National Association of Managed Care Regulators to resolve difference between state and federal marketing requirements.

We have taken several initiatives to better educate beneficiaries about managed care appeal rights as well.

We are adding a new section to the *Medicare Handbook* on managed care appeals. Appeal rights will be a major focus of the upcoming handbook covering both traditional Medicare and the Medicare+Choice program, which will be mailed to all beneficiaries in Fall 1998.

We are adding a section on how to appeal payment decisions to HCFA's publication *Managed Care,* which informs beneficiaries about managed care plans.

In October 1996, HCFA and the HHS Inspector General published an advisory bulletin: *What Medicare Beneficiaries Need to Know About Health Maintenance Organizations (HMO) Arrangements: Know Your Rights*. This booklet provides information on how beneficiaries may file complaints and appeals, and was updated last year to address the expedited review process established in April 1997.

In July 1997, HCFA issued a Program Memorandum to all Medicare managed care plans, including model appeal language for member materials and notices of service denials. Beginning January 1, 1998, all plan documents that describe member rights must incorporate appeal language approved by HCFA.

After the expedited review regulation was published in April 1997, HCFA's Central Office staff and the Center for Health Dispute Resolution (Medicare's external appeals contractor for managed care) provided training on appeals to HCFA's Regional Offices. Attendees included beneficiary advocates and industry officials.

Last year, HCFA produced and distributed a training module for the state-level Insurance Counseling and Assistance programs (ICAs), which included detailed information about managed care plans and questions and answers on appeals.

HCFA's October 1997 publication *Your Medicare Desk Reference* (targeted at Social Security offices and consumer organizations) includes information on appealing decisions under fee-for-service, managed care, and to a Medicare Peer Review Organization (PRO).

HCFA's Center for Beneficiary Services engages in regular communication with the ICAs and beneficiary advocacy groups to ensure that beneficiaries receive accurate and up-to-date information regarding their appeal rights.

Mr. BECERRA. Thank you very much, Madam Chair.

Mrs. JOHNSON of Connecticut. Thank you.

Mr. Flynn, I just wanted to ask you one follow on question. In your testimony, you state that you believe your education program and your customer surveys and things like that give you a pretty good handle and give your participants a pretty good handle on their rights of appeal, and your level—your knowledge of their satisfaction, or dissatisfaction. Eighty-six percent of the respondents were—believe that their claims are processed accurately in your most recent survey. Of the 14 percent who weren't satisfied, what percentage of those cases were about billing errors and what percentage were about survey denial?

Mr. FLYNN. I don't know the answer to that question, Mrs. Johnson. The statistics cited in my statement have to do with claims processing generally, and don't get more precise in terms of the disputed claims process. The survey that we did in 1995 did focus on

the disputed claims or patient appeals process specifically, and on OPM's administration of it. And, while I don't have comparable questions, we do know in that year that a statistically valid sample of our respondents felt that our action about half the time was appropriate, and that people felt it was easy to understand why we had come to the conclusion we did. Now that's a rough surrogate for satisfaction at the appellate level itself but that's about as close as I can get right now.

Mrs. JOHNSON of Connecticut. What plans do you have to improve that 50 percent?

Mr. FLYNN. Well, it would first require us to decide that that was needed. I mean the thing that is important, I think, to remember here is that the people that we surveyed are at the second level already, and in about 70 percent of the cases that we review, we uphold the plan's decision. So there is, expectedly I think, a natural reaction for individuals not to be satisfied with the decisions that they got from us because they came to us at the second level in an effort to have a plan's decision overturned. I really don't know what the target should be. I think, actually, I'm kind of heartened by the fact that about half felt that we came to a conclusion that they felt satisfied with.

Mrs. JOHNSON of Connecticut. Now you also mentioned that you had many fewer appeals from the managed care plans than from the fee-for-service side. As a Federal employee, whose husband recently retired, and so I recently entered your system, my recollection is that I had no choice but managed care plans in Connecticut. But maybe I didn't notice the fee-for-service choice but as I recall noticing——

Mr. FLYNN. Well, Mrs. Johnson, I would be more than happy to make sure you are fully aware of all your choices in the Federal Employees Health Benefits Plan. [Laughter.]

Mrs. JOHNSON of Connecticut. Well, I had very good choices. I had very good choices. And I'm not surprised that you are getting fewer complaints from managed care than you are from fee-for-service because in a fee-for-service system, by its nature, each sort of medical episode is independent and on its own. But I do think it's worth noting on the record because, as Mr. McCrery pointed out, this is a very important issue but we have to see it in perspective and not react inappropriately. So there are some very good things happening out there in managed care. I think one of the things we're—one of the reasons we're all interested in the appeals process is because we feel that a timely prompt appeals process with clear explanations is critical to people getting access to quality care. And that if we can address this problem, then some of the others will fall away, others that might require more radical solutions.

So I think this is terribly important but I do—I was very interested that, in a sense, you are sitting here testifying to the fact that one of the largest health care systems in the world, the Federal Employees Health Benefits Program, is primarily managed care and is getting fewer complaints from the managed care sector than the fee-for-service sector, is that correct?

Mr. FLYNN. That's correct, yes, ma'am.

Mrs. JOHNSON of Connecticut. I thank this first panel very much, appreciate hearing from you.

Mr. STARK. May I——

Mrs. JOHNSON of Connecticut. Excuse me, I'm sorry.

Mr. STARK [continuing]. May I follow-up with Mr. Flynn?

Mrs. JOHNSON of Connecticut. Mr. Stark.

Mr. STARK. Thank you.

Mr. Flynn, I have a couple of questions. Recently, a member of my staff was denied, by Mid-Atlantic Medical Services of Rockville, payment for emergency care. He's a diabetic and he passed out. And he was taken by ambulance to the hospital. Mid-Atlantic denied the emergency care on the basis that he didn't call first for permission. And it's somewhat beyond me how somebody who is unconscious in the back of an ambulance could call for permission. But, assuming that they are kind and sensitive to their patient's needs, they probably have a way that that can be done.

This was made an issue in the press, and your office called my office to follow up on it. Now, that's a pretty tough way to get your medical plan to do the right thing, is to try to get a story published in the Washington Post or the New York Times, or these other great papers that follow those issues. But, my question is, what would be your normal procedure?

I had the same problem in my family with Blue Cross in Maryland a couple of years ago. We were being denied a service on the basis of pre-existing conditions. My wife wasn't pregnant, and they said that's a pre-existing condition, so we won't pay for fertility treatment. I said, "that makes good sense to me." I wonder how many people have a pre-existing condition of not being pregnant? [Laughter.]

But, I got precious little help on that appeal. If somebody, other than a Member of Congress, calls and complains, "they're hassling me to pay for my emergency room care," or "they won't give me services," what do you do?

Mr. FLYNN. Well, first of all, the overwhelming majority of situations like that are resolved immediately at the plan level.

Mr. STARK. No, I'm saying it gets to you; what do you do?

Mr. FLYNN. If it gets to us, we will, if it gets to us in the form of the need for a quick decision to be made because there's a real emergency out there, we will do whatever it takes to get in touch with the plan and find out what's going on.

Mr. STARK. What if it's not an emergency; it's just a denial of payment?

Mr. FLYNN. If it's a denial of payment and it's been through the regular appellate process at the plan level, we'll accept it as a disputed claim. We'll gather the information from the individual and the plan and render a decision. In this particular case, it never came to us for a decision. And clearly, the plan, once it had all the facts in front of it, made the right decision.

Mr. STARK. Is the decision that you render binding on the plan?

Mr. FLYNN. Yes, it is.

Mr. STARK. So, I'll come back—what's the statute of limitations?

Mr. FLYNN. The statute of limitations on, in this particular case?

Mr. STARK. Yes, on any of it.

Mr. FLYNN. Or in the other case about pregnancy?

Mr. STARK. A statute of limitations on any case. My second question is this: Do you have a procedure, a board or a Committee in Congress that makes a decision on new benefits? I don't know whether OPM requires coverage for bone marrow transplant. But, if it was being suggested to OPM that we add to our Federal Employees Benefit Plan a certain benefit, what is the procedure? Is that done through a Committee in Congress? Do you have a Committee that studies this? Could you explain that to us?

Mr. FLYNN. I'll try and answer that question very briefly. Each year the plans that participate in the Federal Employees Health Benefits Program enter into a new contract year, and there are changes in benefit levels every year. That process begins in the Spring of each year when we issue what's known as our annual call letter. It outlines what our negotiating objectives with 350 plans that participate in the program are for the year that begins the next January. Plans also——

Mr. STARK. OK, right there. How do you determine what you might like to add for me, as a benefit, do you hear from your Members, Members of Congress?

Mr. FLYNN. We hear from our Members; we hear from Representatives; we have oversight by various Committees here in the Congress. We stay in touch with developments in the health care industry and that sort of thing.

Mr. STARK. But there is no specific day when OPM states, "This is the day we're going to have suggestions"? Is there a formalized process?

Mr. FLYNN. No, there's no formal process, Mr. Stark.

Mr. STARK. OK.

Mr. FLYNN. But that outlines what we would like to see. And then the plans come in at the end of May.

Mr. STARK. How would this work? If I have a benefit I want to add, if I talk to you, would that at least start the process?

Mr. FLYNN. Yes, it would.

Mr. STARK. OK, I'll talk to you. Thank you. [Laughter.]

Thank you, Madam Chairman.

Mrs. JOHNSON of Connecticut. Well, thank you. That's very interesting to me because the Congresswomen's Caucus is very interested in requiring the Federal Employees Benefits Plan to cover contraceptive medication.

Mr. STARK. We'll both be to see you. [Laughter.]

Mrs. JOHNSON of Connecticut. And so that's very interesting. And it's also, I think, worth noting that HCFA has a technical advisory Committee that makes recommendations in regard to coverage decisions but its meetings are closed to the public, is that not so, Mr. Hash?

Mr. HASH. We have, actually, it was correct, Madam Chair, but we have disbanded that because we made a determination that it was not consistent with the Federal Advisory Committee Act and we are in the process of reformulating a coverage advice system within——

Mrs. JOHNSON of Connecticut. Thank you. I think that's a very constructive step. I felt the time was too late to bring it up, but I'm glad to hear that, and glad it did come up.

I did have one other question that is just too important to neglect and I had forgotten it earlier. Mr. Flynn, in joining, in becoming a Federal employee in your coverage plan, my choices were the same HMOs as any other employee of any employer in Connecticut had. And to my knowledge, the Federal employees benefits that that HMO offered weren't much different from the benefits that they were offering to others. Now if we require a review process that, for example, has brief short turnaround times for medically urgent matters and so on and so forth, do you believe that these plans will extend those same privileges to everyone in the plan, or in your experience are they likely to segregate out benefits for Federal employees? When we make changes that affect the Federal Employees Benefit Plan, will that permeate the health care system and affect benefits in, for example, the self-employed sector, in your estimation?

Mr. FLYNN. Let me try and answer that very quickly at two levels. I think when you have 9 million covered lives, as we do in this program, there can't help but be an influence on health plans when we request something of them as an employer sponsor and they look at whether or not they would like to offer something similar to their other lines of business. But that is, that's an independent decision by a health plan and my guess is that they would look at the issue itself and make a judgment that they felt was in their best business interest. I would imagine that on the administrative side of things, for example, decision, turnaround time on decisions and things like that, there would likely be more susceptibility to adopt a single standard than to have different standards for different employers. But with that caveat that's how I would answer that question.

Mrs. JOHNSON of Connecticut. Thank you very much. I thank the first panel.

Now we will call up Jack Ehnes, the commissioner of Division of Insurance, Colorado Department of Regulatory Agencies, Randall MacDonald, executive vice president of GTE Corp., on behalf of the Association of Private Pension and Welfare Plans, and Stephen deMontmollin, deMontmollin?—sorry—vice president and general counsel of AvMed Health Plans from Gainesville, Florida.

And I want to welcome Mr. MacDonald, not only representing a great corporation but I want him to know that we are cognizant that while today is "Take Your Daughter to Work Day," that he intends to take his daughter to the high school dance tonight and we have no intention of in any way compromising those plans.

STATEMENT OF J. RANDALL MACDONALD, EXECUTIVE VICE PRESIDENT, GTE CORP., ON BEHALF OF THE ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS, NEW YORK, NEW YORK

Mr. MACDONALD. Nor do I.

Mrs. JOHNSON of Connecticut. With that, let me invite you to testify first. And if you cannot stay throughout the questions, please feel free to excuse yourself, Mr. MacDonald.

Mr. MACDONALD. Thank you, Madam Chair. And my daughter will be glad to hear that it's on the record that I intend to leave to make sure I get home.

It is truly a great opportunity to be able to tell the GTE story. I am here today talking about a health plan which voluntary covers more than 90,000 employees, 60,000 retirees, as well as all of their dependents in 50 states. I'm also here to say that GTE was the first company to voluntarily accept and implement the Consumer Bill of Rights as a result of the Presidential Commission on Health Care Quality.

I am also, as you mentioned, appearing on behalf of the Association of Private Pension and Welfare Plans. We spend about $500 million per year on direct health care costs to attract a work force that is really differentiated based on talent. It clearly is in our own self-interest to take this issue seriously. We have to offer a range of health plan choices. We have to ensure that they are managed well and, most importantly, we have to ensure on a fiduciary basis that we are consistently and fairly administering them for all participants.

I'm tempted to get into a complex explanation, but in its simplest form I would suggest that employers are voluntarily driving the solutions that you are seeing in the marketplace today. I think it's important to keep in perspective that we are looking at millions of Americans and, or in the case of GTE, hundreds of thousands of employees who are securing health care coverage every day without much fanfare, to be very truthful. We literally have millions and, or thousands, of employees who are very satisfied patients.

I think in many ways there are discussions today that are focusing on less than 1 percent of the occurrences that we tend to use as horror stories and while Congressman Stark is not here at the moment, I would suggest that in one case if that happened to one of our employees, about the diabetic coma, I would suggest to you that that health plan would not be offered next year. Perhaps that's the first message: that the Federal Government ought to begin to think about its role as a group purchaser and be very selective in the quality of the plans that they offer and horror stories like this will no longer exist. So I do think the whole issue needs to be put in perspective.

I would, second, suggest that our view on grievances and appeals is important but I would also take exception with the fact that it is the most important thing. I would suggest to you that what people are most interested in is the ability to have coverage for health care, and second, to ensure that it is done in a quality manner. It is not the issue of whether or not I can appeal it. I don't ever want to appeal for it as long as it works.

In that regard, I think that GTE has a concept of where we start and that is the whole concept of information. We need to first identify high quality health plans, share the feedback with the plans. It's a continuous improvement, and work to correct problems, real or perceived. And if they're not corrected, there has to be some form of accountability for that. We have to ensure that plans are offering services that are medically necessary. You do not want to return to the horror stories of the eighties where you see inflation in the medical care community skyrocketing, and then see, ultimately, the plans being dropped, because I will suggest to you that they will be dropped. We fixed the problem the first time. We may not have a chance the second time.

What we ought to be thinking about is the ability to identify the best practices for the best providers and figure out how that can be allayed across the Nation, so that, in essence, what we're really focusing on is making the right decision in the first place. Simply put, I think how it should work is that the plan should be in writing, and it should be easily understood.

Second, I think that in reality the items covered, and not covered, should be specifically mentioned. Directions on how to secure those services, and if indeed an appeal is necessary, how, when, and where it should be filed.

We do, indeed, as a company, support the use of external appeals. We still believe that this concept is in its infancy. In essence, there are not that many national experts that are available and we may be, indeed, creating an entire industry if we're not careful. I would suggest that experimentation of different approaches may be the most appropriate. Medicare, GTE, other public and private purchasers, should really be the incubator of that process.

I want to caution this Subcommittee to recognize that public policy changes can either stabilize coverage, or create additional incentives for its decline. We need to recognize who provides the coverage, why do they do it, and, most important, the fragile nature of that coverage if it is de-stabilized.

And with that in mind, I would suggest to you that the concept of liability truly scares me. I think that, in essence, if we begin to assign liability to employers, I think we'll simply get out of the business. And that in and of itself may be an alarming view, but I think it is a reality.

I think, in essence, the conclusions that I would make is that the issue is coverage. Policies that encourage employers to maintain coverage, and allow incentives and other employers to obtain that coverage in a way that's relevant for both the individual and the employer. Remember employers who drop coverage add to the uninsured and to the government's payroll in some way.

I believe in the market. Health plans and employers are in the best position to respond to emerging and changing demands. We can be, and should be, discriminating purchasers. We need to get real value from the health plans, not because a series of laws have been passed. I believe in the market in that I think it's preferable, frankly, to have health plans falling all over themselves, competing for GTEs share of the business and using evidence-based practices to ensure that the quality of that health care that's delivered meets the expectations of those who are receiving it. We shouldn't be worried about boasting their compliance records; we ought to be boasting about the quality of the services that are provided. We should be trying to stimulate innovation and excellence.

In conclusion, I would suggest that the government really should begin to think about acting as a purchaser, that we should be focusing on quality; we should be focusing on the 40 million Americans who do not have coverage, and we should be allowing the employer community to continue its innovation and creativity that it has shown in this marketplace.

Thank you for allowing me to testify.

[The prepared statement follows:]

Statement by J. Randall MacDonald, Executive Vice President, Human Resources and Administration, GTE Corporation on behalf of the Private Pension and Welfare Plans

Chairman Thomas and members of the Subcommittee, my name is J. Randall MacDonald. I am Executive Vice President, Human Resources and Administration for GTE Corporation. We at GTE share your commitment and interest in ensuring access to quality healthcare. Thank you for the opportunity to speak about the importance GTE places on quality healthcare and the benefits to our 91,000 U.S. employees, more than 60,000 retirees, and their dependents.

With 1997 revenues of more than $23 billion, GTE is one of the world's largest telecommunications companies and a leading provider of integrated telecommunications services. In the United States, GTE provides local service in 28 states and wireless service in 17 states; nationwide long-distance and internetworking services ranging from dial-up Internet access for residential and small-business consumers to Web-based applications for Fortune 500 companies; as well as video service in selected markets.

Outside the United States, the company serves more than 7 million telecommunications customers. GTE is also a leader in government and defense communications systems and equipment, directories and telecommunications-based information services, and aircraft-passenger telecommunications.

GTE is one of the largest publicly held telecommunications companies in the world with revenues of $23.3 billion in 1997. GTE is also the largest U.S.-based local telephone company and a leading cellular-service provider—with wireline and wireless operations that form a market area covering more than one third of the country's population. GTE also is a leader in government and defense communications systems and equipment, aircraft-passenger telecommunications, directories and telecommunications-based information services and systems.

GTE has employees and retirees in every state. We offer healthcare benefits to our employees and retirees nationwide.

I appreciate the opportunity to present how GTE provides health benefits to our employees and their families and the steps that we and other employers take to ensure that coverage decisions are made accurately and fairly.

I am appearing before you today on behalf of the Association of Private Pension and Welfare Plans (APPWP-The Benefits Association), a national trade association of companies concerned about the employee benefits system. APPWP's members include Fortune 500 companies and other organizations that provide benefit services to employees. Collectively, APPWP's members either sponsor or administer health and retirement plans covering more than 100 million Americans.

I have recently completed my service as a member of the President's Advisory Commission on Consumer Protection and Quality in the Healthcare Industry and I would like to share my perspectives with you on several of the recommendations contained in our report to the President and GTE's efforts to implement them for our employees.

GTE'S PERSPECTIVE ON HEALTHCARE BENEFITS

Our approach to grievances and appeals begins with selecting health plan partners committed to operating in the best interests of our employees and our expectation of fair and consistent coverage determinations.

GTE spends more than $500 million each year on direct health costs. We project that we incur a similar additional cost in lost time from work because of health problems of employees or their family members. It is in our own self-interest to have healthy employees at work and we take seriously our efforts to provide employees with a range of health plan choices to meet their personal needs and we work hard at seeing that these plans are managed well.

In addition, GTE is keenly aware that we must compete for one of our most valuable assets: a skilled and committed workforce. GTE, and other employers like us, provide health benefit plans to employees as part of overall compensation designed to attract and retain talented employees. But it also goes much further than that. We also share with our employees a strong and mutual interest in maintaining a high quality, affordable set of benefits that are administered consistently and fairly for all plan participants. We are committed to selecting the best possible health benefit plans, with proven records of performance, and we work closely with our health plan partners to resolve problems when they occur and to reduce administrative errors for the benefit of our plan participants.

Every full-time and eligible part-time GTE employee may choose a healthcare plan that meets their family's needs including either a traditional fee-for-service plan or a point-of-service plan, except one specific labor agreement that provides

otherwise. This means that almost every one of our employees can select a plan that will allow him or her to see the doctor of their choice. Additionally, we offer more than 120 quality managed healthcare plans throughout the country—including both staff and Individual Practice Association (IPA) model HMOs.

In this voluntary environment, more than sixty-eight percent (68%) of GTE's employees voluntarily chose managed healthcare plans in 1998, and an additional sixteen percent (16%) selected a network based "Preferred Provider Plan." Less than ten percent (10%) selected a traditional indemnity plan. We believe that GTE employee elections reflect the quality of care, higher level of benefits, satisfaction, service, and overall value that managed healthcare plans offer. We are also actively involved in setting tough, meaningful standards for the health plans that we offer to our employees and we continuously monitor and evaluate these plans to ensure they maintain high performance levels. Finally, we strongly believe in the value of informed choices and we work closely with our health plan partners to provide clear, reliable information to guide employees in making decisions about how the different health plans operate and their responsibilities as plan participants.

In short, GTE's primary healthcare objective is to ensure that our beneficiaries have access to the best healthcare resources available and we are receiving superior value for the money we are spending.

At GTE, we work to establish long-term partnerships with the plans we select and we believe in continuous quality improvement. Long-term relationships with health plans promote stable enrollee relationships with the plans of their choice, with the provider networks, and ultimately pay off by placing a greater focus on improved healthcare status of our employees and the larger community where our employees and customers live. We view these partnerships as a process where all parties learn from each other and drive toward higher levels of performance with appropriate economic and market share rewards for their innovation and success.

We also work to correct problems if a plan fails to perform at or above our performance standards, first by sharing our findings directly with the plan and soliciting their review and commitment to take corrective action. Additional steps include notifying employees of the particular problems and, if not corrected, "freezing" any additional enrollment. The final step of discontinuing the offering of a plan is only considered when problems persist.

The final critical link in successful health plan management is giving our employees the information they need to make appropriate decisions and then paying careful attention to the results from employee satisfaction surveys. We are convinced that a large part of the reason that so many of our employees voluntarily elect managed healthcare plans is because of the information we provide about them during the annual enrollment period.

Each year, we conduct extensive mailings to employees summarizing the health plan options available to them and giving them information on each option that is based on the type of information that they have told us helps them to make decisions. In addition to basic information about the size of the plan's membership, how long it has been in business, and any differentiating attributes, we highlight those plans that meet GTE's "Benchmark" status as one of the best in terms of combining access, quality of care, service, satisfaction, and overall cost-effectiveness. We also actively promote plans that meet GTE's highest rating, "Exceptional Quality Designation," which is reserved for those plans that have been rated by us as having the very best overall quality of all of the plans offered by GTE throughout the country. These are the select group of plans that, in our evaluation, offer the highest combination of healthcare quality and member satisfaction. These designations do not come easily in a competitive marketplace and, I can assure you, our health plan partners work very hard to earn them.

We want our employees to have a choice of high quality health plans that are committed to working closely with us over the long term to deliver high levels of service at a fair price. We try to foster a sense of customer focus in how health plans meet our needs, and those of our employees.

MAKING THE RIGHT DECISIONS ON COVERAGE

GTE's employee healthcare elections have changed dramatically over the years. Like most companies, for many years we provided health benefits primarily through traditional, comprehensive, indemnity-type plans where benefits for all medically necessary and appropriate care were explicitly and discretely defined in the plan documents. One of the most common misperceptions is that managed healthcare plans are more restrictive than the typical indemnity plans of the past. The reality is that managed healthcare improves access to more extensive healthcare services including (a) coverage for preventive health services which indemnity plans usually

restrict or exclude altogether, and (b) elimination of the economic barriers to healthcare access. Managed healthcare plans use modest fixed-dollar co-payments in lieu of large annual deductibles and additional co-insurance. This allows consumers to know their out-of-pocket costs before seeking healthcare services.

