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THE ARTICLE BY STUDDERT AND GRESENZ[1] IN THIS ISSUE of THE JOURNAL is a valuable contribution to the debate about US managed care policy and patients' rights. The analysis of enrollee appeals from 2 California-based health maintenance organizations (HMOs) provides an important look inside the "black box" of prospective coverage decision making, which typically remains hidden from view in the absence of judicial appeal or the very occasional government study. Judicial review of prospective coverage decisions is rare because of the cost and complexity of litigation. Even retrospective appeals are unusual, given the inability in most health insurance disputes to recover damages for death or injuries caused by wrongful denial of benefits by group health plans,[2] a limitation that reduces the economic feasibility of litigation.

Based on direct review of thousands of appeals, the authors made several notable findings. First, appeals are rare. Four million enrollees produced about 15 000 private coverage appeals over the 2-year time period from which the researchers drew their sample. Second, the majority of appeals concern services not yet furnished (ie, are prospective). Third, not all appeals involve traditional questions of medical necessity. While approximately one third of their sample of appeals raised questions about conventional medical necessity for particular patients, the remaining two thirds of the disputes involved either "contractual coverage" claims (a conclusion that a condition or treatment, even if necessary, is "extracontractual" and thus not covered) or what the authors term "choice of provider" claims (access to out-of-network care). The authors note that all of their research categories can raise issues of medical judgment.

The authors conclude that some portion of appeals concerning medical necessity involve the problem of "societal uncertainty" regarding the boundaries of medical care, and also surmise that disputes over contract terms or choice of provider might be lessened through better drafting of insurance contracts and more consumer education about the limits of their coverage.

At first blush, readers might discount the importance of this study. Some might argue that the study shows that health plan appeals are rare, and when they do occur, are unlikely to involve services of real clinical significance. Others might conclude that HMO enrollment is low compared with other, more loosely structured, private group coverage arrangements such as preferred provider organizations (PPOs),[3] which are relatively free of the types of constraints found in HMOs and thus might be expected to produce even fewer appeals.

See also p 864.

Either conclusion would be wrong. Rarity is a hallmark of all classes of legal action, whether formal judicial disputes or informal ones resolved through an internal appeals process. In a society that values legal rights, not merely public and private largesse, it is essential to understand what happens when individuals exercise their rights. Furthermore, although there certainly are claims that involve mere "social uncertainty," to use the authors' characterization (a term that may just as aptly describe the arbitrary limits on health care that the insurance industry might seek to impose), other claims involve life and death decisions. Indeed, the case that began what has turned into a decade-long congressional focus on external review of health plan coverage decisions was *Corcoran v United HealthCare*.[4] In this case, a an infant born at home died after the mother's plan refused to preapprove inpatient preterm labor management.

The essence of health insurance is an enforceable, formal promise to furnish a specified form of coverage to persons who meet contractual qualification standards. Where that promise is allegedly breached, it is the very right of enforcement that lifts insurance out of the world of charity care and into the realm of basic guarantee. The potential for erroneous interpretation of contract terms in relation to particular patients is significant, and the stakes can be enormous. Such was the case of Ethan Bedrick, who was born with cerebral palsy and who was denied physical and speech therapy after a claims reviewer reached the baseless conclusion that care was medically unnecessary because, in the reviewer's view, the toddler had no chance of making significant improvement.[5] The company's conduct was condemned by the US Court of Appeals for the Fourth Circuit (one of the most conservative federal circuits) as not merely inhumane but as an unlawful reading of the insurance contract by a medical reviewer.

A key role of law in the United States is to ensure fairness in those circumstances in which individual rights are threatened. The notion of using vague and subjective concepts such as "societal uncertainty" to deny basic, fair process should be of concern to those who place value in a just system. This is particularly so in the case of the administration of health insurance benefits, in which erroneous contractual interpretation by inexperienced or biased insurance company personnel may result in the unfair denial of health care that might seem unimportant to some but truly significant to others. For example, what might be dismissed as unnecessary speech therapy by a claims reviewer who values only complete "recovery" to "normal" functioning becomes incredibly important to parents of a child with cerebral palsy who is trying to attain basic speech.

