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Unfinished Business: The Affordable Care Act and the Problem of Delayed and Denied ERISA Health Care Claim, 47 J. Marshall L. Rev. 887 (2014)

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UNFINISHED BUSINESS: THE
AFFORDABLE CARE ACT AND THE
PROBLEM OF DELAYED AND DENIED
ERISA HEALTHCARE CLAIMS

KATHERINE T. VUKADIN*

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I. INTRODUCTION

The Affordable Care Act (ACA)¹ grew out of a longstanding desire to bring universal healthcare coverage to Americans.² But universal healthcare was not the only goal. Some longed to see ERISA's preemption of state-law remedies softened, so that healthcare claims in ERISA plans could no longer be delayed and denied with impunity. Reform of ERISA's preemption provision was for years a rallying cry for judges forced to mete out ERISA preemption's stark consequences; judges observed repeatedly that there should be some sort of disincentive to improper denials.³

While the ACA now extends coverage to more Americans, ERISA preemption remains unchanged. So, when ERISA healthcare plans—which insure most Americans—improperly delay or deny healthcare claims, the plans still risk nothing more than the eventual payment of that claim's value. ERISA preemption takes away state law remedies and replaces all of them with an ERISA claim, whose remedy is at most the value of the denied benefit. Plans need not compensate participants for consequences resulting from the plans' claims processing mistakes. The ACA leaves these rules untouched. With preemption reform extinguished, the ACA instead offers little more than change at the margins to claims processing, together with the new availability of external review for ERISA claim denials.

This article posits that ERISA claims processing and preemption reform is the unfinished business of the ACA—without

1. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 199 (2010).

2. The ACA's goal is to “expand health insurance coverage while also reforming the health care delivery system to improve quality and value. It also includes provisions to eliminate disparities in health care, strengthen public health and health access, invest in the expansion and improvement of the health workforce, and encourage consumer and patient wellness in both the community and the workplace.” *Reform Overview: Summary of the Health Reform Legislation*, Health Reform GPS, <http://healthreformgps.org/summary-of-the-legislation/> (last visited Mar. 1, 2014).

3. *See, e.g.*, *Gatlin v. Nat'l Healthcare Corp.*, 16 F. App'x. 283, 290 (6th Cir. 2001) (noting that “a stiffer penalty encourages plan administrators to alter their behavior with respect to employee appeals...”); *Perrin v. Hartford Life Ins. Co.*, No. 06-182-JBC, 2008 WL 2705451, at *4 (E.D. Ky. July 7, 2008) (determining an insurer will take a closer look at the administrative record and its denial decisions if it is faced with more than the prospect of merely reinstating benefits”); *Elliott v. Metro. Life Ins. Co.*, No. 04-174-DLB, 2007 WL 1558519, at *3 (E.D. Ky. May 29, 2007) (stating that insurance companies “would likely take a much closer look at denial decisions, and the presentation of that decision, if forced to take into account the possibility that fees will be awarded”); *Powell v. Premier Mfg. Support Servs., Inc.*, No. Civ A. 01-05-0012, 2006 WL 1529470, at *10 (M.D. Tenn. June 1, 2006) (noting that “[a] fee award serves as a deterrent to conclusory statements that are devoid of specific and fact-supported reasons for denial of benefits”).

it, the consumer remains consistently disadvantaged by both the process and substance of healthcare claims processing. In terms of process, established principles of human behavior such as framing and inertia continue to ensure that the claims process flows always in the health plan's favor and few consumers question their assigned share of the costs. On the other hand, the ACA attempts to reform the claims process by adding external claims review; yet seen in another light, these purportedly ameliorative steps are new roadblocks between the healthcare consumer and the accountability that results from a published judicial opinion.

Substantively, the ACA leaves ERISA preemption intact so that plan participants with denied claims must work tirelessly and with exacting attention to detail in order to appeal and eventually win back—at most—the value of the denied or delayed claim. Without further changes to the claims process and ultimately, to ERISA preemption, the ACA includes more people in health plans but also leaves them vulnerable to the vagaries of health plan decision-makers. The promise of universal, meaningful healthcare coverage therefore remains incomplete.

II. ERISA PREEMPTION REFORM AS A LONGSTANDING TENET OF HEALTHCARE REFORM

Since the early twentieth century, a healthcare reform movement has sought broader access to healthcare for Americans.⁴ Passed into law in 1974, ERISA did not become part of this reform agenda until the harsh impact of ERISA's preemption of state laws became clear.⁵ Since then, preemption reform has waxed and waned in its presence and importance on the legislative and healthcare reform agenda.

4. See STAFF OF THE WASH. POST, LANDMARK: THE INSIDE STORY OF AMERICA'S NEW HEALTH-CARE LAW AND WHAT IT MEANS FOR US ALL 2 (2010) (discussing the broad implications of passing the ACA). The ideas that resulted in the ACA have been part of the public discourse in America for a century. *Id.* Theodore Roosevelt enunciated the idea of healthcare for all Americans in the early 20th century. *Id.*

5. In *Pilot Life v. Dedeaux*, 401 U.S. 41 (1987), a plaintiff brought a tortious breach of contract claim against Pilot Life, based on the company's alleged bad faith denial of the plaintiff's disability benefits claim. Faced with ERISA preemption, the plaintiff argued that ERISA's "savings" clause applied, because the law was one that regulated insurance. *Id.* at 48. The Supreme Court disagreed, holding the state law claims were not "saved" because they were not specifically directed at the insurance industry. *Id.* at 56-57. Thus, ERISA's preemption provision was interpreted broadly, to cut off state remedies even for those whose benefits were improperly denied. *Id.*

A. ERISA's Limited Remedies and the Preemption Reform Movement

ERISA preemption is notorious for the limited remedies that it provides when plan participants' claims are delayed or denied improperly. ERISA preempts all state laws that "relate to" ERISA plans, as well as causes of action that duplicate or supplant a claim under ERISA's enforcement provisions.⁶ The result for plan participants is that when plans delay payment or do not follow procedural requirements, there is generally no remedy.⁷ Even when plans wrongfully fail to pay participants' claims, the participant can recover only the value of the benefit that should have been paid originally.⁸ The recovery of attorney's fees is far from certain, even for successful ERISA plaintiffs.⁹ Recently, there has been some hope

6. 29 U.S.C. §§ 1132, 1144.

7. See, e.g., *Amos v. Plan Adm'r of Orion Healthcorp, Inc., Employee Ben. Plans*, H-11-4623, 2013 WL 5964506, *18 (S.D. Tex. 2013) (stating that "ERISA does not require strict compliance with its procedural requirements, mandating only that plan administrators substantially comply with the statute and accompanying regulations"); *Lacy v. Fulbright & Jaworski*, 405 F.3d 254, 256-57 (5th Cir. 2005) (determining after studying § 1133 of ERISA that "even if the denial notice were held to fall short of *strict* compliance with those requirements, it is indisputably in *substantial* compliance," and the notice will "suffice."); *Wade v. Hewlett-Packard Dev. Co. LP Short Term Disability Plan*, 493 F.3d 533, 540 (5th Cir. 2007) (noting that the "[f]ailure to fulfill procedural requirements usually does not give rise to a substantive damage remedy" (quoting *Hines v. Mass. Mut. Life Ins. Co.*, 43 F.3d 207, 211 (5th Cir. 1995))).

8. "Section 514 preemption of state law, and, therefore, state remedies, leave ERISA's section 502(a) civil enforcement scheme as the sole avenue of relief for negligent medical necessity and other benefits determinations. Appropriate relief would normally be found by filing a state tort claim for monetary damages, but under section 514, this is no longer possible since state tort or legislative relief would not be saved as limited to the business of insurance. Yet, section 502 only permits equitable relief for obtaining benefits that have been denied or delayed. Ex ante, this can require a patient to pursue the plan's administrative appeals process and/or retain an attorney and seek preliminary injunctive relief while in the midst of a health crisis—a daunting process for even healthy claimants." Mary Ann Chirba-Martin, *Drawing Lines in Shifting Sands: The U.S. Supreme Court's Mixed Messages on ERISA Preemption Imperil Health Care Reform*, 36 J. LEGIS. 91, 97 (2010).

9. See, e.g., *Graham v. Hartford Life & Accident Ins. Co.*, 501 F.3d 1153, 1162 (10th Cir. 2007) (holding that attorney's fee issue was not ripe until after plan administrator's review on remand); *Quinn v. Blue Cross & Blue Shield Ass'n*, 161 F.3d 472, 479 (7th Cir. 1998) (affirming lower court's holding that defendant did not complete a proper vocational review and that denial of disability benefits was arbitrary and capricious but reversing fee award because defendant's decision was not "totally lacking in justification"); *St. Joseph's Hosp. v. Carl Klemm, Inc.*, 459 F. Supp. 2d 824, 834 (W.D. Wis. 2006) (denying motion for attorney's fees, based on the absence of evidence

for ERISA claimants seeking equitable relief for breach of fiduciary duty; the exact contours of that relief are being developed.¹⁰

When ERISA was enacted, the healthcare landscape was quite different, with most individuals receiving health insurance from plans that were regulated by state laws.¹¹ When ERISA was initially discussed and developed, employer-sponsored health plans were hardly discussed, except with regard to fiduciary duty and reporting rules.¹² Because state law was understood to govern health insurance, insurance contracts were left out of ERISA's general preemption of state law.¹³ As employers discovered the advantages to self-funded ERISA-governed plans,¹⁴ the number of ERISA plans increased dramatically.¹⁵ Also, at the time ERISA was enacted, insurers and employers tended not to question physicians' diagnostic decisions—if a physician judged a therapy necessary, it

that defendant was “simply out to harass” plan participant).

10. See, e.g., *Kenseth v. Dean Health Plan, Inc.*, 722 F.3d 869 (7th Cir. 2013); Susan Harthill, *The Supreme Court Fills A Gaping Hole: Cigna Corp. v. Amara Clarifies the Scope of Equitable Relief Under ERISA*, 45 J. Mar. L.R. 767 (Spring 2012) (analyzing the Supreme Court's decision to recognize claimant's right to sue for breach of fiduciary duty).

11. JAMES A. WOOTEN, *THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974: A POLITICAL HISTORY* 281-82 (2004); *ERISA Preemption: Remedies for Denied or Delayed Health Claims, Hearing Before the Subcommittee on Labor, Health, and Human Services, Education and Related Agencies of the Senate Committee on Appropriations*, 105th Cong. at 8 (statement of Olena Berg, Assistant Secretary, Pension and Welfare Benefits Administration, Department of Labor) [hereinafter Senate Hearing], available at www.gpo.gov/fdsys/pkg/CHRG-105shrg50024/pdf/CHRG-105shrg50024.pdf.