In addition, most managed healthcare plans are rapidly engaging in sophisticated, value-added pharmaceutical benefit strategies designed to provide highly effective programs to combat and proactively manage complex diseases. Finally, managed healthcare has significantly improved the integration of information available to practicing healthcare providers to evaluate the wide range of treatment options for a particular condition and allows for much better decisions to be made about which of the options are most likely to lead to improved, patient-specific healthcare.

The one thing that distinguishes managed healthcare from the indemnity plans that preceded them is that more decisions about what is considered "medically necessary and appropriate" are made up-front, rather than after the service has already been provided. In the past, when these types of decisions were made, they largely affected the issue of whether a payment would be made by the plan for a service that had already been provided. Now, under managed healthcare, the healthcare provider and the patient often know the plan's decision before the service has actually been provided. This means that everyone involved—the patient, the provider, the plan, and the employer—has a stake in making sure that the right decisions are made in the first place, and that decisions are made consistently and fairly.

At GTE, we strongly subscribe to the concepts of evidence-based medicine and standards for coverage of medical services. This means defining benefits in terms of the treatment that is most suitable for the patient, based on proven medical technologies and practice. GTE holds health plans accountable for making sure that medical practitioners have the flexibility to do what is required for their patients. But we also believe that it is not enough to simply cover whatever a treating physician prescribes. Not every treating physician is always right. We want plans to bring individual physician decision making into a system of accountability, to ensure that the treatment proposed is consistent with the latest and accepted medical knowledge. Many in the healthcare field seem to consistently believe that "more is better." We believe that only "better is better," and "better" may be more—or fewer medical services. We believe our employees deserve protection against non-evidenced based medical services and have encouraged others to support this basic consumer protection. For example, removal of cataracts once required a minimum hospital stay of five to seven days. These are now routinely done on an out-patient basis for most patients. The point here is evidenced-based medical services should be based on the patient's needs and not on out dated historical practices or the convenience of healthcare providers. Given the high cost and quality risks of healthcare, non-evidenced based services can no longer be the responsibility of plan sponsors.

Medicine is not yet—and may never be—entirely science-based. There continue to be significant areas where there is not yet medical consensus. Where disagreements occur—as they inevitably will—we want these to be resolved fairly and quickly, and when additional medical judgment is needed, we want final decisions to be made that keep pace with constantly emerging medical technology and advances.

I can assure you from my own experience that nothing we do in our health benefits program is more important, or more difficult, than ensuring that the best decision is made for an employee or a member of their family in difficult coverage cases. And, we have an even higher obligation required by law to act dispassionately, consistently, and in the interest of all plan participants. In practice, that means it is just as important to ensure that we are covering appropriate and needed care as it is to ensure that we are not paying for inappropriate or unnecessary services. In either case, once the decision is made for a single individual, it then must be our policy to act consistently in all future cases, knowing that coverage interpretations must change based on emerging medical science.

When our employees have questions or concerns about the decisions made about their health benefits, the first step is to make sure all parties have complete information to make sure that the correct decision was made. Most are relatively straight forward coverage decisions and are quickly resolved. Where questions continue, we ask that both the guidelines involved in these cases and the specific clinical cases in question be reviewed by independent medical practitioners including the best medical providers available anywhere in the country to provide the patient with specific clinical findings regarding the proposed treatment, including whether the proposed treatment is within the medically appropriate coverage provided by their plan.

The point that I want to underscore is that we do not attempt to substitute our judgment for the judgment of medical professionals. Our job—and legal responsi-

bility—is to make sure that our healthcare plans are administered properly and consistently. We rely on medical professionals to make medical judgments. In fact, we strongly believe that medical decision making must remain in the medical arena. Where disagreements over medical issues occur, we seek independent medical judgment so that the best decision possible can be made about the services provided to our employees. And where there is reasonable doubt, we want these decisions made in the employees favor, consistent with our interest in having a health plan that is both perceived, and truly is acting, in their interests.

By moving toward "evidence-based medicine," we can subject both coverage decisions and medical treatment decisions to an objective test of what has been shown to work best and is in the patient's best interest. Evidence-based medicine is the best hope we have for seeing that patients with chronic, rare, or difficult conditions get the best treatment available, based on the best medical knowledge, and actually improve their condition.

Making informed, consistent decisions about what is covered under a health benefit plan is a serious responsibility that needs to be undertaken by those with a commitment to making the best decisions possible. If we are honest with ourselves, we must also recognize that in many cases, the job of making health benefit coverage decisions involves difficult judgment calls based on the best available information at the time. It is extremely important that public policy recognize our common interests in seeing that these difficult but essential decisions are made properly so that we do not end up with a system that encourages or requires coverage for services that are excessive, unproven, inappropriately delivered, simply unnecessary, and perhaps even dangerous to the patient's health.

RECOMMENDATIONS FROM THE PRESIDENT'S ADVISORY COMMISSION

The recommendations of the President's Advisory Commission were achieved by reaching consensus among a widely divergent group of independent-minded commissioners. All of us were motivated by a common desire to make the world's best healthcare system even better than it is today.

I can honestly tell you that the by-product of this consensus document is far better than it would have been if we had split apart and only issued a report that highlighted our occasional differences. Along the way, we learned that no single Commissioner, industry, or constituency held a monopoly on the consumer's best interests in the healthcare system.

Did the Commission reach consensus on every issue? No, we did not. We vigorously debated a number of issues where ultimately we concluded that we could not reach agreement. For example, there were strong proponents on the Commission for certain mandated benefits, standardized benefit packages, any willing provider concepts, mandatory offerings of open network, increased provider and consumer accountability, and the consumer protections of evidenced-based medical care I previously described. I am sure that you can guess where I was on these sorts of topics. We found it difficult to mandate coverage requirements in a voluntary system, but pledged to work collaboratively for continuous improvement.

We certainly did not need a Presidential Commission to find that divergent interests did not agree on all issues. The important work of the Commission was in identifying the many areas where we did agree—employers, health plans, healthcare providers, union representatives, consumer advocates, and public purchasers—and the need to move forward for the benefit of both providers and consumers. Let me touch on a few of those for you that are particularly relevant to today's hearing.

INFORMATION

We agreed that a well-functioning healthcare system depends upon good information in the hands of the individuals who are making decisions about how their health plans operate, how services are provided, and the healthcare providers who participate in their networks. As I have already mentioned, we at GTE believe that clear, relevant, and well-presented information is a vital tool for our employees in making informed choices. We can all do better in this area, including government programs, I should add. I believe that consumer responsive information will continue to be an evolutionary, rather than prescriptive, process. We can learn from each other and should listen carefully to those who must use this information at the end of the day. The goal should be to give all of the information that is truly worthwhile in a form that is consumer friendly, and avoid the tendency to bury people with information that is only understandable or appreciated by healthcare technicians.

CLAIMS REVIEW PROCEDURES

Again, this is an area where a number of positive recommendations have been made. The Commission recommended much shorter time periods for making coverage decisions than is currently required by federal regulations and an even shorter process for expediting the review of cases that involve urgent care needs. In addition, the Commission proposed that plan participants be provided with written explanations of all decisions and a review by appropriate medical professionals when it is required.

I agree that the current time frames need to be updated. The Commission's recommendations now need to be tested against market place reality to determine the most appropriate and practical time frame for plans and plan participants.

EXTERNAL REVIEW

This was undoubtedly one of the most difficult issues for the Commission to resolve, but I believe that in the end, the Commission made a valuable contribution on the issue of when health plans should seek external review of certain coverage decisions. The Commission proposed that plans seek independent, external review by appropriate medical professionals in cases that involve coverage decisions related to treatments that are (1) "experimental or investigational in nature," or (2) where services may not be considered medically necessary. The Commission concluded that external review should be available where "the amount in question exceeds a significant threshold or the patient's life or health is jeopardized."

Reasonable people may disagree on many of these issues, including many employers and health plans. We at GTE find external review to be an extremely valuable way to resolve coverage issues that involve medical judgment. We also believe that this is an evolving field and that no single "best practice" model for external review has yet emerged. While we support external review and have voluntarily incorporated it into our practices, we intend to be fully engaged in the debate about how it works best by learning pragmatic approaches from our health plan partners.

We fully understand that many organizations are not at the same place that we are in this area, and that external reviews require sophisticated contracting with well-recognized national medical experts who are often in short supply and whose services can be quite costly. We believe that plans that implement an effective dispute resolution process will receive the reward of increased market share from satisfied consumers and discriminating purchasers. GTE is working with enlightened public and private healthcare purchasers and responsible health plans to identify the best models and mechanisms for extending external reviews more quickly and efficiently than can be accomplished though a bureaucratic or legislative mandate. In addition, we believe that much more needs to be done in the area of outcomes research and medical technology assessment. These will provide decision makers with the kind of information that they can rely upon to make the best decisions possible in these areas at the earliest possible stage, so that our knowledge about what is proven and effective is able to keep pace with the constant advances in medical practice.

GTE believes that the best way to put the recommendations of the President's Commission in place is through the mechanism that we already use effectively. We have committed ourselves to moving forward on the recommendations contained in the Consumer Bill of Rights proposed by the President's Commission and we are working with all of our health plan partners to make these recommendations a reality for our employees. In addition, we have successfully encouraged many other employers and organizations concerned with healthcare value and member satisfaction to begin to adopt these proposals. All the leading national health plans have joined with us in this effort, but I regret that the State, County and Municipal representatives are the largest segment that have not begun to move forward for their own employees and those within their responsibility.

I believe that legislation on grievance and appeal procedures is both unnecessary and unwise. However, federal agencies already have sufficient authority to revise their current regulations to adopt sensible standards to ensure that all plan participants get timely and appropriate review of their healthcare claims. In doing so, the agencies should work closely with all interested parties on updating the current regulations, especially where there is already broad agreement that changes need to be made.

CONCLUSION

Finally, let me conclude by encouraging the members of this Committee to keep in mind the importance of maintaining and encouraging the positive involvement of

employers in the process of arranging and financing healthcare benefits. Employer sponsorship has made it possible for the private healthcare marketplace to evolve at an astonishing pace with a minimum of government involvement with demonstrated positive results for more than 100 million Americans. Employer sponsorship creates purchasing clout in the market to secure high quality, cost effective plans and to hold health plans accountable for improving their performance and satisfying their enrollees.

The issues presented in today's testimony are important to improve the confidence of health care consumers. We believe that health plans and employers are in the best position to respond to emerging and changing demands. In fact, there is ample evidence that healthcare reform is alive and well—and is being driven by discriminating purchasers working to meet the needs of their employees.

By contrast, we are concerned that additional legislative mandates, especially those that could make plan sponsors liable for health treatment decisions and outcomes, would force even large employers to back away from voluntary health coverage.

Over the next several years, we expect that accountability will shift from a concern about the processes and performance of plan operations—that has been the focus of so much attention today—to a concern about the effectiveness of plans in improving the health status of their enrollees and of the general population.

This will be the ultimate test for medical practice and of our healthcare system. It will also be the ultimate measure of value for employers and other healthcare purchasers. Their active, engaged efforts to reach for this high standard will be essential to future success.

Thank you for offering me the opportunity to share our view, our success, and our vision of the challenges that will continue to emerge.

Mrs. JOHNSON of Connecticut. Thank you very much, Mr. MacDonald.

Mr. Ehnes.

STATEMENT OF JACK EHNES, COMMISSIONER, DIVISION OF INSURANCE, COLORADO DEPARTMENT OF REGULATORY AGENCIES, DENVER, COLORADO, ON BEHALF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

Mr. EHNES. Good morning, Madam Chair, Members of the Subcommittee. My name is Jack Ehnes. I'm the Commissioner of Insurance for the State of Colorado. I'd also like to add that in a prior work career, I was an employee benefits manager for the largest self-funded plan in Colorado, so I have a perspective both as a regulator, and as an employer, and as a purchaser when I make my comments.

Today my remarks will summarize the three areas that's covered in detail in my written statement. First, I'm going to talk about the NAIC Health Carrier Grievance Procedure Model Act. Second, I'd like to tell you what the states have already done in making sure that consumer grievances are addressed in a fair and independent manner. And then, finally, and maybe most importantly, I'd like to discuss with you an approach that we feel may be the best way for Congress to legislate on this issue without micromanaging health regulation by the States.

No issue is more important to State insurance regulators than the successful resolution of consumer complaints about health plans. This is why State governments devote so many resources to complaint handling and resolution. This is also why the NAIC adopted the Health Carrier Grievance Procedure Model Act. This model requires all health carriers to establish clear mechanisms for

resolving employee complaints. Under the model, indemnity carriers only need to provide a one-step process. With indemnity insurance, the services have already been provided and the dispute generally centers around who will pay the providers.

Managed care plans must create a two-step process. The second step is required because sometimes the plan has denied treatment before the treatment has been given. The second level process must be as independent as possible. The majority of people performing the review must be health professionals in the appropriate field. Where services have been denied, the professional involved may not be in the covered person's health plan, and may not have a financial interest in the outcome of the review. Seventy-two hour expedited reviews are required if the time limits of the standard procedure would seriously jeopardize the life or health of a covered person.

In 1996, Colorado, along with six other States, enacted legislation and promulgated regulations concerning the provisions of this Model Act. And I just might show you here, this is a brochure but we're really attempting to communicate this throughout Colorado in a variety of ways. But the title of this brochure says, "What Happens When Your Health Insurance Co. Says 'No?'" In very simple plan terms, it goes through what grievance processes are available to the public. We make this available on the Internet. But, particularly, we're going to place it in provider offices, doctor offices, hospital offices, where these issues arise. And providers need to be counseling patients.

Madam Chair, all 50 States have passed legislation requiring health maintenance organizations, or managed care plans to establish some type of consumer grievance and appeals process. Other State laws regarding how a managed care plan conducts its business and deals with its consumers also come into play. For example, because Maryland requires a prudent layperson standard for payment of emergency room claims, my colleague, Commissioner Steve Larson, was able to order the payment of the full claim and fine Optimum Choice for failing to pay the claim of a women who fell off of a cliff. It was reported in the front page of The Washington Post. The case, of course, has been discussed several times already this morning. This is the order issued by the insurance commissioner for the State of Maryland ordering that insurance company to pay the claim in full in early March.

Yet, the member States of the NAIC do not feel that the current grievance model goes far enough. In the 18 months since we adopted this model, our members have developed a great deal of interest in requiring an external review process as well. At our spring meeting, the members of the NAIC decided to revise the grievance model to provide for independent, external review appeals mechanism, and that process of developing that model should be completed by next year.

But even without a change in the model by the NAIC, 17 States have already passed legislation that provides for an external appeals process. California, Texas, and Maryland are among the States that have taken some action in this area. In fact, the Maryland legislature passed this bill less than 2 weeks ago. These external reviews take many forms.

During our 1998 legislative session, the Colorado legislature also debated the adoption of an external grievance procedure. Unfortunately, the bill was introduced late in the session, not allowing adequate time for development. Our legislature wanted to review what other States had already accomplished to decide what approach works best in Colorado. But we expect that the bill will be drafted throughout the summer and reintroduced in January.

As you can see by the chart we have over here of all the States and what action they've already taken, all States in the country require HMOs to have some type of internal procedure for addressing grievances. The 17 States in blue require an external grievance procedure of some type.

It's also important to note that State insurance departments routinely assist consumers who have complaints about a plan's denial services. The Maryland example happens everyday on a small basis in every insurance department around the country.

Given this, the members of the NAIC do not wish to see Federal preemption of requirements for grievance procedures. However, if Congress feels compelled to mandate an external grievance process, that we would request that States be given the utmost flexibility to address the needs of our consumers. Instead of drafting a specific external review requirement and mandating that the States meet, or exceed, this new Federal standard, Congress should first develop an independent procedure for ERISA plans. Congress could then require that the States implement some type of external procedure within a set time period. Congress could even work it out so that State action and Federal regulatory action were completed at the same time. This way States that had already acted, or were planning on acting in the near future, would not have to take additional action other than gubernatorial certification.

In summary, this proposed State-Federal partnership would have three major features: It would list the general topics that Congress wanted the States to address; it would set a date by which States had to act; and if a State failed to act, the requirement set by the Federal Government for ERISA plans would apply to all State-licensed insurers.

In conclusion, the members of the NAIC feel States have already responded. All States require some type of grievance procedure for HMOs, and 17 States have gone further requiring an external process. We recognize, however, that we need to do more. By fall, our model law will be amended to include an external grievance procedure. However, we recognize that ERISA plans do not offer the same level of protections for their enrollees as the States offer. We urge Congress to amend ERISA to provide these provisions. We also ask that if Congress wants to compel States to take action, that it do so in the least prescriptive possible. We believe the State-Federal partnership approach, outlined in my written statement, ensures that all consumers receive similar levels of protection without congressional micromanagement.

Thank you for the opportunity to testify, and, of course, I'd be glad to answer any questions.

[The prepared statement follows:]

Statement of Jack Ehnes, Commissioner of Insurance, State of Colorado, on behalf of the National Association of Insurance Commissioners' Special Committee on Health Insurance

I. *Introduction*

Good morning, Mr. Chairman and Members of the Subcommittee. My name is Jack Ehnes. For four years I have been the Commissioner of Insurance for the State of Colorado. I am also the Vice Chair of the Accident and Health Insurance (B) Committee of the National Association of Insurance Commissioners (NAIC). I am testifying this morning on behalf of the NAIC's (EX) Special Committee on Health Insurance. I would like to thank you for providing the NAIC with the opportunity to testify today about due process within the health care industry including the NAIC's Health Carrier Grievance Procedure Model Act.

The National Association of Insurance Commissioners (NAIC), founded in 1871, is the organization of the chief insurance regulators from the 50 states, the District of Columbia, and four of the U.S. territories. The NAIC's objective is service to the public by assisting state insurance regulators in fulfilling their regulatory responsibilities. Protection of consumers is the fundamental purpose of insurance regulation.

The NAIC Special Committee on Health Insurance is composed of 41 state insurance regulators. The Special Committee was established as a forum to discuss federal proposals related to health insurance and to provide technical assistance to Congress and the Administration on a nonpartisan basis. Over the past several years, other members of the NAIC have had the privilege of testifying before this Subcommittee on various legislative proposals.

II. *NAIC's Five Model Acts*

Beginning in 1993, the states, with the assistance of the members of the NAIC, have done extensive work to help ensure that the health care provided by state-regulated health plans is of the highest quality. In 1996, the states, through the NAIC, adopted five model acts that set standards for managed care plans on a range of topics. These managed care model acts are the:

- Health Carrier Grievance Procedure Model Act;
- Managed Care Plan Network Adequacy Model Act;
- Utilization Review Model Act;
- Quality Assessment and Improvement Model Act;
- Health Care Professional Credentialing Verification Model Act.

The Health Carrier Grievance Procedure Model Act works with the other four model acts to create a comprehensive regulatory structure at the state level for managed care health plans. In some instances they apply to fee-for-service plans as well. Their purpose is to protect the consumer, especially when carriers and health plans restrict a consumer's choice of providers, or use incentives to direct consumers to particular providers.

A NAIC model law becomes effective in a state only when that state's legislature chooses to enact the model or legislation based on the model. A state is free to modify an NAIC model to meet the needs of consumers and/or the market within the state. As with all our models, the NAIC is monitoring state legislatures to determine which states have adopted provisions of some or all of these managed care models.

The states through the NAIC developed the Health Carrier Grievance Procedure Model Act and the four other managed care models because they recognized that the delivery of health care services was rapidly evolving away from fee-for-service insurance arrangements to managed care arrangements of many types. State insurance regulators have observed this market evolution firsthand because state insurance departments have a principal role in regulating managed care entities. Insurance regulators appreciate the need to strengthen protections for consumers participating in managed care plans.

III. *Health Carrier Grievance Procedure Model Act*

No issue is of greater concern to consumers or state insurance regulators than the appropriate resolution of consumer complaints about health plans. The NAIC's Health Carrier Grievance Procedure Model Act requires both health carriers and managed care plans to establish clear procedures for resolving enrollees' complaints. The term "grievance" is broadly defined and explicitly includes complaints about denials of care or treatment.

Graduated Levels of Review: The model requires *all health carriers* to provide a "first level grievance review." These reviews enable a covered person to submit written material to a health carrier, but the carrier is not required to have a meeting with the complainant. There are separate requirements for grievances involving an adverse determination based on a utilization review decision and grievances involving all other matters. An adverse determination means a decision by a health carrier that an admission, availability of care, continued stay or other health care service has been reviewed and does not meet the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced or terminated.

A health carrier must issue a written decision containing: the names, titles, and qualifying credentials of the reviewers who participated in the first level grievance review process; a statement of the reviewers' understanding of the covered person's grievance; the reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the carrier's position; a reference to the evidence or documentation used as the basis for the decision. In cases involving an adverse determination, the carrier must provide the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the decision. If applicable, the carrier must also provide a description of the process to obtain a second level grievance review and the written procedures governing a second level review, including the time frames; and the notice of the covered person's right to contact the insurance commissioner's office, including the phone number and address of the commissioner's office.

A health carrier that offers managed care plans must establish an independent second level grievance process. This additional step provides a covered person dissatisfied with the outcome of the first level review the option of a second review. The second level review is offered to managed care enrollees since they would not have the option, as a fee-for-service patient would, of possibly seeking to obtain the service from a different source. At the second level review the covered person has the right to appear in person before authorized representatives of the health carrier. A carrier must ensure that a majority of the persons reviewing a second level grievance involving an adverse determination are health care professionals who have the appropriate expertise. In cases where there has been a denial of service, the reviewing health care professional may not be a provider in the covered person's health benefit plan and may not have a financial interest in the outcome of the review. The requirement of an independent reviewer does not apply, however, when such a reviewer is not reasonably available. This may be the case in small states where providers, especially specialists, are likely to have contracts with every major health plan.

If a face-to-face meeting is not practical for geographic reasons, the health carrier must provide and pay for the option of communication between the covered person and the reviewers by other means, such as a conference call or a videoconference. The health carrier must also provide a written decision containing specified information. The decision must be issued within five working days after the review meeting, and that meeting must be held within 45 working days from the time that the health carrier receives a request from a covered person for a second level review.

The requirement that the health plan offer a managed care consumer the opportunity for a face-to-face meeting with the plan is a very significant feature of this model. Because the model defines "grievance" to include an adverse determination made pursuant to a utilization review process, consumers have the right to meet with the plan to resolve disputes about the denial of care.

Expedited Reviews: The model also requires a carrier to perform expedited reviews if the timeframe of the standard grievance procedure would "seriously jeopardize the life or health of a covered person or would jeopardize the covered person's ability to regain maximum function." Once the review is started, the health carrier must reach a decision within seventy-two (72) hours.

Grievance Procedures: Health carriers are required to use written procedures for receiving and resolving grievances from covered persons and are required to file a copy of the procedures with the commissioner. The model act requires an annual report to be filed with the commissioner. Carriers are required to attach a description of the grievance procedures to the policy, certificate, membership booklets, outline of coverage or other evidence of coverage provided to covered persons. The procedures document is required to include a statement of a covered person's right to contact the commissioner's office for assistance at any time. The statement must include the telephone number and address of the commissioner.

Grievance Register: Health carriers are required to maintain written records to document all grievances received during a calendar year. The model act defines minimum information to be contained in the register and requires the register to be

maintained for the longer of three years or until the commissioner had adopted a final report of an examination that contains a review of the register for that calendar year.

Plans are required to submit an annual report to the insurance commissioner that includes: 1) the total number of grievances; 2) the number of grievances referred to the second level of review; 3) the number of grievances resolved at each level; 4) the number of grievances appealed to the commissioner of which the health carrier has been informed; 5) the number of grievances referred to alternative dispute resolution procedures or resulting in litigation; and 6) a synopsis of actions being taken to correct problems identified.

Another significant feature of the NAIC's Health Carrier Grievance Procedure Model Act is that it coordinates with the NAIC's Utilization Review Model Act. Both models require health plans to disclose the clinical review criteria used for making utilization review determinations. This ensures that both consumers and providers know the basis of a denial and have the necessary information to challenge the plan's decision.

