

PRACTICING MEDICINE THROUGH PAPERWORK AND ALGORITHMS: HOW HEALTH INSURERS PROMOTE PATIENT HARM AND WHAT CONGRESS SHOULD DO ABOUT IT

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I. INTRODUCTION

For every American, except the wealthy, what care a health plan *will pay* for determines what care the patient *will receive*.¹ Care is not determined by the patient and her doctor, or by what is the most effective evidence-based intervention at that time. It is not even determined by what a *minimally competent* physician would do to avoid malpractice—the “generally accepted standard of care” (GASC)² developed by practicing clinicians and their non-profit medical and clinical societies.³

A health plan approves or denies care based on its own medical review standards or on standards purchased from another company; in many cases, that company is either a subsidiary of the plan or a for-profit, proprietary clinical-guideline developer.⁴ The committees that develop these proprietary guidelines may not include clinicians in active practice or in the specialty area of concern, and often, information about these committees and their process is not readily

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1. See Shameek Rakshit et al., *How Does Cost Affect Access to Healthcare?*, KFF HEALTH SYS. TRACKER (Jan. 12, 2024), <https://www.healthsystemtracker.org/chart-collection/cost-affect-access-care/> [https://perma.cc/AHH7-GLCY] (According to the 2022 KFF National Health Interview Survey, 43% of adults reported they or a family member in their household postponed needed health care due to cost from being uninsured or underinsured).

2. Peter Moffett, M.D. & Gregory Moore, M.D., J.D., *The Standard of Care: Legal History and Definitions: the Bad and Good News*, 12 WEST J. EMERG. MED. 109, 111 (2011) (discussing The Modern Definition of Standard of Care: “That which a *minimally competent* physician would do under similar circumstances.” (emphasis added)).

3. Wit v. United Behav. Health, No. 14-CV-02346-JCS, 2019 WL 1033730, at *14–15 (N.D. Cal. Mar. 5, 2019) (defining generally accepted standards of care with references to several non-profit medical and clinical societies) (*aff’d* in part, *rev’d* in part, and *remanded*, 79 F.4th 1068, 1089-90 (9th Cir. 2023)).

4. *Id.* at *10; see *Clinical Guidelines*, UNITED HEALTHCARE, <https://www.uhcprovider.com/en/policies-protocols/clinical-guidelines.html#:~:text=UnitedHealthcare%20uses%20evidence%2Dbased%20clinical,not%20a%20guarantee%20of%20coverage> [https://perma.cc/BW67-5JW9] (last visited Oct. 21, 2025); see also *Clinical Editors*, MCG, <https://www.mcg.com/about/clinical-editors/> [https://perma.cc/H3TJ-FDZC] (last visited Oct. 21, 2025) (describing the role of MCG’s clinical editors in overseeing MCG’s care guidelines).

available to providers and patients alike.⁵ Further, unlike individual clinicians, no one involved in the design, implementation, or application of these care-determining guidelines has accountability or legal liability for wrongfully denying care and any damage it may cause to the patient. For most Americans, *coverage denied is likely care denied*.⁶

Since coverage largely determines access, why do health plans not use the available treatment standards from non-profit medical and clinical societies whose members are *practicing* clinicians, such as the American Academy of Pediatrics, the American Psychiatric Association, the American College of Emergency Physicians or the American College of Obstetrician-Gynecologists? Why reinvent the wheel? The short answer appears to be profit.⁷ The more detailed story involves the ways our insurer-focused health care industry rewards middlemen, consultants, and bloated corporate bureaucracies that have not added value, but cost an enormous amount.⁸ Since health insurers widely incorporated managed care procedures—such as prior authorization, medical necessity review, proprietary medical guidelines, utilization management systems, and pharmacy benefit managers—into their offerings to health plans of all funding types, health care costs have steadily increased while our population health has decreased, with many already disadvantaged communities feeling disproportionate effects.⁹

Why are health insurance companies and third-party administrators (TPAs) not held accountable for the real health and economic damages patients suffer when care is unjustifiably denied? When insurer clinical guidelines or coverage decisions fall below GASC, these denials cause a host of problems for patients and clinicians involving significant, sometimes irreparable, economic, physical

5. *Id.*; see also INST. OF MED., CLINICAL PRACTICE GUIDELINES WE CAN TRUST (Robin Graham et al. eds., The Nat'l Acad. Press, 2011). <https://www.nam.edu/cpgstandards> [<https://perma.cc/3H9H-YWUB>] (discusses issues with lack of transparency and conflicts of interest in the current system of clinical guideline development and recommends standards by which trustworthy guidelines should be developed and assessed).

6. Rakshit et al., *supra* note 1.

7. See Press Release, Letitia James, Attorney General, State of New York, Attorney General James Provides \$13.6 Million to Consumers Who Were Denied Mental Health Care Coverage (May 20, 2022), <https://ag.ny.gov/press-release/2022/attorney-general-james-provides-136-million-consumers-who-were-denied-mental> [<https://perma.cc/PA8J-A6ZE>]; see also T. Christian Miller et al., “Not Medically Necessary”: Inside the Company Helping America’s Biggest Health Insurers Deny Coverage for Care, PROPUBLICA (Oct. 23, 2024), <https://www.propublica.org/article/evicore-health-insurance-denials-cigna-unitedhealthcare-aetna-prior-authorizations> [<https://perma.cc/RQG5-LKKN>].

8. See William H. Shrank et al., *Waste in the US Health Care System: Estimated Costs and Potential Savings*, 332 JAMA 15, 1501–09 (Oct. 15, 2019) (discusses estimated cost of administrative complexity of \$265.6 billion compared to cost of “overtreatment” \$75.7 billion to \$101.2 billion.)