12. WOOTEN, *supra* note 11, at 281.

13. Senate Hearing, *supra* note 11, at 8-9.

14. In a notorious example of an insurance executive's frank assessment of ERISA's advantages, the executive noted in a memo that “[t]he advantages of ERISA... are enormous: state law is preempted by federal law, there are no jury trials, there are no compensatory or punitive damages, relief is usually limited to the amount of benefit in question, and claims administrators may receive a deferential standard of review...[For a set of] 12 claim situations where we settled for \$7.8 million in the aggregate...[i]f these 12 cases had been covered by ERISA, our liability would have been between zero and \$0.5 million.” The memorandum goes on to note: “While our objective is to pay all valid claims and deny invalid claims, there are gray areas, and ERISA applicability may influence our course of action.” Memorandum from Jeff McCall to IDC Mgmt. Grp. & Glenn Felton (Oct. 2, 1995), available at www.erisa-claims.com/library/Provident%20memo.pdf.

15. “Sixty-one percent of covered workers are in a self-funded plan, similar to the percentage reported in 2012. The percentage of covered workers who are in a plan that is completely or partially self-funded has increased over time from 49% in 2000 to 54% in 2005 and to 59% in 2010.” The Kaiser Family Found. & Health Research & Educ. Trust, *Employer Health Benefits: 2013 Annual Survey* 176 (2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20131.pdf>.

was accepted as such.¹⁶

Once the harsh consequences of ERISA preemption began to take shape, individual cases made their way to the press and to Congressional offices, eventually coalescing into the goal of ERISA preemption reform.¹⁷ A few notorious cases became touchstones of the reform movement.¹⁸ There are numerous, less celebrated cases of plans ignoring the regulations or committing serious procedural violations without remedies.¹⁹ ERISA preemption, which employers and plans had long enjoyed, thus became a political liability.²⁰

As the ERISA preemption reform movement coalesced, so did a highly committed insurer and plan sponsor opposition. The lobbying effort against ERISA preemption reform is remarkable for its consistency, organization, and effectiveness. Each time politicians introduced legislation that would permit plaintiffs to seek state remedies against plans that improperly deny healthcare claims,

16. WOOTEN, *supra* note 11, at 283.

17. WOOTEN, *supra* note 11, at 284 (noting that a number of highly-publicized cases led to a “political backlash against managed care that led to state and federal legislative initiatives”).

18. In one such case, a doctor recommended that a woman with a high-risk pregnancy be admitted to hospital; based on United Healthcare’s utilization review, the hospitalization was denied and the fetus went into distress and died. *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321, 1324 (5th Cir. 1992). When she sued for wrongful death, among other claims, her state claims were all preempted by ERISA. *Id.* at 1338. The case was mentioned during Senate hearings on ERISA reform and became a rallying cry for ERISA reformers. *See, e.g.*, Senate Hearing *supra* note 11 (referencing the Corcorans’ story multiple times as a basis for why reform is necessary).

19. *See, e.g.*, *LaFleur v. La. Health Serv. & Indem. Co.*, 563 F.3d 148, 157 (5th Cir. 2009) (noting that substantive damages for a flagrant regulatory violation could include retroactive reinstatement of benefits but that the court “ha[s] not fully identified the scope of available remedies” for procedural violations); *Abatie v. Alta Health & Life Ins.*, 458 F.3d 955, 971 (9th Cir. 2006) (holding that the most flagrant disregard for claims regulations can result in de novo review of the plan administrator’s decision; citing no possibility of a substantive remedy); *Bard v. Bos. Shipping Ass’n*, 471 F.3d 229, 244 (1st Cir. 2006) (striking evidence and awarding benefits based on remaining evidence where procedural violations were “serious, had a connection to the substantive decision reached, and call[ed] into question the integrity of the benefits-denial decision itself”). In *Schoedinger v. United Healthcare*, No. 4:04-cv-664 SNL, 2006 WL 3803935, at *8 (E.D. Mo. Nov. 6, 2006), the court awarded attorney’s fees to an insured who had faced repeated delays and denials of his claims. The court noted: “Whether it be purposeful or negligent, insurance companies regularly reduce and deny claims without cause, thereby increasing the cost of healthcare to providers and patients alike. If it became cost prohibitive for insurance companies to engage in that behavior, it would incentivize more accurate claims administration and processing in the future.” *Id.*

20. Clark C. Havighurst, *How the Healthcare Revolution Fell Short*, 65 LAW & CONTEMP. PROBS. 55, 76 (2002) (noting that ERISA “turn[ed] what appeared to be a legislative blessing into a political curse”).

lobbyists' response was well organized, swift, and emphatic.²¹

The first serious congressional efforts at reform were initiated after the Supreme Court's decision in *Pilot Life* announced the breadth of ERISA preemption.²² In 1991, Senator Howard Metzenbaum (D-Ohio) introduced a bill that would have saved from preemption statutes and common law providing remedies for the improper administration of benefit plans or claims processing.²³ Senator Edward Kennedy was among the co-sponsors.²⁴ Representative Howard Berman (D-Cal) introduced a companion bill in the House of Representatives.²⁵ Representative Berman explained that his bill was specifically intended to address the Supreme Court's decision in *Pilot Life*.²⁶

Lobbyists representing employers and even the tobacco industry reacted strongly and negatively to the bills. Representatives of the National Association of Manufacturers (NAM) wrote to congressional leaders, urging that the legislation be defeated and arguing that the bills were "based on unsubstantiated examples of problems" and emphasizing the uniformity of ERISA law.²⁷ NAM is a lobbying organization with documented ties to the tobacco industry.²⁸ The members of NAM

21. Curtis D. Rooney, *The States, Congress, or the Courts: Who Will Be First to Reform ERISA Remedies?*, 7 ANNALS HEALTH L. 73, 75 (1998) (noting that while "ERISA has been amended numerous times since its inception, attempts to change the exclusive damages and preemption provisions have met with considerable controversy").

22. *Pilot Life Co. v. Dedeaux*, 481 U.S. 41, 56-57 (1987).

23. See S. 794, 102d Cong. §§ 1 (1991) (addressing the issue of preemption but also requiring the Secretary of Labor to conduct a study on ERISA and the preemption of State laws).

24. *Id.*

25. H.R. 1602, 102d Cong. § 2 (1992).

26. Roger C. Siske & Joni L. Andrioff, *Selected Topics in ERISA Preemption*, C758 ALI-ABA 45, 58 n.4 (1992). The text of the bill would have amended ERISA as follows:

(ii) nothing in this title shall be construed to relieve or exempt any insurance company or other insurer from any provision of the statutory or common law of any State to the extent that such provision provides a remedy against insurance companies or other insurers who, in the administration of an employee benefit plan or in the processing of insurance claims thereunder, engage in unfair insurance claims practices in connection with such claims, except that nothing in this clause shall be construed to relate to remedies against plan sponsors.

27. Letter from Randolph M. Hale of NAM (the National Association of Manufacturers) to The Honorable Pat Williams, Chairman, Labor-Management Relations, Committee on Education and Labor (Sept. 25, 1991).

28. Letter from Eugene Hardy, Vice President of NAM, to Fred Panzer, Vice President of NAM, noting that the CEO of R.J. Reynolds Tobacco

were of course employers in their own right, and would have been affected in that role by any change to ERISA preemption. At the same time, however, the tobacco companies were pursuing a strategy on labeling laws that consisted principally of a preemption argument, specifically one that frequently analogized to ERISA preemption.²⁹ Faced with this opposition, the ERISA preemption bills did not pass.

The ERISA preemption reform movement came to the fore once again in the mid to late 1990s. In 1996, President Clinton established an Advisory Commission on Consumer Protection and Quality in the Health Care Industry³⁰, which recommended a Patient's Bill of Rights that included avenues for grievances and complaints.³¹ The Commission's final report to the President noted the impact that improperly denied claims could have on patients' health and economic conditions.³² The commission reached no agreement on an ERISA reform proposal, and no such proposal was included in the commission's recommendations.³³ The proposals did, however, result in rulemaking that reformed the claims process for ERISA plan participants and called for the disclosure of increased levels of information to participants.³⁴ The focus, however, remained

International, Inc. and a Vice President of Philip Morris USA were serving on the board of NAM (Oct. 12, 1979).

29. Memorandum from Jones, Day, Reavis & Pogue to R.J. Reynolds Tobacco Company, *Improving Our Preemption Position in Existing Cases Through New Legislation* (March 26, 1991) available at <http://legacy.library.ucsf.edu/tid/drl12a00/pdf?search=%22erisa%20preemption%20tobacco%22> (discussing definitions in ERISA statute and possible similar definitions that could be adopted in tobacco-related legislation).

30. Exec. Order No. 13,713, 61 Fed. Reg. 47,659 (1996) available at www.presidency.ucsb.edu/ws/?pid=53292 (last visited Jan. 17, 2014).

31. The President's Advisory Comm'n on Consumer Prot. and Quality in the Health Care Indus., CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES, (July 17, 1998), available at <http://archive.ahrq.gov/hcqual/final/appenda.html>.

32. The President's Advisory Comm'n on Consumer Prot. and Quality in the Health Care Indus., STRENGTHENING THE MARKET TO IMPROVE QUALITY, (July 19, 1998), available at <http://archive.ahrq.gov/hcqual/final/chap10.html> (explaining that harm results when, "inappropriate benefit coverage decisions . . . impinge on or limit the delivery of necessary care."). The report goes on to explain that a wrongful denial of coverage, "can lead to a delay in care or to a decision to forgo care entirely." *Id.* The report notes that, "even a small number of mistakes . . . can have serious, costly, or fatal consequences," such as, "additional health expenses, increased disability, lost wages, and lost productivity." *Id.*

33. Rooney, *supra* note 21, at 102-03

34. Employee Retirement Income Security Act of 1974; Rules and Regulations for Administrative and Enforcement; Claims Procedure, 63 Fed. Reg. 48390 (Sept. 9, 1998) (codified at 29 C.F.R. pt. 2560); Proposed Amendments to Summary Plan Description Regulations, 63 Fed. Reg. 48376 (Sept. 9, 1998) (codified at 29 C.F.R. pt. 2520).

firmly on changes to the claims process rather than the addition of remedies available to plan participants when the process failed.

The 105th Congress saw the introduction of multiple ERISA reform proposals, all of which failed to gain the traction necessary to become law.³⁵ Instead of taking indiscriminate aim at ERISA preemption, these proposals reflected lessons learned from past attempts and took a more nuanced tack. One significant concession was the inclusion of provisions aimed at allaying some of the employer lobby's greatest concerns, which were liability for negligent claims processing and the loss of ERISA's uniformity.³⁶ Nevertheless, the employer lobby found none of the proposals acceptable. Lobbyists lined up against the more comprehensive legislation, which included an ERISA preemption reform provision.³⁷ While the Norwood proposal contained a provision that purported to shield employers from liability for medical decisions, analysts and lobbyists argued over the effect that such a provision would actually have, with some arguing that its purported protections may not amount to much.³⁸ The "Patient Protection Act" (H.R. 4250) that eventually passed in the House contained no ERISA reform—and the 105th Congress adjourned before passing any version at all of the Patient Protection Act.³⁹

35. H.R. 1415, 105th Cong. (1997); S. 644, 105th Cong. (1997).

36. H.R. 1749, 105th Cong. (1997) (creating a federal remedy rather than simply removing ERISA preemption and permitting all state law remedies); Heather Hutchinson, *The Managed Care Accountability Act*, 32 IND. L. REV. 1383, 1384 (1999).

