PSYCH
APPEAL

Safeguarding Mental Health Care

April 29, 2021

The Honorable Robert C. "Bobby" Scott
Chairman, Committee on Education and Labor
United States House of Representatives
2176 Rayburn House Office Building
Washington, DC 20515-6100

Re: Health, Employment, Labor, and Pensions Subcommittee Hearing
Meeting the Moment: Improving Access to Behavioral and Mental Health Care (April 15, 2021)

Dear Chairman Scott:

This letter is in response to your April 23, 2021 request for additional testimony relevant to the April 15, 2021 Health, Employment, Labor, and Pensions ("HELP") Subcommittee hearing on access to mental health care. You specifically asked me to address the following:

> Dr. Bendat, consumers have certain rights to appeal adverse benefit determinations by health plans and insurers, including the right to external review. What are some of the challenges that consumers face in utilizing the external review process under current law? What particular issues are prevalent with respect to self-insured ERISA plans? What steps can be taken to address these problems through either legislative or regulatory efforts?

External Review Processes Under ERISA

Although ERISA provides participants and beneficiaries of non-grandfathered group health plans the right to external reviews of adverse benefit determinations,[1] the external review process operates differently with respect to group health plans that are fully-insured and those that are self-funded. Since health insurance issuers offering group

[1] 29 U.S.C. § 1185d, incorporating 42 U.S.C. § 300gg-19(b).

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health insurance coverage are subject to concurrent state and federal regulation, their adverse benefit determinations based on medical necessity[2] are generally subject to the "state external review process."[3] The state external review process requires states to directly select, assign cases to, and oversee so-called Independent Review Organizations ("IRO"s).[4] External reviews of adverse benefit determinations by health insurance issuers offering group health insurance coverage in states[5] without an external review process are subject to either the "federal external review process"[6] or the "alternative, federally-administered external review process."[7] While states may permit self-funded ERISA group health plans to participate in their external review process,[8] self-funded group health plans overwhelmingly participate in the federal external review process. Under the federal external review process, health insurance issuers offering group health insurance coverage (in jurisdictions without a state external review process) and self-funded group health plans, primarily through their fiduciaries (*i.e.,* claims administrators), are permitted to privately contract with IROs.[9]

Conflicts of Interest Undermine the Independence
of the State and Federal External Review Processes

Outside the state and federal external review processes, health insurance issuers and claims administrators often also contract with the same IROs that conduct external reviews to perform internal reviews when in-house personnel are unavailable. IROs that serve as internal review agents operate to support the business needs of health insurance issuers and claims administrators. Thus, even if internal and external reviews are not assigned to the same IRO in any given case, IROs are conditioned to view health insurance issuers and claims administrators—not consumers—as their clients. In fact, URAC, which accredits IROs, defines "Client" to be "A business or individual that purchases services from the [IRO].[10] As the National Association of Independent Review Organizations ("NAIRO") rightly admits, "The fact that IRO's may perform independent reviews at levels 'internal' to a health plan poses potential conflicts of interest for IRO's."[11]

[2] 29 C.F.R. § 2590.715-2719(c)(2)(i).
[3] 29 C.F.R. § 2590.715-2719(c).
[4] 29 C.F.R. § 2590.715-2719(c)(2)(vii)-(viii).
[5] https://www.cms.gov/CCIIO/Resources/Files/external_appeals
[6] 29 C.F.R. § 2590.715-2719(d)(1)-(3).
[7] 29 C.F.R. § 2590.715-2719(d)(4).
[8] 29 C.F.R. § 2590.715-2719(c)(1)(ii).
[9] 29 C.F.R. § 2590.715-2719(d)(2)(iii)(A)(2).
[10] 2011. *Independent Review Organization: External Review Standards*. 5th ed. Washington, D.C.: URAC, pp.14-36, 73-75.
[11] n.d. *Preserving the Integrity and Viability of Independent Medical Review.* [online] NAIRO, p.6. Available at: https://www.nairo.org/assets/docs/NAIRO-White-Paper-Preserving-the-Integrity-and-Viability-of-Independent-Medical-Review.pdf [Accessed 26 April 2021].

Mental Health Challenges

Under the federal external review process, the client-vendor conflict skews the framing of disputes and precludes relief for parity violations. Because the federal external review process directly tasks claims administrators with assigning external reviews to IROs,[12] claims administrators holding the purse strings routinely instruct IROs to exclusively opine on whether disputed services are medically necessary or experimental/investigational, despite current regulations directing IROs also to determine whether adverse benefit determinations based on medical judgment apply parity-compliant medical management techniques.[13] By improperly limiting the scope of external reviews, even when parity concerns are expressly raised by consumers, claims administrators evade review of systemic and potentially discriminatory nonquantitative treatment limitations. Simultaneously, they also avoid costs associated with the use of legal experts, which IROs are permitted (but routinely fail) to engage.[14] This gamesmanship is entirely consistent with a 2005 URAC/NAIRO survey of IROs' primary review methodologies, finding that "client preference" was the leading determinant of primary review basis for internal reviews and was a close second (to regulatory requirements) with respect to external reviews.[15]