9. CHRISTI A. GRIMM, DEP’T OF HEALTH & HUM. SERVS., OFF. OF INSPECTOR GEN., OEI-09-19-00350, HIGH RATES OF PRIOR AUTHORIZATION DENIALS BY SOME PLANS AND LIMITED STATE OVERSIGHT RAISE CONCERNS ABOUT ACCESS TO CARE IN MEDICAID MANAGED CARE 2, 22 (July 2023), <https://oig.hhs.gov/oei/reports/OEI-09-19-00350.asp> [<https://perma.cc/78SE-EZYK>]

and mental harm.¹⁰

A. Thesis Statement

This Note argues Congress must act to pass federal legislation, modeled in part on the Jim Ramstad Model Legislation for States but expanded to include all health care funding sources.¹¹ This proposed legislation will ensure health plans of all types are rid of “discretionary clauses” so they are accountable and liable for medical review criteria and coverage decisions that fall below the GASC, just as practicing clinicians may be liable for *malpractice* if their treatment falls below the GASC. Further, health insurers need to have the same level of liability for bad faith as other types of insurers.¹² When health insurers and TPAs act in bad faith, the consequences can be irreparable, even deadly. Current regulatory actions and available remedies are a small price for insurers to pay for the profit gained from denying medically necessary GASC. Scores of patients are harmed every day with little recourse.¹³ This must change, and Congress must change it.

B. The Jim Ramstad Model Legislation for States

The Jim Ramstad Model Legislation for States¹⁴ was inspired by the

10. *Id.* at 22; see generally Anna Jo Bodurtha Smith et al., *Insurance-Mediated Disparities in Gynecologic Oncology Care*, 139 OBSTET. GYNECOL. 305, 305–12 (Feb. 2022).

11. See generally *New Guide Helps Consumers Fight Coverage Denials of Mental Health & Addiction Care*, KENNEDY FORUM (Apr. 22, 2021), <https://www.thekennedyforum.org/press-releases/new-guide-helps-consumers-fight-coverage-denials-of-mental-health-addiction-care/> [<https://perma.cc/L32K-3WBY>] (the “Proposed Ramstad for All Care Act” is the author’s proposed modification of the Jim Ramstad Model Legislation for States. The state parity model legislation is aimed at increasing mental health parity law protections at the state level. The author’s Proposed Ramstad for All Care Act is proposed *federal* legislation that would apply to all health care conditions and all types of health plans regulated in whole or in part under federal law).

12. The American health insurance system is a complicated patchwork of publicly and privately funded health plans with a complicated regulatory system beyond the scope of this Note. For the purposes of this Note, the term “health insurers” refers to the corporate entities who provide managed care and TPA services to both public and privately funded health plans. The term “health plan” is used to describe health insurance coverage generically. Managed Care Organization (MCO) refers to the health insurer corporate entities and subsidiaries that contract with health plans to provide utilization management and medical review.

13. See Francis Beifuss, *Illusory Remedies: Why Lacking Oversight and Penalties Leave Half of the Country With Only a Shadow of Healthcare*, 62 UNIV. LOUISVILLE L. REV. 761, 761. (2024); see also Grimm, *supra* note 9 (raising concerns that some Medicaid recipients under managed care organizations may not receive medically necessary services that should be covered because of a lack of state oversight and access to external medical reviews).

14. David Lloyd, *Jim Ramstad Model State Legislation to Advance Mental Health and Addition Equity By Requiring Compliance with Generally Accepted Standards of Care*, Kennedy Forum, <https://www.thekennedyforum.org/app/uploads/2021/05/Ramstad-Model-Legislation-May-2021.pdf> [<https://perma.cc/L32K-3WBY>] (last visited Oct. 31, 2025) (See Appendix A for relevant Ramstad Act language).

California Mental Health Parity Act Update, also known as SB 855, passed in response to the 9th Circuit's class action decision in *Wit v. United Behavioral Health (UBH)*.¹⁵ Governor Gavin Newsom signed S.B. 855 into law on September 25, 2020 with the goal of improving California's state enforcement of mental health parity protections. The new law applies to all California health plans and disability insurance policies issued, amended, or renewed on or after January 1, 2021. S.B. 855's relevant language states:

In March 2019, the United States District Court of the Northern District of California ruled in *Wit v. United Behavioral Health*, 2019 WL 1033730 (Wit; N.D.CA Mar. 5, 2019), that United Behavioral Health created flawed level of care placement criteria that were inconsistent with generally accepted standards of mental health and substance use disorder care in order to 'mitigate' the requirements of the federal Mental Health Parity and Addiction Equity Act of 2008.¹⁶

As *Wit v. UBH* demonstrates, despite having over fifteen years to comply, some insurers and TPAs maintain persistent resistance to, and in some cases, ongoing defiance of mental health parity law, especially as it applies to medical review policies and criteria.¹⁷ *Wit* also represents a larger concern with managed care organization (MCO) medical review criteria in general – the use of proprietary clinical guidelines that may not comport with evidenced-based GASC and which appear to focus on cost control over quality of care.¹⁸ The Ramstad Model Act for states seeks to improve mental health parity law compliance by requiring state-regulated health plans to use mental health (MH) and substance use disorder (SUD) review guidelines that comport with GASC, rid health plan contracts of discretionary clauses, and prohibit denial of services “primarily for the economic benefit of the insurer [or] purchaser.”¹⁹ The proposed Ramstad for All Care Act expands upon these requirements by requiring all medical review criteria used in any health plan, for any condition, to comply with GASC. As discussed below, this reform is necessary to protect

15. *Cal. Health & Safety Code* §§ 1367.045, 1374.721, 1374.72 (West 2021); *Cal. Ins. Code* §§ 10144.52, 10144.5 (West 2021); S.B. 855, The California Mental Health Parity Act Update, https://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB855 [<https://perma.cc/5XNS-U4K8>] (modified several sections of California code to require insurance carriers doing business in California to incorporate GASC into their medical necessity review processes for mental health and substance use disorder treatment, among other provisions).

16. S.B. 855, Sec. 1(k), (Cal. 2020), https://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB855 [<https://perma.cc/5XNS-U4K8>].

17. *Wit v. United Behav. Health*, No. 14-CV-02346-JCS, 2019 WL 1033730, at *22 (N.D. Cal. Mar. 5, 2019).

18. *Id.* at *47–48; see INST. OF MED., *supra* note 5, at 7; see also Moffett & Moore, *supra* note 2, at 111; see generally Annie Waldman, *How UnitedHealth's Playbook for Limiting Mental Health Coverage Puts Countless Americans' Treatment at Risk*, PROPUBLICA (Nov. 19, 2024), <https://www.propublica.org/article/unitedhealth-mental-health-care-denied-illegal-algorithm>, [<https://perma.cc/M9K4-6Y7Z>].