37. Anne B. Allen, *Employers Resist a Chilly PARCA*, available at www.thefreelibrary.com/Employers+resist+a+chilly+PARCA.-a020326714 (last visited Jan. 17, 2014) ("Associations that have been active in opposition to PARCA include the Health Insurance Association of America, the National Association of Manufacturers and the National Federation of Independent Business. Look for RIMS to join these ranks soon, as it is in the process of drafting a position paper opposing PARCA.").

38. H.R. 2723, 106th Cong. at 100 (1999) (stating that employers would not be held liable unless they, "exercise discretionary authority to make a decision on a claim"); HEALTH INSURANCE ASSOCIATION OF AMERICA, LIABILITY OF EMPLOYERS AND PLAN SPONSORS UNDER DINGELL-NORWOOD (H.R. 2723) AND SHADEGG-COBURN (H.R. 2824) (1999) http://lobby.la.psu.edu/001_Managed_Care_Reform/Organizational_Statements/HIAA/HIAA_Liability_of_Employers_and_Plan_Sponsors_Under_Norwood-Dingell.htm (concluding that any purported employer shield based on the absence of discretion was illusory); Alyssa J. Rubin, *Spurred by Public's Complaints, Congress Offers Managed-Care Cures*, L.A. TIMES, Oct. 22, 1997 <http://articles.latimes.com/1997/oct/22/news/mn-45433> (quoting Anthony Knettel, director of health policy for the ERISA Industry Committee which represents Fortune 500 companies as stating that, "The employer would have to look over the shoulder of the HMO and would be liable for all the things that the insurer and the HMO have control over").

39. Rooney, *supra* note 21, at 103.

Congress continued to debate patients' rights and whether ERISA preemption should be revised so as to permit lawsuits against managed care organizations—some commentators describe this debate as one of the “most contentious” health policy debates.⁴⁰ Ted Kennedy in particular continued to take a leadership role, as a longtime champion of health care reform whose ideas shaped the ACA and most previous healthcare reform legislation passed in the past two decades.⁴¹

In these debates, Kennedy argued that ERISA preemption was a fundamentally necessary piece of any attempt to reform ERISA. In a 1998 Senate hearing, he framed the issue as one of fairness—no other American industry is insulated from the damage caused by negligent decisions and actions; why should ERISA plans be protected when their negligent decisions cause harm?⁴²

At the same hearing, Olena Berg, then Assistant Secretary for the United States Department of Labor's Pension and Welfare Benefits Administration, predicted that while external review of denied claims would improve plan participants' lot, the procedural enhancements would not remove the incentive to arbitrarily deny claims, because so few plan participants ever access the appeal processes.⁴³ She noted also the disproportionately small remedies

40. Peter D. Jacobson, *The Role of ERISA Preemption in Health Reform: Opportunities and Limits*, LEGAL SOLUTIONS IN HEALTH REFORM 1, 1, 13 (1999) available at www.law.georgetown.edu/oneillinstitute/research/legal-solutions-in-health-reform/Papers/ERISA.pdf (noting that “the preemption provisions of [ERISA] will play a major role in determining the contours of any health reform initiative[.]” and predicting, “considerable congressional opposition” to any proposal that would weaken ERISA preemption). The commentator goes on to outline one possible amelioration of ERISA preemption—a regulatory revision of the term “benefit” to include reasonable economic and noneconomic damages. *Id.* at 4.

41. Barry R. Farrow, *Health Reform and Ted Kennedy: The Art of Politics . . . and Persistence*, 14 N.Y.U. J. LEGIS. & PUB. POL'Y 445, 447 (2011) (noting that the ACA, “bears the indelible mark of Senator Edward Kennedy, who acted for forty years as a strong tailwind, pursuing health care reform forward and making contributions to insurance reform through HIPAA and the Massachusetts health reforms, which provided a partial template for the final version of the ACA”).

42. See Senate Hearing, *supra* note 11, at 3 (stating “every other industry in American can be held responsible for its actions. Health plan decisions can truly mean life or death, and they do not deserve immunity”).

43. *Id.* at 7. “[P]lans can comply with procedural requirements, they can meet all of those, and still arbitrarily deny claims. Now, external review might take care of a large part of that, but many participants, we know, never question that initial determination. They never go into the appeals process. They just assume that that determination was properly made . . . if the only consequence for plans that engage in this kind of practice . . . is paying the benefit they would have had to pay in the first place, they have no reason to do the right thing and strong economic reasons for denying valid claims.” *Id.*

that can result from ERISA preemption.⁴⁴ While expanded internal and external review of claims decisions would be helpful, these changes, without more, would not solve the problem of wrongfully denied claims or the financial incentives to delay and deny claims.⁴⁵ She noted the enduring issue of self-interested decision-making⁴⁶ and the fact that some wrongful denials would result in economic harm. To shield plans from harm under these circumstances, she argued, is to make ERISA an anomaly in our legal system.⁴⁷

Judges and commentators too called for ERISA preemption reform, as they dismissed without a remedy cases in which beneficiaries were denied their contracted benefits and suffered serious harms.⁴⁸ Commentators believed that the time had come for healthcare reform and revisions to ERISA's harsh preemption provision.⁴⁹

The 107th Congress was scheduled to debate the "Bipartisan Patient Protection Act" when it returned from its August recess in

44. *See id.* at 43 (noting that if the failure to approve a necessary CAT scan results in the plan participant becoming disabled, the remedy under ERISA is the cost of the test that she should have received in the first place).

45. *Id.*

46. *See id.* at 11 (explaining "Procedural rights, even when honored, cannot eliminate negligent or self-interested decision making by those determining whether claimed coverage has been promised by the plan").

47. *See id.* (noting that "[i]n other contexts throughout our legal system, foreseeable injuries caused by a failure to deliver what has been promised must be compensated").

48. *See, e.g., Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49, 52 (D. Mass. 1997) (dismissing claims based on an incorrect denial of benefits that led to the beneficiary's death; calling ERISA preemption "a shield of immunity that protects health insurers, utilization review providers, and other managed care entities from potential liability for the consequences of their wrongful denial of health benefits"); *Tolton v. American Biodyne, Inc.*, 48 F.3d 937, 943 (6th Cir. 1995) (stating "one consequence of ERISA preemption, therefore, is that plan beneficiaries or participants, bringing certain types of state actions—such as wrongful death—may be left without a meaningful remedy"); *Turner v. Fallon Cmty. Health Plan*, 953 F. Supp. 419, 424 (D. Mass. 1997) (finding "an unfortunate consequence of ERISA preemption is, therefore, that plan beneficiaries or participants who bring certain kinds of state actions, e.g., wrongful death, may be left without a meaningful remedy . . . Sadly, the case at bar compels a like result"). "Plaintiff's state common law claims are preempted by the broadly sweeping arm of ERISA." *Id.* "Plaintiff is left without any meaningful remedy even if he were to establish that [the insurer] wrongfully refused to provide the [bone marrow transplant] his wife urgently sought." *Id.*; Paul M. Secunda, *Sorry, No Remedy: Intersectionality and the Grand Irony of ERISA*, 61 HASTINGS L.J. 131, 135 (2009) (calling for legislative reform of ERISA's denial of remedies).

49. *See Havighurst supra* note 21 (noting the "public backlash" against managed care and noting that "[g]iven this environment, the time has come for both managed care reform and ERISA reform").

2001; there was a consensus that some version of the bill would pass.⁵⁰ ERISA reform failed again, however, after the attacks of September 11, 2001, took the national agenda in a completely different direction: national security became the most urgent issue, and ERISA reform once again fell to one side.⁵¹

Even state waivers from ERISA preemption could not succeed in Congress. In 2007, certain states sought ERISA waivers from Congress so health care reform could be attempted in the states.⁵² At hearings over the issue, employer lobbying groups such as The National Business Coalition on Health, the American Benefits Council, and the ERISA Industry Committee argued that preemption should remain in place.⁵³ These groups lobbied actively on behalf of business interests, appearing again during the healthcare reform debate of 2009 and following.⁵⁴ With regard to ERISA waivers, the ERISA reform efforts were unsuccessful, once again resulting in maintenance of the ERISA status quo.⁵⁵

50. Mary Ann Chirba-Martin, *Drawing Lines in Shifting Sands: The U.S. Supreme Court's Mixed Messages on ERISA Preemption Imperil Health Care Reform*, 36 J. LEGIS. 91, 136 (2010).

51. *See id.* at 136 (explaining that “[w]hat soon became clear is that no part of the bill could survive the September 11, 2001 attacks. At that point, matters of national security became all consuming, patients’ rights toppled from the legislature’s agenda and, as described earlier, Pegram’s promise of available state remedies evaporated with Davila’s resuscitation of broad ERISA preemption”); *see also* *The Business of Congress After September 11, 2001*, THE BOOKINGS INSTITUTION POLICY DIALOGUE 2 available at www.brookings.edu/~media/research/files/papers/2002/1/01politics%20binder/pd01.pdf (herein *The Business of Congress After September 11, 2001*) (last visited Dec. 15, 2013) (noting that security measures took precedence in a bipartisan effort following September 11, 2001).

52. *The Business of Congress After September 11, 2001*, *supra* note 51, at 132.

53. Martin G. Resier, *The U.S. House of Representatives Energy and Commerce Committee Subcommittee on Health*, National Coalition on Benefits 4 (June 25, 2009) available at <http://democrats.energycommerce.house.gov/sites/default/files/documents/Testimony-Reiser-HE-Comprehensive-Health-Reform-Discussion-Draft-2009-6-25.pdf>.

54. *Infra* note 65.