The lack of transparency under the federal external review process poses additional challenges for ERISA health plan participants and beneficiaries. Current regulations simply require health insurance issuers and claims administrators to contract with IROs of their choice without subjecting either party to routine governmental oversight. Consequently, alarming coverage trends for mental health care easily evade detection by federal regulators charged with enforcing MHPAEA. For example, data from California's external review process identified that out of 13,000 requests for external reviews based on medical necessity, external reviews overturned more mental health denials than for any other type of medical condition, and found that health insurance issuers improperly denied coverage of mental health services in 48 percent of all cases.[16]

Additionally, absent governmental oversight of the federal external review process, health insurance issuers, claims administrators, and IROs are not required to

[12] 29 C.F.R. § 2590.715-2719(d)(2)(iii)(A).
[13] 29 C.F.R. § 2590.715-2719d(1)(i)(A). Ironically, the regulation does not require group health plans and their fiduciaries, including claims administrators, to automatically produce evidence concerning relevant nonquantitative treatment limitations to IROs. Unsurprisingly, this information is neither volunteered by claims administrators who operationalize nonquantitative treatment limitations nor requested of them by their contracted IROs.
[14] 29 C.F.R. § 2590.715-2719(d)(2)(iii)(B)(1).
[15] *Preserving the Integrity and Viability of Independent Medical Review*, *supra*, n.11, at pp.10-11.
[16] Wagner, L. and Escamilla, F., 2016. *State Finds Mentally Ill Improperly Denied Coverage for Treatment Nearly Half the Time*. [online] NBC Bay Area. Available at: https://www.nbcbayarea.com/news/local/state-finds-mentally-ill-improperly-denied-coverage-for-treatment-nearly-half-the-time/136786/ [Accessed 26 April 2021].

disclose data concerning their compliance with external review timeframes and notice requirements. This lack of transparency is particularly troubling with respect to expedited external reviews, which by definition are intended to avert jeopardy to life or health.[17] In fact, under the federal external review process, IROs are permitted to terminate external reviews and automatically reverse adverse benefit determinations when health insurance issuers and claims administrators fail to provide timely and complete information.[18] Yet it remains entirely unknown whether, how often, and with respect to which health insurance issuers and claims administrators IROs exercise this discretion (if at all).

Of further concern is that, despite ERISA expressly providing for the identification of medical or vocational experts whose advice was obtained on behalf of a health plan in connection with an adverse benefit determination,[19] IROs routinely conceal the identities of external reviewers from consumers. This practice violates the spirit, if not the letter of the law, and precludes consumers from vetting external reviewers' representations about their qualifications and independence, which are not always accurate or complete. Considering that judges are perfectly capable of making independent, high stakes, and sometimes unpopular decisions with full disclosure of their identities, there is simply no compelling justification for external reviewers to remain anonymous.

Recommendations for Reform

Only the alternative, federally-administered external review process established by the Department of Health and Human Services ("HHS")[20] and state external review processes operated by regulators such as the California Department of Managed Health Care ("DMHC")[21] come close to insulating consumers from the conflicts of interest and lack of regulatory oversight described above. This is because these regulators exclusively contract with IROs that do not accept direct business (including internal review assignments) from health insurance issuers and claims administrators in any market segment. Under these regimes, health insurance issuers and claims administrators are unable to influence or game the external review system. The only caveat is that the alternative, federally-administered external review process does not require its contracted IRO to disclose external reviewer identities, placing consumers at a serious informational disadvantage.

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[17] 29 C.F.R. § 2590.715-2719(d)(3)(i). Problematically, 29 C.F.R. § 2590.715-2719(d)(3)(ii) requires claims administrators to "immediately" conduct preliminary reviews of requests for expedited external reviews without specifying an exact time limit in which to complete any such review. Additionally, 29 C.F.R. § 2590.715-2719(d)(3)(iii)(A) requires claims administrators to assign expedited reviews to IROs pursuant to the requirements for standard review, suggesting that health plans may take up to 5 business days in which to transmit required data, albeit via an expeditious method such as fax or email.
[18] 29 C.F.R. § 2590.715-2719 (d)(2)(iii)(B)(3).
[19] 29 C.F.R. §2560.503-1(h)(3)(iv).
[20] https://externalappeal.cms.gov/ferpportal/#/home.
[21] https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/rules-and-regulations/public-comments/1210-28876/00025.pdf

In light of the above, I urge Congress to pass legislation or require amended regulations that: 1) prohibit IROs that conduct internal reviews for health insurance issuers or claims administrators from participating in any state external review process, regardless of whether they adjudicate internal and external reviews in any given case; 2) abolish the federal external review process; 3) require self-funded ERISA health plans to participate in the alternative, federally-administered external review process operating under governmental oversight; and 4) mandate disclosure of external reviewer identities under any external review process sanctioned by Congress.

Sincerely,

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