19. Lloyd, *supra* note 14.

patients, employers, and taxpayers from sub-par outcomes and diminishing returns for money spent on health care.

II. BACKGROUND ON THE ISSUE – THE COMPARATIVE COST OF AMERICAN HEALTH CARE AND THE ROLE OF MANAGED CARE ORGANIZATIONS

According to the Organization for Economic Co-operation and Development (OECD), the United States spent an estimated \$12,742 per person on health care in 2022, the highest among similar nations. The second-highest spending nation was Switzerland, which spent \$9,044 per capita. Average spending among the OECD nations, excluding the United States, was \$6,850 per capita.²⁰ Far and away, the U.S. is an outlier in administrative expenditures, spending \$1,001 per capita compared to the second highest, Switzerland, at \$392 per capita. OECD nations spend an average of \$213 per capita, and the lowest spending nation, Japan, spends \$74 per capita.²¹

Does this higher spending translate into better patient experiences and better health outcomes, providing more value for our health care dollar? It appears the answer is no. The U.S. does not outperform its lower spending counterparts in most health categories, and in several common categories, such as diabetes management, childbirth safety, infant mortality and life expectancy, the U.S. performs worse.²² The high administrative costs American employers and taxpayers fund are attributed predominately to insurance company profits and provider overhead dedicated to billing and record keeping for claims submissions.²³ In a national survey of insured adults, most rated their health plan favorably; however, most also reported having difficulties with denied claims, prior authorization problems, and network provider access problems.²⁴ Of those who experienced difficulties with insurance coverage, nearly half were unable to resolve the issue.²⁵ As a result of their insurance issue, 17% of survey respondents could not access needed physical care, 43% could not access needed mental health care, and 15% reported a decline in health status due to the coverage problems.²⁶ The data indicates that our expensive MCO-driven system creates complicated processes for patients and providers that does not translate into improved access, quality of care, or health outcomes.

20. *How Does the U.S. Healthcare System Compare to Other Countries?*, PETER G. PETERSON FOUND., <https://www.pgpf.org/article/how-does-the-us-healthcare-system-compare-to-other-countries/> (last updated Aug. 16, 2024) [<https://perma.cc/2ADX-NKS5>].

21. *Id.*

22. *Id.*

23. Emily Gee & Topher Spiro, *Excess Administrative Costs Burden the U.S. Health Care System*, CTR. FOR AM. PROGRAM (Apr. 8, 2019), <https://www.americanprogress.org/article/excess-administrative-costs-burden-u-s-health-care-system/> [<https://perma.cc/3LCR-ANF5>].

24. Karen Pollitz et al., *Survey of Consumer Experiences with Health Insurance*, KFF (June 15, 2023), <https://www.kff.org/private-insurance/poll-finding/kff-survey-of-consumer-experiences-with-health-insurance/> [<https://perma.cc/YP39-VUNT>].

25. *Id.*

26. *Id.*

Despite these results, a small number of MCO parent companies are increasingly in control of our health system. Consolidations among health insurers over the last several years has led to the same limited number of MCOs controlling what medical care Americans can access – all without accountability or liability for physical harm, mental anguish, or pain and suffering when medically necessary care is delayed or denied.²⁷ According to a recent Health and Human Services report, in July 2020, approximately 72% of Medicaid enrollees received their coverage through MCOs and more than half of Medicaid spending in fiscal year 2021 was paid to MCOs.²⁸ Medicaid-managed care programs are increasingly responsible for enrollees in long-term care and supports services—nursing home patients, medically fragile children, and people with physical, intellectual and developmental disabilities—who are ill-positioned to navigate the labyrinth of information, rules and requirements of managed Medicaid.²⁹ Like Medicaid, Medicare is increasingly managed by MCOs. In 2024, 32.8 million people, or 54% of the eligible Medicare population, were enrolled in a Medicare Advantage plan, and the Medicare Advantage MCOs received \$462 billion, or 54%, of total federal Medicare spending. Medicare Advantage enrolls a disproportionate share of people of color in Medicare as well as an increasing number of dual eligible beneficiaries, or people who are eligible for both Medicaid and Medicare.³⁰ The vast majority of self-insured employer plans use MCOs as TPAs.³¹ State regulated employer-sponsored plans and Affordable Care Act Marketplace health plans rely heavily on large national MCOs.³² Health insurance premium costs for employers increased by 27% from 2018 to 2023, with employee contributions increasing by 19%.³³ Health care spending accounted for over 17% of the Gross Domestic Product in 2022, at \$13,493 per person.³⁴ Consequently, as taxpayers and insured persons, Americans have significant interest in MCOs' ability to determine what medical care patients receive and the conditions under which

27. Leemore S. Dafny, *Evaluating the Impact of Health Insurance Industry Consolidation: Learning from Experience*, 33 COMMONWEALTH FUND ISSUE BRIEF 1, 1–2 (Nov. 20, 2015), <https://www.commonwealthfund.org/publications/issue-briefs/2015/nov/evaluating-impact-health-insurance-industry-consolidation> [https://perma.cc/D8JF-7DXG].

28. Grimm, *supra* note 9, at 2.

29. *Id.* at 2–4.

30. Meredith Freed et al., *Medicare Advantage in 2024: Enrollment Update and Key Trends*, KFF (Aug. 8, 2024), <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/> [https://perma.cc/LZW5-PUYP].

31. Fred Hunt, *Everything You Wanted to Know About TPAs But Were Afraid to Ask*, SOC'Y OF PRO. BENEFITS ADMIN., <https://spbatpa.org/article/everything-you-wanted-know-about-tpas-were-afraid-ask> [https://perma.cc/WB2Z-6Y8Y] (last visited Nov. 20, 2024).

32. Dafny, *supra* note 27.

33. *2023 Employer Health Benefits Survey*, KFF (Oct. 18, 2023), <https://www.kff.org/report-section/ehbs-2023-summary-of-findings/> [https://perma.cc/FM6F-M8XB].