In 1996 Colorado enacted legislation and promulgated regulations containing the provisions of the Health Carrier Grievance Procedure Model Act.

All 50 states require health maintenance organizations or managed care plans to establish consumer grievance and appeals processes. These processes vary in their complexity. Several representative state samples follow. The following section on individual state action was put together using data provided by The National Conference of State Legislatures.

• **Georgia** requires every HMO to maintain a complaint system that has been approved by the commissioner. A grievance hearing must be conducted by a panel of not less than three people. Enrollees must be notified in writing of the determination. Notice of an adverse determination must include specific findings, the policies and procedures for making the determination, and a description of the procedures, if any, for reconsideration of the adverse decision.

• **Illinois** requires every HMO to submit for the director's approval a system for the resolution of grievances. The procedures must be fully and clearly communicated to all enrollees. The process must take place within specific time frames. Enrollees must be notified in writing of the determination.

• **Louisiana** requires that every HMO establish and maintain a grievance procedure approved by the commissioner. The HMO must inform enrollees annually of the procedures, including the location and phone number of where grievances may be submitted.

• **Nebraska** requires each HMO to establish and maintain grievance procedures that provide for the resolution of grievances initiated by enrollees. The procedures must be approved by the director of insurance after consultation with the director of regulation and licensure.

• **Nevada** requires the commissioner (in consultation with the state board of health) to approve the system developed by managed care organizations for resolving enrollee complaints. Denials of coverage must be in writing, must provide the reason for the denial and the criteria used in making the determination. The enrollee must also be notified of the right to file a written complaint.

• **New York** requires HMOs to establish and maintain a grievance procedure. Grievances can be filed in writing or by phone. The grievance process must take place within a specific time period. Notice of an adverse determination must be in writing and explain the process for filing a grievance. Expedited determinations must be made by phone followed by a written notice within three business days.

• **Wisconsin** requires all HMOs to establish and use an internal procedure that is approved by the commissioner. Enrollees must be provided with complete and understandable information describing the internal grievance process.

IV. *External Review of Grievances*:

There has been much recent discussion about the desirability of requiring a health plan to have an independent external review process. The NAIC's model does not require a health plan to submit a grievance to the review of an external entity or state agency. In general, the grievance process required by the NAIC's Health Carrier Grievance Procedure Model Act is a process internal to a health carrier or plan. It does, however, require a managed care entity or carrier that performs utilization review to convene an independent, impartial panel of experts to review denials of care.

In the 18 months since the NAIC adopted its grievance and utilization review models, the interest in requiring independent external appeals has grown greatly, both in Congress and among state legislatures. At its Spring National Meeting in

March 1998, the NAIC's Accident and Health Insurance (B) Committee, of which I am the Vice Chair, decided to revise the NAIC's grievance model to provide for an independent external appeals mechanism. We hope to complete this revision expeditiously.

At least seventeen states have passed legislation that provides for some type of specific independent external appeals process. These states are Arizona, California, Connecticut, Florida, Maryland, Michigan, Minnesota, Missouri, New Hampshire, New Jersey, New Mexico, North Carolina, Ohio, Rhode Island, Tennessee, Texas, and Vermont. Other states may enact bills this year.

State independent external appeals mechanisms take various forms. There are at least six possible approaches already found in state law. A state that is developing an independent external appeals process would examine these processes and determine which one would fit best in that state, or a state could combine aspects of these approaches and create something more suitable for its own market:

1. The appropriate state entity develops a list of independent reviewers. Once it is determined that an external appeal is necessary, the health plan chooses a reviewer from this list. The reviewer cannot have a financial interest or any other connection to the case. If the list maintained by the state does not include a reviewer with appropriate experience to conduct the external independent review, then the health plan along with the appropriate state entity will choose a reviewer who is mutually acceptable to perform the review." (Arizona.)

2. Independent review entities are accredited by a private, nonprofit accrediting organization. The accrediting organization is under contract with the appropriate state entity. (California.)

3. The enrollee appeals to the appropriate state entity. The state entity appoints an independent, impartial health entity to perform a medical review. (Connecticut, Missouri, Rhode Island, Texas.)

4. The state creates a panel that hears all external appeals. The panel is composed of state employees. Panel staff performs an initial review to determine if the panel will hear the case. If the case is heard, the panel presents its findings to the appropriate state entity, which issues a final determination. (Florida.)

5. The enrollee may choose an alternative dispute resolution mechanism to resolve the HMO's internal appeal decision. (Minnesota.)

6. The appropriate state entity performs the review. (Tennessee,Michigan)

In its 1998 legislative session, the Colorado legislature debated the adoption of an external grievance procedure. Because the legislation was introduced late in the session, the legislature had insufficient time to examine the bill. The Colorado legislature wanted to review what other states had already accomplished and decide which approach would work best for the citizens of Colorado. The bill will be redrafted between now and the beginning of the next session in January 1999. It is expected to pass since there was limited opposition to the bill last session.

V. *The Roles of State and Federal Government in Regulating Health Care*

Federal Role: The enactment of the Employee Retirement Income Security Act of 1974 (ERISA) created a dual regulatory structure in this country for health insurance and heath benefits. Had ERISA not been enacted, we would strongly oppose any federal role in setting quality standards including mandating an external grievance procedure. However, because state insurance departments lack jurisdiction over self-funded ERISA plans, and because we believe that consumers within ERISA plans would benefit from the same types of protections available under state law, the NAIC has advocated, in past testimony, that Congress amend ERISA. We therefore think it appropriate that Congress set standards—including grievance procedures—for ERISA plans.

With respect to state-regulated insurers and health plans, we continue to believe that the states are better able to determine what works best in their marketplace. The delivery of health care services is a local activity. Health markets are determined by geographic factors, demographics, the level of market penetration by different types of entities, the composition of the health care workforce, and consumer preferences, among other factors. A single federal standard will be difficult to apply to diverse populations and different geographic areas and may stifle innovation in local markets. As we have already seen, states have already approached the subject of independent external grievance procedures in many different ways, each designed to fit the needs of their citizens and health care market.

State Role: State insurance departments conduct many critical activities which directly relate to and are intimately connected with the required grievance procedure. These activities are labor intensive

Consumer Complaints: A primary role of state insurance departments is the handling of consumer complaints. The help provided by consumer services divisions is one of the most critical services offered by state insurance departments. It is arguably the service that consumers appreciate most. In resolving consumer complaints, state insurance departments are acting, in part, as an external appeal. If the health plan is denying care contrary to its contractual obligations, a department of insurance can take many different actions, which range from fining the plan to revoking its license. Often a pattern of consumer complaints regarding denials of care will lead the department of insurance to perform a "market conduct" examination.

Market Conduct Regulation: "Market conduct" refers to how the regulated entity conducts its business within the state's market, including such activities as marketing, the issuing of policies, and the handling of consumer complaints. A large number of complaints or a pattern of complaints will trigger a market conduct exam. An exam may also be triggered by a large number of enrollee grievances and appeals. If a regulated entity fails its market conduct examination the department of insurance can require the entity to take corrective action.

In recognition of the important role state insurance commissioners play in resolving consumer complaints, the NAIC recently formed the Consumer Complaints Working Group. This group will review the complaint handling process, including the handling of health plan complaints, of insurance departments across the country. The working group will then identify the "best practices" used by insurance departments, will publicize these practices, and will encourage all state regulators to incorporate them into their department's efforts. In keeping with providing assistance to state insurance departments, the NAIC maintains the largest database in the world on final actions taken against all insurance companies, including health insurers.

VI. *Federal Preemption*

All states require HMOs to have internal procedures for addressing grievances. Seventeen states require an external grievance procedure. It is also important to note that state insurance departments routinely assist consumers who have complaints about a plan's denial of services or other matters. Given this, the members of the NAIC do not wish to see federal preemption of state requirements for grievance procedures.

However, if Congress feels compelled to mandate a specific grievance procedure (i.e. an external process), then the members of the NAIC would request that the states be given the utmost flexibility. In order to provide this flexibility we would urge you not to use the legislative model embodied in the Heath Insurance Portability and Accountability Act of 1996 (HIPAA).

At the time of HIPAA's enactment in 1996, prescribing a detailed set of minimum federal requirements seemed far preferable to total preemption of state law implementing small group and individual health insurance market reforms. The HIPAA model recognizes the integrity of state insurance law and the state regulatory framework. This approach made sense for the implementation of federal standards relating to the issuance, portability, and renewability of health insurance.

However, the legislation required states to enact complex changes to state law within a very limited timeframe. It was a difficult task for most states to modify their laws to conform to the complex federal statute. HIPAA's preemption language required most states to enact the provisions of the federal law into state law in order to retain enforcement authority. It also required them to repeal any state law provisions that conflicted with the federal statute. Therefore, while the federal statute did not preempt existing state law, it did require a comprehensive review of state law and significant new state legislation in most jurisdictions.

Federal Principles—State Specifics: There is another approach Congress should adopt. Rather than enacting specific requirements and allowing states to "do better," the federal government could simply direct the states to adopt an independent external grievance procedure and provide a deadline for action. Instead of drafting a specific independent external grievance procedure and mandating that the states meet or exceed this new federal standard, Congress should first develop an independent external grievance procedure for ERISA plans, and then require the states to implement some type of independent external grievance procedure within an explicit time frame. Congress might also specify the characteristics of that procedure (e.g. the reviewer(s) cannot have a financial stake in the outcome; the process must be timely). The governor of the state would then certify that the state met the requirements of the federal principles. States that had already adopted an acceptable independent external grievance procedure would not have to take any action.

Such a Congressional statement of principle gives the states the most flexibility and minimizes Congressional micromanagement. Unlike the HIPAA model, states that have already acted in the areas outlined by Congress would not have to take any additional action. This is better for consumers because a state could tailor its external grievance procedure requirements to its specific marketplace and could take its consumers into account.

In summary, legislation modeled on this state-federal partnership would have three major features: (1) it would list the general topics or problems that Congress wants the state to address to protect consumers and ensure health care quality. Congress might also specify the *general* characteristics of acceptable state legislation, but it would not establish *detailed* requirements or *specific provisions* that states must adopt to address these topics. (2) Congress would set a date by which states must act to address these issues; and (3) if a state failed to act, the requirements set by the federal government for ERISA plans would apply to state-licensed insurers.

The federal principles—state specifics approach has other strengths in addition to maximizing state flexibility. It would allow Congress to address immediately the lack of protections contained in ERISA for beneficiaries of ERISA plans. Another strength is that this more general approach does not penalize states that have already implemented an external grievance process. Unlike the HIPAA model, federal principles—state specifics legislation would be drafted to let these state laws stand, even if the provisions were not identical to the federal law's requirements for ERISA plans. Allowing states this flexibility would not detract from the major goal of federal quality legislation: the protection of consumers.

Resources: It is important to note, however, that any standards the federal government creates for ERISA plans will essentially be meaningless if Congress does not provide the regulating body with adequate resources. To regulate the business of insurance in 1996, state insurance departments employed over 1,000 financial examiners and 360 market conduct examiners. They initiated over 1100 financial examinations, over 790 market conduct examinations, and approximately 660 combined examinations. In addition, state insurance departments responded in 1996 to a combined total of more than 386,000 consumer complaints and more than 3.5 million consumer inquiries. Clearly, regulating insurance carriers is a labor intensive proposition.

VII. *Conclusion:*

States recognize the importance of providing managed care enrollees with the ability to appeal an unfavorable determination made by a health plan. All states have already acted to require HMOs to establish a grievance procedure. Seventeen states (compared to nine in 1997) have already enacted an independent external grievance procedure requirement.

Congress should not attempt to micromanage the managed care marketplace and force diverse regions and localities into a "one-size fits all" approach. Rather, states should be given the flexibility to continue the development of innovative solutions to complex problems, including the development of independent external grievance procedures for health plans.

In providing federal guidelines, Congress will ensure that all consumers receive similar types of protections. In allowing the states to determine what those specific solutions are, Congress will ensure that innovative solutions to local problems are not disregarded.

I appreciate the opportunity to testify today. The NAIC is looking forward to working with Congress.

Mrs. JOHNSON of Connecticut. Thank you very much.

Mr. deMontmollin.

STATEMENT OF STEPHEN J. DEMONTMOLLIN, VICE PRESIDENT AND GENERAL COUNSEL, AVMED HEALTH PLAN, GAINESVILLE, FLORIDA

Mr. DEMONTMOLLIN. Madam Chair, and Members of the Subcommittee——

Mrs. JOHNSON of Connecticut. Would you say your name for me so I can understand it?

Mr. DEMONTMOLLIN. OK. Madam Chair and Members of the Subcommittee, I'm Steve deMontmollin.

Mrs. JOHNSON of Connecticut. "deMontmollin," thank you.

Mr. DEMONTMOLLIN. I'm vice president and general counsel of AvMed Health Plan which is Florida's oldest and largest not-for-profit health maintenance organization——

Mrs. JOHNSON of Connecticut. Excuse me, could you pull the microphone closer to you?

Mr. DEMONTMOLLIN. Yes, ma'am.

Mrs. JOHNSON of Connecticut. And talk right into it.

Mr. DEMONTMOLLIN [continuing]. Serving some 375,000 members, including approximately 70,000 Medicare members throughout the State. AvMed is an IPA model HMO and contracts with close to 7,000 private physicians, and 126 hospitals, is federally qualified and is accredited by the National Committee for Quality Assurance and the Joint Commission on Accreditation of Health Care Organizations. Both accreditation organizations require written grievance and appeals procedures for addressing member complaints.

I appreciate the opportunity to testify today. Managed care isn't perfect, just better by far than unmanaged, uncoordinated, unaccountable, unaffordable care. Managed care is an approach to the delivery and financing of health care which changes somewhat the relationship between the physician, the patient, and the payer of health care services.

With the growth of managed care comes new issues with which you, the States, the managed care industry, and my company must deal. One of the most troublesome issues is the potential for a managed care company to deny payment for medically necessary services to subscribers despite the recommendation of the treating physician.

My company recognizes that plans like ours that have the ability to deny or reduce coverage for nonauthorized services need a mechanism for members to seek review of claims that have been denied or covered at a lower than expected level of benefits. In fact, any plan that provides for the financing of health care must have such a system to address the member's concerns about payment decisions. My company is a member of the American Association of Health Plans, and heartily endorses the mandatory AAHP policy which states, "Health plans should explain, in a timely notice to the patient, the basis for a coverage or treatment determination in which the patient disagrees, accompanied by an easily understood description of the patient's appeal rights and the timeframes for an appeal. An expedited appeals process should be made available for situations in which the normal timeframe could jeopardize a patient's life or health. Appeals should be resolved as rapidly as warranted by the patient's situation."

The Florida legislature, as far back as 1972, enacted the first HMO enabling act and declared its intent as follows: "Faced with a continuation of mounting costs of health care, coupled with the State's interest in high quality care, the legislature has determined that there is a need to explore alternative methods for the delivery

of health care services with a view toward achieving greater efficiency and economy in providing these services." In that first enabling act, the legislature mandated that health maintenance organizations have, "a grievance procedure that will facilitate the resolution of subscriber grievances and that both includes formal and informal steps available within the organization."

Grievance and appeals procedures are required of health plans by the States and by the Federal Government for federally qualified HMOs and other health plans contracting with Medicare, as well as contractors for Federal Employees Health Benefits, and AvMed is proud to be a contractor for both the Medicare Program and the Federal Employees' program.

Using my State as an example, Florida requires that each health plan have a written grievance procedure available to its subscribers for the purpose of addressing complaints and grievances, an expedited grievance procedure and external review by the State. In 1984, the legislature created an external appeals process through the Florida statewide subscriber assistance program. This external appeals process was designed to provide assistance to subscribers, including those whose grievances are not resolved to the satisfaction of the subscriber in the internal grievance and appeal process at the HMO.

I have described in some detail in my prepared remarks the Florida internal grievance procedures, the expedited internal grievance procedures, and the external grievance procedures, and would be pleased to discuss those procedures further should the Subcommittee Members so desire.

In closing, I would like to offer that any consideration of an external review process should be guided by several principles: Foremost, an external review process should not be initiated unless, and until, a subscriber has exhausted the internal appeals process, including the internal expedited review process if applicable, established by the health plan. Additionally, the scope of review for an external review process should be limited and clearly defined.

More generally, an external review process should be fair to all parties, administratively simple, nonadversarial, objective and credible, accessible, cost-efficient, time-limited, and subject to quality standards. Subscriber grievance and appeals processes are evolving as health plans, consumer groups, and regulators seek to find a suitable balance between consumer protection and a high-quality, cost-efficient health care delivery and financing system.

AvMed, and the other AAHP member plans, are committed to upholding high standards of patient care, and we are likewise prepared to be held accountable for our actions. And we believe that all health care organizations and providers should likewise be held accountable.

Thank you for the opportunity to testify today.

[The prepared statement follows:]

Statement of Stephen deMontmollin, Esq., Vice President and General Counsel, AvMed Health Plan

Mr. Chairman and members of the Subcommittee, I am Steve deMontmollin, Vice President and General Counsel of AvMed Health Plan which is Florida's oldest and largest not-for-profit health maintenance organization, serving some 375,000 members, including approximately 70,000 Medicare members, throughout the state. AvMed contracts with close to 7,000 private physicians and 126 hospitals, is Feder-

ally qualified and is accredited by the National Committee for Quality Assurance and the Joint Commission on Accreditation of Healthcare Organizations. AvMed is a member of the American Association of Health Plans (AAHP) which represents 1,000 HMOs, PPOs, and similar network plans. AAHP member companies are dedicated to a philosophy of care that puts the patient first by providing coordinated, comprehensive health care. Together, AAHP members provide care for over 100 million Americans nationwide.

Health plans provide a vehicle for systematic quality improvement that is not available under the old-style fee-for-service health care system. Health plans combine a number of interrelated features that foster a comprehensive approach to quality, including:

• selection of a defined, fully-credentialed network of providers who can work together on care and quality issues;

• provision of comprehensive services across the spectrum of inpatient and outpatient settings, allowing a full range of quality improvement interventions; and

• clinical and fiscal accountability for the health care of a defined population—allowing population-based data collection, analysis, intervention, and monitoring—and ensuring accountability for performance.

These unique characteristics enable network-based plans to deliver quality care, and to be accountable for the care provided. The organizations and individuals who purchase health care, including consumers, employers, and the federal and state governments, demand this accountability. It is the accountability that provides the mechanism for marketplace competition based on quality.

I appreciate the opportunity to testify today about the important role appeals, and grievances play today in ensuring that consumers' needs and concerns are addressed in a timely fashion by health plans. All health care delivery systems, including provider-sponsored networks, offered to all subscribers should be required to meet comparable standards governing quality of care, access, grievance procedures and solvency. Subscribers should have confidence that all options meet standards of accountability that ensure that they will have access to all benefits and rights regardless of the choice of plan they select. My comments today will focus on the following appeals and grievances issues:

• Health Plan Initiatives

• State Grievance Procedure Requirements

HEALTH PLAN INITIATIVES

AAHP-Putting Patients First

The American Association of Health Plans has issued a policy on grievances and appeals which is now a requirement for its member health plans. The Florida Association of Health Maintenance Organizations has adopted the AAHP policy and mandates it for FAHMO members as well. The Putting Patients First initiative advocates a set of specific policies that promote high quality care in a manner that meets the needs of individual patients. AAHP members strongly believe that all plan enrollees should have the information they need to understand their rights and that timely procedures should be in place to permit them to pursue their rights. Educating beneficiaries about their rights is critical. It is not only important that enrollees be given information about their appeal rights at an appropriate time, but that information needs to be clear and the processes for pursuing those rights need to be readily accessible. However, notification requirements also need to be implemented in a way that respects the patient/physician relationship. A careful balance is required not only to ensure that beneficiaries understand and can exercise their rights at the time most beneficial to them, but also to avoid interfering in physician-patient discussions about care. While situations may occur in which there is disagreement about treatment decisions, it is common for physicians and their patients to discuss difficult clinical issues and reach agreement about a course of treatment that meets clinical objectives and responds to beneficiary concerns. A successful appeals notification process should respect successful interactions, while providing appropriate notification of rights when disagreement occurs. The policy issued by AAHP and endorsed by FAHMO states:

• "Health plans should explain, in a timely notice to the patient, the basis for a coverage or treatment determination in which the patient disagrees, accompanied by an easily understood description of the patient's appeals rights and the time frames for an appeal. An expedited appeals process should be made available for situations in which the normal time frame could jeopardize a patient's life or health. Appeals should be resolved as rapidly as warranted by the patient's situation."

To promote implementation of this policy as expeditiously as possible, AAHP member plans are being encouraged to review their internal policies and practices to ensure adherence.

STATE GRIEVANCE PROCEDURE REQUIREMENTS

Internal Grievance Procedures

Grievance and appeals procedures are required of health plans by the states, and by the federal government for federally qualified HMOs and other health plans contracting with Medicare as well as contractors for federal employees' health benefits. Using my state as an example, Florida requires that each health plan have a written grievance procedure available to its subscribers for the purpose of addressing complaints and grievances, an expedited grievance procedure, and external review by the state through the Statewide Subscriber and Provider Assistance Panel which will be described more fully below.

Definitions

Florida law distinguishes between a "complaint" which is "any expression of dissatisfaction by a subscriber, including dissatisfaction with the administration, claims practices, or provision of services, which relates to the quality of care provided by a provider pursuant to the organization's contract and which is submitted to the organization or to a state agency," and a "grievance." A complaint is part of the informal steps of a grievance procedure and is not part of the formal steps of a grievance procedure unless it is a "grievance." A "grievance" "means a written complaint submitted by or on behalf of a subscriber to an organization or a state agency regarding the:

- (a) Availability, coverage for the delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review;
- (b) Claims payment, handling, or reimbursement for health care services; or
- (c) Matters pertaining to the contractual relationship submitted by or on behalf of a subscriber eligible for a grievance and appeals procedure provided by an organization pursuant to contract with the Federal Government under Title XVIII of the Social Security Act.

An "adverse determination" means a coverage determination by a plan that an admission, availability of care, continued stay, or other health care service has been reviewed and, based upon the information provided, does not meet the plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and coverage for the requested service is therefore denied, reduced, or terminated. An "urgent grievance" means an adverse determination when the standard time frame of the grievance procedure would seriously jeopardize the life or health of a subscriber or would jeopardize the subscriber's ability to regain maximum function.

Every health plan is required by Florida law to have a grievance procedure. Plans, as part of their procedure, must inform subscribers that they have one year from the date of the occurrence to initiate the grievance and that the member can appeal to the Statewide Subscriber and Provider Assistance Panel after the final disposition of the grievance through the plan's grievance process. Health plans must report annually to the Agency for Health Care Administration all grievances and their final dispositions. Plans must respond to an initial complaint within a reasonable time. The organization must also inform the member that the member can submit a written grievance at any time. The plan in addition must inform the member that the plan will assist the member in preparing the written grievance.

The grievance procedure must at a minimum contain the following:

- 1. An explanation of how to pursue redress of a grievance.
- 2. The names of appropriate employees or departments that are responsible for implementing the grievance procedure.
- 3. A list of the addresses and toll free numbers of the grievance department, the Agency for Health Care Administration and the Statewide Subscriber and Provider Assistance Panel.
- 4. The description of the process through which a subscriber may contact the toll free hot line of the Agency for Health Care Administration.
- 5. An expedited review process.. Notice that the member can use binding arbitration, if provided in the contract, instead of the Statewide Subscriber and Provider Assistance Panel.

• 6. A procedure giving access to the grievance procedure to members who cannot submit a written grievance.

With respect to a grievance regarding an adverse determination, a plan must make available to the subscriber a review of the grievance by an internal review panel; such review must be requested within 30 days after the plan's transmittal of the final determination notice of the adverse determination. A majority of the panel must be persons who previously were not involved in the initial adverse determination. A plan must establish written procedures for a review of an adverse determination and the procedures must be available to the subscriber. In any case when the review process does not resolve a difference of opinion between the organization and the subscriber, the subscriber may submit a written grievance to the Statewide Provider and Subscriber Assistance Panel.