55. Hawaii is the one state to have obtained an ERISA exemption. *See* The Hawaii Uninsured Project Policy Brief, *A Historical Overview of Hawaii's Prepaid Health Care Act* 5, available at www.healthcoveragehawaii.org/pdf/PHCA%20Historical%20Brief.pdf (explaining ERISA would have preempted Hawaii's Prepaid Health Care Act, but Hawaii's congressional delegation sought and obtained an ERISA waiver). The provision reads as follows: “(B) Nothing in subparagraph (A) shall be construed to exempt from subsection (a) of this section - (ii) any amendment of the Hawaii Prepaid Health Care Act enacted after September 2, 1974, to the extent it provides for more than the effective administration of such Act as in effect on such date.” *Id.* The ERISA exemption applies only to the Hawaii Prepaid Health Care Act as enacted on September 2, 1974, and prohibits any substantive changes to the PHCA. *Id.*

Thus, a long line of ERISA preemption reform efforts failed one after another, prompting some commentators to question the purpose of the repeated efforts. Some have speculated that such issues are undertaken because they make for good posturing as well as steady sources of campaign funds.⁵⁶

B. A Fizzling ERISA Reform Movement

In the debates leading up to passage of the ACA, ERISA preemption reform proposals appeared multiple times. They were quickly rejected, however, again due to strong business opposition.⁵⁷ Indeed, the attempts at ERISA preemption reform did not appear as a principal objective of the reform effort, to the point that some have described ERISA reform as having effectively been dropped from the legislative “wish list.”⁵⁸

Still, in late 2009, ERISA preemption was once again part of the healthcare reform discussion. The larger healthcare reform bill did not contain a provision addressing any reform of ERISA preemption.⁵⁹ Nonetheless, two separate bills were introduced that would have done just that. One, H.R. 3925, introduced by Jim McDermott (D-WA), would have precluded preemption of State causes of action “relating to the denial of a claim for benefits under

56. See Havighurst, *supra* note 20, at n. 70 (noting that “Congress has been more eager to entertain legislative proposals than to pass them, perhaps because supporters find the issue a good one on which to posture and because both sides find it a lucrative source of campaign contributions”).

57. See Heather T. Williams, *Fighting Fire with Fire: Reforming the Health Care System Through a Market-Based Approach to Medical Tourism*, 89 N.C. L. REV. 607, 660 (Jan. 2011) (voicing that the healthcare industry has a significant and well-funded lobbying presence in Washington, D.C.); see Dan Eggen, *Health Sector Has Donated Millions to Lawmakers*, WASH. POST, Mar. 8, 2009, at A9, available at www.washingtonpost.com/wp-dyn/content/article/2009/03/07/AR2009030701748.html (recognizing that “[t]he health-care sector has long ranked with financial services and energy interests as one of the most powerful political forces in Washington, and it spent nearly \$1 billion on lobbying in the past two years alone”); see also David D. Kirkpatrick, *At State Level, Health Lobby Fights Change*, N.Y. TIMES, Dec. 29, 2009, at A1 (detailing the efforts of health care industry lobbyists to affect health care reform at the state level). See Robert Steinbrook, *Election 2008—Campaign Contributions, Lobbying, and the U.S. Health Sector*, 357 NEW ENG. J. MED. 736, 736-38 (2007) (describing election contributions and lobbying resources of the health care sector).

58. See Chirba-Martin, *supra* note 8, at 136 (expressing “it has taken eight years for health care to reemerge as a domestic priority, but fixing ERISA is no longer on the legislative wish-list”).

59. See H.R. 111th Cong. 3200 §151(a)(2) (1999) (presenting “nothing in paragraph (1) shall be construed as affecting the application of section 514 of the Employee Retirement Income Security Act of 1974”), available at www.gpo.gov/fdsys/pkg/BILLS-111hr3200ih/pdf/BILLS-111hr3200ih.pdf.

a health care plan.”⁶⁰ The other attempt, known as the Shadegg Amendment, would have permitted state lawsuits against ERISA plans.⁶¹

Lobbyists’ reaction to these proposals was swift and strongly negative, advancing basically the same objections that had been voiced in the past.⁶² The business community continued to emphasize ERISA’s more uniform rules and (with a marked lack of empirical support) the cost increases that could occur if employers were subject to the full panoply of state remedies.⁶³ The American Benefits Council, for example, said the amendment would expose employers to “potentially ruinous exposure to liability” and would result in “fewer employers being willing to sponsor health benefits for employees.”⁶⁴ Other groups echoed these sentiments.⁶⁵ Business interests nationwide made the preservation of ERISA preemption a high priority, bombarding congressional leaders with position papers and arguments against the reform of ERISA preemption.⁶⁶ Many of these communications were signed by some of the most prominent companies in America.⁶⁷

60. H.R. 111th Cong. 3925, 1 (Oct. 26, 2009) available at www.americanbenefitscouncil.org/documents/hr_3925_111th.pdf.

61. Shadegg Amendment to H.R. 3962 available at http://housedocs.house.gov/rules/3962/Shadegg3962_198.pdf.

62. *Shadegg Amendment Would Increase Litigation, Health Costs and Leave Employers Vulnerable*, AMERICAN BENEFITS COUNSEL 1-2 (Nov. 4, 1999) available at www.americanbenefitscouncil.org/documents/hcr_erisa_shadegg-analysis110409.pdf (last visited Dec. 10, 2013).

63. *Id.* Similar to lobbying materials in past debates over the costs and benefits of reforming ERISA preemption, these lobbying materials do not include any back-up for the position that arguments regarding increased costs and the benefits of uniformity. *Id.*

64. *Id.*

65. National Coalition on Benefits Press Release, *Statement from National Coalition on Benefits on Shadegg’s ERISA Proposal* (Nov. 5, 2009), available at www.coalition-nonbenefits.org/media/pdf/NCB_Shadegg_Response_110509.pdf. The press release notes “strong opposition” to the amendment and states that the amendment would “crumble the health care coverage that 177 million Americans have today . . . [t]he proposal threatens to erode the flexibility of ERISA—the cornerstone of employer-based coverage—resulting in a more costly, more litigious health care system that will drive employers away from voluntarily providing benefits.” *Id.*

66. Letter from Karen Ignagni, President and Chief Executive Officer of America’s Health Insurance Plans to Speaker of the House Nancy Pelosi and House Republican Leader John Boehner (Nov. 5, 2009).

67. Letter to President Barack Obama from American companies including American Airlines, Best Buy, Dollar General, Boeing, Eastman Kodak, available at <http://democrats.energycommerce.house.gov/sites/default/files/documents/Testimony-Reiser-HE-Comprehensive-Health-Reform-Draft-2009-6-25.pdf> (last visited Jan. 31, 2014); see also Testimony of Martin G. Reiser, Chairman of the National Coalition on Benefits, before the U.S. House of Representatives Energy and Commerce Committee, Subcommittee on Health

Even without ERISA preemption reform, passage of the ACA was far from certain. Early in President Obama's effort to reform health care, the Obama team set out some rules to ensure that the reform effort did not meet the same end as President Clinton's 1993-94 attempt.⁶⁸ One guiding rule was that opposition should be neutralized rather than defeated.⁶⁹ The Obama team would seek ways to work with the various industries and interests that had made short work of the Clinton health care initiative.⁷⁰ The team used this approach to work with the large pharmaceutical companies and with the insurance interests.⁷¹ Even with this approach, the vote was a close one, with House Speaker Nancy Pelosi working vote by vote to negotiate support for the ACA, quelling uprisings from various factions of the Democratic party.⁷² In this context then, it is not surprising that so controversial an issue as ERISA preemption—that would have raised the ire of so many employers and insurers—was not championed.

In the end, ERISA preemption was left out of the ACA. In place of preemption reform, the ACA offers procedural refinements and rules; the most significant of these are enhanced internal review and claims regulations, together with mandatory availability of external review.

While these revisions to ERISA are not insignificant, they show that the ERISA preemption reform movement has made very little progress since Ted Kennedy's senate hearing in 1998. At that hearing, industry and employer representatives urged that instead of reforming ERISA preemption, Congress should instead reform the internal claims procedures and provide for mandatory external review.⁷³ Industry representatives stopped short of agreeing to

(June 25, 2009), *available at* <http://democrats.energycommerce.house.gov/sites/default/files/documents/Testimony-Reiser-HE-Comprehensive-Health-Reform-Discussion-Draft-2009-6-25.pdf> (urging that ERISA preemption remain intact and that employers be permitted to retain the existing "flexibility" that ERISA provides). The National Coalition on Benefits counts some of America's largest companies among its members. Membership, NATIONAL COALITION ON BENEFITS, www.coalitiononbenefits.org/Membership/ (listing companies such as Wal-Mart, Nike, Food Lion, and many others).

68. Staff of the *Washington Post*, *supra* note 4, at 15.

69. *Id.* at 16.

70. *Id.*

71. *Id.*

72. *Id.* at 30.

73. *See* Senate Hearing, *supra* note 11, at 15 (specializing in employee benefits law, Mr. Robert Gallagher, of Groom & Nordberg, a Washington, DC firm, urged that the repeal of ERISA preemption would be "disastrous" for ERISA healthcare plans). He argued if ERISA preemption were repealed, employers would scale back benefits. *Id.* Another industry representative, Mark A. Smith, employee benefits compliance manager at AMP, said that even though external review might present problems, it was preferable to

these reforms on the spot, but voiced enthusiasm for that type of reform.⁷⁴ In the end, the ACA featured claims processing reform of exactly the sort that industry representatives outlined in the 1998 hearings, of the sort long known to be acceptable to employer groups, and of the sort that Ted Kennedy and others had said would be wholly inadequate to address the power imbalance in ERISA claims processing.

III. REFORMING ERISA AT THE MARGINS

In place of more sweeping ERISA preemption reform, the ACA offers procedural reform only. The goal of these regulations is not to provide any sort of remedy if participants suffer from negligent plan decision-making, or if plans do not follow the processes outlined in the regulations.⁷⁵ Instead, the regulations aim to make external review processes mandatory and more uniform, to make claims processes more structured, and to improve the extent to which benefits actually provided conform to the plan terms.⁷⁶ The focus is strictly on improving the process

reform ERISA remedies:

Mr. Smith: I cannot speak on behalf of NAM, but at AMP we have been involved in developing policy statements, where, as an alternative to changing some of these ERISA remedies, we would certainly favor some type of an appeal process to help resolve some of these issues.

Senator Specter: How about external appeal?

Mr. Smith: Under the right circumstances. That is fraught with certain difficulties, as well. But it is something we would certainly prefer to some of the ERISA remedy changes.

Id. at 46.

^{74.} *Id.*

^{75.} Interim Final Rules for Group Health Plans and Health Insurance Issuers, 75 Fed. Reg. 43341 (July 23, 2010). The federal regulation states that “[t]his guidance is intended to ensure that plan participants and beneficiaries are promptly accorded the important protections under the [ACA] that provide for fuller and fairer processing of claims, the right to appeal claims that are denied, and the right to obtain effective external review of claims on appeal.”

Id.

^{76.} *Id.* The regulations are also intended to provide benefits that might otherwise have been improperly denied, and to provide greater “certainty and consistency” in the handling of benefit claims and appeals and “improved access to information about the manner in which claims and appeals are adjudicated,” potentially leading to greater efficiency in the system. *Id.* While the regulations’ stated goals note that improper denials and delays can cause “substantial harm,” the regulations note that their goal is to reduce such improper denials, not provide any remedy for the harm suffered. *Id.* See also Roy F. Harmon, *An Assessment of New Appeals and External Review*

and adding more steps—each step represents an opportunity to correct an incorrect decision. Each of the steps requires, however, a participant’s wherewithal, organizational skills, and advocacy.