34. *National Health Expenditure Accounts Data*, CMS, <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/historical#:~:text=U.S.%20health%20care%20spending%20grew,see%20the%20downloadable%20files%20below> [https://perma.cc/DPU8-SNYY] (last visited Oct. 31, 2025).

the decisions are made. Americans should expect our representatives in Congress to act when MCO medical review decision-making deficiencies lead to significant harm to patients and an increase in costs that impact American families and employers.³⁵

*A. Examples of Harm Caused by Typical Managed Care:
Organization Medical Reviews*

Typical managed care review processes have long disadvantaged patients, especially the most vulnerable. For example, applied behavior analysis therapy (ABA) has been considered GASC for autism spectrum disorder (ASD) for over twenty-five years.³⁶ ASD is a complex, lifelong developmental condition that typically appears during early childhood and can impact a person's social skills, communication, relationships, and self-regulation. ASD manifests differently in each person. It is defined by a certain set of behaviors that affect language, social skills and executive functioning.³⁷ ASD is often referred to as a "spectrum condition" because it affects people differently and to varying degrees.³⁸ ABA is an intensive outpatient treatment that improves the disabling features of autism, such as deficits in language/communication, cognitive functioning, executive functioning, understanding social cues, and regulating repetitive, compulsive, injurious, or aggressive behaviors that interfere with daily living and learning. Conservative estimates indicate the lifetime costs for supporting a person with autism, outside of medical care, is \$2 to 3 million³⁹ ABA therapy can save \$1.6 million per person through reduced need for special education and other taxpayer-funded support services costs outside of medical care.⁴⁰ Because it is intensive and provided in one-to-one or small group sessions for up to 40 hours per week, ABA is too expensive for most families to afford without insurance coverage. Despite all available evidence, and the endorsements by

35. See PETER G. PETERSON FOUND., *supra*, note 20.

36. *Scientific, Professional and Government Organizations' Position on the ABA from the Neurobehavioral Unit (NBU)*, KENNEDY KRIEGER, <https://www.kennedykrieger.org/patient-care/centers-and-programs/neurobehavioral-unit-nbu/applied-behavior-analysis/scientific-professional-and-government-organizations-position-on-the-aba-from-the-neurobehavioral-unit-nbu> [https://perma.cc/47MB-4U22] (last visited Oct. 31, 2025).

37. *The Autism Experience: Understanding Autism*, AUTISM SOC'Y OF AM., <https://autism.society.org/the-autism-experience/> [https://perma.cc/U5KS-3RJK] (last visited Oct. 31, 2025).

38. *Id.*

39. *Autism Costs Estimated to Be \$500 Billion, Potentially \$1 Trillion, by 2025*, U.C. DAVIS (July 28, 2015), <https://www.universityofcalifornia.edu/news/autisms-costs-estimated-be-500-billion-potentially-1-trillion-2025> [https://perma.cc/U26M-DLTF]; Penn Today, *Lifetime Costs for Autism Spectrum Disorder May Reach \$2.4 Million Per Patient, Penn Study Finds*, UNIV. OF PA. (June 9, 2014), <https://penntoday.upenn.edu/news/lifetime-costs-autism-spectrum-disorder-may-reach-24-million-patient-penn-study-finds#:~:text=In%20a%20study%20published%20online,to%20cost%20%241.4%20million%20in> [https://perma.cc/LH4J-B6ME].

40. Eric Larsson, *Is Applied Behavior Analysis and Early Intensive Behavioral Intervention an Effective Treatment for Autism? A Cumulative History of Impartial Independent Reviews*, LOVAAS INSTIT. (2013), <https://www.behavior.org/resources/649.pdf> [https://perma.cc/2AS7-6Z7H].

major medical societies, health insurers generally refused to cover ABA until parents advocated for state laws or mandates.⁴¹ It took parent advocates over twenty years to get coverage in all fifty states through a combination of legislation, executive action, and mental health parity enforcement action.⁴² During that time, thousands of people with autism who could not access prescribed ABA therapy suffered irreparable harm from the lost opportunity for treatment. This is especially true for people from middle class or lower socioeconomic backgrounds and already disadvantaged communities who continue to access clinical autism treatment at much lower levels.⁴³ Consequently, families and taxpayers will incur significantly greater costs of care for this generation deprived of the opportunity to access GASC treatment.

Many insurers and TPAs refuse to approve ABA therapy at the number of hours that are GASC level; they simply deem the hours to not be medically necessary, often without a more detailed explanation.⁴⁴ Further, some TPAs advise self-insured employers against offering any ABA coverage despite GASC, federal mental health parity requirements, and the fact that state autism mandate laws demonstrate ABA is a GASC treatment for ASD.⁴⁵ Historically, TRICARE, a health program for military families, has provided even more limited access to autism treatment than private insurance because it ignores GASC and health insurance industry standards in favor of its own opaque standards, research, and determinations about what treatments are effective.⁴⁶ The TRICARE ABA “pilot program” effectively prohibits delivery of ABA

41. See *History of Autism Mandate Laws*, Arc of Ind. (2022), <https://cdn.arcind.org/wp-content/uploads/2022/05/Historyof-Autism-Mandate-Laws-1.pdf> [https://perma.cc/3FM4-NXYE].

42. *Id.*

43. Jessica E. Rast et al., *Hospital Inpatient Stays for Autistic Youth and Youth With Other Disabilities*, 149 PEDIATRICS S1 (2022), <https://publications.aap.org/pediatrics/article/149/Supplement%204/e2020049437R/185642/Hospital-Inpatient-Stays-for-Autistic-Youth-and?autologincheck=redirected?nfToken=00000000-0000-0000-0000-000000000000> [https://perma.cc/MCV6-BQRN].

44. Telephone Interview with Karen Fessel, Executive Director, Mental Health and Autism Insurance Project (Mar. 27, 2024).

45. U.S. DEP’T OF LAB., 2022 MHPAEA REPORT TO CONGRESS at 52, 23, 44, <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/report-to-congress-2022.pdf> [https://perma.cc/V74Q-MUKW].