EXPEDITED INTERNAL GRIEVANCE PROCEDURE

A health plan in Florida must have a written procedure for an expedited appeal of an urgent grievance. In an expedited review, all necessary information, including the plan's decision must be transmitted between the plan and the subscriber by telephone, facsimile, or the most expeditious method available. In an expedited review, an organization shall make a decision and notify the subscriber as expeditiously as the subscriber's medical condition requires, but in no event more than 72 hours after receipt of the request for review. In any case when the expedited review process does not resolve a difference of opinion between the organization and the subscriber, the subscriber may submit a written grievance to the Statewide Provider and Subscriber Assistance program.

EXTERNAL GRIEVANCE PROCEDURES

Statewide Provider and Subscriber Assistance Program (SPSAP)

Some states have legislated processes for external or independent review of adverse decisions made by health plans. For example, last year three states (Arizona, Connecticut, and Texas) have enacted laws with external review provisions, and two states (New Jersey and New Mexico) have issued regulations with such provisions. These states join California, Florida and Rhode Island, all of which had some form of independent review of disputes prior to 1997.

In Florida, the external review is accomplished by the Statewide Provider and Subscriber Assistance panel. This six-member panel was established by the Florida Legislature to provide assistance to subscribers by hearing the grievances they have against health maintenance organizations which have not been resolved to the subscriber's satisfaction. The panel recommends to the Agency for Health Care Administration any actions the Agency or the Department of Insurance should take concerning both individual cases as well as the types of grievances. This program has three components: 1) responsibility to provide assistance with unresolved grievances to both subscribers and providers of HMOs; 2) review of quarterly unresolved grievance reports submitted by HMOs; and 3) the imposition of fines, after investigation, for failure to comply with quality of care standards.

HOW IT WORKS

• HMOs and the agency notify subscribers of their right to appeal to panel at completion of plans' internal grievance processes
• Subscriber voluntarily completes and returns SPSAP form and medical release to the Agency for Health Care Administration
• Agency notifies HMO of subscriber's appeal and requests data
• Case review initiated by Agency staff and case is discussed with panel members to determine if case meets criteria for hearing
• Hearings are generally open to the public but may be closed in whole or in part upon request of a party for confidentiality of medical record or other legitimate privacy purpose
• Case heard (not subject to the Administrative Procedures Act); panel prepares recommendations to Agency or Department of Insurance
• Agency or Department issues final determination based on panel recommendations.

The Statewide Subscriber and Provider Assistance Panel is chaired by the Florida Consumer Advocate and is composed of employees of the Florida Agency for Health Care Administration and the Florida Department of Insurance. The panel also contracts with a medical director of a health maintenance organization and a primary care physician. The panel reviews cases submitted to it by members who are not

satisfied with the results of their HMO's grievance procedure. The panel then makes recommendations to the agency and the department on actions that the agency or department should take in a particular case.

External review is also utilized by HCFA and the Office of Personnel Management (OPM). HCFA requires HMOs to submit adverse or unresolved grievances to independent reviewers such as the Center for Health Dispute Resolution that are contracted with HCFA. The contracted reviewer makes the final decision in those grievances.

Similarly, OPM utilizes external review in its administration of the Federal Employee Health Benefit Plan (FEHBP). OPM contracts with HMOs to provide federal employees health coverage. As part of the contract, HMOs must have a grievance procedure. Federal employees who have a complaint about an HMO must use the HMO's full grievance procedure. However, if the federal employee is dissatisfied with the HMO's determination, the employee can appeal the HMO's decision to OPM.

In my view, any consideration of an external review process should be guided by several principles. Foremost, an external review process should not be initiated unless, and until, an enrollee has exhausted the internal appeals process, including the internal expedited review process, if applicable, established by the health plan. Additionally, the scope of review for an external review process should be limited and clearly defined. More generally, an external review process should be fair to all parties, administratively simple, non-adversarial, objective and credible, accessible, cost efficient, time limited, and subject to quality standards. Grievance and appeals processes are in a state of evolution with changes being initiated by health plans, the states and, as more fully appears below, the Health Care Financing Administration. The common purpose is to adequately protect the consumer while contributing to a quality health care delivery system.

Subscriber grievance and appeals processes are evolving as health plans, consumer groups and regulators seek to find a suitable balance between consumer protection and a high quality, cost efficient health care delivery system. AvMed and the other AAHP member plans have demonstrated that they are listening and responding to consumers' needs. We are committed to upholding high standards of patient care. AvMed and the other AAHP member plans are prepared to be held accountable for our actions, and we believe that all health care organizations and providers should likewise be held accountable.

AvMed Health Plan welcomes the Subcommittee's interest in these issues, and I thank you for the opportunity to testify today.

Mrs. JOHNSON of Connecticut. Thank you very much.

Mr. MacDonald, under what circumstances does GTE decide to use an external appeals process? How useful has external appeals, has the external appeals process been in resolving coverage disputes, and has your company ever done an analysis of the costs to provide external appeals?

Mr. MACDONALD. We typically use external appeals processes after all internal processes have been used, and they tend to focus on that type of coverage that would be viewed as experimental, in particular, is one that we tend to focus a great deal on or medically complex. I would tell you that they have been few and far between, but I think the distinguishing characteristic is that we allow ourselves to go out and find nationally recognized experts that we are not limited by, for instance, the particular State or the locality of where the occurrence may have taken place. It gives us the ability to go back out and look for competent physicians to do that. To be very candid with you, I don't know of any study that would talk about costs. I can assure you that anything like that has a cost to it, but I don't have the specific numbers.

Mrs. JOHNSON of Connecticut. So most of these disputes are about the use of experimental treatments and appropriate care in complex cases. When, in going through this process, does the pa-

tient have to agree to the external experts that you're going to use, or is there any communication about that?

Mr. MACDONALD. There's a great deal. To answer your question, does the patient have to agree to the external expert, no, because, in essence, and I think it's an important point that we are the ones that are offering these plans voluntarily. And so there isn't an issue about whether there's an agreement or not. These are not mandated plans. These are plans that we use on the basis of a competitive business posture. So on that basis, we do have the right for that determination.

Second, I think that what we have found is that we have very strong communication. We have our own internal standards by which we will respond. We have direct dialog on case management with these people, so there's a lot of back and forth in that regard. I think communication is absolutely critical. When it's all said and done, if people understand why they were right or why they were wrong, that's what they're really asking for.

Mrs. JOHNSON of Connecticut. And as to the issue of timeliness, do you have any idea what the timeframes are in which appeals within your plan are determined?

Mr. MACDONALD. We have an internal standard that is less than what ERISA is calling for. We typically try to resolve our appeals in less than 60 days. I'd also like to tell you that on a percentage basis, it's less than one-tenth of 1 percent, and I think part of the reason is that we do a very good job of communicating information up front during the enrollment process, and we provide a lot of quality information.

So what we have within GTE is an educated consumer, and they are going to the good plans. They are not going to the plans, for instance, that Congressman Stark talked about because we eliminate those plans. We make them accountable for their actions. We had 137 plans, for instance, about 5 years ago, we've dropped about 12 to 14 of those plans because they just don't meet government, quality standards. The Federal Government might do well to be very selective in how they focus on quality.

Mrs. JOHNSON of Connecticut. On the other hand, is there any way you can get back to us with more detailed information in less than 60 days?

Mr. MACDONALD. Sure, I can do that.

Mrs. JOHNSON of Connecticut. Because in particularly differentiating kinds of care, if you're dealing only with very, for the most part on that, well, that 60 days dealt with all your appeals, correct?

Mr. MACDONALD. That's correct.

Mrs. JOHNSON of Connecticut. If you could get back to us with more detail on what kinds of appeals were dealt with and what timeframe, that would be very helpful.

[The information was not available at the time of printing.]

Mrs. JOHNSON of Connecticut. And that goes to my last question, which is really to the whole panel: Clearly, all of you think that the external appeals process has a place in our system and is useful, but all of you have cautioned against our mandating a prescriptive solution.

First of all, I'd like you to enlarge a little bit about what you think we should be saying and then how do we reach the self-em-

ployed? Is opening ERISA the only option, or is requiring a process set up by State regulators a way to get to that, or if we require the Federal Employees Benefit Plan, Medicare, and Medicaid to have a certain kind of process, would that ultimately affect the kinds of processes that govern the self-insured sector? Anyone who wants to start may.

Mr. MACDONALD. Go ahead.

Mr. EHNES. Sure.

Mrs. JOHNSON of Connecticut. Mr. Ehnes.

Mr. EHNES. In terms of how to, I guess, develop a broad-base standard. I think we recognize that it's unlikely the States are going to be empowered to regulate in some fashion that ERISA market, that's why I was encouraging in my testimony that you do take action in some format to develop standards for that ERISA market as soon as possible, because I think, as this chart would indicate, that if it turns out you're still debating this a year from now and we're back with this chart again, a lot more of that chart is going to be blue for States, and if you haven't taken action in the ERISA market, I think the unlevel playing field will just be exacerbated all the more.

Mrs. JOHNSON of Connecticut. So you don't think action in the regulated market will permeate the ERISA market?

Mr. EHNES. Well, you know, I think if you have testimony from GTE, and Xerox, or Eastman Kodak, and we compare those standards, what they're doing to what you're proposing in your bills, or what States are doing, probably. It looks like there's going to be a lot of comparability. My sense is that in those types of employers they infuse those kinds of standards into their plans. But the reality is self-insured employers goes down to an employer of 50 people, and I've worked with a lot of businesses like that that are self-insured. And to think that an employee would go to the human resource manager of a 50-person company and expect to get fair, unbiased, objective treatment. I can't even get in that ballpark of that kind of conception.

Mrs. JOHNSON of Connecticut. But from your experience, both in working in that sector and as an insurance commissioner, at the State level and then part of the national organization, if we, if State commissioners establish this plan for appeal, and make it cover all licenses insurers, or if we mandate a certain kind of process for Federal health—for Federal employees, would plans actually, an HMO that opens itself to all employers and covers both self-insured, and nonself-insured, would they really have a separate appeals process for me within that plan, rather than anybody else in that plan?

Mr. EHNES. I think it has a sentinel effect in that manner. I would have to agree it has some effect, but I would not agree that it provides the tightness in the system that I think you are expecting, and I guess that's why we would still encourage, if we're going to set standards on one side, you set standards on both sides.

Mrs. JOHNSON of Connecticut. And you don't fear that, if we get into opening up ERISA, we won't go too far?

Mr. EHNES. Well, you've got a whole variety of bills in Congress opening up ERISA, and I think——

Mrs. JOHNSON of Connecticut. Do you think any of them go too far?

Mr. EHNES. [continuing]. I think the most prominent issues, like this issue, need to be opened up and addressed.

Mrs. JOHNSON of Connecticut. But that is not the entire issue. You know, in legislating, if you open up a certain situation, and particularly if you have on the table, a lot of bills that go too far—and you may think that none of the bills go too far. I happen to think that some of them will be very destructive to the evolution of our health care system. So, you know, recognizing that danger, are there—first of all, do you think it's a danger? Do you think there are bills that go too far, and do you think, in your experience of legislating, that it is impossible for a legislature to overkill? And if that's a real danger, what are our options? How could we reach the self-employed? Excuse me, the self-insured market without opening up ERISA?

Mr. EHNES. Well, I don't have the solution without opening up ERISA. I would agree with you entirely that there's a propensity to overkill in some areas of health legislation, but the political reality is, I have to be candid with you, regardless of what you do in Congress, those statehouses will continue, in the next 2 years, to work on this issue every day. It will happen. I think the real question before you is do you want the people that are in insured plans to feel they've got those protections coming through statehouses, and those employees that work in self-insured, maybe not the GTE, or the Eastman Kodak, but the vast majority of the population.

In Colorado, it's a small-business State. It isn't a Fortune 100 State. So the extent of my self-insured market is 50 percent of my population. They're coming under unequal protection, and I don't know how you can avoid dealing with the inequity of this issue because the State legislatures are intent on addressing this.

And if I could add one other point that Congressman Stark made, that I feel is very valid, is: regardless of the number of appeals that make it to that external process, it does have a strong tightening process on the internal processes of the HMO, knowing that the external piece is out there. So it isn't necessarily critical that it's 5, or 100, or 1,000 going to that external piece, but that independence does create, I think, a stronger integrity in the organization itself.

And I do happen to subscribe to the theory that health plans want your business as customers. This article in the Washington Post about not paying your care when you go in for an emergency, obviously, it's a ridiculous situation and who's going to enroll in this health plan thinking they're not going to get their services paid? It has an enormous impact. But the other piece I'd like to say is you can pass these laws, and the fact is Maryland had a prudent person law on the books for emergency care that was the law the commissioner used to enforce, but unless—your real objective here is to gain compliance; it isn't just to pass the law.

And I guess I'd like to just again come back to my message, is there is a lot of value in having local communities, through statehouses, debate these bills and work through the issues? I have learned that you can gain a lot of compliance through that mecha-

nism. They, even though they may not agree with the bill initially in the statehouse, they work through the process. There is a lot of public attention to it in your local community and you can get the companies on board. I do worry about uniform Federal standards and whether it results in real compliance, not just a law, but real compliance at the local level.

Mr. DEMONTMOLLIN. Can I follow up on that, Madam Chairman?

Mrs. JOHNSON of Connecticut. Yes.

Mr. DEMONTMOLLIN. With respect to Florida, Florida has, since 1985, had an external review process in place. It involves three representatives from the Agency for Health Care Administration, three from the Department of Insurance, and is chaired by the consumer advocate of the State of Florida. They contract with a primary care physician from a health plan and they also have a provider there in the peer specialty area of the issue that comes before the board.

There are 4.2 million Floridians in HMOs in Florida. For the period, October 1993 to March 1997, the total number of cases opened were 403; settled before a hearing, 100; ineligible or out of jurisdiction, 118; heard by the panel, 52; the average elapsed days was 197 and the average dispute amount was $4,337.

I have accompanied a member of our board of directors, on a 2-hour trip down to Orlando, Florida from Gainesville, appeared before the panel, which told the petitioner, the subscriber, that orthopedic shoes simply were not a covered benefit under the contract she had negotiated through her employer. We got back in the car and drove back home. This year, the Governor of Florida has recently signed a bill that passed overwhelmingly and was sponsored by the Agency for Health Care Administration that would narrow slightly the types of issues that are taken to this appeals panel.

Now, there are obligations to notify members of their rights at all stages—when we sign them up, every time there's an open enrollment throughout the year, in the member contract, and in our contracts with providers. Constant notification to our members that they have a right, not only to appeal any decision of the plan at the Statewide Subscriber and Provider Assistance Panel, but they can also call a 1–800 number, a hotline number directly in the State. So while I would associate myself with Mr. MacDonald's remarks with respect to ERISA, I would simply say that the States do need this flexibility on external appeals—because, if politics is local, then I can assure you that health care is likewise local.

Mr. MACDONALD. Could I just respond quickly?

Mrs. JOHNSON of Connecticut. Yes.

Mr. MACDONALD. I recognize the issue of time. You asked, do things go too far, are there other ways to do it? I mean, I think there's a real-life example happening right before us, is that in November of this year, the presidential commission gave a bill of rights, and then a company like GTE voluntarily stood up and said, we're going to subscribe to those bill of rights. I stand before—or sit before you today being able to represent that we know for a fact that health plans, and/or employers, 60 million Americans are now covered voluntarily by that bill of rights, that they've signed up voluntarily with efforts that we've done to work with them.

In addition to that, President Clinton has asked the Federal Government to subscribe to those bill of rights as well. There's 150 million Americans that are already, on a voluntary basis, working with the fruits of that effort. So I think that you don't necessarily have to change laws to make things happen. The marketplace can demand that.

Second, I would suggest to you why it sounds good for external appeals. I mean if there is, there is an aura about that. The reality of it is, are there recognized experts? Is there a supply of talent out there that can ultimately provide that service? I don't know if that exists today. We're having a hard time finding them as one company. So you can legislate the right, but if there is no ability to ultimately give that right, what good is it? So I don't even know if the experts exist. I think this is a cottage industry at best right now.

And then, last but not least, the issue of cost. This is a very competitive workplace that we are in right now on a global basis, and I don't care if it's one-tenth of 1 percent, or one any, it's a cost. When it's all said and done, it's a cost, and that's what drives business right now. How much does it cost?

Mrs. JOHNSON of Connecticut. Mr. Stark.

Mr. STARK. That's pretty sad, Mr. MacDonald. There are other things, in business besides costs. I'd like to say that people can know the cost of everything and the value of nothing. But, that's a major change in the way employers tend to think about employees from what we had in past decades. We're making a lot of money in this country. Maybe that shows that it's working. But, we still have 42 million, or 43 million people without any health insurance.

Mr. MACDONALD. So why are we having this hearing?

Mr. STARK. I don't know. We are the only country in any of the countries in which you do business that does not have universal health care. Countries that compete with us certainly do. And my answer is, if we had it, you could afford it because it would probably save you money in the long-run. But that's where we ought to start.

Let me follow up. You're afraid of liability, you said. You said it truly scares you. Does GTE operate any health plans as such? Or do you have a company that runs the health plan? Could you be a health plan legally?

Mr. MACDONALD. No.

Mr. STARK. OK. Some of the managed care reform bills before Congress that eliminate the ERISA protections, specifically protect the employer. Would that assuage your fears? In other words, if the health plan makes a medical decision my theory is they ought to be liable for it. If you don't make any medical decisions, and instead allow the health plan to make those decision, I mean, you are specifically protected. Would that raise your comfort level.

Mr. MACDONALD. No.

Mr. STARK. OK.

Mr. MACDONALD. Because the reality of it is that, while I may not be liable in that instance, if there is liability associated to the health plan, that's a cost that the health plan is going to pass along somehow, some way to me, hidden or direct.

Mr. STARK. All right. We have a variety of figures which people don't quite yet agree on, but so far indications are that the cost of the ERISA liability provision pretty minimal. I mean, relative to a major liability suit, it's minimal.

Mr. MACDONALD. I'm not sure what you said was minimal.

Mr. STARK. There are those who would suggest to you that the cost of removing the ERISA exemption is not great if the plans aren't scallywags. But that's a matter on which we don't have much certain data yet.

Mr. MACDONALD. I think this is very relevant to your district. I think there is a significant cost associated with that and the preemptive provisions of ERISA are very important. Right now in order to do the cost of doing business in San Francisco, and I want you to understand up front that we offer domestic partner benefits in certain of our businesses because it's a competitive necessity. But I'm also now being told by certain cities of what my benefit coverage must be in order to do work there, but not just in that city; I have to offer that for all employees GTE-wide.

Mr. STARK. Time out. I'm just talking about the liability issue; I'm not talking about the level of benefits which States may, or may not, prescribe. Look, that's off the table for this conversation. I'm suggesting to you that the costs of a managed care plan that has ERISA exemption from liability and for a managed care plan under State law is not high. Often they're the same plans; it's just some members are exempted from liability and other members aren't.

Mr. Ehnes, you estimate that 50 percent of Coloradans are exempt.

Mr. EHNES. Yes.

Mr. STARK. That is what it is in Maryland, we understand. And I don't know what it is in California. You think you're doing a good job, don't you?

Mr. EHNES. I think we do a very good job.

Mr. STARK. Don't you think you protect the people of Colorado?

Mr. EHNES. Yes.

Mr. STARK. Don't you think you ought to protect all of them?

Mr. EHNES. Yes.

Mr. STARK. I do, too. And I think it's that simple. I think Mr. Pomeroy was here in your seat not many years ago when he was the commissioner of insurance in North Dakota. He said to us, over the issue of Medigap, that if in a few years he couldn't deliver a majority of the States with Medigap controls, he would stipulate that the Federal Government ought to do it. Well, you guys couldn't get together to do it. I think only 14 States really had Medigap standards, and so we passed a Federal Medigap law. I think that serves the people of Colorado well, don't you?

Mr. EHNES. Yes.

Mr. STARK. I'm willing to give you a shot, but I have to remove the ERISA exemption to give you the chance to do your job. Is that fair?

Mr. EHNES. Right.

Mr. STARK. And if you don't do your job, meaning all of your members, or let's say a majority of the insurance commissioners pass strong consumer protection standards, would you say that we

ought to have minimum Federal standards? That way, in the States that don't comply, people can't go across the border and buy insurance in the neighboring State by mail and harm the insurers who do the right thing in Colorado.

Mr. EHNES. I think it's appropriate to say an issue of this critical importance, that a drop-dead date, it can be meaningful for States, but the problem, again, is by setting—if we want to call that word, the HIPAA, Health Insurance Portability and Accountability Act, approach of the floor approach as setting some minimum standards, you do force whatever it is, 17 States, or by the time you add 29 States to recycle all the legislation back in their States to redebate it, when, in fact, you might have decided that it's 23 days and a State said it was 14. That's Mickey Mouse, I have to say.

Mr. STARK. I agree if, as I suspect, all the States will have good bills long before we do. But if we were to act first, it would probably help the States because at least you'd set some minimal standards and then they could argue about the frosting on the cake. But my guess is that you're going to find a majority of the States with good legislation, and all we're going to have to do is take away that ERISA exemption of responsibility, as I'd like to call it. Can you think of any reason the managed care plans will tell us they need this protection? I'd suggest that Mrs. Johnson has, but I don't think she remembers that she said that. Plans should pay for the service and then we'll argue about after providing the service. The managed care plans say, "Goodness, gracious, that will hurt us," because I imagine that's the only way they save any money. I don't know of any way that managed care plans can reduce the cost of medical care except by denying it. There's been precious little evidence to the contrary.

Do you require in Colorado that the care be provided and they argue about the cost later, or is your law silent on that?

Mr. EHNES. Well, on this grievance issue, specifically, if you're sitting in the hospital and receiving treatment, and your doctor is asking for additional services, or extended stay, the plan's, the turnaround time actually is 1 day.

Mr. STARK. OK.

Mr. EHNES. The plan needs to make a decision in 1 day. But having said that, the plan——

Mr. STARK. Suppose they don't come back with the decision; may the doctor then go ahead and provide the service and argue about the cost later?

Mr. EHNES. Yes, the plan must cover the hospital stay or treatment until you've been notified of the denial. They're accountable.

Mr. DEMONTMOLLIN. Mr. Stark, since I'm the only member representing a health plan, may I respond to that?

Mr. STARK. Sure.

Mr. DEMONTMOLLIN. I disagree entirely that we believe that the doctor should not act as a doctor on behalf of the patient. The health plan is making a coverage decision about who's going to pay. There are courts that recognize that utilization review, or utilization——

Mr. STARK. Excuse me, go back; I'm not sure I understand. You believe that, if the primary care physician requests a procedure, the procedure should be done?

Mr. DEMONTMOLLIN. Precisely. In one case——

Mr. STARK. OK, and then argue about the costs——

Mr. DEMONTMOLLIN. Well, let me just make the point.

Mr. STARK. OK.

Mr. DEMONTMOLLIN. The court held that, "whether or not the proposed treatment is approved, the physician retains the right, and indeed the ethical and legal obligation, to provide appropriate treatment to the patient." State attorneys general have expressed similar opinions. The North Carolina attorney general wrote that "denial of third party payment may have a direct impact upon a patient's decision of whether or not to undergo the treatment. However, such denial does not prohibit the patient from seeking treatment without third party benefits. It does not prohibit the attending physician from providing the treatment."

Mr. STARK. Mr.——

Mr. DEMONTMOLLIN. What I say to our medical directors is simply this, "You are the patient's advocate. You are to use, for instance, the U.S. Department of Health and Human Service's Agency for Health Care Policy and Research Practice Guidelines. You are to use the ones that are promulgated by the Agency for Health Care Administration in the State of Florida, and you are to have a science-based, or evidence-based, collaboration with the treating physician, which, hopefully, will lead to the more fully informed consent on the part of the consumer. But you, the plan medical director, are making coverage decisions. You are to say to that doctor, 'It is your patient. You have to do what you think is right.'"

Mr. STARK. Let me just put this in laymen's terms that I can understand. In your plan if I have a family practitioner, or an internist, and they say to me, "Have a sigmoidoscopy, and——

Mrs. JOHNSON of Connecticut. Mr. Stark, if I could ask you to move forward. We can come back to this——

Mr. STARK. I'm sorry.

Mrs. JOHNSON of Connecticut. Mr. McCrery has to leave.