A. The ACA’s Amendments to ERISA’s Claims Processing Procedures

The ACA’s revisions to ERISA’s claims processing procedures bring new structure and standards, as well as an external review feature.

1. Revisions to Claims Processing Procedures

Even before the ACA, ERISA called for benefit plans to provide a “full and fair review” to participants whose claims for benefits are denied.⁷⁷ In 2000, the Department of Labor added the requirement that ERISA plans establish “reasonable” claims procedures, notification of decisions, and a manner of appeal.⁷⁸ The new rules developed under the ACA provide additional structure and specifics for initial claims determinations and any subsequent reviews, as well as procedural enhancements regarding access to the claims file, relevant diagnostic codes, and other information.⁷⁹

Claimants have access to more information under the new rules. Plans must let claimants review the claims file and present evidence and testimony in the appeals process.⁸⁰ The plan must

Processes—ERISA Claimants Get “Some Kind of Hearing,” 56 S.D. L. REV. 408 (2011) (providing an assessment of whether the reforms are likely to achieve these goals).

77. 29 U.S.C. § 1133 (1974). Every benefit plan must “provide adequate notice in writing to [any] participant or beneficiary whose claims for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant,” and to “afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.” *Id.*

78. Employee Retirement Income Security Act of 1974, 65 Fed. Reg. 70265 (Nov. 21, 2000).

79. See 26 C.F.R. § 54.9815-2719T (2011) (allowing the Secretaries of the Internal Revenue Service, the Department of Labor, and the Department of Health and Human Services to set out the external review process through a series of rules and technical releases); 26 C.F.R. § 54.9815-2719T (temporary regulations that expire on July 22, 2013, according to § 54.9815-2719T(h)); § 2590.715-2719 (“interim final regulations” with no stated expiration date; Department of Labor Technical Releases; Affordable Care Act Implementation FAQs (Part 1), FAQs-1,-8, and -9, at www.dol.gov/ebsa/faqs).

80. See 29 C.F.R. § 2590.715-2719 (b)(2)(ii)(C) (2013) (stating that “[a] plan and issuer must allow a claimant to review the claim file and to present

also give the claimant any new rationale for issuing an adverse claims decision on appeal, giving the claimant sufficient time to respond before the decision is issued.⁸¹ The plan is required to provide any new or additional evidence that the plan used in connection with the appeal.⁸²

Independence and impartiality of the decision-maker are also addressed. The plan must ensure that the adjudication of claims and appeals is performed in a manner designed to promote independence and impartiality, meaning that promotions and compensation cannot be based on a claims processor's record of denying claims.⁸³

Before the new rules, plans that ignored claims processing rules faced few consequences; the new rules try to change that. Now, if a plan fails to conduct timely appeals or does not adhere to the claims processing guidelines, administrative remedies are deemed exhausted and a plan participant may seek external review.⁸⁴ In addition, if the claimant opts to go straight to court, the plan cannot benefit from the deference afforded a decision made by a fiduciary with discretion⁸⁵; under these circumstances, the claim or appeal is deemed denied on review "without the exercise of discretion by an appropriate fiduciary."⁸⁶

Given the low percentage of claims that are appealed or the even smaller number that are appealed externally, it is unclear how significant a disincentive this would be.⁸⁷ That is, if few claimants are using the appeals avenues available to them, it is not clear how many will seek this more aggressive avenue or even know that it exists.

Furthermore, the strict compliance rule has been softened

evidence and testimony as part of the internal claims and appeals process").

81. *Id.*

82. *Id.*

83. See 29 C.F.R. § 2590.715-2719(b)(2)(ii)(D) (2011) (explaining that "[t]he plan and issuer must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision [and] accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits").

84. *Id.* § 2590.715-2719(b)(2)(ii)(F)(1).

85. *Id.*

86. *Id.*

87. See *infra* note 113 and accompanying text (explaining that 60% of plan participants facing a problem with claims processing do not contact their plans, even if the problem will cost them more than \$1,000; the vast majority of denied claims are not appealed, and only a miniscule percentage reach external review (only one, for example, in Connecticut's state-run program in 2012)).

from its original version. While the July 2010 rules provided this consequence for even de minimis departures from the claims processing rules, that stance quickly changed. After insurance companies and plan sponsors reacted negatively to the rule of strict compliance, the departments relented, instead opting to excuse those errors that are (1) de minimis, (2) non-prejudicial, (3) attributable to good cause or matters beyond the plan's or issuer's control, (4) in the context of an ongoing good faith exchange of information, and (5) not reflective of a pattern or practice of non-compliance.⁸⁸

The new rules also mandate continued coverage during the appeals process—if a denial involves the reduction or ending of treatment, the treatment must continue during the appeal's pendency.⁸⁹ In addition, notices must be given in a culturally and linguistically appropriate manner,⁹⁰ and diagnosis and treatment codes must be disclosed upon request.⁹¹

2. External Review

The ACA amends ERISA's claims processing procedures to add an additional and binding external review by an independent review organization (IRO).⁹² Plans must "implement an effective external review process that meets minimum standards established by the Secretary."⁹³ The rules set out a safe harbor provision that provides specific guidelines that, if followed, will shield a plan from enforcement action on the external review issue. According to the safe harbor provision, plans must assign external reviews to an IRO accredited by URAC (Utilization Review Accreditation Commission) or by another national accrediting organization.⁹⁴ Plans must contract with three IROs and rotate assignments among them.⁹⁵

Initially, the scope of decisions to which the external review procedure would apply was broad, applying to any adverse benefit decision except those based on lack of eligibility to participate in the plan.⁹⁶ Less than a year later, a temporary rule narrowed that

88. 29 C.F.R. § 2590.715-2719(b)(2)(ii)(F)(2).

89. *Id.* at § 2590.715-2719(b)(2)(iii).

90. *Id.* at § 2590.715-2719(e).

91. *Id.* at § 2590.715-2719(b)(2)(ii)(E)(2).

92. Patient Protection and Affordable Care Act § 2719, 42 U.S.C. § 300gg-19 (2010) (amending the Public Health Service Act, and incorporated by reference into ERISA, 29 U.S.C. § 1133).

93. *Id.*

94. U.S. DEPT OF LABOR, TECHNICAL RELEASE NO. 2010-1, at 2, 4 (2010).

95. *Id.* at 4.

96. *See* Temp. Treas. Reg. § 54.9815-2719T(a)(2) (2010) (adopting the

scope, so that now only the following types of decisions are included: those decisions concerning (1) medical judgment (except those involving contractual or legal interpretation without medical judgment), or (2) a rescission of coverage.⁹⁷

With regard to the standard of review, independent review organizations are not to give the denial any deference—the review for each externally reviewed claim is *de novo*.⁹⁸ Some health insurers, governmental officials and commentators have greeted the external review provision enthusiastically,⁹⁹ while some commentators have questioned whether external review will mean much to most plan participants.¹⁰⁰ Thus, while the ACA reforms claims processing at the margins and adds external review, ERISA preemption remains intact so that plan participants with denied

definition of “adverse benefit determination” as stated in 29 C.F.R. § 2560-503-1(m)(iii)(4).

The term “adverse benefit determination” means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

29 C.F.R. § 2560-503-1(m)(iii)(4) (2001).

97. 29 C.F.R. § 2590.715-2179(d)(1)(ii)(A)-(B).

98. TECHNICAL RELEASE NO. 2010-1, at 3-7.

99. Press Release, U.S. Dep't of Labor Press Office, Administration Announces New Affordable Care Act Measures to Protect Consumers and Put Patients Back in Charge of Their Care: New Regulations Give Patients Right to Appeal Health Plan Decisions; New Grants Program Strengthens State and Territory Consumer Assistance Programs (July 22, 2010), *available at* www.dol.gov/ebsa/newsroom/2010/ebsa072210.html (last visited Mar. 17, 2014) (stating that the new rules would help end “some of the worst insurance company abuses”); Dustin D. Berger, *The Management of Health Care Costs: Independent Medical Review After “Obamacare”*, 42 U. MEM. L. REV. 255, 288 (Winter 2011) (noting the “consensus seems to be that [independent medical review] is a critical consumer protection against faulty or biased MCO denials of care” and observing that “[independent medical review] may even legitimize the process of utilization review because it ensures that consumers can resort to an independent and unbiased medical appeal”).

100. See Harmon, *supra* note 76, at 409 (suggesting that “on balance, however, the inconsistency and complexity of the new rules, the historic underutilization of external review, and disparity in legal and medical resources between participants and plan administrators leave substantial doubt as to the advantages claimed for the new procedures”).

claims must work tirelessly and with exacting attention to detail in order to appeal and eventually win back—at most—the value of the denied or delayed claim.

B. Claims Processing and the Individual Claimant

The new rules embrace process over remedy, pitting well-financed repeat players against the sick and usually unrepresented plan participant. The ACA adds external claims review to the existing internal appeals; yet given the burdens and multiple claims that illness often brings, the path to eventual external review becomes a war of attrition between unevenly-matched opponents. The new process is marked by multiple steps and an absence of incentives for attorneys to participate, meaning that only the most energetic and sophisticated individuals are likely to pursue multiple levels of appeal to their conclusion. And, the human tendency to remain with a default option works in the plan's favor—once a claim is denied, for any reason, it is up to the plan participant to shift the momentum.

1. The Allure of the Default Option

Significantly, to take advantage of the full benefit of the new rules, a plan participant must have time and energy to resist the default stance of denial and initiate an appeal. Time and energy are of course resources in short supply for those suffering from illness.

If a claim is denied improperly¹⁰¹ the onus shifts to the plan participant to marshal evidence and take action. As an initial step, the plan participant must first overcome the general human tendency to remain with the default option, even where the default option is not the most beneficial.¹⁰² The default or status quo is

101. The number of denied claims is difficult to measure, but estimates place the denial rate at approximately 3.8 percent of all claims filed. Frank B. Cohen, *Denials & Appeals Survey*, (Mar. 22, 2010), www.crnhealthcare.com/downloads/Denials-and-Appeals-Survey-3-2010.pdf (last visited Mar. 17, 2014); physicians report that they lose money because claims are not paid accurately. Barry Shatzman, *How Medical Practices Can Reclaim Lost Revenue From Denials*, MEDICAL BILLING BLOG, (June 27, 2012, 11:26 AM), www.mbrbilling.com/blog/bid/129876/How-Medical-Practices-Can-Reclaim-Lost-Revenue-From-Denials (last visited Mar. 17, 2014).