46. See generally *How TRICARE’s Autism Care Demonstration Differs*, NCAAS (June 21, 2023), <https://www.nationalautismcoalition.org/news/2023/6/21/how-tricares-autism-care-demonstration-differs> [https://perma.cc/Q9ZM-NYKE]; *Independent Analysis of Department of Defense’s Comprehensive Autism Care Demonstration Program*, NAT’L ACADEMIES, <https://www.nationalacademies.org/our-work/independent-analysis-of-department-of-defenses-comprehensive-autism-care-demonstration-program> [https://perma.cc/QA7L-2B87] (last visited Oct. 31, 2025); Nat’l Acad. of Sci., Eng’g, and Med., *The Comprehensive Autism Care Demonstration: Solutions for Military Families*, NAT’L ACAD PRESS, <https://www.nationalacademies.org/read/29139/chapter/7#130> [https://perma.cc/7AXA-65FJ] (last visited on Feb. 3, 2026).

according to relevant GASC.⁴⁷ If TRICARE is permitted to ignore GASC in common conditions like autism, our military readiness could be affected negatively by causing families to leave military service to access minimally competent care for their loved ones.⁴⁸

Women are also greatly affected by substandard care that results from gynecologic oncology prior authorization-related treatment delays and insurer clinical guidelines that do not comport with GASC. Prior authorization is associated with an over two-week delay in gynecological cancer treatment, which impacts survival, and disproportionately affects women in already marginalized communities.⁴⁹ Medical review guidelines and network policies that ignore GASC significantly impact the quality-of-care women receive, as outlined in the *Insurance-Mediated Disparities in Gynecologic Oncology Care* study quoted below:

One third of women with a gynecologic cancer never see a gynecologic oncologist. Up to 40% of Medicare Advantage plans lack an in-network gynecologic oncologist, and 33% of private insurance plans do not include an in-network National Cancer Institute-accredited cancer center, limiting access to surgical advances and clinical trials. Women with Medicaid insurance and gynecologic cancer are *25% less likely to receive guideline-concordant care*. Among insured women, 50% experience financial [hardship] during gynecologic cancer treatment, and costs may be even higher for certain Medicare enrollees.⁵⁰

Further, Medicare–Medicaid coverage is associated with less guideline-concordant care with 44% of dually eligible beneficiaries receiving chemotherapy compared with 60% of exclusively Medicare-covered or privately insured individuals. In ovarian cancer, having private insurance was associated with a 6-month longer survival compared with having public insurance after controlling for sociodemographic, cancer, and treatment factors, a survival gain similar to those seen in recent chemotherapy advances.⁵¹

Issues in work-up are known contributors to racial disparities with

47. Anne Marshall-Chalmers, *Troops Weigh Leaving Service Over Lack of Care for Kids With Autism Under Tricare*, WAR HORSE (Oct. 19, 2023), <https://thewarhorse.org/us-military-kids-with-autism-lack-treatment-under-tricare/> [https://perma.cc/2H87-URK2].

48. *Id.*, see also Karen Ruedisueli, *Independent Review Will Examine TRICARE's Autism Coverage*, MOAA (Nov. 7, 2023), <https://www.moaa.org/content/publications-and-media/news-articles/2023-news-articles/advocacy/independent-review-will-examine-tricares-autism-coverage/> [https://perma.cc/P63P-3KMQ].

49. Anna Jo Bodurtha Smith et al., *Insurance and Racial Disparities in Prior Authorization in Gynecologic Oncology*, 46 GYNECOLOGIC ONCOLOGY REP. 1, 1–3 (Mar. 11, 2023).

50. Anna Jo Bodurtha Smith et al., *Insurance-Mediated Disparities in Gynecologic Oncology Care*, 139(2) OBSTET. GYNECOL. 305, 305–12 (Jan. 5, 2022).

51. *Id.* at 308.

Black women more likely to face diagnostic delays—and twice as likely to die of endometrial cancer.⁵²

Although 90% of gynecologic cancer prior authorizations appealed are ultimately approved by insurers, 80% of patients and clinicians never try to appeal insurer denials because of time and limited staff resources.⁵³ Prior authorization has been associated with two-week or greater delays in treatment initiation and significant patient stress.⁵⁴ When a patient needs insurance coverage for lifesaving GASC treatment, inappropriate delays and denials unnecessarily add to the costs and the physical and emotional toll.

The staff members that medical practices must designate to handle prior authorizations, appeals, and peer review calls that involve below GASC insurer guidelines could be better utilized to provide value-added patient education, care coordination, and patient follow-up calls.⁵⁵ This would allow physicians to spend more time with patients and allow staff more time to assist with value-added, patient-focused activities that increase quality of care and patient, staff, and physician satisfaction.⁵⁶

Vulnerable seniors, many of whom are disabled or have chronic conditions, are at similar risk of harm from substandard care resulting from inappropriate denials from Medicare Advantage MCOs. According to a report from KFF, a non-profit, non-partisan health care policy organization, in 2021, over 80% of Medicare Advantage appeals for denied care were decided in favor of the patient, but only 11% of denials were appealed. One MCO, Centene, overturned 94% of its denials upon appeal. Therefore, a significant number of Medicare Advantage beneficiaries go without needed care, are denied unjustifiably, and suffer from undue treatment delays or forgone treatment.⁵⁷

After allegations that some MCOs were inappropriately delaying or denying medically necessary care for Medicaid beneficiaries, Congress requested the Health and Human Services Office of Inspector General (HHS-OIG) to study managed Medicaid denials.⁵⁸ These delays and denials are especially troubling for the vulnerable and disadvantaged groups covered by Medicaid, which includes people who are poor, pregnant women, babies, children and adults with

52. *Id.* at 307.

53. *Id.*

54. *Id.* at 308.

55. Vinayak Madhusoodanan et al., *Is Time Spent on Prior Authorization Associated with Approval?* 19(2) J. NURSING PRAC. 1, 1–5 (Feb. 2023); see Ani Turner et al., *Impacts of Prior Authorization on Health Care Costs and Quality*, NAT'L INST. FOR HEALTH CARE REFORM (Nov. 2019), <https://www.nihcr.org/wp-content/uploads/Altarum-Prior-Authorization-Review-November-2019.pdf> [<https://perma.cc/Q3YG-S873>].

56. Joan Stephenson, *U.S. Surgeon General Sounds the Alarm on Health Worker Burnout*, 3(6) JAMA 1, 1–2 (June 7, 2022).

57. Jeannie Fugelsten Biniek et al., *Medicare Advantage Insurers Made Nearly 50 Million Prior Authorization Determinations in 2023*, KFF (Jan 28, 2025), <https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/> [<https://perma.cc/WM3S-MC9S>].