Mr. STARK. I'm sorry, but I just want to make one point. Your plan would say whatever the doctor says, I get, but if there's a dispute later on between you, and the doctor and me about whether I should have that, or whether you cover it, it's only a fight over who's going to pay?

Mr. DEMONTMOLLIN. We say it is a science-based collaboration with the treating physician. Make sure that that treating physician advises the member of what our practice guideline is, what we believe is medically necessary. We advise them of their appeal rights if they should disagree with our denial of the payment of that, but what that doctor and that patient decided to do vis-a-vis the treatment decision is one that should rightly remain there.

Mr. STARK. And the treatment goes right ahead. And then we argue—in effect, we argue only about the money. I think we're saying the same thing.

Mr. DEMONTMOLLIN. Absolutely.

Mr. STARK. I'm sorry, Madam Chairman, but I think this is an area you're interested in, too. I'm not sure that every plan operates that way, but I'm certainly pleased that your's does. Thank you.

Mrs. JOHNSON of Connecticut. Mr. McCrery.

Mr. MCCRERY. Mr. Ehnes, do you have any jurisdiction over any ERISA plans?

Mr. EHNES. We have no jurisdiction over the self-insured market, right, to be——

Mr. MCCRERY. Oh, self-insured?

Mr. EHNES. Right, but, I mean, to the extent——

Mr. MCCRERY. But on fully insured ERISA plans, you do have jurisdiction, don't you?

Mr. EHNES. To the extent——

Mr. MCCRERY. So it's not 120 million people that are exempt from State regulation, is it? As has been said here by somebody at one point, it's more like 32 to 48 million people?

Mr. EHNES. Well, it's about half my State that is self-insured and not subject to State regulation. I guess I want to—I mean I was sensitive to that comment. To the extent that employers are using more insured managed care plans, the more they would come under State regulation—and there is some indication that is occurring, that there's a shift back toward insured markets for some employers. So that it is a proper comment, to the extent those States adopt grievance mechanisms and more employers use insured plans, then they will come under that regulation.

Mr. MCCRERY. I just wanted to make sure everybody understood that ERISA doesn't mean, "exempt." Only self-insured ERISA plans are exempt from State regulation, and that number, the number of people in self-insured ERISA plans, is somewhere between 32 and 48 million, not 120 million people in the country.

Mr. MacDonald, you were doing just fine until your last statement—[Laughter.]—when you said basically, "Cost is everything." You didn't mean that. I know you didn't mean that because earlier you said that you're in a competitive business and you offer health insurance and you want to make sure it's good health insurance because you are in a very competitive business. So I'm going to give you a chance to rehabilitate yourself. [Laughter.]

We all know that cost is important. And you're in business and you're in business to make a profit. And although my good friend from California occasionally denigrates profitmaking, it is basically what has made this country tick for a long, long time, and tick pretty well. So I happen to like people who make profits and I think that has given us a society that has generated the highest standard of living for the greatest number of people in our society. Having said that though, we do care about our employees don't we? I mean, a happy employee is a good employee, right?

Mr. MACDONALD. I'm getting the message. [Laughter.]

You know, it's interesting that you said that, Congressman, and I thank you for the opportunity to clarify my intention. My father always used to tell me that, "You know, Randy, you'll be a very successful man someday when you learn to keep your mouth shut." [Laughter.]

So I probably have not heeded that warning over the years. I have to tell you that, and I think that the prime example of that is, if cost was everything than why would we be even offering health care? The bottom line is that we are looking to differentiate ourselves in the marketplace through our people. And the ability

to have those people be a satisfied employee represents ultimately a satisfied customer.

And I would ensure—I can assure you that while we constantly manage our costs, we're always focused on the issue of quality, whether it be in the workplace or with our customer. So you're absolutely right. I will also be very truthful in saying to you that cost is a consideration as it relates to our shareholders so that's what I was attempting to say, and I will try to remember my father's words. [Laughter.]

Mr. MCCRERY. Absolutely.

Mr. DEMONTMOLLIN. Mr. McCrery, I think that it's likewise clear that cost follows quality, that if you improve the quality sufficiently, as GTE has done through their RFPs to our industry, then clearly the costs are going to come down. The question is whether it's best through a voluntary market system as NCQA, with the National Committee for Quality Assurance, or is it better to come from this body?

Mr. MCCRERY. I think I've already answered that question from my viewpoint, but I'll give Mr. MacDonald another chance to buttress my belief. Mr. deMontmollin mentioned RFP, that's a Request for Proposal, I presume?

Mr. MACDONALD. That's what you intend, yes.

Mr. MCCRERY. Does GTE actually go through that process of developing an RFP for health plans seeking their business, seeking your business?

Mr. MACDONALD. Yes, in fact, if you remember in my testimony——

Mr. MCCRERY. That's a lot of trouble, isn't it, to actually put all that down on paper, and prescribe exactly what you want for your employees, why do you do that?

Mr. MACDONALD. Our belief is that by establishing quality standards to my colleague's point that we can ultimately increase our satisfaction with our employees, with their dependents, and to Congresswoman Johnson's point is that we're also affecting the local market as well, because by establishing those standards, for instance, in Tampa, Florida, as an example, where we have a large concentration of employees, establishing those standards in that marketplace are having an effect for all people who are participating in that plan. We drive quality through the process. If you don't meet our quality standards, you are not a vendor to GTE.

Mr. MCCRERY. That's an important point. When you contract with a health plan for your employees in a given location, that health plan serves people other than just your employees, doesn't it generally?

Mr. MACDONALD. Yes, sir, yes, sir, very much so.

Mr. MCCRERY. So the quality standards that you put in your RFP and that you look for when you're contracting with health plans has an effect on that local market, doesn't it, outside GTE? It certainly affects other people who contract with that health plan?

Mr. MACDONALD. That's unequivocal.

Mr. MCCRERY. Thank you.

Mrs. JOHNSON of Connecticut. Just to follow up on that then, it's not your experience because this is an issue—the question I was

asking Mr. Ehnes earlier, in your experience, then, when you contract with plans that are already in the Florida market, and make sure they meet your standards, you see them offering that plan to everybody then with your standards and not singling out your people for different treatment?

Mr. MACDONALD. Yes, I mean, I think that that is probably one of the most significant by-products of working with plans like that is because we are establishing quality and the fact that you drive quality, you drive the cost considerations, you drive greater patient satisfaction. Why would somebody use a process just for a GTE employee and not for another patient from another company, if, indeed, you're going to be able to manage the process in a way. That's the word—that's what health care is all about right now is managing health care. And you're going to apply the best principles to those situations.

Mrs. JOHNSON of Connecticut. So as you contract with plans and improve their standards then all participants in their plan, whether they're from your company or other companies, benefit?

Mr. MACDONALD. Either directly or indirectly, yes.

Mrs. JOHNSON of Connecticut. That's very logical.

Mr. Ehnes, do you wish to comment?

Mr. EHNES. I would, actually; thank you. Back to, actually, his earlier comments again on cost though, the way insurance works is, to the extent that someone can strip costs off a health plan and an employer still wants to offer health care, can make decisions around parts of that plan, they certainly will do that, not necessarily in the Fortune 500 market, but in the small and middle market where everything, any additional costs could make, could drive whether they're going to continue to offer insurance. So although there is some market effect, I have to say, where the good employers, or particularly, the large employers, tend to set quality standards in a community, I think it does have beneficial culture to the community. There is always a countervailing force in insurance where businesses are working the other direction.

Mrs. JOHNSON of Connecticut. I appreciate that, but in this particular instance, if a big actor in the market requires you to set up an external appeals process, so you develop the mechanism and the context—the contacts, then it's far easier for the small employer participants to also be covered by that. And it gives you, in a sense, a market advantage in marketing yourself to those small employers without putting on the small employer the whole cost of setting up the external appeal process. I do think, as in—that in this issue, as well as in every other issue, we have to be very sensitive to the cost of insurance in the small employer market because that's where we're seeing the reduction in coverage for cost reasons. But I think the, I think what Mr. MacDonald is saying is that once he gets a plan to do this, then they've done it for him because it's an economic benefit for them, but they have it there for everyone else and it would be much easier then for small employers to participate in it is the way I read it.

Mr. MACDONALD. I think you might be surprised to learn that in some instances we actually subsidize higher cost plans because they meet our quality standards and therefore we cut our subsidy to those plans who may be substandard to that quality standard.

So the issue of cost and quality are in the decisionmaking process all the time and that's what ultimately would drive the byproduct to the local community.

Mrs. JOHNSON of Connecticut. In other words, in some instances the improvement in quality that you get from the external review process makes it worth paying more for the plan?

Mr. MACDONALD. Yes, because we think ultimately——

Mrs. JOHNSON of Connecticut. I'm seeing that too.

Mr. MACDONALD [continuing]. They're managing the health care in a way that is most cost-effective and in the highest quality manner.

Mrs. JOHNSON of Connecticut. Interesting.

Mr. DEMONTMOLLIN. Mrs. Johnson, this is happening all over the country. Martin Marietta joined with Walt Disney in the Orlando area; went not only to the health plans and said, "Here are our standards," but also to the providers. For instance, the Orlando Regional Medical Center. It's important to understand that HEDIS, Health Plan Employer Data and Information Set, came out of the private sector, that the National Committee on Quality Assurance and their standards came out of the private sector. And it seems to me that the major employers have made a significant contribution, a tremendous contribution, in this area, and this is another reason why I associated myself with Mr. MacDonald's remarks on the ERISA preemption.

Mrs. JOHNSON of Connecticut. I think that is a very wise note on which to include the testimony of this panel, that HEDIS did come out of the private sector and most of our quality oversight mechanisms have come out of the private sector at the—with the stimulus of participation of the big providers.

Thank you very much for your testimony. Have a great time tonight, Mr. MacDonald.

Mr. MACDONALD. Thank you, appreciate it.

Mrs. JOHNSON of Connecticut. And now for our final panel: David Richardson, president, Center for Health Dispute Resolution; Peter Goldschmidt, president of the Medicare Care Management Corp.; James Parkel, member of the board of directors, the American Association of Retired Persons; and Vicki Gottlich, staff attorney, National Senior Citizens Law Center. Welcome.

Mr. Richardson.

STATEMENT OF DAVID A. RICHARDSON, JR., PRESIDENT, CENTER FOR HEALTH DISPUTE RESOLUTION, PITTSFORD, NEW YORK

Mr. RICHARDSON. Yes, thank you. The Center for Health Dispute Resolution is a corporation based outside Rochester, New York, and I'm president of the Center. We work exclusively in the area under review by this Subcommittee, namely, managed care appeals. We've been the Medicare sole national appeal agent for managed care for 9 years. We conduct reviews under three different State independently regulated programs, and we provide reviews for some ERISA employer plans and HMOs on a voluntary basis. We've conducted over 40,000 reviews over the last 9 years, and these reviews come from every State, and hundreds of health plans

and all the variety of configurations, IPA, group network, and what have you.

I'm also glad to see next to me, Dr. Goldschmidt, because between the two of us, we represent about 98 percent of the external review market. And I'd like to point out that, while we are a small industry, I think, based on our experience, we are more than what I would typically deem a "cottage industry."

I want to make just a few highlights today from the written testimony. One, I want to talk about why appeals are necessary. Second, I want to talk about why the Medicare model, with some improvements, I think is the best available. And, third, I'll leave you with some recommendations.

Let's start with why appeals are necessary. In the language of the announcement for this testimony, the first reason I think appeals are necessary is because they're due process protection that give consumers confidence. And whether, or not, the plans are at fault, and whether, or not, the plans have made mistakes of various types, it is a reality that consumer confidence is eroded and needs to be restored in the health system. I can tell you that we get cases from people who apparently had a good situation in the HMO but once the denial was made, they draw upon all the rhetoric and all the bad feelings about the HMO bubbles to the surface. So confidence is an issue.

However, it is true, and I do agree with the speaker from GTE and the industry, that there are very many protections and quality systems that have been built, such as NCQA, HEDIS, FAQS, and so forth. The difficulty with these systems is they are designed to raise the performance of the plans, generally, and they deal with raising measures for general population. We don't yet know how to guarantee the best possible health care for a given individual in a given circumstance. Managed care plans are incredibly complicated organizations that have to make millions of business decisions and clinical decisions on an annual basis. It's true that 95 percent of the people are well satisfied, but plans are going to make mistakes simply because of the complexity. So we should understand that the real purpose of appeals is to provide a remedy when people, when plans do make mistakes.

Second, we find through our external review experience, and I think this is comparable for all of us that do reviews, in whatever setting, that even after an internal plan review, we will find that the plan has violated its own rules, or has not provided medically necessary service in about 25 to 30 percent of the cases that come to us. So I would like to suggest that the key to resolving the debate about appeals is for advocates and spokespersons to recognize that appeals programs serve both interests.

Now why is the Medicare model the best model? I'll point to four issues. I want to emphasize a couple. One reason that the Medicare model is superior is because of its definition of disputes that are eligible. Medicare says that if you are aggrieved by a denial, you have a right to appeal. It's as simple as that. Medicare does not say that that denial has to be of a certain type or that it has to be given a label.

Conversely, if we look at the programs that are promulgated in the States, if we look at the NAIC model, if we look even at the

President's Commission's recommendations, we find that conditions are put on appeals. The most common one is to limit the appeal for those denials that are "related to medical necessity." But in California we have otherwise good legislation that limits appeals to terminally ill patients. What we have found in Medicare, remember we have 10 years experience in an open system, and 40,000 cases, is that 60 percent of denials are not related to medical necessity.

Plans use a variety of reasons, often valid, for denying claims, such as, eligibility, failure of the enrollee or provider to abide by the rules. For example, "you were supposed to call the 800 number but you didn't," exhaustion of benefit limits, contract interpretation. In fact, most plans go through a decisionmaking hierarchy in which they apply these rules before they get to medical necessity.

So why is it problematic to limit appeals to medical necessity? One, because 60 percent of the cases are never going to get to external review. Second, I know that this Subcommittee, and people who are astute in health care, tend to focus on HMOs in the context of providing quality health care, or attempting to provide quality health care. But outside of the beltway, enrollees believe they have bought a financial product. It is still insurance and when that claim is denied, these enrollees are mad as hell and they really don't care why it was denied. So if your objective is to build confidence in the system, then all sides are better served by an appeal program that does not involve rules which enrollees are going to regard as gimmicks.

Mrs. JOHNSON of Connecticut. Mr. Richardson, if you could move a little more rapidly——

Mr. RICHARDSON. I'm sorry.

Mrs. JOHNSON of Connecticut. [continuing]. There are some hearings starting and so we get to them.

Mr. RICHARDSON. I'll move right ahead.

The second reason that I support the Medicare model is because it's linked to coverage policy. And what I mean by that is that our decisions are based upon coverage rules, and when we learn that the coverage rules aren't working, there's feedback. A prominent example is, for example, that we were one of the first people to produce evidence on the problem of emergency denials not being related to a "prudent person" definition.

Finally, the Medicare appeal system is widely publicized, as was talked about, and provides automatic external review.

I'll jump ahead to the recommendations. There are a few things that you might consider doing to help on the Medicare side. First, Medicare nonplan providers currently have no obligation to cooperate in the appeal process. This is causing us and plans problems. Specifically, neither us, nor the plans, can get medical records to do external review in an expeditious basis from nonplan providers.

Second, nonplan providers are putting Medicare beneficiaries in collection while the appeal process unfolds. And third, we don't have the ability to find the nonplan provider liable. We either have to give the bill, if you will, to the beneficiary or the HMO, and in some cases it's the provider who should be liable.

Second, I'd ask you to consider indemnifying those of us that do this work. It's very difficult to get insurance and there's a very imperfect market.

As far as my final recommendation, I do believe that Federal standards are required and I would offer the Medicare model, as I've explained in my testimony as the basis.

Thank you.

[The prepared statement follows and an attachment is being retained in the Committee files.]

Statement of David A. Richardson, Jr., President, The Center for Health Dispute Resolution

The Center for Health Dispute Resolution ("CHDR") is a corporation based near Rochester, N.Y. and I am President and founder of the Center. We work exclusively in the area under review by the Sub-Committee today—health insurance appeals. We have been Medicare's sole national appeal agent for managed care for 9 years, we conduct review pursuant to three State independent appeal programs and we provide external review to ERISA employer plans and HMOs on a voluntary basis. We have conducted over 40,000 external reviews, drawn from every State and hundreds of varied health plans.

When we began this work ten years ago, managed care "appeals" was hardly a noteworthy topic. Since then, there has been an explosion of interest. Some 15 States have enacted external review legislation. The President's Commission has reported on this topic and numerous bills have been introduced to this Congress.

As a leading provider of managed care appeals, I am glad this topic is receiving attention. Properly structured and implemented, appeals systems are powerful and effective tools. As Chairman Thomas said in his announcement, appeals systems provide due-process which, in turn, maintains consumer confidence in the managed care strategy. I sincerely appreciate this recognition of the importance of our work, and look forward to any support that the legislative process can provide.

But I am also concerned. From my view in up state New York, the debate about appeals seems unnecessarily emotional and divisive. Proponents of appeal regulation cite sensational cases involving terminally ill patients and portray managed care decision-makers as profiteers. Conversely, some segments of business and industry respond with public relations campaigns that flatly characterize regulation as an invention of Frankenstein. I am saddened and distressed by unfair and extreme rhetoric on both sides of this issue. We need to find a way to displace anger and distrust in our health system with communication, compassion and confidence.

Appeal systems are a key ingredient in the managed care model. It is true that the regulators, accreditors, payers, and HMOs have developed an array of methods for measuring and promoting quality of care. Consequently, well over 90% of enrollees in managed care are very satisfied. However, managed care involves an incredibly complex set of provider relationships, rules, computer systems and, of course, the intrinsic complexity of individual health and health care. Consequently, all of our management and quality tools are imperfect. These protections can and will fail for a given enrollee in a given instance. Not because most HMOs and their physicians are amoral, greedy or uncaring, but simply because no organization as complex as an HMO can execute perfectly.

The appeal system is, therefore, the option of last resort for persons who fall through the cracks of our imperfect managed care policies and plans. It is the final, and vital, remedy for the person who believes the system has failed him/her. Equally, it is the ultimate source of feedback to the prudent policy maker or HMO administrator who realizes complaints are a most fruitful source for program improvement.

The key to resolving the contentious debate about appeals is thus for consumer advocates and industry spokespersons to recognize that appeals programs serve both of their interests equally. If advocates will permit HMOs to make the honest mistake, and HMOs will admit mistakes cannot be fully avoided, both parties will support the strongest appeal programs imaginable. The question will not be how much appeal programs cost, but rather how much can be invested in this important tool.

Looking across the country and HMO industry, there are few examples of appeal systems that are based on this philosophy, or are robust and implemented with any vigor. One exception is the Medicare managed care model. Today, I want to report on its performance, and propose it as a model for other populations as well.

In recommending the Medicare appeal program as a national model, I realize that Congress and the American public often distrust federal government health regulation. But there are exceptions to every rule. Some of us remember when Congress took the initiative to regulate nursing homes and intermediate care facilities for the mentally retarded. These are examples of effective regulatory programs.

Likewise, the Medicare appeal program is cost effective regulation that works. This is not only my personal view. For instance, a recent American Bar Association roundtable of industry experts concluded, "the structure of a universal grievance and appeal system should generally use the Medicare model as a foundation." [1] Congress itself recently codified current Medicare HMO appeal practice within the bipartisan Balanced Budged Act. This Committee should give great weight to Congress's recent endorsement and recognize that the Medicare model is also applicable to other managed care populations.

THE MEDICARE MANAGED CARE APPEAL MODEL

I want to discuss four positive features of the Medicare Managed Care Model:

- All denial disputes, not just "medical necessity" denials, are eligible for review.
- The Medicare appeals process is linked to coverage policy.
- Medicare appeal rights are widely publicized.
- The Medicare model provides for automatic *independent* review offered by a multidisciplinary team including physicians.

I will also discuss areas for improvement, some of which may depend upon action by Congress.

1. ALL COVERAGE DISPUTES ARE ELIGIBLE FOR THE MEDICARE APPEAL SYSTEM

The first distinguishing and positive attribute of the Medicare appeal system is its straightforward, all-inclusive definition of disputes subject to full appeal. A beneficiary may appeal an HMO denial of virtually any type of claim for reimbursement or request for service (prior authorization). The Medicare approach is far more inclusive than NAIC, most State programs and the recommendations of the President's Commission. For example, a California program limits external appeals to terminally-ill patients. Other State programs limit appeals solely to denials on the basis of "medical necessity." The President's Commission further limits appeal rights to costly cases.

Because the Medicare program does not limit appeals, by type, we now have 9 years of national experience and data about the volume and type of (external) appeals that arise in an open system. This data dispels many of the myths and fears about appeals. For example, the HMO industry is correct that most enrollees are satisfied with HMO care and decisions. Only 1 to 2 persons, per 1,000 enrollees per year, seek to use the external appeal process. Consumers are not appeal happy, and an open program is not a great administrative or financial burden.[2]

Secondly, when appeals do arise, it is because HMOs deny claims or service requests for a wide assortment of reasons—not just because of "medical necessity." Plans also issue denials on the basis of questions about enrollee eligibility, alleged failure of the enrollee or provider to abide by HMO rules, exhaustion of benefit limits, or contract interpretation. In fact, many Plans seem to prefer to site these reasons, because they are more straightforward and less contentious than "medical necessity." Thus the majority of Medicare appeal cases do not reflect medical necessity issues. Over 60% of Medicare appeals arise from so called "coverage" issues.

The Committee may know that insurance industry and business interests generally want to exclude these "coverage" questions from external review. Thus they want to exclude the majority of denials from due process. Why is this wrong—not only for the consumer, but also for the industry?

First, it is wrong because if the goal of an appeal system is to retain consumer confidence in managed care, it is self-defeating to construct barriers to appeal. Inside the Beltway and the employee benefits office, health experts think managed care is about quality and improved health status. But most consumers still regard managed care as health insurance—a financial product. If these consumers believe a claim is incorrectly denied, and upheld in internal grievance systems, they are mad as hell and want redress. The explanation that external appeal is limited to "medical necessity" questions is at best irrelevant and, at worst, regarded as a semantic trick by the insurer.

Secondly, in attempting to limit rights to appeal, the industry acts like it has something to hide, when it has nothing to hide. In our objective/external appeal we uphold the majority of HMO coverage denials, and nearly 90% in some service categories. Where we do overturn HMO denials we see no conspiracy. We see errors of execution by enormous organizations that process thousands of decisions and

[1] American Bar Association, Commission on Legal Problems of the Elderly Report.

[2] Medicare's administrative cost for external appeals is under 4 cents per member month. The total value of service in dispute in l966 was estimated at 32 cents per member month.

transactions daily. Some error rate is to be expected, and the forward thinking Plan or employer group will welcome all means, such as external review, that might provide feedback to detect and fix mistakes.

Third, the tendency to limit appeal programs to "medical necessity" denials oversimplifies the appeals process. The problem is oversimplified by suggesting that medical science, or "the best" health care is the sole criteria for resolving disputes. This view leads to the conclusion that a viable appeals program consists simply of individual case review by an independent doctor.

It is obvious that physicians should make medical necessity decisions in appeals. However, in making these decisions clinicians need support and orientation regarding the (valid) coverage policies that may constrain medical judgment. This is a reflection of the truism that Medicare and other insurance programs have limits and do not provide for all care possibly beneficial to a given patient (i.e., "the best" care).

Here, legislators in particular face a real burden to be explicit and courageous about the limits of appeal programs. The easy thing to do is to promise the public an appeal system that will guarantee "the best" health care on the basis of unfettered review by independent physicians. The hard and right think to do is to remind the public that managed care involves limits and appeals programs operate within those (valid) limits.

2. The Medicare Appeals Process is linked to Coverage Policy

The second desirable feature of the Medicare appeal system is an intentional link between coverage policy and the appeal process. This Committee has held hearings on Medicare (FFS) coverage policy and is aware of HCFA's efforts in this area. The appeal process uses these policies as decision criteria, while also illuminating and informing the policy process. One clear example is the role of Medicare managed care appeals in review of HMO denials of emergency care. Examination of Plan decision making, and even our own early internal decisions, revealed a bias towards "expert" clinical judgment of the severity of emergency encounters. Our data lead directly toward development of the "prudent lay person" standard, now codified in the Balance Budget Act and generally adopted by the managed care industry.