102. See CASS SUNSTEIN & RICHARD THALER, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS* 34-35 (2009) (noting that people tend to remain with the default option in such diverse areas as seating in a classroom, asset allocation in a retirement plan, beneficiary selection in a retirement plan, selection of television program, in that they tend to select the program that follows the one they initially chose, and even

powerfully attractive, and this human tendency is readily exploited. The status quo bias can be observed in a multitude of different settings: as a recent exploration of choice architecture points out, the individuals in charge of magazine circulation, for example, likely know that if a person must contact the magazine or pick up the telephone to cancel a subscription that will otherwise renew automatically, the person will probably keep the subscription in place.¹⁰³

The reasons people tend to select the default choice are numerous, and apply with even greater force to individuals who are ill or who are caring for someone ill. One reason is inattention—individuals might intend to select a different option, but they never get around to it.¹⁰⁴

In addition, the framing of the available options affects the choices that individuals make.¹⁰⁵ In particular, the default option may come with an implied endorsement from the entity setting the default.¹⁰⁶ This is certainly the case with health plan decisions, which often include the words “your responsibility” or similar language that suggests a final or even moral responsibility to pay the amount that the plan has determined is the participant’s appropriate share.¹⁰⁷

Not only is this general default pressure at play with denied ERISA claims, but Americans with denied healthcare claims face additional and numerous pressures that render them even more likely to stay with the default than the average healthy person. The pressures facing health plan participants include the following:

- *Difficulty in deciphering and understanding copious medical bills.* A recent report explores case study after case study of individuals who were inundated with medical bills

receipt of a magazine subscription that they never read).

103. *Id.* at 56.

104. *Id.*

105. See Amos Tversky & Daniel Kahneman, *The Framing of Decisions and the Psychology of Choice*, 221 *SCIENCE* 453, 458 (1981), available at www.jstor.org/stable/1685855 (noting that “the susceptibility of preferences to variations of framing raises doubt about the feasibility and adequacy of the coherence criterion” that the authors had adopted).

106. *Id.*

107. See Blue Cross of California, *How to Read Your Explanation of Benefits* (Aug. 2000), available at <http://w2.anthem.com/clients/uofc/How%20to%20read%20your%20EOB.pdf>. (using as an example a Blue Cross of California document depicting an EOB which shows a box with an amount of money that states, “It is your responsibility to pay,” rather than “amount due” or “our determination”). This framing of the decision makes a difference to individuals’ perception of the correctness of the decision and whether it should be appealed.

and unable to sort them out or appeal those that were improperly denied, particularly because the individuals were ill or caring for someone who was ill.¹⁰⁸

- *High number of different medical bills and claims.* The sheer number of medical bills generated by a serious illness can be overwhelming.¹⁰⁹ Even a single surgery can generate bills—and hence, claims—from numerous sources, such as the physician, radiologist, anesthesiologist, laboratory, and so on.¹¹⁰ If an illness is protracted, the bills and claims multiply even further. So if the general tendency is to remain with a default due to inattention, the person with a denied healthcare claim has even greater difficulty paying attention to a multitude of claims, sorting through the reasons for any denial, and taking time to advocate for a reversal.
- *Inability to advocate.* Patients and their caregivers often lack the ability to advocate for themselves, due to the pressure of illness and other strains brought on by illness.¹¹¹
- *Reluctance to contact health plan.* Individuals facing disputes with their health plans tend not to even contact their plan to resolve problems; when they try to resolve a claim denial or other problem, most people facing such a problem had to attempt a resolution for a month or longer,

108. See THE HENRY J. KAISER FAMILY FOUNDATION, MEDICAL DEBT AMONG PEOPLE WITH HEALTH INSURANCE 29-30 (Jan. 2014) *available at* <http://kff.org/private-insurance/report/medical-debt-among-people-with-health-insurance/> (explaining one case study, where a parent of a child with autism had numerous claims for autism treatment denied, although she had no idea why). A teacher who was the subject of another case study had to pay for a mammogram, even though that preventive procedure was in fact covered at 100%; she was not aware that she could appeal that decision or that her state had a Consumer Assistance Program that would have helped her appeal. *Id.* at 23. Another case study focused on a medical transcriptionist who had an ambulance claim denied, even though another had been paid. *Id.* She said it did not occur to her to appeal the claim, and said that she would not have had time to do so even if she had known about the possibility. *Id.*

109. See *id.* at 14 (discussing how one individual in the study received 125 different medical bills over a four-month period). See *generally id.* at 22-36 (stating many of the individuals studied as part of the report found that the high number of medical bills made the process of assessing and paying the bills difficult).

110. *Id.* at 22-36.

111. See *id.* at 13-14 (finding “[m]ost others interviewed were not able to effectively track bills and resolve mistakes, including Gwen, who “works in the health care industry and considers herself knowledgeable about health claims”). Yet, “[B]etween caring for her frail husband and working full time as the sole breadwinner, she simply couldn’t manage.” *Id.* at 14.

or they were simply unable to resolve it at all.¹¹² Even when denials or other problems generate out-of-pocket costs exceeding \$1,000 or resulted in a serious decline in health, sixty percent of individuals did not contact their health insurance plan to resolve the problem.¹¹³

Because of these and other pressures, it is scarcely surprising that claimants drop out of the internal and external appeals process in large percentages, at each successive level of appeal.¹¹⁴ As the ACA's new rules took shape and the departments accepted public comments on proposed rules, industry commentators pushed the burden of action always further onto claimants, with the default option favoring the plans. Initially, the new rules required strict adherence to the claims processing procedures, but that has been watered down, and the burden of action and proof once again placed squarely on the plan participant. Initially, even a de minimis violation of the claims processing rules would have allowed a plan participant to short-circuit the claims process and proceed directly to external or judicial review.¹¹⁵ In the public comment period following the proposal, however, industry representatives expressed vehement opposition, arguing that many plan participants would be permitted to bypass internal review and go straight to external review or litigation, which, the employer and industry representatives argued, would raise the costs for all participants.¹¹⁶ Numerous entities commented on

112. *Id.* at 14.

113. *Id.*

114. See *Between You and Your Doctor: The Private Health Insurance Bureaucracy: Hearing Before the Subcomm. on Domestic Policy, 111th Cong. 46* (2009) (statement of Patricia Farrell, Senior Vice President, Aetna Inc.) (finding “[i]n 2008 only a small percentage of claims generated an appeal or a complaint.”); Advocacy for Patients with Chronic Illness, Inc., *How to File Insurance Appeals*, www.advocacyforpatients.org/hifile.html (last visited on Mar. 3, 2014) (stating that 94% of denials are never appealed). See, e.g., Caroline E. Mayer, *The Claim Game: Here's How to Fight Back When Your Insurance Company Denies a Claim*, AARP, Nov. 2009, at 30 (citing Connecticut's healthcare advocate Kevin Lembo as stating that 96% of denials are not appealed). See also *Connecticut General Life Insurance Company, Addendum to Health Insurer Annual Statement 2012 Annual Statement*, Vt. Dept of Fin. Regulation 2-3, available at www.dfr.vermont.gov/sites/default/files/CIGNA%20S200%20Report.pdf (last visited Jan. 31, 2014) (reporting that out of 152,492 medical claims in 2012, of which 3,367 (2.2%) were denied such that members were directly impacted (defined as denials due to reasons other than “contractual obligations or other contractual or administrative requirements”). With regard to post-service appeals, there were 37 first-level appeals, 5 second-level appeals, and just one external appeal. *Id.* at 4.

115. 29 C.F.R. § 2590.715-2719, *supra* note 80, at (b)(2)(ii)(F).

116. See Letter from Kathryn Wilber, Senior Counsel, Health Policy, American Benefits Council, to Office of Health Plan Standards and Compliance Assistance, Employee Benefits Security Administration 5-6 (Sept.

behalf of consumers, but the lengthy legal analysis was for the most part contributed by industry giants such as the American Benefits Council and UnitedHealth Group.¹¹⁷

The departments relented, and the rule now does not apply if the exception is (1) *de minimis*, (2) non-prejudicial, (3) attributable to good cause or matters beyond the plan's control, (4) in the context of an ongoing good-faith exchange of information, and (5) not reflective of a pattern or practice of non-compliance.¹¹⁸ Upon written request, a claimant can obtain the plan's basis for its position that the plan met this standard.¹¹⁹

To overcome the plan-favoring default with regard to this rule, then, the participant must recognize the plan's departure from the rules *and* be aware of the possibility of short-circuiting the claims process. In addition, should the plan resist the short-circuiting process by asserting the exception, the claimant would need to know also about the option to submit a written request for an explanation. Even if the claimant does take such a step, the claimant is ill-equipped to know whether the plan is correct in asserting that the claimant's particular treatment is part of a "pattern or practice of non-compliance." This information would be hard to come by without having discovery into the plan's practices or being part of some sort of claimant group.

In a similar retreat, the departments backed away from the

30, 2010) www.dol.gov/ebsa/pdf/1210-AB45-0088.pdf (quoting an example of the opposition). The letter in pertinent part states, "[w]e believe there is a strong likelihood that the strict adherence standard will operate to allow many claimants to essentially bypass internal appeals processes, which generally provide claimants and plans with an efficient and cost-effective means for timely resolution of disputed benefits claims. Such a rule is undesirable from a policy perspective as it will permit individuals to initiate expensive external review processes or file suit in Federal court, for appeals that could most appropriately be resolved at the internal appeals level in a timely and cost-effective manner. According to the Preamble to the Interim Final Rule, a recent report found that the average cost of an external review was \$605. Increased plan costs are ultimately shouldered by participants as well, in the form of higher employee contributions for coverage." *Id.*

117. During the public comment periods, large industry players provided the bulk of the close analysis; individuals and consumer groups weighed in equal or greater numbers, but without the lengthy analyses provided by giants such as UnitedHealth Group and U.S Chamber of Commerce. *See, e.g.*, Email from Terry Tryan, Employee Benefits Agency, to Employee Benefits Security Administration (June 28, 2011) www.dol.gov/ebsa/pdf/1-2719-IFR.pdf (quoting a claims liaison through an agency who notes that many of his clients do not understand the claim and appeal denials) He requests, "I would like to see subscribers able to appeal their claims and understand the denials. The language within an insurance company sometimes carries over in the subscribers realm and they have no clue of what the carrier is saying." *Id.*

118. 29 C.F.R. § 2590.715.2719, *supra* note 80, at (b)(2)(ii)(F).

119. *Id.*

new rules' initial requirement that plans automatically provide the diagnosis and treatment codes it used as part of an adverse benefit determination.¹²⁰ The rules now provide that this information is available upon the participant's request, again placing the burden of action upon the already-burdened plan participant.¹²¹

Thus, in terms of process, established principles of human behavior such as framing and inertia continue to ensure that the claims process flows always in the health plan's favor and few consumers question their assigned share of the costs. Once a claim is denied, the default choice is always that the claim remains denied. In practice, the default option of remaining denied is exactly what happens with regard to the vast majority of denied healthcare claims.

2. Unrepresented Claimant Versus Repeat Player

The appeals process pits individual plan participant against a repeat player—the plan or its representative. With regard to external review, even the decision-maker is a repeat player with a business interest in an outcome favoring the plan.