58. Grimm, *supra* note 9, at 1.

disabilities, foster children, and elderly nursing home patients. Medicaid is a federal and state-funded program administered by the states.⁵⁹ Federal Medicaid regulations require states to monitor MCOs' appeals and utilization management processes,⁶⁰ yet the HHS-OIG report concluded most states do not routinely review MCO denials for appropriateness.⁶¹ Further, many states do not have a mechanism for patients and providers to submit a prior authorization (PA) denial to an independent medical reviewer; that is, the same MCO reviews its own denials.⁶² For Medicaid enrollees who do have access to external review, 46.3% of MCO denials were reversed in whole or in part.⁶³ For many Medicaid enrollees, the state administrative fair hearing process is intimidating, cumbersome, and difficult to navigate.⁶⁴ First, the HHS-OIG report found several MCOs that did not notify Medicaid beneficiaries about fair hearing availability and processes in a timely and understandable fashion as required by federal regulation, and they often missed required timeframes for PA decisions.⁶⁵ Medicaid enrollees only appealed 11.2% of MCO PA denials, and a bare 2.1% of Medicaid enrollees requested a fair hearing, though the study found 38.3% of appealed denials were overturned.⁶⁶

Overall, Medicaid denial rates were over double the denial rates seen in Medicare Advantage managed care plans.⁶⁷ One MCO, Molina, had a PA denial rate of over 40%.⁶⁸ The HHS-OIG report raises significant concerns about health equity and quality of care for vulnerable groups who are significantly impacted by care delays and disruptions.⁶⁹ OIG expressed concern that while federal regulations require that MCOs may not arbitrarily deny or reduce a required service because of a patient's diagnosis, type of illness, or condition, risk-based payment systems such as capitation, coupled with the profit motive may incentivize MCOs to deny access to covered services.⁷⁰ Further, Medicaid enrollees have low incomes and approximately 50% of enrollees are people of color.⁷¹ These individuals are already at a higher risk of experiencing barriers to access quality health care, have increased poor outcomes, and are more likely to forgo burdensome appeals and administrative fair hearing processes.⁷² These administrative burdens, coupled with low reimbursement, may cause providers to refuse to contract with Medicaid or to limit the number of Medicaid patients

59. KFF *Medicaid 101* (October 8, 2025), <https://www.kff.org/medicaid/health-policy-101-medicaid/?entry=table-of-contents-introduction> [<https://perma.cc/2VFX-HRQ4>].

60. 42 C.F.R. § 438.66.

61. Grimm, *supra* note 9, at 9.

62. *Id.* at 12–14.

63. *Id.* at 35.

64. Grimm, *supra* note 9, at 7.

65. *Id.* at 15–16.

66. *Id.* at 34–36.

67. *Id.* at 7.

68. *Id.* at 32.

69. *Id.* at 17.

70. *Id.* at 1.

71. *Id.*

72. *Id.*

they will see, further exacerbating health inequities experienced by Medicaid enrollees. Disadvantaged populations are more likely to experience treatment abandonment due to administrative burdens of medical review, leading to further health inequities.⁷³

While certain to elicit pushback from the powerful insurance lobby,⁷⁴ these proposed reforms are reasonable and necessary to fulfill long standing promises from Congress to address consumer concerns with the rising costs and diminishing returns for money spent on health care. Requiring all plans to follow GASC will serve to better meet the reasonable expectations of the insured. According to a 2023 American Hospital Association press release, a recent survey found 83% of patients want their medical providers to determine what care they receive – not their insurance company.⁷⁵ GASC represents a basic level of care patients should expect in terms of clinical competence;⁷⁶ it follows that this basic level of care is expected to be covered. Surely, employers, the government and taxpayers expect the minimum level of competent care to be purchased for our health care dollars. Patients expect coverage for chronic conditions, not simply acute, urgent, or emergency care. Patients expect reasonable parameters for chronic condition management and on-going care. Patients, clinical providers, and employers expect value, transparency and reasonably accurate information from insurers.⁷⁷ Patients with chronic conditions should not expect to have to fight the same fight over and over with their insurer every authorization period or fight the same fight each and every time they are required to switch insurers by their employer. Patients should not discover years later that a denied mental health treatment was required to be covered under federal mental health parity law. After the death of a family member from cancer, loved ones should not suffer from knowing the deceased may have survived if the insurer had approved the GASC diagnostic test or chemotherapy agent prescribed. Congress and insurers must recognize access to basic health care is increasingly seen as a human right and required component to liberty.⁷⁸ A recent survey shows an overwhelming majority of Generation Z believes health care is a human right, including 87% of respondents overall and

73. Turner, *supra* note 55.

74. Joseph Choi & Karl Evers-Hillstrom, *How a lobbying blitz led to weaker Medicare Advantage reforms*, THE HILL (Apr. 7, 2023), <https://thehill.com/policy/healthcare/3938311-how-a-lobbying-blitz-led-to-weaker-medicare-advantage-reforms/> [<https://perma.cc/JG3S-XJES>].

75. Press Release, American Hospital Association, *New Surveys Find Majority of Patients, Doctors & Nurses Say Health Insurer Policies Reduce Access to Care* (July 11, 2023), <https://www.aha.org/press-releases/2023-07-11-new-surveys-find-majority-patients-doctors-nurses-say-health-insurer-policies-reduce-access-care> [<https://perma.cc/5CDT-4Z7Z>].

76. Moffett & Moore, *supra* note 2, at 111.

77. Am. Hosp. Ass'n, *supra* note 75; Pollitz et al., *supra* note 24.

78. Mary Gerisch, *Health Care As a Human Right*, AM. BAR ASS'N (Nov. 19, 2018), https://www.americanbar.org/groups/crsj/publications/human_rights_magazine_home/the-state-of-healthcare-in-the-united-states/health-care-as-a-human-right/ [<https://perma.cc/NFB4-D4MC>].