The appeal/coverage link, occurring within the public Medicare program, helps to militate against the abuse of appeals as a source of hidden or silent rationing or policy making. If the nature of our decisions (as opposed to confidential identifying data) was hidden, HMOs or even HCFA could simply relegate all difficult decisions to our review. But our decisions, including rationales, are shared with the enrollee, the Plan and HCFA. So our decisions can be, and are, challenged and improved.

3. Medicare Appeal Rights are Widely Publicized

Although HCFA has been sued twice for failure to implement the appeal process, Medicare and its HMOs have actually done a fairly effective job of informing consumers about appeal rights. HCFA requires Plans to describe appeal rights in enrollment materials and the Agency reviews these descriptions. Plans must also include a notice of appeal rights in each claim or coverage denial. While there is room for improvement, we are now receiving over 1,000 cases per month for Medicare external review. By contrast, entire State external review programs are generating only a handful of cases.

4. The Medicare Appeals Process Includes Automatic, External Review

The Medicare model involves 5 levels of escalating appeal, following a beneficiary challenge to an HMO retrospective claim, or pre-service prior authorization request:

- HMO (internal) Reconsideration
- HCFA (CHDR) External Reconsideration
- SSA Administrative Law Judge (ALJ) Review
- Appeals Board Review
- Judicial Proceeding

Since August, 1997, beneficiaries enrolled in managed care have access to two appeal venues—expedited and normal. Under expedited review, the Plan has 72 hours, with minimal exceptions, to complete an internal Reconsideration. Under normal review, the Plan has 60 days for this process. The beneficiary has a right to present evidence, in person or otherwise, to the Plan Reconsideration, which should be a "de-novo" review.

Medicare is unique in requiring external review (by CHDR) automatically if the Plan fails to find totally in favor of the member in Plan Reconsideration. Thus the member does not have to ask for CHDR review, and it is required if the Plan fails to make its Reconsideration decision within the applicable time frame.

Our independent review is conducted "on the record" or on the basis of a hard copy case file submitted by the HMO directly to us. Pursuant to our agreement with HCFA, we do not take (unwritten) testimony from beneficiaries or Plans. This limitation is offset, to some extent, by the possibility of an in-person hearing before (at the HMO level) or after (at the ALJ level) our review. We do require, pursuant to a published manual, that HMOs submit case files with a standard form and standard attachments, including medical records. We have the right to request additional information from the Plan, including statements from members, which we find necessary to exercise in about 50% of cases. This process, and the overall tracking of cases, is supported by a data system. Statistical reports generated by this system have been made available to the Subcommittee and are widely used by HCFA, Plans, advocacy and research organizations.

Each appeal is assigned to a professional case manager, who oversees the review process, executes appeal correspondence, and may make actual decisions unless the deciding factor is medical necessity as judged by our physician consultants. When we began our work in 1989 we exclusively used nurses as case managers. However, as explained above we found that the majority of cases involved issues other than medical necessity (e.g., compliance, coverage, etc.). We have since added attorneys, medical record specialists, nurse/attorneys and a physician/attorney. Thus a multidisciplinary professional team has proven necessary to address the gamut of issues arising in appeal cases.

In review of the case file, the CHDR professional first determines if the enrollee is eligible and properly enrolled. If questions exist, the case may be referred to a HCFA Regional Office for evaluation for retroactive disenrollment. Secondarily, the reviewer determines the item(s) denied by the Plan and its denial reason. This is contrasted with any beneficiary (or provider) arguments for coverage. The Plan's rebuttal to these arguments, if any, is considered. Although CHDR is independent and not an advocacy organization, we recognize that beneficiaries are not expert in matters of HMO coverage or medical science. Accordingly, we do consider arguments in favor of the beneficiary that are apparent in the facts, but might not be expressly raised by the member.

The policies and criteria that we apply in review are twofold. First, Medicare HMOs are bound to provide Medicare Part A and Part B benefits. Accordingly, we must consider Medicare FFS regulation and its numerous interpreting manuals (e.g., Coverage, SNF, Hospice, etc.). Simultaneously, we consider Medicare regulations and manuals that apply directly to managed care.

40% of our cases do involve questions of medical necessity and must be referred to a physician, dentist or chiropractor for evaluation. We maintain a panel of professionals in all specialties for which we have recurring need for review. Most of these professionals practice in the Rochester area, but also maintain faculty appointments at the teaching hospital, The University of Rochester Medical Center. We also employ a chief physician consultant from Harvard School of Public Health, and he assists in recruitment of physicians from this institution for unusual cases or rare disease review.

If we uphold the HMO denial, and the matter in controversy is $100 or more, the beneficiary may obtain a hearing before and ALJ. A total of 528 hearings were reported in 1997, when 6% of beneficiaries subject to CHDR review sought an ALJ proceeding. HMOs currently do no have the right to appeal to the ALJ, but do have a right to attend a hearing called by a beneficiary. Either party may request a review by the Appeal Board if the matter in controversy is over $1,000. We are aware of approximately 50 requests in 1997. Our system does not track judicial review, and we are aware of only a few cases filed in the ten years of our tenure. The Court dismissed these case because available remedies (i.e., the appeal process steps) had not been exhausted.

MEDICARE APPEALS: AREAS FOR IMPROVEMENT

Although the Medicare appeal system is the best model available, it is not perfect. The most frequent criticism is delay in appeal processing—particularly for urgent cases. This problem was addressed by HCFA regulation, effective August of last year, creating a 72 hour "expedited" appeal process at the HMO level, plus a shortening of our time frame to 10 days or less. HCFA's upcoming BBA regulation will reduce the time frame for processing routine cases. Both HMOs and CHDR experience delays obtaining medical records and when unpredictable spikes occur in appeal volume. Finally, the Administrative Law Judge (ALJ) process is not timely, although it is not under HCFA's direct control.

Advocates have expressed concerns about limitations in HMO denial and appeal rights notices, HMO misdirection of appeals to a (different) "grievance" system, and

absence of support of enrollees in the process. Plans sometimes question the application of Medicare FFS coverage rules to the HMO setting. These problems should be expected in any appeal system and do not, in my opinion, substantially limit the effectiveness of the Medicare model. Nevertheless, we continue to work internally, with HCFA, advocates and Plans to improve the appeal program.

There are a few areas in which Congress might assist us to improve the Medicare appeal program. Appeals often involve enrollee care with "non-plan" providers, or those doctors and hospitals outside the HMOs' network. Although these providers are usually Medicare FFS participants, they are not expressly required to cooperate with managed care appeals. They should be required to provide medical records, and should be prohibited from instituting bill collection efforts against enrollees, pending the outcome of the complete appeal process. CHDR sometimes determines that a non-plan provider has rendered unnecessary services. Currently, we have no authority to find the provider "liable" for this care. Our options are limited to upholding or overturning the HMO denial, or to assigning liability either to the HMO or the member. We should have authority to assign liability to providers, or to refer the case to entities that could effect this judgement.

I would ask Congress to explicitly indemnify organizations and individuals that agree to provide external appeal services. We deal with many medically significant, but contentious cases. Standard malpractice policies exclude coverage for "review," and there is a poor market for procurement of insurance.

Congress should be aware of and periodically track emerging issues in appeal review. In Medicare, two current noteworthy topics are integration of HMO and FFS coverage policies and scope/duration of appeal decisions in ongoing care cases.

APPEAL POLICY RECOMMENDATIONS: GENERAL

Appeal requirements are proliferating at both the State and federal level. Consumers and HMOs are increasingly subject to duplicative or conflicting processes—sometimes with conflicting results in the same case. Many of the newer program requirements are poorly constructed and will not ultimately prove workable for government, business, the consumer, or the health plan. Conversely, the Medicare appeal model is widely regarded as effective and has low administrative and claim cost impact. A number of Plans that are implementing voluntary (external) appeal programs are emulating the Medicare model.

Any broad federal legislation for appeals should use the Medicare model as its basis. To repeat, critical elements of the Medicare model are: (i) applicability to all denials, irrespective of reason, (ii) public disclosure of decision logic and link to applicable coverage policies, (iii) effective consumer education about the appeal program, and (iv) automatic independent review.

The Medicare appeal contractor (currently CHDR) was selected in a competitive procurement and operates under the oversight of HCFA. Legislation broadening appeal coverage should provide for some comparable mechanism, perhaps accreditation, to insure the quality and independence of appeal services.

Mrs. JOHNSON of Connecticut. Thank you very much, Mr. Richardson.

Dr. Goldschmidt.

STATEMENT OF PETER G. GOLDSCHMIDT, M.D., PRESIDENT, MEDICAL CARE MANAGEMENT CORP., BETHESDA, MARYLAND.

Dr. GOLDSCHMIDT. Thank you. I'm Peter Goldschmidt, president of Medical Care Management Corp. We are pleased that the Subcommittee invited us here today to learn about our experience in conducting external expert reviews of medical care.

Mrs. JOHNSON of Connecticut. I'm sorry, Dr. Goldschmidt. There's a fire alarm, and so we have to evacuate the building. You can smell it. I've been wondering about that.

Would you submit your testimony for the record, and if you can hang around if we're able to reconvene in half an hour, we'll do so.

So if you'll submit your testimony, but those of you who can hang around, please do so. Thank you.

[Whereupon, at 12:25 p.m., the hearing adjourned subject to the call of the Chair.]

[Submissions for the record follow:]

Statement of Jim Parkel, AARP Board Member, American Association of Retired Persons

Good morning. I am Jim Parkel from New Fairfield, Connecticut, and a member of the Board of Directors of the American Association of Retired Persons. I am pleased to present the views of AARP's membership on the Medicare managed care appeal process.

Six million Medicare beneficiaries are currently enrolled in Medicare managed care plans. The pattern of rapidly increasing enrollment in managed care persists, as about 100,000 new enrollees sign up every month. A high rate of enrollment is projected to continue as the new Medicare+Choice program is implemented. Consequently, it is important to examine frequently, as we go forward, how well beneficiaries are being served and what protections they need. We commend the Committee for doing just that, and allowing us to share our views on the Medicare managed care appeal system.

Given the built-in financial incentives in managed care to limit use of services, there is a risk that a particular treatment decision will be made not because it is best for the patient but rather because it will save the plan money. While most plans act responsibly, there are some that will improperly restrict access to needed care. Effective quality oversight is essential, but it is also essential to have a strong appeal system that allows enrollees to challenge decisions by their plans. Moreover, both have an important the sentinel effect by deterring problems before they occur.

The Medicare program has the foundation for such a system for managed care enrollees. The system is not perfect, and it is not always implemented properly, but the critical elements are in place, to a greater or lesser degree, through statute and regulation. The basic elements in place in Medicare merit serious consideration for the private sector.

To understand what is needed in a managed care appeal system, it is first necessary to understand the unique problem faced by managed care enrollees. In fee-for-service Medicare, the beneficiary, in most cases, has already received the care in question and the dispute is about payment. In managed care, payment disputes can and do arise, but the majority of managed care appeals in Medicare are brought by enrollees who have not yet received treatment because the plan has denied the care in question, or by enrollees for whom services have been suddenly terminated or reduced, or are about to be terminated or reduced, because the plan has decided that further services are not required.

KEY ELEMENTS OF A MANAGED CARE APPEAL PROCESS

To adequately protect enrollees when a dispute arises over medical services which are denied, terminated or reduced, a managed care appeal system must include five critical elements. Implicit in this discussion is an assumption that enrollees know in a general way that they have appeal rights and that they do not have to accept what the plan tells them. However, this level of understanding does not yet exist in the Medicare managed care program. With that caveat, these are the five key elements to an effective managed care appeal process.

1. Speed. Most people would agree that speed is essential when a medical treatment decision is involved. Most treatment decisions should be made within a few weeks, and some within a few days or even hours.

2. Notice and opportunity to be heard.In order to challenge a decision, the enrollee has to have clear, timely notice of the plan's decision, the reason for the decision, and instructions on how to appeal. In order to ensure a full and fair review of the dispute, the enrollee must be able to present his or her side of the case.

3. Appropriate medical expertise. In general only health care professionals should make clinical decisions. A member of the plan administrative staff, without medical training, is not qualified to assess surgical risk, or the side effects of different drugs, or the benefit that can reasonably be expected from additional physical therapy.

4. Continuity of care. This is a major concern for enrollees whose care is about to be terminated or reduced. It makes no sense to cut back on treatment, or to force a patient to leave a hospital, and then later decide that this was an error. In many cases, the care cannot be re-started, and where it can, the interruption in care may

have caused serious and possibly irreversible harm. Treatment disputes in these cases should be resolved before any change in treatment occurs.

5. Outside independent review. A plan denial of medical care should be reviewed by someone having no relation to the plan and no stake in the outcome. Unbiased review is essential in a managed care environment where the health plan's financial incentives may encourage saving money over delivery of appropriate, perhaps expensive, care. In a dispute with a building contractor over what type of flooring should have been installed in your house, you would never agree to let the contractor be the sole judge of the matter, especially where the contractor stood to benefit financially by not putting in what you wanted. Impartial review is even more important where health and safety are at stake. Outside independent review accomplishes two things: it corrects wrong decisions, and it also has a sentinel effect. We believe that plans are more careful when they know that an objective, external review is part of the process.

THE MEDICARE MANAGED CARE APPEAL PROCESS

Against this background, now consider how the Medicare managed care appeal process works. There are five steps in the current appeal process. This testimony focuses primarily on the first three steps because that is where most cases are resolved.

Step 1—Formal denial by the plan. If there is a question or a disagreement about what care should be provided, the plan is required to give the enrollee a written decision, stating in understandable language, the basis for the decision and explaining the enrollee's appeal rights. The technical term for this is an "organization determination." Every enrollee who disagrees with a denial of care, or with a termination or reduction of care, needs to know the reason for the plan's decision and how to have that decision reviewed.

Step 2—Reconsideration by the plan. If the enrollee requests reconsideration, the plan must have the case reviewed by individuals who were not involved in the original determination. Any questions about medical necessity must be resolved by a physician with appropriate expertise in the field of medicine relevant to the treatment at issue. The enrollee may present evidence in person or in writing. The plan must give the enrollee a written decision, stating the specific reasons for the decision and explaining further appeal rights.

Step 3—Outside independent review. If the plan does not decide fully in favor of the enrollee, the case is reviewed by HCFA's outside contractor-the Center for Health Dispute Resolution, also known as "CHDR." CHDR is a private organization with no ties to the plans. CHDR is paid for its work by HCFA, not by the plans. If CHDR decides in favor of the enrollee, this has no effect on the amount Medicare has to pay the plan. Medicare will continue to pay the same capitation amount, regardless of the outcome. CHDR arranges for review by clinicians of clinical issues and for review of contract and legal issues by other trained staff. The enrollee may submit written evidence but may not appear in person.

Step 4—Administrative hearing. If the enrollee is still dissatisfied, in most cases he or she will qualify for a hearing before an administrative law judge. The administrative hearing is provided and paid for by the Medicare program. The enrollee may make written submissions and may appear in person and present evidence. In some cases, there may also be further review within the Department of Health and Human Services.

Step 5—-Judicial review. If the amount in controversy exceeds $1,000, the enrollee may seek review in federal court.

There are two special systems within the appeal process which supplement the process in critical ways.

The first is "expedited review." This is a system for rapid review of cases where the enrollee's medical condition requires that a treatment decision be made right away. In this situation, if waiting the amount of time that it would take for a regular, non-urgent appeal could jeopardize the enrollee's health or ability to regain function, then the plan must issue the written organization determination as rapidly as the situation requires, with an outside limit of 72 hours. The same time limit applies to an expedited reconsideration. External review by CHDR must also be expedited.

The other is a special system for review of hospital discharges. This is extremely important for enrollees who believe they are being sent home too soon. All Medicare beneficiaries, those in fee-for-service as well as those in managed care, are entitled to have a proposed discharge from the hospital reviewed immediately by a Peer Review Organization (";PRO"). A PRO is a private organization which has a contract with the Medicare program to monitor and evaluate quality of care given to Medi-

care beneficiaries, including so-called "immediate review" of hospital discharges. During PRO immediate review (which usually takes 24 hours or less), the enrollee may remain in the hospital until noon of the day after the PRO renders a decision. The plan must continue to cover the cost of the stay up to that point, regardless of how the PRO decides.

ASSESSING THE MEDICARE APPEAL PROCESS

With this overview of the process in mind, I would like to share with you our ideas on how the Medicare managed care appeal process measures up in light of each of the five critical elements listed earlier: speed, notice and opportunity to be heard, appropriate medical expertise, continuity of care, and outside independent review. It is important to keep in mind that HCFA will be issuing major new regulations in June for the entire Medicare+Choice program, including the appeal process, and that a full assessment will need to include these new developments as they come "on line."

Speed

Through the expedited review process, Medicare assures a very rapid appeal in urgent situations. This is an essential protection, and it targets effectively the situations where speed is needed most. However, the time limits for regular appeals are far too long. The regulations allow the plan to take 60 days to issue the formal denial and 60 more days to complete reconsideration. That means that in the best of circumstances, when the plans actually meet these extremely generous deadlines (which does not always happen), four months can pass before the case even goes to outside appeal. This is not reasonable for most treatment decisions. In our view, the first two steps, together, should not take longer than 30 days in most cases. We understand that HCFA is concerned about the lengthy process and is planning to revise the time limits in forthcoming regulations. However, the new time limits will be meaningless without compliance by the plans.

Notice and opportunity to be heard

The written Medicare notice requirements are fairly good but implementation is a problem. The requirements are supposed to ensure that enrollees receive clear, timely written notice of the plan's decision, of the basis for the decision, and of their appeal rights. However, all too often the plans simply ignore the requirements. We hear frequently of cases where the formal denial is delayed indefinitely or never communicated to the enrollee, or the reason given for a denial is meaningless (for example "service not covered" or "not medically necessary). Therapy may be suddenly terminated with little or no advance warning. While Medicare managed care enrollees have a general notion that they can appeal, most are uncertain about their appeal rights in a particular situation. They need to be told, at the time the disagreement arises, that they can appeal and how to go about it. Often the plans do not give them this information. Most enrollees do not know, and are not told, that they have an absolute right to an expedited appeal if a doctor says that delay could be medically harmful.

In general, the Medicare managed care appeal system does provide adequate opportunity to be heard. However, lack of information about the basis for the plan's decision has an adverse effect the right to be heard. In order to challenge a denial of services one has to now the reasons for the denial.

Appropriate medical expertise

The Medicare statute, as amended last year by the Balanced Budget Act, now specifically requires that when a plan does a reconsideration, any determination of medical necessity must be made by a physician with appropriate expertise in the area of medicine involved. This is essential. A credible medical evaluation during reconsideration can reduce the number of appeals, provide a better record for review in the cases that are not resolved at that point, and reduce public distrust of managed care. In the past, many plans have not met this standard. We hope they will begin to take the matter seriously.

Medical expertise is also a part of outside independent review by CHDR. The details of CHDR's review are established through its contract with HCFA. Clinical matters are reviewed by clinicians with appropriate expertise.

Continuity of care

With respect to hospital discharges, Medicare does extremely well. As explained before, the PRO immediately reviews a contested discharge, and the enrollee is al-

lowed to stay in the hospital until the matter is resolved. The most important element in this system is the financial protection given to the enrollee—protection against liability for the cost of the extra day or days needed for PRO review, regardless of how the PRO decides. Without such protection, PRO review is meaningless. Few people could risk facing a bill for $700 or $1,000 a day. If that were the price of losing the appeal, only a small number of beneficiaries could afford to appeal. The policy of allowing the enrollee to remain in the hospital during the appeal without additional financial responsibility assures that ongoing acute care, often where the patient is in very fragile condition, is not interrupted.

For other services, however, Medicare has not yet addressed the problem of continuity of care. In general, Medicare does not require plans to resolve disagreements about terminating or reducing care prior to imposing the change. We understand that the problems are complicated and that the plans have legitimate cost and administrative concerns. However, as more beneficiaries are encouraged to enter managed care, it becomes essential that we tackle and begin to resolve the problems that are precipitated by this evolution in health care delivery. AARP is prepared to work with HCFA and with the plans to find solutions that are reasonable for everyone.

Outside independent review

This is the part of the appeal process where Medicare probably performs best. Outside review by CHDR is truly independent. In addition, it is quick, it is free to the enrollee, and it costs the Medicare program only pennies per enrollee per month. CHDR is also an extraordinarily valuable source of data about the program and about individual plans. For example, CHDR data can help answer such questions as—

- What situations or services are triggering disagreements?
- Is there a compliance problem or rather an education problem?
- How are the plans carrying out their part of the appeal process?

In addition, information about how frequently a particular plan is overruled by CHDR, or what services generate the most appeals, could be very helpful to an enrollee who is trying to choose a plan or decide whether to change plans.

Review by CHDR is not the only form of outside, independent review in Medicare. As explained earlier, hospital discharges are subject to review by the local PRO, which is an independent, outside organization. Also, although few cases proceed as far as an administrative hearing, the administrative law judges who conduct the hearings provide outside, independent review.

CONCLUSION

On balance, we give the Medicare managed care appeal process high marks. Compared to what is available in private sector managed care, the Medicare appeal process remains the gold standard, despite its shortcomings. Moreover, as increasing attention is given to improving protections for people enrolled private sector plans, the Medicare appeal process can serve as a model. While not all of it can be applied outside of Medicare, much of it can.

THE AARP FOUNDATION
History and Role

The AARP Foundation was established in the District of Columbia in 1961 as a 501(c)(3) nonpartisan charitable corporation, contributions to which are tax deductible. As an affiliate of AARP, the corporation was originally named the Retirement Research and Welfare Association and was set up to engage in the study and discussion of issues affecting aging persons.

In 1983, the Retirement Research and Welfare Association changed its name to the AARP Foundation and shifted its emphasis to promoting projects and community service endeavors related to the social welfare, maintenance, and improvement of health and educational services for older persons. During the 1980s and early 1990s, the AARP Foundation received grants for various AARP projects and also awarded small grants to a variety of community service, educational, and social welfare groups.

On December 19, 1995, the President signed into law the Lobbying Disclosure Act of 1995 which prohibits 501(c)(4) organizations that lobby from receiving federal funds. Although the lobbying act only applies to new grants, AARP transferred all of its public and private grant programs (staff, funds, and administration) to the AARP Foundation. These transfers were approved by all of the federal funding agencies.

The AARP Foundation administers educational, employment and community service programs funded by both private and federal grants totaling an estimated $72 million in 1997. Major programs of the AARP Foundation include the AARP Senior Community Service Employment Program and the AARP Tax-Aide Program. The AARP Foundation's five-member Board of Directors is appointed by the AARP Board of Directors and provides oversight and guidance to the AARP Foundation's management. The Administrator of the AARP Foundation supervises the Foundation's administrative, financial, and professional activities. Under a service provider agreement, AARP provides the AARP Foundation with support services and specialized skills needed to carry out some of the grant-funded programs.

Statement of Peter G. Goldschmidt, MD, PH, DMS, President, Medical Care Management Corporation

We established Medical Care Ombudsman Program to meet a particular need: a credible, objective mechanism to provide expert reviews of cases' medical facts to help patients and payors to make decisions involving complex and contentious medical care. Through expert reviews of cases' medical facts, we tell plans, providers, and patients not what they want to hear but what each needs to know about the fit between the patient and the proposed therapy. The program is now in its sixth year. It has been remarkably successful in achieving its objective, and in responding to clients' and patient's needs for credible, authoritative information. We have more

AARP Statement of Federal Grants & Contracts Pursuant to Rule XI, Clause 2(g)

On December 19, 1995, the President signed into law the Lobbying Reform Disclosure Act of 1995 which prohibited 501(c)(4) organizations that lobby from receiving federal funds. Although the lobbying act only applies to new grants, AARP transferred its grant programs (staff, funds, and administration) to the AARP Foundation, a 501(c)(3) nonpartisan, charitable corporation established in the District of Columbia in 1961. These transfers, effective January 1, 1996, were approved by all of the federal funding agencies.