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The rarity of HMO appeals might be evidence of the extent to which members deem it futile to fight with their insurers. Of course, in the context of this study, rarity also could be a good sign; a deluge of appeals might suggest deep and systemic problems with the quality of the plan's operations. Moreover, although this study involves only HMOs, it is critically important not to be misled by arbitrary product nomenclature concocted by corporate executives, lawyers, policy makers, and health services researchers. The study deals with plan characteristics that are common to virtually all modern health insurance, whether loosely or tightly structured. Health plans today rest on certain basic building blocks that have become embedded in the modern concept of health insurance. It is these building blocks—not specific product types—to which the study speaks.

The first building block is an enforceable written contract that delineates the components and limitations of coverage and typically vests extensive interpretive power in the insurer. For medical and legal reasons, there are limits on how specific the coverage terms can get.[6] As a result, virtually all such contracts contain broad coverage limitations and exclusions that must be interpreted in relation to specific patients. These decisions involve complex analyses involving the application of contract terms to individual medical fact and review is essential, regardless of plan product. For example, in addition to defining medical necessity, a contract might contain broad exclusionary clauses that limit or prohibit certain treatments (eg, experimental treatment, care for acquired immunodeficiency syndrome, or conditions for which no "significant improvement" can be expected) and whose application involves sophisticated exercise of medical judgment.[7,8]

The second building block is a network of participating health professionals and health care entities and institutions that furnishes covered services. In most private arrangements, access to certain services can be obtained with a higher co-payment; in others, such as classic HMOs or Medicaid plans, the network is exclusive unless out-of-network care is approved by the plan. Network-style insurers promise covered care through their networks and thus must permit out-of-network care when network care is unavailable. Although the authors somewhat euphemistically classify network disputes as "choice of provider" cases, these disputes can raise extremely serious medical issues. For example, in *Pappas v Asbel*,[9] a health plan member was left permanently paralyzed when the health plan's medical director refused to approve out-of-network neurologic emergency care.

The third building block is utilization management. Prospective decision making may vary in frequency depending on the specific nature of the insurance contract (eg, a closely managed HMO vs a more loosely structured PPO contract). The *Corcoran* case[4] illustrates the potential for prospective review to result in major harm. Furthermore, the need for rapid and fair review of prospective treatment decisions is particularly striking when, as in the study by Studdert and Gresenz, the medical group that furnishes health care also operates under a financial risk contract and is authorized to make binding expenditure decisions for patients.

Regulations issued by the Clinton administration in 2000 were designed to infuse rigor into the appeals process maintained by employer-sponsored health plans covered by the Employee Retirement Income Security Act (ERISA),[10] which governs insurance arrangements for more than 150 million workers and their family members. Whether these rules will be vigorously enforced remains to be seen.

In recent years, greater legislative attention has been given to external administrative review of health plan decisions. More than 40 state legislatures have enacted such laws,[11] which were saved from ERISA preemption by the US Supreme Court in *Moran v Rush Prudential HMO*.[12] Under legislation that died in the 107th Congress, ERISA would have been amended to extend external review safeguards to members of all ERISA plans, whether or not subject to state regulation. In keeping with the Supreme Court's decision in *Pegram v Herdrich*,[13] the legislation would have guaranteed external review rights in all cases raising medically reviewable questions, regardless of any arbitrary dispute classification system (eg, "medical necessity" vs "contractual"). Such safeguards exist not only for members of most state-regulated insurance plans but also for Medicare and Medicaid beneficiaries.

Whether the 108th Congress revives this legislation remains to be seen. In his January 28, 2003, State of the Union speech, President Bush did not identify patient protections as a priority, and long-time observers tend to view health care consumer protections as a topic of concern in times when more pressing issues, such as rising numbers of uninsured persons and skyrocketing health costs, are not on the table. In the end, however, the question of whether individuals can actually secure the services for which they are eligible is as intrinsically important to the health care coverage debate, since without enforceability, insurance is effectively coverage in name only.

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