77% of Generation Z conservatives.⁷⁹ Consistently, most Americans, including a majority of conservatives, believe government has a role in ensuring access to health care.⁸⁰

American health insurance pricing is highest in the world,⁸¹ yet it is not guaranteed to cover the GASC, the minimally competent physician standard.⁸² How is this acceptable to taxpayers and the Congress that represents them, or to employers that fund Employee Retirement Income Security Act (ERISA) plans and rely on TPAs? The price paid does not match expectations. Requiring all health plans to cover GASC should also help increase health equity by better protecting Medicaid and Medicare beneficiaries. GASC mandated coverage would promote recognition that it is artificial to separate physical and mental health. This artificial mental health/physical health distinction leads to stigma, inequities, suboptimal care, poor care coordination, poor outcomes and therefore higher costs.⁸³

B. Background and Gaps in the Law – Wit v. UBH, MHPAEA, and ERISA

Wit v. United Behavioral Health (UBH) demonstrates gaps in the law that promote outcome inequity, substandard care and higher costs. Approximately 50,000 beneficiaries of as many as 3,000 ERISA-governed and state-governed health benefit plans formed three putative classes to take action against the claims administrator, UBH, for breach of fiduciary duty and improper denial of benefits for residential and other mental health/substance use disorder (MH/SUD) treatments.⁸⁴ The plaintiffs claimed the TPA improperly developed and relied on internal guidelines that were inconsistent with plan terms, state-mandated criteria (for state regulated plans) and GASC, despite the fact the plans required a treatment be GASC as a pre-condition for coverage. The plaintiffs alleged UBH breached its fiduciary duties to act solely in the interests of the participants and beneficiaries by developing and implementing coverage criteria inconsistent with GASC.⁸⁵

79. Ebonie Megibow et al., *Generation Z Takes the Reins*, AAMC (May 1, 2023), <https://www.aamchealthjustice.org/news/polling/generation-z-takes-reins> [https://perma.cc/8D5E-5B87].

80. Jocelyn Kiley, *Most continue to say ensuring health care coverage is government's responsibility*, PEW RESEARCH CTR. (Oct. 3, 2018), <https://www.pewresearch.org/short-reads/2018/10/03/most-continue-to-say-ensuring-health-care-coverage-is-governments-responsibility/> [https://perma.cc/KQP4-FD3C].

81. PETER G. PETERSON FOUND., supra note 20.

82. Employee Benefits Security Administration, *Compliance Assistance Guide: Health Benefits Coverage Under Federal Law*, Dep't of Lab., <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide.pdf> [https://perma.cc/V4E8-WLMQ] (last visited Aug. 29, 2025).

83. David Osborn, *The poor physical health of people with mental illness*, 175 W. J. MED. 329, 332 (Nov. 2001).

84. *Wit v. United Behav. Health*, No. 14-CV-02346-JCS, 2019 WL 1033730, at *4 (N.D. Cal. Mar. 5, 2019).

85. *Id.*

The District Court held UBH's internal medical review guidelines were deficient in eight categories compared to GASC guidelines.⁸⁶ "In the context of this case, generally accepted standards of care are the standards that have achieved widespread acceptance among behavioral health professionals. There is no single source of generally accepted standards of care. Rather, they can be gleaned from multiple sources, including peer-reviewed studies in academic journals, consensus guidelines from professional organizations, and guidelines and materials distributed by government agencies."⁸⁷ The court found, because of financial incentives to keep benefit expense down, UBH regularly reviewed detailed financial forecasts that included projections of expected benefit expense and benefit expense targets it wanted to achieve. It tracked performance monthly, taking action to address benefit expenses that exceed its projections. The court determined the internal clinical guidelines were "infected" with financial considerations.⁸⁸ UBH placed representatives of its Finance and Affordability Departments in key roles in the clinical guideline development process throughout the class period, including membership on the committee that would ultimately approve or veto guidelines.⁸⁹ The court noted, "[p]erhaps the most telling example of the emphasis UBH placed on financial considerations in its decision making with respect to the Guidelines relates to UBH's decision *not* to adopt the American Society of Addiction Medicine (ASAM) Criteria for making substance use disorder coverage determinations Despite the clear consensus among UBH addiction specialists that the ASAM Criteria were preferable to UBH's own Guidelines from a clinical standpoint, UBH consistently refused to replace its own Guidelines with ASAM Criteria without first obtaining approval from the Finance Department."⁹⁰ Consequently, the court held UBH's interpretation of the ERISA plan requirements was unreasonable and an abuse of discretion due to structural and financial conflicts of interest.⁹¹ For the ERISA plans, the court determined UBH breached its fiduciary duties of loyalty and care by adopting more restrictive coverage guidelines than the GASC.⁹² For the state regulated plans, the court held UBH violated mandated level-of-care requirements in four states.⁹³ The court ordered UBH to reprocess the claims according to GASC, and appointed a special master to oversee compliance for 10 years.⁹⁴ UBH did not appeal the district court's ruling that its guidelines violated the state law mandated criteria; however, it did appeal the ERISA-based claims to the 9th Circuit.⁹⁵

UBH was granted a 9th Circuit panel review, which reversed the district

86. *Id.* at *14 and *22.

87. *Id.* at *14.

88. *Id.* at *47.

89. *Id.*

90. *Id.* at *49.

91. *Id.* at *52–53.

92. *Wit v. United Behav. Health*, 79 F.4th 1068, 1080 (9th Cir. 2023).

93. *Id.* at 1079.

94. *Id.* at 1081.

95. *Id.* at 1068.

court judgement that UBH wrongfully denied benefits to ERISA beneficiaries.⁹⁶ The panel concluded that UBH was not required to provide coverage according to GASC, as the plan's discretionary clause grants UBH authority to interpret plan terms.⁹⁷ The 9th Circuit panel held the district court abused its discretion by ordering claims reprocessing, citing *Cigna Corp. v. Amara*, stating “[p]laintiffs and the district court did not explain or refer to precedent showing how reprocessing constitutes relief that was typically available in equity for infirm Guidelines unrelated to Plaintiffs’ claim for benefits.”⁹⁸

The *Wit* case is on-going. The 9th Circuit panel vacated its January 2023 ruling, potentially opening the door for some plaintiffs’ claims to be reprocessed, and 15 states, the District of Columbia, the Department of Labor, the Kennedy Forum and other advocates filed amici briefs to support the plaintiffs’ petition for rehearing en banc by the 9th Circuit Court of Appeals.⁹⁹

State regulators continue to attempt to bring United Healthcare, the nation’s largest health insurer and UBH parent company, and its subsidiaries into compliance with state and federal mental health parity law via enforcement action. For example, in 2022, the New York Attorney General announced the completion of \$13.6 million in payments to consumers denied health care coverage under a landmark agreement with United Healthcare.¹⁰⁰ The payments resolved New York’s federal lawsuit against UBH for illegally denying coverage of outpatient psychotherapy for thousands of members.¹⁰¹

In 2021, Illinois passed Public Act 102-0579¹⁰² based upon the Jim Ramstad Model Legislation for States to address insurers’ ongoing efforts to defy compliance with mental health parity law. The Act provides for increased enforcement to benefit consumers, civil monetary penalties, and a “no dumping on public programs” provision to combat the insurance industry’s practice of designing benefit restrictions and plan terms to encourage potential enrollees to seek services from public programs.¹⁰³ The Illinois legislature cited the *Wit* case as the impetus for enacting additional measures. “Despite the strong actions taken by the Illinois General Assembly, the court in *Wit v. United Behavioral*

96. *Id.* at 1088.