AARP FOUNDATION

	1996 Actual	1997 Estimated	1998 Projected
Revenues			
Department of Labor: AARP Senior Community Services Employment Program (SCSEP) (1)	$46,155,000	$50,377,000	$52,500,000
Environmental Protection Agency: AARP Senior Environmental Employment (SEE) Program (2)	21,126,000	18,000,000	
Internal Revenue Service: AARP Tax-Aide (3)	3,327,000	3,267,000	3,350,000
Housing and Urban Development: AARP Home Equity Information Center	257,000	393,600	
Health & Human Services:			
AARP Early Detection and Control of Breast Cancer Project	253,000	324,900	
AARP National Legal Assistance Support Project	40,000	132,700	112,500
AARP Technical Assistance Project for Statewide Legal Hotlines	40,000	110,400	75,000
AARP Suicide Evaluation and Prevention Project		49,400	
AARP Ombudsman Training and Technical Assistance	51,000		
AARP Improving Early Access to Mental Health Services Project	87,000	66,500	
AARP Health Care Fraud and Abuse Prevention		50,000	200,000
Department of Justice: AARP Hispanic Messaging for Anti-Telemarketing Fraud			133,400
Anticipated Grant Awards			166,300
Total Federal Grants	**$71,336,000**	**$72,771,500**	**$56,537,200**

Three Largest Programs:

(1) The AARP SCSEP is a work-training program authorized under the Older Americans Act of 1965. Eligible program applicants must be at least 55 years of age, physically able to work, and have income at or below the poverty level. This program operates in 102 locations in 33 states and Puerto Rico. For the grant-year ending June 30, 1997, the program served over 13,000 individuals and had an unsubsidized placement rate of 39%.

(2) The AARP SEE Program placed retired, or unemployed individuals, 55 or older, in technical assistance roles with the EPA. For the last grant year, participants were enrolled in 33 locations throughout the United States. Multi-year cooperative agreements were projected originally for 12 months in 1997, until a decision was agreed to with EPA for the AARP Foundation to phase out the program on 9/12/97. The program was transitioned to the National Older Worker Career Center (NOWCC) effective 9/13/97.

(3) The AARP Tax-Aide Program provides free tax counseling for low and middle-income individuals, 60 and over, through a network of more than 10,000 sites and 30,000 volunteers. In 1997, this program helped over 1.5 million taxpayers.

than 150 corporate clients, more than 550 expert reviewers, and have reviewed almost 7,000 paid and volunteer cases. About 10% of our case reviews have been free reviews for individual patients. Less than one half of a percent of cases proceed to litigation.

Our remarkable success rests on the following four pillars:

• Our vigilance in protecting our independence, which permits us to focus on patients' medical needs

• Our credibility, which permits us to attract the very best clinicians as reviewers

• Our dedication to detail, which produces high quality, timely reviews

• Our quality assurance mechanisms, which allow us to ensure clients receive objective reviews of cases' medical facts.

Clients use our services for three principal reasons:

• The high quality of our reviews

• The timeliness of our reviews

• Reviewers' willingness to stand behind their reviews in the rare court challenge.

Our Medical Care Ombudsman Program has resulted in:

• Patients receiving beneficial treatments that they might not otherwise have received

• Reduction in the number of patients receiving treatments that were unlikely to have benefitted them

• Increase in the number of patients made aware of clinical trial options available to them.

ORIGINS OF CORPORATION AND PROGRAM

Medical Care Management Corporation was established by Peter Goldschmidt and Grace Ann Monaco in 1992 to provide health insurers, managed care organizations, employers, and others with solutions for managing issues of patient access to high technology, high risk, high cost medical care cases. Increasingly, clients were facing costly court challenges regarding policy exclusions for experimental and investigational treatments and other complex and contentious cases. The cornerstone of Medical Care Management Corporation is our Medical Care Ombudsman Program.

Medical Care Management Corporation provides a process to enhance patients' early access to appropriate treatments and clinical trials. This Medical Care Ombudsman Program provides payors and patients with an independent, objective review of proposed treatments. This remarkably successful program is based on the volunteer ombudsman program that Grace Ann Monaco developed in 1970 for pediatric cancers and which has been used by the Candlelighters Childhood Cancer Foundation and most recently by the Childrens Brain Tumor Foundation of Woodbridge Virginia.

NEED FOR AN INDEPENDENT EXTERNAL REVIEW PROCESS

An independent external case review process is necessary for may reasons, including the following:

• Medical technology assessments are inadequate and incomplete, and can never address the question of whether a treatment is appropriate for the individual patient for whom it has been recommended

• Internal health plan coverage decision—especially appeal—processes can never be free from the appearance of conflict of interest

• A credible, objective review process must exist to inform the health plan and the patient whether or not a recommended treatment is in the patient's best interest; simply paying for everything would waste resources and threaten patients' health.

Medical technology assessments attempt to determine if a specific treatment is effective, that is, improves patients' health status more than doing nothing or more than an alternative standard therapy. Technology assessors face formidable problems. The published literature may not include all studies (because some studies have been accepted for publication but have not been published, which is often the case in an active field). Studies may not involve the same treatment, especially because new treatments evolve rapidly as practitioners gain experience in their use, limiting assessors' ability to compare or aggregate findings from different studies. Many studies are scientifically inadequate. There may be no completed studies, especially for new and emerging technologies. The technology assessment process, including its findings are subject to challenge. Moreover, no matter how adequate a health plan's process for assessing medical technology, if qualified providers believe that a treatment is effective for some types of patients, someone has to determine whether or not the treatment is appropriate for the patient for whom it has been proposed, that is, whether or not the patient is of the type for whom the treatment

is known to be effective, and the patient does not exhibit characteristics that would make an otherwise effective treatment inadvisable. Thus, for all practical purposes, payors must rely on a case-by-case assessment to determine, for example, whether or not a treatment is experimental or investigational for the particular patient for whom it has been proposed.

If health plans set up an internal process to assess cases, it is always subject to charges of potential bias, especially when the cost of the treatment is high. The problem is compounded when a payor must review a patient's appeal of its original determination not to cover a proposed treatment. Presently, in these circumstances, if a patient is dissatisfied with a payor's decision, he or she has no option but to sue in court. At this stage the patient and/or provider (who may steer the patient to a lawyer) is heavily invested in the proposed treatment—whether or not it is appropriate—making it difficult, if not impossible, to reason with the patient and/or provider. Further, court challenges of payors' decisions are costly to patients, providers, and payors.

Simply paying for any proposed treatment may not be a wise decision. Payors have a fiduciary responsibility to manage purchasers' premiums wisely. Otherwise they increase group plan health care costs to the point that purchasers insist on containing them by cutting back or eliminating services. Some emerging technologies may not be effective and some may harm patients. Further, a treatment that is effective for some patients may harm others because of their specific circumstances. An objective, external review process that provides expert reviews of proposed treatments offers the best way to determine whether or not a treatment is appropriate for the patient, including the question of whether or not the treatment is experimental or investigational for that particular patient.

REQUIREMENTS OF SUCCESSFUL EXTERNAL REVIEW PROGRAMS

Requirements of a successful external review process include the following. The external review organization:

- Must be independent and unbiased, that is, not subject to political influence or manipulation, and must be able to adapt to clients' and patient's changing needs and circumstances for objective, credible information about recommended treatments
- Must select reviewers
- Must determine the form of the review
- Must use only qualified reviewers who are matched to the treatment proposed in the case under review
- Must credential reviewers
- Must have in place a meaningful quality assurance and quality improvement process
- Must determine and make payments to reviewers to compensate these experts fairly for the time they spend reviewing cases
- Must publish information on credentialing, review, and quality assurance and improvement processes and procedures so that payors, providers, and patients can understand how the program operates.

The key to a successful external review program lies in the quality of its reviews, which in turn, depends on reviewers' integrity and the quality of their reviews. To ensure objectivity, the external review organization—and not the payor or patient—must select both the reviewers and the form of the review, to avoid the appearance of trying to select or to steer the reviewer toward a certain determination. Further, the external review organization must use only qualified reviewers, must exclude those who have a real or apparent conflict of interest, and must assign available, qualified, conflict-free reviewers without prejudice (which can be achieved, for example, by random or rotational assignment). A qualified reviewer is one who meets certain credentialing criteria (for example, relevant specialty board certification) and who provides scientifically-supportable reviews in a timely manner. To assure the quality of reviews, the external review organization must publish a detailed description of its structured quality assurance program, including, for example, its criteria and process for credentialing reviewers, assessing reviews' quality, educating reviewers to improve the quality of their reviews, and improving the quality assurance program. To ensure that qualified experts will devote the time needed to conduct careful and thorough reviews of cases, the external review organization must be permitted to pay reviewers a reasonable fee for the time that they devote to this important effort.

MEDICAL CARE OMBUDSMAN PROGRAM

Medical Care Ombudsman Program provides independent, objective expert reviews of cases' medical facts. The program's credibility and acceptance stems from our dedication to ensuring that clients—payors and patients—receive straightforward answers to questions about a treatment's status or appropriateness for the individual patient for whom it has been proposed, including, where applicable, the scientific adequacy of a clinical trial and/or whether or not the particular patient meets study criteria.

Since its inception, our Medical Care Ombudsman Program has reviewed more than 6,000 cases for our more than 150 corporate and other clients. We have more than 550 active reviewers most of whom are academically-affiliated. They are located throughout the country. The program offers the same services that we offer to our clients at no charge to patients, for as many volunteer assessments as our reviewers have agreed to provide. About 85 percent of our reviewers participate in the volunteer review program.

To our knowledge, less than one-half of one percent of cases reviewed have proceeded to litigation. None in which the client followed our recommended procedures resulted in a jury judgment against the client. The program has resulted in patients receiving beneficial treatments that they might not otherwise have received, a reduction in the number of patients receiving treatments that were unlikely to have benefitted them, and an increase in the number of patients made aware of clinical trial options available to them.

REVIEW SERVICES

Medical Care Ombudsman Program provides reviews in 7 to 10 business days after reviewers receive complete review materials. When clients have an urgent need, we provide rush reviews within three business days, and express reviews within 48 hours (with an oral review in 24 hours), subject to reviewers' availability. There is no fee for joining the program. Clients pay a fixed fee for each review; there is no annual or other minimum payment. We offer discounts to users who order more than 100 reviews per year.

PROGRAM CLIENTS

Our clients include large and small insurance companies, health maintenance organizations, preferred provider organizations, independent practice associations, self-insured employers, third-party administrators, utilization review companies, lawyers, doctors, and patients.

REASONS CLIENTS REQUEST REVIEWS

Clients request reviews for many reasons, including the following:

- To obtain independent expert reviews of a recommended treatment plan
- To facilitate the identification and coverage of medically appropriate care
- To diffuse conflicts of interest that patients and courts may perceive exist with in-house reviewers
- To use a process that appears to deter litigation, and provides expert witnesses if litigation ensues.
- To validate an in-house reviewer's analysis.
- To secure expert analysis when in-house reviewers are not sufficiently knowledgeable about the recommended treatment plan.
- To provide a 'second opinion option' to employees and insureds.
- To meet regulatory requirements for external review of appeals.

Our expert reviews inform payors and patients about treatment choices. They permit clients to channel scarce resources into treatments that are most likely to benefit patients, to minimize litigation resulting from coverage disputes, and to provide an appropriate way to resist pressures from some providers to pay for inappropriate levels of care that are unlikely to benefit patients. Our experience suggests that we save payors $20 to $25 for each review dollar. Further, our expert reviews can also protect patients' health.

TYPES OF REVIEW CASES

Medical Care Ombudsman Program usually reviews cases that involve use of high technology, high risk, high cost medical procedures. Our review cases are usually complicated and involve cutting-edge medical care; some are unique. Cases involve treatments for every type of cancer, for example, high dose chemotherapy with allogenic, autologous, stem cell or unrelated donor rescue, and proton beam radio-

therapy. The program also reviews other types of cases—including, for example, cardiac cases, fertility problems, immune system diseases, pediatric and adult procedures involving solid organ transplants (eg, heart, heart-lung, kidney, liver, and pancreas), plasmapheresis, apheresis, gene therapy, novel uses of drugs, biologicals, and vaccines, and other high technology interventions that pose high risks to patients and incur high costs to payors. We also review cases in all domains of medicine for which the plan has denied coverage and the patient has appealed the denial, as well as controversial approaches, sometime referred to as 'alternative medicine.'

REVIEWS

Reviewers focus exclusively on cases' medical aspects, address clients' questions, and describe the basis for their views, including, where appropriate, citations to the relevant medical literature. We recommend that clients always use a panel of three experts to obtain an idea of the extent of consensus among experts regarding the answers to their questions regarding the appropriateness of a recommended treatment plan. We provide reviewers with structured guidance to assist them to produce a usable review, that is, one that address clients' questions, is clear and unambiguous, and provides rationale for decisions and cites evidence in their support. Our experts draw on their extensive clinical experience, the medical literature, and their intimate knowledge of their fields of expertise. After reading reviewers' analysis, clients can talk directly to reviewers to obtain additional information. We monitor reviews for focus on the questions asked, coherence, substantiation, and timeliness. We invite clients' feedback on the quality of reviews.

REVIEWERS

We have more than 550 credentialed reviewers. They encompass all domains of medicine; many are pediatric and medical oncologists. Our reviewers are located throughout the country. Most reviewers are in charge of academic departments or affiliated with academic institutions and practice in the nation's leading medical centers.

About three-fourths of our reviewers have agreed to participate in litigation on their pretreatment reviews. All three-member review panels include at least one member who has agreed to participate in litigation. About one-quarter will consider participating in litigation on cases that did not go through the Medical Care Ombudsman Program process prior to entering litigation if they agree that a client's decision was medically appropriate.

REVIEWER RECRUITMENT AND CREDENTIALING

Current reviewers recommended most of the reviewers that we add to our panels. Most are in academic medicine. Occasionally, experts request that we consider using them as reviewers. Reviewers complete a credentialing document in which they describe their qualifications, licenses and privileges, the diseases and procedures that they consider themselves to be qualified to review and the reasons that they consider themselves qualified to review cases in these areas, and their availability to review cases.

Generally, Medical Care Ombudsman Program reviewers are physicians. All of our physician-reviewers are board-certified and they are in active medical practice with admitting privileges at JCAHO accredited hospitals. Occasionally, it is appropriate to use non-physician scientists or other experts as reviewers, when, for example, a client's questions involve such matters as a therapeutic agent's chemical properties or the views of an expert in pathology, language, education, or psychology.

MATCHING CASES TO REVIEWERS

Reviewers are experts in the types of cases that we ask them to review. Clients have no control over the assignment of reviewers to their cases. To preserve the program's objectivity, we match a case's circumstances to reviewers' qualifications, and rotate review assignments among available qualified experts. We never send a case to a reviewer affiliated with the recommending physician's institution or the institution where the recommended procedure will be conducted. Further, we ask our reviewers to identify any real or apparent conflicts of interest. Where the reviewer identifies such conflict, we reassign the case to another qualified reviewer.

ASSURING AND IMPROVING THE QUALITY OF REVIEWS

Our primary goal is to provide clients with objective, high quality expert reviews of cases' medical facts. We follow the principle of continuous quality improvement [1] to provide clients with expert reviews of the highest possible quality. In providing reviews, reviewers use their extensive knowledge and best professional judgement and, as needed, support their opinions with citations to the relevant medical literature. Clients can ask reviewers to amplify points expressed in their reviews. In addition, we act promptly to ask a reviewer to clarify his or her review on those few occasions when a client complains about an ambiguity in the review that they have received. We continue to use only reviewers who provide coherent, well-substantiated, timely reviews. Based on reviewer and client feedback and our analyses of completed reviews, we refine the guidance we offer to clients (about the questions that they ask reviewers to address) and to reviewers (about how to respond to clients' questions). We also survey our clients each year to ascertain how we can better meet their needs for credible, objective information about cases' medical facts. The results of our 1996 survey showed conclusively that clients use our services for three principal reasons: the quality of our reviews, their timeliness, and reviewers' willingness to stand behind their reviews in the rare court challenge. Subsequent surveys have confirmed these findings.

REVIEW RESULTS

The percentage of recommended treatment plans that reviewers find to be medically appropriate depends on the type of case:

- For intensive chemotherapy our expert reviewers agree with providers' recommended treatment plans in about 40 to 60 percent of cases.
- When clients use our expert reviewers to validate their in-house reviewers' analysis, our reviewers confirm the in-house reviewers' assessment in 60 percent of these cases. This result illustrates the potential risk of deciding claims based solely on in-house reviews.
- In about 50% of the treatment plans that the provider has labeled a clinical trial, the patient proposed for the trial either does not meet its eligibility criteria or the so-called clinical trial is not scientifically adequate. In an increasing number of cases, the patient offered an inappropriate care option or enrollment in a scientifically inadequate clinical trial—which would not be covered by the health plan—would be eligible for a clinical trial that the health plan would cover—for example, NCI-sponsored or Clinical Cooperative Group trials—but the patient does not appear to have been referred to such a trial.

RESULTS OF SPECIAL STUDIES

At clients' request, we undertake special studies that may shed light on the agreement between reviewers on panels or other relevant matters. Because of the cost of such studies, we cannot afford to undertake them routinely, because to do so would incur additional costs that we would have to pass on to clients generally. Recently, we were able to analyze information pertaining to certain reviews. We provided this information in our biennial newsletter to reviewers. This analysis showed that with respect to a series of multiple myeloma cases (recommended for high dose chemotherapy with stem cell rescue) for which we had assembled 2-expert panels, that the experts were of the same mind in 80% of the cases.

Recently, the Journal of the American Medical Association published a letter that we wrote that contained the results of our analysis of certain review results [2]. Between October 1996 and April 1997, our review panels analyzed the medical records that client's provided to them for 55 breast cancer cases in which the recommended treatment was high dose chemotherapy with some type of stem cell rescue or transplant. The client had requested a 3-reviewer panel for 16 cases, a 2-reviewer panel for 17 cases, and a single reviewer for 22 cases. Aggregate results of these independent reviews showed that for half of the cases (47%), the panel found that there was insufficient information in the medical record (unanimously in 63% of cases involving a 3-reviewer panel) to answer the question: Is the treatment experimental or investigational for this patient as defined in the contract language?. When they could tell, the panel judged just under half (45%) of the recommended treatments to be experimental or investigational for the particular patient. For this same set of patients, the panel found that the recommended treatment was medically appropriate for the particular patient in under half (43%) of the cases.

OBSTACLES TO UNBIASED, COST-EFFECTIVE EXTERNAL REVIEW

Ideally, health plans would be encouraged to have in place a coverage decision mechanism that:

• Permits patients to seek external review (and thus obtain a second opinion), without feeling that they are challenging either the provider or the plan

• Results in patients receiving the care that they need—including, when appropriate, participation in scientifically adequate clinical trials or other worthwhile scientific research—while protecting patients from inadvisable care and protecting the health plan from wasting resources

• Is credible and acceptable to purchasers, patients, and providers.

Such mechanisms will almost certainly have to include external expert review of complex and contentious cases. Inevitably, no matter how well-designed coverage decision mechanisms may be, in some number of cases coverage disputes will arise. In these cases, the purpose of mandated external review is to ensure that the patient receives the best possible advice regarding the advisability of the recommended treatment and the health plan is not forced to pay for care that is unlikely to benefit the patient nor for care that is inferior because an alternative exists that would likely provide the patient with more health benefit or is otherwise more in the patient's interest. It is not sufficient to mandate an external review process. It is also necessary to ensure that the process produces the right outcome for the patient: the highest possible quality review, one that is a careful, considered, well-supported expert opinion about the advisability of the treatment for which the patient has been recommended.

Some of the requirements imposed on the conduct of external expert review by legislation and/or regulations may have the effect of biasing the process against patients' interests, because, for example, they will prevent reviewers from commenting unfavorably on treatments that may be inappropriate, less favorable than alternatives, or, if not dangerous, harbor risks out of all proportion to expected benefits. Among the most troubling state mandates or legislative or regulatory requirements (referred to here as mandates) are the following:

• Mandates that all external reviewers must be medical practitioners licensed in the state (in which the patient is to be treated). This requirement has no scientific basis. It treats medicine as a provincial concern without regard to scientific standards of medical practice. States with only one academic medical center, which would normally provide high technology treatments, would be precluding their citizens from obtaining the highest quality external review because potential reviewers drawn from this academic medical center would have a conflict of interest. Even in our most populous states, such requirements may impose implied, if not explicit, pressures to be less than candid when reviewing proposed treatments. Moreover, as we have learned, practitioners at academic medical centers do not always propose treatments that are in patients' best interests. To protect patients' interests, external review organizations should be free to select the most qualified experts to conduct a case review, without regard to their licensure in a specific state.

• Mandates that require the external review organization to provide lists of reviewers to the state or to reveal the identity of case reviewers to the patient or to the provider. Reviewers may be subject to intimidation or harassment. The net result is likely to be a diminished pool of qualified experts who are willing to conduct reviews, and, less rigorous reviews because willing experts are likely to be less critical and might pull their punches when commenting on inappropriate therapy for fear of retaliation. We provide our clients with a short blinded biographical sketch of each reviewer as a matter of course and encourage them to share not only this sketch but also the reviews with the patient and his or her provider (with the reviewer's identity redacted). When requested by the client, we also provide the patient with a specially written summary of the review. To protect patients' interests, there should be no requirement to provide lists of reviewers. With respect to case reviewers' identity, external review organizations should be required only to provide patients and providers with reviewers' qualifications, for example, board-certifications, specializations, and a description of the reviewer's experience in medicine and research; it is not essential to reveal the reviewer's name nor that of his or her current institution, except in the rare instance that a case proceeds to litigation.

• Mandates that impose additional credentialing and administrative costs. For example, there may be needlessly duplicative credentialing requirements that certainly add to costs but that are unlikely to produce commensurate benefits. When external review organizations must bear these costs, it is almost inevitable that they have to include them in the fees that they charge to their clients. What may have started out as a reasonably-priced review, may become an expensive service, or, to keep prices down, external review organizations may be forced to cut corners and

thereby reduce the quality of the resultant reviews. To protect patient's interests, credentialing and administrative mandates for external review should only address recognized deficiencies in the way that external review organizations provide reviews or in the quality of their reviews, lest they raise needlessly the cost of these reviews, which will once again rachet up the cost of health care out of all proportion to resultant benefits.

• Mandates that require the state to contract directly with external review organizations. The state's requirements may make it difficult, if not impossible, for us to provide the high quality reviews that have become the hallmark of our service. The state has to decide to which external review organization to assign a particular case, and this assignment may not be based on the quality of the organization's reviews. The permitted payment may be so low that high caliber reviewers will choose not to participate, or, if they do participate, to spend less time and effort on their reviews. The net result will be to penalize conscientious reviewers, and to encourage an inferior product that will not meet the needs of the patients that the mandate was meant to serve. To protect patients' interests, states should encourage plans to adopt appropriate coverage decision mechanisms that include external review. There should be no need for the state to arrange these reviews. Instead, the state should focus on oversight functions, including, for example, the development of mechanisms to accept and investigate consumers' complaints about their health plans' handling of appeals and other coverage decisions, including provisions for appropriate sanctions against health plans that deny patients meaningful access to high quality, independent, objective, external expert reviews.

REFERENCES

1. Wilson LL, Goldschmidt PG. Quality Management in Health Care. New York: McGraw-Hill, 1995.

2. Goldschmidt PG, Monaco GP. Investigational treatments: process, payment, priorities (letter). JAMA 1997; 278(17): 1402–1403.

FOOTNOTES

1. There are no universally accepted definitions of the terms experimental and investigational. We use the following definitions. Experimental treatment—one that is neither known scientifically nor accepted generally by qualified medical practitioners to be effective for the type of patient for whom it is being proposed. The treatment may be known or accepted to be effective for other types of patients (but not the type for whom it is being proposed). Experimental is a property of a treatment or procedure. Investigational treatment—one that is the subject of an investigation. An investigational treatment may an effective treatment or it may be an experimental treatment. For example, in a clinical trial, investigators may be comparing two treatments generally accepted by qualified medical practitioners to be effective for the type of patient enrolled in the study, to determine scientifically which one is the most effective. While the investigators are engaged in research and the treatments are investigational, neither treatment should be regarded as experimental because if a physician were to propose the treatment for the type of patient enrolled in the trial, qualified medical practitioners would generally consider it to be appropriate.

