



## policy points

### The President Acts to Protect Patients Although Congress was unable to achieve a patients' bill of rights, the U.S. Department of Labor has provided more rights for workers covered by employer-sponsored health plans.

BY JEFF ATKINSON



A Patients' Bill of Rights did not make it through Congress during the

Clinton Administration. Although Republicans and Democrats agreed on most of the broad provisions that such a law should have, they disagreed on some of the details. As a result, patients are still waiting for Congress to guarantee their rights in dealing with a health-insurance company.

As President, however, Bill Clinton had the power to make changes administratively. Although the changes were

not as sweeping as those that could be enacted by Congress, the U.S. Department of Labor, acting on instructions from President Clinton, adopted new rules to provide protection to patients. Secretary of Labor Alexis Herman said that the new rules will offer people "a faster, fairer, and more informed process for handling their claims and appeals to pay benefits."

The rules, which were

adopted in November 2000 and will take effect January 1, 2002, apply to more than 130 million persons whose health insurance is provided by private sector employers under the Employment Retirement Income Security Act (ERISA). The rules impose three main requirements on employer-sponsored health plans.

First, the rules set time limits within which health plans must respond to requests from

patients for service. Second, health plans must adopt internal systems by which patients can appeal decisions to deny coverage. (Most health plans already have such systems.) Third, the health plans must disclose certain types of information to patients.

#### Turn-around time

The time period within which a group health plan must respond to a patient's request for service varies with the nature of the service and the level of urgency. For requests for coverage made before a service is rendered ("a pre-service claim"), the health plan must respond "within a reasonable period of time appropriate to the medical circum-

**When a physician is given a specific reason for denial of care, she will be in a better position to present additional facts or arguments regarding why the treatment or procedure should be covered.**

## POLICY POINTS

Continued from previous page

### Response time for claims

The U.S. Department of Labor has issued new regulations which set time limits for employer-sponsored health plans to respond to requests for coverage of treatment. The length of time for the response and any extensions of time vary with the type of request and the level of urgency. The rules were published in 29 Code of Federal Regulations (CFR) Part 2560.503-1, 65 Federal Register 70265, Nov. 21, 2000. The related rules regarding disclosures that must be made to workers enrolled in employer-sponsored health plans were published the same day in 29 CFR Part 2520.102-3 -2520-104b-3, 65 Federal Register 70241.

Type of service	Response time	Extension of response time for good cause
Pre-service claim	Within 15 days	15 days
Urgent care	3 days (or less)	Only if insufficient information given to health plan
Post-service claim	30 days	15 days
Disability claim	45 days	30 days

stances, but not later than 15 days after receipt of the claim by the plan.” The time period may be extended an additional 15 days for good reasons beyond the control of the plan.

If a claim involves “urgent care,” the administrator of the group health plan must notify the patient no later than 72 hours from receipt of the claim, unless the patient (or patient’s representative) had provided incomplete information. If the administrator believes the information provided is insufficient, the administrator must notify the patient of that within 24 hours. Although 72 hours is the time period specified by regulations, the maximum time period for notification could be shorter if the circumstances require.

In cases involving reduction or termination of concurrent care decisions, the plan administrator must notify the patient sufficiently in advance to allow the patient to appeal. (A “concurrent care decision” is described as “an ongoing course of treatment to be provided over a period of time or number of treatments.”)

For claims that are handled after the service has been rendered, the plan administrator must notify the patient no later than 30 days after receipt of claim (subject to one 15-day extension for reasons beyond the plan’s control). Disability claims must be handled within 45 days (subject to a 30-day extension).

### Internal appeals

The new regulations provide that every employee health plan shall give claimants “a reasonable opportunity to appeal an adverse benefit determination . . . under which there will be a full and fair review of the claim and the adverse benefit determination.”

When a claim is denied, the plan must provide the patient with five pieces of information: (1) the specific reason or reasons for denial of the claim; (2) reference to specific plan provisions on which the denial was based; (3) a description of any additional material the patient needs to file a valid claim along with an explanation of why such material is necessary;

(4) a description of the plan’s appeals procedures and the patient’s right to file an action in court following an adverse benefit determination; and (5) a copy of any internal rules, guidelines, or protocols that were used in making the adverse decision.