Of the three parties involved in the appeals process (participant, plan, and external reviewer), the individual participant faces the greatest number of structural challenges. First, the individual is most likely new to the claims and appeals process, unlike the plan and external reviewer, who may face these issues multiple times per day. Second, the participant will likely be unrepresented by counsel. Even though the reform law is replete with procedural requirements that even sophisticated institutional players are still trying to assess, there are no incentives for lawyers to represent claimants in the administrative process.¹²² And, even if a claimant reaches a federal court and

120. U.S. DEPT OF LABOR, T.R. 2010-2, INTERIM PROCEDURES FOR INTERNAL CLAIMS AND APPEALS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (Sept. 20, 2010).

121. Group Health Plans and Health Insurance Issuers: Rules Relating to Internal Claims and Appeals and External Review Process, 76 Fed. Reg. 37213, at 37231 (proposed June 24, 2011).

122. Attorney's fees are not available for administrative action without litigation, so the availability of attorney's fees is no detriment at all to administrators who would refuse to pay claims initially and then pay on appeal or settle the claim as soon as litigation is initiated. *See Parke v. First Reliance Standard Life Ins. Co.*, 368 F.3d 999, 1011 (8th Cir. 2004) (joining "the Second, Fourth, Sixth, and Ninth Circuits in holding that the term 'any action' in 29 U.S.C. § 1132(g)(1) does not extend to pre-litigation administrative proceedings"); Harmon, *supra* note 76, at 440 (noting that "[a]s with prior law, the ERISA claimant's attorney cannot obtain an award of

wins the value of the denied claim, attorney's fees for the administrative phase are still generally unavailable.¹²³ Attorneys' fees for the judicial phase may be granted but are far from a certainty.¹²⁴ Therefore, the claimant must cope not only with the burdens of being ill, but must also attempt to navigate—without help—the complex ERISA rules.

Some free help is available, but many plan participants are unaware of it. The ACA provides for Consumer Assistance Grants, designed to provide claimants with additional information and “assist [consumers] with filing complaints and appeals.”¹²⁵ Twenty-three states have put these programs into place; the rest have not.¹²⁶ A Kaiser Family Foundation report notes, however, that even in the states that have adopted them, the programs have not been sufficiently funded.¹²⁷ Consumers outside states with Citizens Assistance Programs can contact the Department of Labor directly to request help.¹²⁸ The DOL will attempt to resolve the dispute through informal settlement procedures.¹²⁹ In

attorneys' fees and costs for these administrative proceedings”).

123. *Id.*

124. *See, e.g., Graham, Quinn, and St. Joseph's Hosp. supra* note 9.

125. *See* Catalog of Federal Domestic Assistance, Affordable Care Act (ACA) Consumer Assistance Program Grants, <https://www.cfda.gov/index?s=program&mode=form&tab=step1&id=61fad740681f80f7baea3832a8a16fdbwww.cfda.gov/?s=program%mode=form&tab=step1&id=61fad740681f80> (last visited Jan. 29, 2014) (quoting the language out of the goal of the Consumer Assistance Program Grants as charging recipients with collecting data on consumer inquiries and complaints to “help the Secretary identify problems in the marketplace and strengthen enforcement”). *See also Funding Opportunities*, THE CENTER FOR CONSUMER INFORMATION, <https://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/> (last visited Jan. 29, 2014) (giving more information on states with assistance centers (and those without)).

126. *Id.*

127. *See* KAISER FAMILY FOUNDATION, *supra* note 108, at 21 (noting that “the law authorizes ‘such sums as are necessary’ to support CAPs but only appropriated \$30 million”). No funding has been announced since 2012, even though the CAPs “are the only entities required, by federal law, to help privately insured people resolve health plan complaints and claims disputes and file appeals. Absent this help, as case studies illustrate, some people may continue to be overwhelmed by insurance paperwork they cannot understand and even incur debt for bills insurance should have paid.”

128. *Request for Assistance from the Dept. of Labor, available at* <https://www.askebsa.dol.gov/WebIntake/Home.aspx> (last accessed Mar. 15, 2014).

129. *Id.* The DOL offers the following assistance with disputes:

Requests for Assistance or Complaints involving alleged violations of Title I of ERISA are handled by Benefit Advisors in our national and field offices. Those who file complaints with us can expect a prompt and courteous response from our staff. Every complaint received will be pursued and, if determined to be valid, resolution will be sought through

numerous instances studied in the recent Kaiser Family Foundation report, individuals were unaware that there was consumer assistance available to help them.¹³⁰ Ultimately, while the repeat player has had years to parse the rules and refine its approach, the individual claimant must forage for free help (if the claimant is able to even know where to look) or proceed through the process alone.

When an external reviewer decides a claim, can it be impartial? The external reviewer is essentially a paid, private company that arbitrates the matter.¹³¹ Unlike a judge, the external reviewer is paid by the party denying the claim.¹³² The rules provide that, to enhance the reviewer's impartiality, the plan must contract with at least three reviewers and rotate assignments among them.¹³³ There is, however, no requirement that the plan remain with any particular reviewing company for a particular period of time and no restriction against dropping one company from the rotation and selecting another. Consumer groups have therefore questioned whether such an arrangement can truly be without bias.¹³⁴

informal dispute resolution. You can expect to receive a status report from the assigned benefits advisor every 30 days. If your valid complaint cannot be resolved informally, it may be referred for further review by our enforcement staff. While we cannot ensure that every complaint will result in an investigation, at the conclusion of enforcement activity, if requested, we will furnish an understandable explanation of the outcome of our review and investigation.

About the Employee Benefits Security Administration, www.dol.gov/ebsa/about/ebsa/main.html (last accessed Mar. 15, 2014).

130. KAISER FAMILY FOUNDATION, *supra* note 108, at 4 (noting that most individuals surveyed did not know where to seek help and that the "burdens of illness made it harder to resolve problems on their own"). In the Kaiser report's case studies, person after person reported that they did not know their state had a Consumer Assistance Program. *See id.* at 23 (stating "[Consumer] did not know her state has a Consumer Assistance Program that would help her file an appeal"); *see id.* at 25 (describing a consumer who wrote to his congressman and others for help but did not know his state had a Consumer Assistance Program that could have helped him with appeals).

131. Harmon, *supra* note 76, at 440.

132. *Supra* note 94.

133. *Id.* "Random selection" is also permitted as a means to reduce bias. *Id.* Aetna, for example, has contracted with three independent review organizations—each, then, stands to receive a large amount of business from this significant company. *Appeals and External Review Q&A*, available at <https://www.aetna.com/health-reform-connection/questions-answers/appeals-external-review.html> (last accessed Mar. 15, 2014).

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

C. External Review as a Barrier to Relief in Federal Court and a Reported Decision

External review has certain advantages, such as lower costs and greater availability than resort to federal court. But unlike judicial opinions, external reviewers' decisions need not explain their reasoning publicly, for the benefit of subsequent plan participants.

With external review, plan participants receive a decision without paying court costs and attorneys' fees, but participants are also denied the benefits of a confrontation in open court, the opportunity to cross-examine witnesses, a public judicial opinion with accompanying reasoning, and the ability to set and benefit from precedent.¹³⁵ A plan may voluntarily change its claims-processing strategy in response to IRO decisions, and there are some reported instances of such an effect.¹³⁶ Plans are not

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

Letter from Advocates for Patients with Chronic Illness to Phyllis Borzi & Karen Pollitz, Dated Jan. 31, 2011, *available at* <http://advocacyforpatients.blogspot.com/2011/01/advocates-letter-on-appeal-regulations.html> (last accessed Mar. 15, 2014); KAREN POLLITZ, GERALDINE DALLEK & NICOLE TOPAY, INST. FOR HEALTHCARE RESEARCH & POLICY: EXTERNAL REVIEW OF HEALTH PLAN DECISIONS: AN UPDATE 11-12 (May 2000), *available at* <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/external-review.pdf> (discussing concerns regarding conflicts of interest, particularly where the reviewing entity performs other takes for the plan or issuer).

135. Harmon, *supra* note 76, at 440 (noting also that “the reform law purports to add additional accountability through the new process requirements with disclosure of decisional rationales and opportunities for submission of additional evidence, but in the end, all for what amounts to paper file review”).

136. See KAREN POLLITZ, GERALDINE DALLEK & NICOLE TOPAY, INST. FOR HEALTHCARE RESEARCH & POLICY: EXTERNAL REVIEW OF HEALTH PLAN DECISIONS: AN OVERVIEW OF KEY PROGRAM FEATURES IN THE STATES AND MEDICARE 6 (1998), *available at* <http://kaiserfamilyfoundation.files.wordpress.com/2013/04/3928.pdf> (noting that “[a]t the outset of Pennsylvania’s program, for example, a significant portion of reviews involved denial of emergency room care. Over time, the number of such reviews has dwindled and regulators attribute this to HMOs learning and understanding the state’s expectations.”); *see also* Laura B. Benko, *Upon Further Review*, 35 MOD. HEALTHCARE, Feb. 7, 2005, at 29 (explaining that when claim denials for bariatric procedures such as gastric bypass surgery, were routinely overturned

required to do so, however, and plan participants do not have access to past decisions in order to assert them as precedent. During the public comment period on the new rules, some urged that information on IRO decisions should be released¹³⁷ but these arguments were not successful. External review decisions, then, are non-public and are not subject to the courts' standard of *stare decisis*.

For plans, another advantage of this lack of public scrutiny is that the practices that might have led a claimant to appeal a claim three times remain hidden. Once a claim reaches federal court, the judge examines the entire record and may comment on claims processing practices or failures to follow the rules.¹³⁸ Resolution of claims at the external review level allows plans to avoid the judicial scoldings that they have received in the past and that become part of the permanent public record.¹³⁹

It is as yet unclear whether external review can serve as a mandatory step prior to filing a claim in federal court. Where a plan does not describe external review as a requirement of the administrative process, courts have denied motions to dismiss based on arguments that the plaintiff has not exhausted the administrative process.¹⁴⁰ In some sense, then, the purportedly ameliorative step of external review is a new roadblock between the healthcare consumer and the consumer's ability to seek benefits by suing the plan and obtaining official precedent in the form of a judicial opinion.

by external review, insurers began to cover the procedure more often in the first instance).

137. In the course of the public comment period for the new regulations, the American Association of Retired Persons urged that external reviewers be required to release the following details:

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

Letter from AARP to the Dep't of Health and Human Servs., Emp. Benefits Sec. Admin., and the Internal Revenue Serv., Dated Sept. 21, 2010, www.dol.gov/ebsa/pdf/1210-AB45-0059.pdf (last accessed Mar. 15, 2014).

138. *See, e.g.,* *Schoedinger v. United Healthcare*, No. 4:04-cv-664 SNL, 2006 WL 3803935, at *8 (E.D. Mo. Nov. 6, 2006) (noting that "insurance companies regularly reduce and deny claims without cause").

139. *Id.*

140. *Goldman v. BCBSM Found.*, 841 F. Supp. 2d 1021 (E.D. Mich. 2012).