2. An effective treatment is one known scientifically or assumed generally by qualified medical practitioners to improve patients' health status (outcome). Effectiveness—the quality of being effective—is a statistical concept. An effective treatment improves the health status of a specified patient population beyond that of doing nothing or that is obtainable with supportive care (the placebo effect), even if some patients' health status is unchanged or worsened by the treatment. The manifest variation in the extent of individuals' health status improvement describes the intervention's risk. Measuring a treatment's effectiveness in terms of health status improvement subsumes the notion of safety (absence of unwanted effects that adversely affect health status). It automatically captures gains (in health status) and losses (injury or harm to patients' health) to yield net improvement (or deterioration). Safety is a judgement about the acceptability of risk, especially early in an intervention's course if it spans an extended period. The term effectiveness is preferable to the term efficacy.

3. Williamson JW, Goldschmidt PG, Colton. T. The quality of medical literature: An analysis of validation assessments. In: Bailor JC, Mosteller F (eds). Medical uses of statistics. Boston: NEJM Books, 1986. This study assessed the quality of articles that assessed the quality of research reports published in the medical literature. According to valid assessments of the quality of the medical literature (involving more than 4,200 articles published in such journals at New England Journal of Medicine

and JAMA), only a small fraction of published research reports are scientifically adequate. Most concerningly, 80 percent of inadequately-designed studies but 25 percent of adequately-designed studies reported a positive finding, for example, that the intervention studied was effective.

4. The term 'status' refers to where along a spectrum from interesting idea to proven effective therapy a treatment proposed for an individual patient sits according to qualified providers. Most often clients are interested in knowing whether or not the treatment is experimental.

5. An appropriate treatment is one that is suitable for the particular patient because he or she fits the profile of patients for whom the intervention is known scientifically or assumed among qualified medical practitioners to be effective, and for whom there are no contra-indications to the intervention or other factors that make it inadvisable, for example, the existence of an alternative treatment that has lower risk and equal benefit. If a patient's physiology is such that he or she is unlikely to survive a recommended treatment, for example, it would not be appropriate for this particular patient, even if the treatment is effective generally for the type of patient involved.

6. Scientific adequacy is a broad terms that covers for example, the scientific importance of the question the study is designed to answer, the adequacy of the study design, and data collection and analysis methods, in terms of likelihood of producing an unequivocal answer to the study question, and protection of human subjects and informed consent issues. In some instances a clinical trial may be scientifically adequate, but the patient whom the provider proposes to enter into the trial does not meet study criteria. In this case, the patient will not contribute to answering the study question.

7. Joint Commission on the Accreditation of Healthcare Organizations. An independent, not-for-profit organization (founded in 1951) that develops organization standards and other performance measures, awards accreditation decisions, and provides education and consultation to hospitals and other health care facilities. [The official Committee record contains additional material here.]

Statement of Vicki Gottlich, Staff Attorney, National Senior Citizens Law Center

INTRODUCTION

I am Vicki Gottlich, an attorney with the National Senior Citizens Law Center (NSCLC). NSCLC thanks you for the invitation to testify today before the Subcommittee on Health of the Ways and Means Committee. We appreciate the Subcommittee's interest in patient appeals in health care, an issue of concern to all consumers.

The National Senior Citizens Law Center is a non-profit organization that provides litigation, education and technical support on issues affecting low-income older people and people with disabilities. For over twenty-five years we have assisted clients and their advocates with problems arising under Medicare, Medicaid and ERISA, and so are very familiar with the grievance and appeals systems for both public health care programs and employer-sponsored plans. Our recent work includes the filing of extensive comments with the Department of Labor in response to their requests for information about the ERISA appeals process and about notices under the COBRA health care continuation provisions. We currently are co-counsel in a case in Arizona concerning the Medicaid managed care appeals process, and in a nation-wide class action challenging the appeals process for disputes involving Medicare home health benefits. NSCLC is not counsel of record in Grijalva v. Shalala, the case challenging the Medicare managed care appeals process, however, we joined in amicus briefs in support of plaintiffs that were filed in the District Court for the District of Arizona and in the Ninth Circuit. We also met with HCFA staff during the development of its Medicare managed care appeals regulations and submitted comments on those regulations, and we have met with HCFA staff concerning the regulations to implement the Medicare+Choice appeals process.

Based on our experience with appeals of health care decisions under various systems, we believe the Medicare system provides, overall, the best protection for beneficiaries. The Medicare system establishes national, uniform standards that apply to all Medicare managed care plans throughout the country. The federal Medicaid statute provides many similar protections, though variations in state Medicaid laws result in a lack of uniformity that hurts some beneficiaries. Unlike Medicare, Med-

icaid makes no provision for expedited consideration, though the federal scheme provides for continuation of care pending external review.

We have great concern for individuals covered under ERISA plans. The long time frames given to plans to make decisions, the lack of impartial decision-makers, and the lack of an independent external review render many ERISA plan claims procedures useless for plan participants seeking medically necessary care. We have yet to encounter an ERISA plan that contains the protections available under Medicare and Medicaid. Those that come closest are generally collectively bargained plans, where the bargaining unit fought for and won additional consumer protections for its members. Although many states have enacted managed care legislation, state laws regulating insurance do not apply to self-insured plans, under which a growing number of plan participants are covered. Further, the complexities of ERISA preemption call into question whether state law provisions establishing grievance and appeals procedures apply even to fully-insured employer-sponsored plans. And many state laws do not contain all of the key elements of an adequate appeals process meeting the standards set by the Medicare and Medicaid programs.

We support federal legislation that establishes an appropriate appeals procedure, including the opportunity for external review, for all consumers. Such legislation would establish a floor of protection that does not currently exist. As Families USA pointed out in its July 1996 report, HMO Consumers At Risk: States to the Rescue, "...large numbers of managed care enrollees are not protected by state legislation. Moreover, the patchwork quilt of managed care legislation across states makes it difficult for multi-state managed care companies to standardize their data systems and operations." (At p. 41).

In developing a patient appeal system that would benefit all consumers, we recommend the following key components:

KEY COMPONENTS OF A MANAGED CARE APPEALS PROCESS BASED ON MEDICARE AND MEDICAID APPEALS PROCESSES

Broad definition of appealable issues: Under the Medicare statute and regulations, an appeal may be taken from any dispute involving a denial of services or payment for services made by the HMO, even if the request is denied only in part. This broad definition allows beneficiaries to appeal as wide range of issues, and not just those involving medical necessity determinations. Thus, an appeal may be taken from a denial of payment for emergency or urgently needed care, from a dispute whether the service is a Medicare covered service, or from a dispute whether the beneficiary meets the eligibility criteria to receive the service (ex., meets the definition of "homebound" to receive home health services.)

The Medicare managed care regulations issued last April clarified that an appeal can be taken when a service is discontinued, such as a skilled nursing facility discharge. Although appeals from reductions of service are being adjudicated through the Medicare managed care appeals process, the Medicaid regulations are much clearer that an appeal may ensue when a service is denied, delayed, reduced or terminated, and should be the model for Medicare and for private plans.[1] *Internal plan review conducted by a medical expert.* The Balanced Budget Act (BBA) adds an important protection to the Medicare internal plan review process. When reviewing determinations that base the denial of coverage on a lack of medical necessity, Medicare+Choice plans must use only a physician with appropriate expertise to make a determination of the necessity of the treatment. In addition, the physician must not have been involved in the initial determination.

Independent external review: Independent external review of the plan determination is a fundamental component of the Medicare system, and should be incorporated into all appeals processes. In the managed care context, with its financial incentives to limit care, external review provides an impartiality that may not always be present in the internal review process. The external review considers whether the service is medically necessary, falls within coverage guidelines, and/or is one for which the beneficiary is eligible, without consideration of the financial impact on the plan of providing the service. Thus, external review keeps plans "honest," and prevents them from using service denials to persuade those with the greatest health care costs to disenroll.

At the HCFA reconsideration level, the Center for Health Dispute Resolution (CHDR) uses registered nurses and accredited medical technicians to perform reviews of the record submitted to CHDR by the HMO. At the hearing stage, the ALJ reviews the evidence and decides whether the determination is in accordance with the Medicare statute, regulations, and case law. Beneficiaries have the opportunity

[1] See 42 C.F.R. 431.200, 431.201, 431.206(c)(2).

to review the record, submit evidence and have a face-to-face meeting with the decision-maker. Taken together, these external review procedures ensure that plans cover Medicare-covered services and comply with Medicare law, and create an incentive for plans to learn and apply Medicare coverage rules.

Medicaid also provides for independent, external review of managed care plan decisions. Reviews are conducted before an impartial hearing officer. As with the Medicare ALJ hearing, the Medicaid fair hearing allows the individual to review the case file and records, present and cross-examine witnesses, be represented by a legal representative, and obtain a written decision. An unfavorable decision may be appealed to state court.

Expedited review: An expedited determination and/or expedited plan review is available under Medicare when the standard, 60-day time frame "could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function." The beneficiary or the beneficiary's doctor may request expedited consideration, which must be granted if the request comes from the doctor. The request may be made orally. The health plan must receive the request for an expedited determination or reconsideration, decide whether the determination will be made through the expedited or regular appeals process, conduct the review, and issue its determination within 72 hours. Health plans can be permitted up to 10 additional days in certain circumstances. If a health plan upholds its original decision in whole or in part, it must forward the case to CHDR within twenty-four hours. CHDR will then conduct an expedited reconsideraton, though current Medicare regulations do not impose any obligations upon CHDR to do so, or establish any time frames within which the expedited HCFA reconsideration must be completed.

KEY COMPONENTS OF PATIENTS' APPEALS BASED ON THE GRIJALVA ORDER

As detailed in the chart we have attached to this testimony, the BBA appeals provisions and the Medicare expedited appeals regulations differ in several respects from Judge Marquez's order in Grijalva v. Shalala, CV 93–711 (TUC ACM (D.Az, March 3, 1997). For one, the Grijalva court shortened the time frame for making the initial organizational determination from 60 to five days. While our conversations with HCFA lead us to believe that HCFA may shorten this time period in the BBA implementing regulations, we do not expect that HCFA will adopt the Grijalva standard.

Another difference involves the criteria for expedited review. Judge Marquez ordered that expedited review occur when services are urgently needed, and he gave examples of situations in which the availability of expedited review is presumed, i.e., "certain types of nursing facility care, certain types of home health and therapy services, and denials of certain types of non-cosmetic surgery." This standard, setting forth concrete examples of when expedited review is needed, is more easily understandable and enforceable by beneficiaries. Judge Marquez also held that a doctor's statement is not required to trigger expedited review, and lay evidence may be used to show urgency. However, the regulations allow only the doctor and/or the plan to decide whether expedited review is required, thus establishing a barrier that, for many beneficiaries, is making the availability of expedited review meaningless.

In terms of defining the key components of a managed care appeals system, the most important differences between Grijalva and the HCFA approach involve notice and the continuation of care pending reconsideration. Adequate notice and continuation of care are the fifth and sixth elements that should be available in all health care appeals systems.

Adequate notice: Adequate notice that complies with all constitutional and statutory requirements makes any appeal system work better. Yet the Medicare regulatory notice provisions do not address some of the problems most commonly experienced by beneficiaries both before the filing of the Grijalva suit and after the implementation of the Medicare regulations last August. Although the preamble to the Medicare regulations explains that beneficiaries initially requesting an organization determination can request an expedited decision, there is no provision for giving such persons advance notice of this right. Without such knowledge, beneficiaries fall within the regular process, which currently allows plans up to 60 days to make a decision. When beneficiaries finally receive notice of the organizational determination, the lack of specificity and detail in the notices causes confusion and misunderstanding. The notices use general and generic terms that do not inform the beneficiary of the factual basis for the denial, explain what specific service is not covered and why, or in any way indicate to the beneficiary the additional information needed to approve the request for services.

Continuation of care: Judge Marquez ordered that the Medicare appeals process require services to be continued until a final expedited reconsideration decision has been rendered. The continuation of care, or, as it is known in many states, "aid paid pending," has been a crucial component of the Medicaid program for years.[2] In many situations, it is the only way to ensure that the beneficiary receive needed care. Unlike in fee-for-service cases, where the issue is payment for services already received, the issue being appealed in the managed care context is the ability to receive needed medical care. The hiatus in care caused by the inappropriate termination of certain services—such as rehabilitative therapies, home health care, a skilled nursing facility stay—often cannot be remedied by a subsequent successful appeal. For example, a patient whose home health services were terminated prematurely may already have been transferred to a nursing home, and so may no longer benefit from the services that were denied.

OMBUDSMAN PROGRAM AS A KEY COMPONENT

An issue not addressed in either the Grijalva decision, the Medicare managed care regulations, or in Medicaid is the need for an independent health care ombudsman to work with beneficiaries through the appeals process and with all of their dealings with their health plan. Ombudsman programs have proven effective in assisting beneficiaries with their disputes with plans, clarifying questions about plans, and clarifying general questions about health care coverage. One of the most successful models is the Sacramento, California, Ombudsprogram operated by Peter Lee of the Center for Health Care Rights.[3]

Medicare beneficiaries have more of an opportunity to get help than other health care consumers. The Omnibus Budget Reconciliation Act of 1990 established limited funding for an Information, Counseling and Assistance (ICA) program in every state. ICA programs aid Medicare beneficiaries in understanding Medicare and their Medigap and other private insurance options, and help beneficiaries who experience problems with their plans. While not called an ombudsprogram, the ICAs perform many of the same functions. The biggest challenge faced by these programs is the lack of resources to perform the beneficiary education and assistance required. Implementation of the Medicare+Choice program, and the anticipated questions that will arise from beneficiaries about the choices available to them, will tax the limited resources of these programs considerably, so that they may not be available to help negotiate a plan's grievance and appeals system.

EXPERIENCE WITH THE MEDICARE MANAGED CARE APPEALS PROCESS

In presenting our testimony to support a strong patient appeals process, we wanted to share with the Subcommittee some of the experiences beneficiaries have had with the Medicare system. NSCLC asked several of the Medicare advocates around the country with whom we work on a regular basis to provide examples of both the effectiveness of the system and its glitches. Several of the examples in this testimony come from an early draft of a report by the Medicare Rights Center (MRC), that documents the first six months of calls to its expedited appeals hotline.[4]

THE MEDICARE APPEALS SCHEME WORKS. FOR EXAMPLE:

• MRC was asked by HCFA to include its telephone number on model denial letters HCFA developed and distributed to managed care plans. Many of the people who called the MRC hot line learned about the organization from the notice. This experience substantiates the importance of providing complete information on notices to beneficiaries, and the usefulness of have an ICA or ombudsprogram available to respond to inquiries.

• A woman in California recovering from a car accident was receiving physical therapy and occupational therapy in the rehabilitation unit of a hospital. Although these services clearly constitute skilled care under Medicare law, and although the services were still medically necessary, the medical group sent notice of discontinuation of coverage. The woman's family contacted a Medicare advocate who asked for an expedited appeal. Within 72 hours, the HMO reversed the medical group's decision, and care was continued.

---

[2] 42 C.F.R. 431.230.

[3] Peter Lee and Carol Scott, Managed Care Ombudsprograms: New Approaches to Assist Consumers Improve the Health Care System (Center for Health Care Rights, Los Angeles, CA 1996).

[4] HCFA's Medicare expedited appeal regulations went into effect on August 28, 1997.

The system worked successfully in the California case for a number of reasons. The medical group sent official notice. The family was knowledgeable enough to seek help from an advocate familiar with Medicare coverage rules, and the advocate requested an expedited appeal. The particular HMO in question is equipped to investigate complaints regarding inadequate care, and has designated specific people to handle expedited appeals. But, as the advocate involved pointed out, the case could have come out differently. The beneficiary is unable to seek help on her own; without family to intervene, she never would have pursued an appeal. The plan involved granted the request for expedited appeal, even though the request was not made by a doctor. Advocates from around the country report that many plans automatically deny requests for expedited review when they come from beneficiaries. In this case, as in many, medical support was difficult to obtain. Neither the doctor nor the therapists wanted to go on record supporting the appeal, even though they believed additional therapy was medically necessary. Finally, this HMO is complying with the law, though the advocate who represents the woman reports other HMOs in the area use untrained customer service representatives who give unrepresented beneficiaries inaccurate information about appeals.

PROBLEMS ARISE WHEN PLANS DO NOT COMPLY WITH THE REGULATIONS AND HAVE NOT IMPLEMENTED AN APPEALS PROCESS. FOR EXAMPLE:

• The failure to provide proper notice still remains a problem, despite the Grijalva case. MRC found that, even though HCFA distributed model denial notices to HMOs, several of the letters received by callers to its hotline were so unclear in their description of the appeals rights that the enrollees did not know what those rights were and could not have pursued an appeal based on the information in the notices. MRC also found that one plan in New York sent the same notice of noncoverage, regardless of the nature of the problem, in violation of the requirements that notices contain a specific reason for denial, and that an HMO cannot use the same reason for all denials.

• An enrollee in Michigan who asked to file an appeal was told by two different people in the plan that he had waived his Medicare appeal rights when he enrolled in an HMO, and that no appeal was available to him. The underlying issue involved the inadequacy of the plan network, and the plan's refusal to refer the enrollee to an outside specialist.

• When an Oregon HMO upheld on reconsideration its original decision to deny coverage of durable medical equipment, the enrollee requested an external review of his case. Despite the fact that unfavorable plan reconsiderations must be sent automatically to CHDR, plan representatives told the enrollee he did not have any further appeal rights.

• MRC received numerous calls from beneficiaries whose request for an appeal was lost or not documented in the record. Other callers related situations in which the HMO failed to act on initial organization determinations or reconsideration within the statutory time periods.

One further difficulty involves the completeness of the record being reviewed at both the plan reconsideration level and the HCFA reconsideration level and the ability of the enrollee to get access to the medical records. Medicare managed care regulations require that a HCFA reconsideration include review of, among other things, ".... other evidence submitted by the parties...."[5] Yet, while CHDR gives directions to plans on how to submit additional evidence to support their decision, no process exists by which beneficiaries may review the records before CHDR and submit additional evidence to support their claim or to correct inaccurate or incomplete records.

• When a Florida enrollee got no response to her numerous attempts to obtain doctor-authorized durable medical equipment from her plan, she finally went out-of-plan to get the equipment. The plan denied reimbursement, and CHDR upheld the plan. At the ALJ level, the enrollee discovered that the plan had not included in the record it sent to CHDR the doctor's referral for the equipment or evidence of her numerous contacts with the plan. The plan had refused to release the records to the enrollee and her attorney, even when requested to do so by the ALJ, so the enrollee could not correct the records earlier.

• A Connecticut HMO denied, without written notice, medically necessary care to an enrollee who had just be discharged from the hospital. The doctor wrote to the plan, and the case was sent to CHDR. CHDR initially declined to give the enrollee's attorney access to the medical records submitted by the HMO. When CHDR finally provided the records, the records contained erroneous information about the enrollee's medical condition, and did not include the materials submitted by the treating

[5] 42 C.F.R. 417.622(a).

physician in support of the appeal. The records were corrected, the treating physician's supporting information was submitted, and CHDR ordered that care be provided.

In the last example, effective advocacy by the treating physician and the beneficiary's attorney resulted in an inappropriate decision being overturned upon external reconsideration. One month later, however, the enrollee was again told orally and not in writing that his care was being discontinued. The doctor again wrote a letter to the plan, and the case was referred to CHDR. Although CHDR, after much discussion, corrected the plan's previous violations, in this instance CHDR declined to order that care be reinstated until the HMO followed the federal regulatory requirement to provide written notice. Further, CHDR upheld the denial based on the recommendations of a consulting physician who applied a standard that did not comply with Medicare regulations. CHDR denied enrollee's attorney access to the consulting physician's evaluation of the case.

As plaintiffs in Grijalva have argued since the complaint was first filed in 1993, HCFA must enforce all Medicare laws and regulations, including those pertaining to the appeals process, and hold accountable any HMO that does not follow them. The failure of HCFA to enforce the Medicare managed care appeals regulations does not in any way diminish the fact that those regulations represent good, sound health care policy. The availability of external review to Medicare beneficiaries assures them that an independent entity with the appropriate expertise in Medicare law will review all claims and protect them against decisions made for reasons that do not comply with Medicare rules. All consumers, regardless of the type of health plan, are entitled to the same protection.

Comparison of *Grijalva v. Shalala* and HCFA's New Medicare HMO Regulations		
Issue	***Grijalva v. Shalala***	**HCFA Regulations**
Appealable Issues	**1. Denial of service** **2. Termination of service** **3. Reduction in service**	**1. Denial of service** **2. Termination of service** **3. Reduction in service not addressed. HCFA states that it intends to address issue in later rules and invites comments on notice and appeal rights for reductions.** **4. HCFA also invites comments on notice and appeal rights "when enrollees are participating in case management programs or other innovative treatment modalities for which there are pre-agreements regarding the service to be furnished."**
Notice	**1. Clear, readable form in 12-point type.** **2. Lay explanation of coverage rule upon which decision is based.** **3. Description of regular, expedited appeal processes, and Peer Review Organization (PRO) review process.** **4. Description of additional evidence to support enrollees' position and of how to obtain doctor's letters and medical records.** **5. Procedures for securing an informal hearing.**	**1. Notice of decision to deny expedited review.** **2. Complete, written explanation of regular and expedited appeals processes.** **3. Notice of adverse determination must inform of right to reconsideration, including right to and conditions for the expedited procedure.** **4. Oral adverse determinations or reconsideration requests must be followed by writing.**
Time Frames	**1. Denial notice given promptly, but no more than 5 working days after written or oral request or referral for service.** **2. At least 1 working day *before* reduction/termination of treatment.** **3. Delay in exceptional circumstances of up to 60 days if health plan needs more information and notify enrollee of specific information needed and time frame.** **4. Expedited decision within 3 working days of expedited reconsideration request; either side can get up to 10 day extension to get additional evidence.** **5. Decision of independent HCFA review agency (currently CHDR) within 10 working days of request for review of denial by HMO of expedited reconsideration.**	**1. Notice within 60 days of request of payment or service, unless expedited determination requested.** **2. If health plan decides to expedite determination, decision within 72 hours of the request.** **3. Extension of up to 10 working days at request of enrollee or if health plan needs additional information and delay is in interest of enrollee.** **4. Expedited reconsideration within 72 hours of request with same 10 day extension.** **5. Must submit to HCFA within 24 hours if adverse determination or if 72 hour or extension period expires.** **6. No time period for HCFA review. HCFA states it will "hold" its contractor to a 10-day period.**

Establishing the Need for Expedited Review	1. Denial or termination of urgent services (e.g. acute care, including certain nursing facility care, home health, therapy, and non-cosmetic surgery). 2. Established by written expiration of doctor. But lay testimony also may be sufficient.	1. 60-day time frame "could seriously jeopardize the life or health of the enrollee, or the ability of the enrollee to regain maximum functioning." 2. Expedited review is automatically granted if requested by a doctor. 3. If an enrollee or enrollee representative requests expedited review, the plan determines whether to grant it. 4. Preamble says decision to deny expedited review is a procedural decision (not an operational decision subject to appeal) and HCFA will consult advocacy and industry groups in developing guidance.
Hearing and Evidence	1. First level HMO reconsideration includes informal, in-person communication with reconsideration decision maker. 2. Informal hearings may be conducted by telephone. 3. At all levels of review, plan doctors must be free to provide supporting evidence without fear of retaliation or reprisal. 4. HMOs must provide medical records in support of request or appeal.	1. All parties to a reconsideration have reasonable opportunity to present evidence, in person as well as in writing. 2. Opportunity to present evidence is limited in expedited reconsideration by shorter time periods.
Continuation of Services Pending Appeal	1. Hearings must continue until a final reconsideration decision has been issued. 2. Services may be terminated if the attending physician determines that continued treatment may be harmful to the enrollee.	1. Regulations are silent, and HCFA does not request comments. 2. HCFA press release, says "Additional improvements to the regulations are also being developed pertaining to continuation of care during the appeal process..."
Implementation	Implementation within 120 days of entry of the March 3, 1997 judgement	Regulations become effective on June 30, 1997; plans must comply by August 28, 1997.

Prepared by Vicki Gottlich, NSCLC

○