If a claim is denied because the procedure or treatment is considered “experimental” or not a “medical necessity,” an explanation of the scientific or medical judgment must be provided free of charge upon request.

Patients must be allowed at least 180 days from an adverse decision by a group health plan in which to file an appeal. (Under the former rules, appeals had to be filed within 60 days.)

The persons reviewing an appeal regarding denial of benefits must give the claim a fresh look. The reviewers are not allowed to give deference to the initial decision. The reviewers also are obliged to “consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.”

The new regulations do not require that there be appeals to expert panels outside the health plan. That type of mechanism was viewed as beyond the power of administrative regulations operating under current law. Both Republicans and Democrats generally favor external appeal systems. If Congress does pass a Patient Bill of Rights in 2001, external appeals are likely to be part of the new law.

The regulations do not preempt state laws. If the law of a state currently provides for external appeals, those laws are still in effect.

### Disclosure of information

A separate set of regulations, also issued by the Department of Labor in November 2000, lists a variety of information that

## POLICY POINTS

Continued from previous page

employee group health plans must include in documents provided to workers. The information must be “written in a manner calculated to be understood by the average plan participant” and must include descriptions of:

- Cost-sharing provisions, including premiums, deductibles, coinsurance, and copayments
- Lifetime caps or other limits on benefits
- Scope of coverage for preventive services
- Scope of coverage for new and existing drugs
- Scope of coverage for medical tests, devices, and procedures
- Composition of network providers (if any); coverage for out-of-network providers
- Limits on selection of primary care providers or specialists
- Limits on obtaining emergency medical care
- Provisions requiring preauthorization or utilization review as a condition of obtaining a benefit or service, and
- Procedures for filing claims and reviewing claims which have been denied

The documents describing health plans also must advise employees that they cannot be fired or otherwise discriminated against because the employee exercised rights under ERISA, including by filing claims for health-care benefits.

### Impact on physicians

The new regulations should facilitate the physician's ability to care for patients. When a request is made for coverage of treatment or a procedure, plans are obliged to respond in a relatively short period

---

**The new rules still permit non-experts to make initial coverage decisions, but appeals must include consultation with a health-care professional with expertise in the field of medicine in question.**

---

of time. If the treating physician certifies that a procedure or treatment is needed “urgently,” the plan will be required to respond in three days or less.

While the regulations do not attempt to set a standard of care that must be provided, they do require that specific reasons be given for denial of care. When a physician is given a specific reason for denial of care, she will be in a better position to present additional facts or arguments regarding why the treatment or procedure should be covered.

In times past, it was common for requests for coverage to be denied by insurance company employees who were not physicians or, who, if they were physicians, did not have expertise in the issue under consideration. The new rules still permit non-experts to make initial coverage decisions, but appeals must include consultation with a health-care professional with expertise in the field of medicine in question.

### Federal Bill of Rights

By the time this issue is published, the new Congress will have convened with a close division in the House and Senate between Democrats and Republicans and a president who was elected by a margin that fell far short of an overwhelming mandate. Congress and the White House will feel pressure to show that they can be effective and work together. An issue to which they will likely give prompt attention will be a Patient Bills of Rights.

A federal Patient Bill of Rights will build on the rules issued by the Department of Labor. In addition to requiring internal appeals in health plans

of decisions denying health-care coverage, Congress is likely to require a system for appeals to panels of medical experts outside the health plans. In addition, a Patient Bill of Rights is likely to prohibit gag clauses, provide more coverage of out-of-network emergency treatment, increase rights of patients (particularly pregnant women and cancer patients) to stay with their doctor of choice, and require more “report cards” on the performance of health plans.

Some of these protections are already the subject of state laws or regulations within the Medicare system. But if Congress adopts the protections, they will protect a much larger percentage of Americans. ■

*Jeff Atkinson teaches courses in health-care reform and health-care contracts at DePaul University College of Law in Chicago, where he graduated summa cum laude. He also writes on legal, medical, and ethical issues.*