IV. THE INCOMPLETE PROMISE OF HEALTHCARE REFORM

Although the will to reform and expand multiple aspects of American healthcare prevailed in 2009, the will to reform ERISA preemption did not. With employers and plans long accustomed to ERISA's freedom from accountability in claims processing, any change to the status quo in that regard proved unacceptable.

The ACA's revisions to claims processing rules are not without some benefit. Ultimately, however, to keep ERISA preemption in place is to allow plans to escape accountability with regard to claims processing and the damage it can cause. In addition, the continued preemption of state law claims means that attorneys have no incentive to participate, and only the most tenacious and sophisticated plan participants will navigate the appeals process to have their denials reversed. Meanwhile, the plan participants who abandon their claim denials bear the brunt of ERISA's cost-saving effect, effectively keeping costs lower for the employer and other plan participants.

A. Enhanced Claims Processing Protections for Participants

Without a doubt, consumers have some enhanced protections under the ACA, as well as additional resources when facing a problem with their claims. The claims processing reforms have brought increased access to information, so plan participants can engage with their providers and work out how to appeal a claim.¹⁴¹ External review has been a boon for many, particularly those with expensive, one-time treatments or a single chronic condition; for these situations, the long march through two levels of internal review and eventual external review makes sense and may be possible. Given the high rate at which denials are reversed on external review,¹⁴² the process has certainly allowed some to obtain benefits that they would not have received before. The new rules provide greater access to timely information regarding the plan's basis for denials, information that can assist participants in preparing an appeal.

In the end, though, the rules keep the burden on participants

141. Juliette Forstenzer Espinosa, *Strengthening Appeals Rights for Privately-Insured Patients: The Impact of the Patient Protection and Affordable Care Act*, Public Health Reports, Jul.-Aug. 2012, at 460, available at www.ncbi.nlm.nih.gov/pmc/articles/PMC3366385/#B23 (last accessed Mar. 16, 2014).

142. *Infra* note 150.

to understand a complex web of rights, sift through paperwork and reasoning, and marshal medical evidence, all while battling the underlying illness that is producing the claims—a challenging prospect indeed. And, if the plan does not follow the rules and improperly denies the benefit, causing disruption, burden on the participant, and medical harm, there is still no remedy. ERISA plan participants who opt to sue stand to receive nothing but the value of the denied benefit. Even attorney's fees are rarely awarded, and generally not unless the claim is actually litigated, so the protracted struggle through the appeals process is strictly at the participant's expense.¹⁴³

B. Preemption as Cost Control

While judicial opinions in ERISA preemption cases are notorious for their complexity,¹⁴⁴ employers' main reason for supporting ERISA preemption is simple: cost.¹⁴⁵ Managed care is of course predicated on contracts between employers, plans, and patients—these contracts often feature financial incentives that reduce unnecessary use of healthcare dollars.¹⁴⁶ These incentives can run counter to the best interests of patients. Health plans have long sought to control costs through capitation, utilization review, physician incentives, and other arrangements.¹⁴⁷ In the end, the current system of ERISA preemption is simply another

143. See *supra* note 122 (noting that attorney's fees are not available for consumers' efforts to obtain reversal of denied claims during the administrative phase).

144. See *Hughes Aircraft v. Jacobson*, 525 U.S. 432, 447 (1999) (noting that ERISA is a "complex and reticulated statute") (citing *Nachman Corp. v. Pension Ben. Guaranty Corp.*, 446 U.S. 359, 361 (1980)); see also *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262 (1993) (describing ERISA as "enormously complex and detailed.").

145. See *supra* note 62 (arguing that the loss of ERISA preemption would expose employer companies to vast liability and lawsuits); see also ERISA PREEMPTION HEARING, *supra* note 11, at 33-34 (discussing financial impact of changes to ERISA preemption and predicting that many employers would scale back coverage or charge more if preemption were altered).

146. Leatrice Berman-Sandler, *Independent Medical Review: Expanding Legal Remedies to Achieve Managed Care Accountability*, 13 ANNALS HEALTH L. 233, 235 (Winter 2004).

147. See David Villar Patton, *Achieving Managed Care Accountability by Ending the ERISA Preemption Defense*, 59 OHIO ST. L.J. 1423, 1426 (1998) (explaining cost control mechanisms such as capitation, utilization review, and others); Patricia A. Danzon, *Tort Liability: A Minefield for Managed Care*, 26 J. LEGAL STUD. 491, 498 (1997) (noting that capitation "shift[s] from passive payment of providers, based on fee-for-service or costs incurred, to various forms of fixed fee payment for a comprehensive episode or period of care, regardless of the volume or cost of services actually delivered").

such form of cost control.

Both sides of the ERISA preemption debate agree that if there were no ERISA preemption, individuals who suffer from the consequences of improper claims processing would seek a remedy, and the incentive of state-law damages would encourage more attorneys to participate.¹⁴⁸ This would naturally cost plans more, as they would have to defend against the lawsuits and pay damages when necessary, which they do not currently have to pay. A rejection of preemption reform does not, of course, make the cost of improper claim denials disappear, but instead places them back on the individual participants who have suffered the denied claims and any consequences.

When a benefit is improperly denied, a plan participant can do one of two things: absorb the cost of the denied benefit himself, or go forward in the multi-level appeal process and attempt to have the denial reversed. Currently, and particularly with regard to smaller claim amounts, the overwhelming majority of plan participants are opting to absorb the cost of improperly denied claims themselves.¹⁴⁹ Those with the time and energy to go forward and advocate for themselves (or perhaps for a relative) meet with an excellent chance of success: when pursued to the level of external review, denials are overturned at a rate of about forty percent.¹⁵⁰ To reach external review, however, participants must remain tenacious through multiple levels of internal review, with the necessary deadlines, gathering of evidence, and marshalling of evidence.¹⁵¹

148. See, e.g., Senate Hearing, *supra* note 11, at 33-34.

149. *Supra* note 114.

150. Karen Pollitz et al., *Assessing State External Review Programs & the Effects of Pending Federal Patients' Right Legislation*, at v. (May 2002), available at www.docin.com/p-347938894.html. See also New York State Insurance Department Annual Report of the Superintendent (2010), available at www.dfs.ny.gov/reportpub/insurance/annrpt2010.pdf (providing that New York State reports annually on its state external review program. While the results may not necessarily be similar to the results of external review under the new ACA rules, the results are still instructive. In 2010, the Department of Insurance received 4,955 applications for external review; of those, 1,869 were not eligible for external review. With regard to 361 applications, the insurance company spontaneously paid the claim, even before the external review took place. Of the 2,370 assigned to external review, 940, or 40 percent, were overturned in favor of the consumer.).

151. See The Iowa Insurance Division, Consumer Advocate Bureau, *A Consumer's Guide to Internal and External Reviews*, available at <http://insuranceca.iowa.gov/health/aconsumersguidetoappealsandexternalreview.pdf> (noting that The Iowa Department of Insurance warns individuals with denied claims that they should plan ahead, request documents, and be prepared to make their case: "If your claim was denied as being not medically necessary, you should ask your medical provider for your medical records and

Those who are in the most difficulty—those too overwhelmed to learn about appeal processes and actually appeal—end up paying for medical care that the plan should have paid. In addition, less sophisticated plan participants may not fully understand their appeal rights or may feel uncomfortable advocating against institutions linked to their employment. These plan participants too, if they abandon appeals of improperly-denied claims, absorb the cost of plan errors and keep costs lower for other participants. This represents part of ERISA preemption's cost savings, because if preemption were removed, the availability of state law remedies would mean that attorneys would be more likely to participate and help participants sue.

Are plan participants from the middle and lower socioeconomic classes contributing more to ERISA plans' cost savings than participants from the middle to upper socioeconomic classes? Some commentators suspect so. Well before external review became part of the ACA, one commentator predicted that required external review of denied healthcare claims would "further rig the system still further in favor of the privileged minority of upper-middle-class consumers."¹⁵² As an illustration, he noted the heroic efforts of the plaintiff in *Rush Prudential HMO v. Moran*¹⁵³ to obtain her choice of treatment and then successfully seek reimbursement for it.¹⁵⁴ When conventional therapies failed her, she sought an unusual surgery from an out-of-state expert; her plan refused to approve the surgery.¹⁵⁵ She underwent the surgery anyway, paying \$94,841.27 and then suing the plan for reimbursement.¹⁵⁶ When only a few are able to take such steps and work through the system with such persistence, wherewithal, and financial resources, then those who cannot take these steps bear the costs—the plan ends up paying for treatments sought by such individuals, while those who cannot negotiate the system

a letter explaining why the denied treatment was prescribed and why other forms of treatment were not appropriate. If your claim was denied as being 'experimental or investigational,' you should ask your medical provider for your medical records, studies establishing the effectiveness of this service, and a letter explaining these studies and the treatment rationale. It may take some time for your medical providers to produce the supporting documents you request. Allow several weeks to get your medical records and a letter from your medical provider, especially if you are requesting them from a large hospital or clinic." Claimants must prepare themselves for a considerable paper chase).

152. *Supra* note 20, at 92.

153. *Rush Prudential HMO v. Moran*, 536 U.S. 355 (2002).

154. *Supra* note 20, at 92.

155. *Supra* note 153, at 360-61.

156. *Id.* at 361.

represent costs savings to the plan.¹⁵⁷

While the *Rush Prudential HMO v. Moran* example is perhaps extreme, the Kaiser Family Foundation's recent study confirms the burden on everyday plan participants.¹⁵⁸ The study presents case after case of individuals ground down by medical expenses, yet so burdened by work and medical care that they are unable to find out about appeals or to find time to file one.¹⁵⁹ None of the individuals in the case studies indicated that they knew about the Citizens Assistance Programs.¹⁶⁰

An additional aspect of the ERISA preemption cost savings is that plans need not pay the consequence for wrongful claims processing or negligent decisions. The risk of an improper denial is borne by the individual plan participant alone, even though the consequences for any individual can be highly significant.

The enduring question, then, is whether this allocation of risk and cost is the proper one—that effectively, the energetic and sophisticated plan participant prevails in navigating the appeals process and having improper denials overturned, while the passive participant pays the price. And whether the participant is able to navigate the appeals process or not, any consequences flowing from the wrongful denial remain with the plan participant.

V. CONCLUSION

It is unlikely that ERISA will be reformed in the near future—after all, numerous groups have an interest in keeping it the way it is.¹⁶¹ The employer and insurer lobby is organized and ready to act whenever an anti-preemption bill is introduced. Without further changes to the claims process and ultimately, to ERISA preemption, the ACA includes more people in health plans but also leaves them vulnerable to the vagaries of health plan decision-makers. The promise of universal, meaningful healthcare coverage therefore remains incomplete.

157. *Supra* note 20, at 84.

158. *Supra* note 111.

159. *Id.*

160. *Supra* note 130.

161. Brendan S. Maher, *Thoughts on the Latest Battles Over ERISA's Remedies*, 30 HOFSTRA LAB. & EMP. L. J. 339, 443 (Spring 2013).