97. *Id.*

98. *Wit v. United Behav. Health*, 79 F.4th 1068, 1088 (9th Cir. 2023) (citing *Cigna Corp. v. Amara*, 563 U.S. 421, 439 (2011)).

99. Press Release, The Kennedy Forum, The Kennedy Forum Applauds the Upholding of District Court Findings in *Wit v. United Behavioral Health* by U.S. 9th Circuit Court of Appeals <https://www.thekennedyforum.org/press-releases/the-kennedy-forum-applauds-the-upholding-of-district-court-findings-in-wit-v-united-behavioral-health-by-us-9th-circuit-court-of-appeals/> [<https://perma.cc/HN6V-NSBZ>].

100. *Attorney General James Provides \$13.6 Million to Consumers Who Were Denied Mental Health Care Coverage*, OFF. OF THE N.Y. STATE ATT’Y GEN. (May 20, 2022), <https://ag.ny.gov/press-release/2022/attorney-general-james-provides-136-million-consumers-who-were-denied-mental> [<https://perma.cc/8B2E-R9VH>].

101. *Id.*

102. Generally Accepted Standards of Behavioral Health Care Act of 2021, Pub. Act No. 102-0579, 2021 Ill. Laws 10633.

103. *Id.*

Health demonstrated how insurers can mitigate compliance with parity laws by denying medically necessary mental health and treatment by using flawed medical necessity criteria.”¹⁰⁴

ProPublica, an independent, nonprofit newsroom that produces investigative journalism, scrutinized United Healthcare’s mental health review practices in jurisdictions that had not yet engaged in enforcement action.¹⁰⁵ Despite being declared illegal in four states, United simply rebranded one of its mental health review algorithms and continues to use it throughout its other markets.¹⁰⁶ The above-described state actions and the results of the ProPublica investigation demonstrate that even though multiple states are scrutinizing the insurer for violating *the same federal law*, United persists in its unlawful behavior in the rest of its market areas.¹⁰⁷ “For United’s practices to be curbed, mental health advocates told ProPublica, every single jurisdiction in which it operates would have to successfully bring a case against it.”¹⁰⁸ Consequently, insurers have little incentive to follow the law due to the complexity of enforcement and the lack of true, make-whole remedies available to consumers in certain health plans, especially Medicaid and ERISA plans.

C. HHS Final Mental Health Parity Rule - Relevant Provisions That Reveal General Gaps in Enforcement

In September 2024, the U.S. Departments of Health and Human Services (HHS), Labor (DOL), and the Treasury issued final rules for implementing federal mental health parity law.¹⁰⁹ The final rules acknowledge, in the over fifteen years since federal mental health parity law was passed, the disparities in coverage for MH/SUD treatment have persisted and grown with “marginalized communities disproportionately impacted.”¹¹⁰ The Departments noted, to promote compliance, they have provided extensive guidance and assistance materials, but disparities continue, especially in terms of nonquantitative treatment limitations (NQTLs).¹¹¹ NQTLs are treatment limitations that are not quantifiable in nature, such as medical review criteria, prior-authorization review processes and procedures, treatment level of care determinations, network requirements and

104. *Id.* at § 2(c)(3).

105. Waldman, *supra* note 18.

106. *Id.*

107. *Id.*

108. *Id.*

109. *See* Requirements Related to the Mental Health Parity and Addiction Equity Act, 89 Fed. Reg. 77586 (Sept. 23, 2024) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, and 45 C.F.R. pts. 146–147).

110. *Id.* at 77586.

111. CTR. FOR MEDICARE & MEDICAID SERV. WARNING SIGNS-PLAN OR POLICY NON-QUANTITATIVE TREATMENT LIMITATIONS (NQTLs) THAT REQUIRE ADDITIONAL ANALYSIS TO DETERMINE MENTAL HEALTH PARITY COMPLIANCE, <https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/mhpeacechecklistwarningsigns.pdf> [https://perma.cc/9E34-QNHR](last visited Jan. 31, 2026).

methodologies to determine out of network reimbursement levels.¹¹² The final rule sought to clarify requirements under the Mental Health Parity and Addiction Equity Act (MHPAEA) and the amendments under the Consolidated Appropriations Act of 2021 (CAA).¹¹³ The CAA sets content and timeline requirements for health plans to provide a comparative analysis of the impact any NQTLs have on mental health or substance use disorder (MH/SUD) treatment versus medical/surgical treatments.¹¹⁴

Also, significant to this Note Thesis, the final rule established requirements for health plans to act on disparities found in these analyses, and it prohibits health plans from “using discriminatory information, evidence, sources, or standards that systematically disfavor or are specifically designed to disfavor access to MH/SUD benefits as compared to medical/surgical benefits when designing NQTLs.”¹¹⁵ The rule provides that health plans must define MH/SUD conditions according to “generally recognized independent standards of current medical practice.”¹¹⁶ This combats the insurance carrier practice of defining a condition in a manner that is most restrictive for coverage to limit access and reduce costs. Further, the final rule winds down the “opt out period” during which self-funded and non-federal governmental plans could choose to forgo compliance with MHPAEA, increasing access to protections for many local government workers and their families.¹¹⁷ Significantly, the rule states, if a health plan provides MH/SUD benefits, they must be “meaningful” when compared to medical/surgical benefits in the same benefits classification, including inpatient and outpatient care, in-network and out-of-network services, emergency care, and prescription drug coverage.¹¹⁸

While the final rule could improve implementation for mental health parity in the covered health plans, patients and clinical providers continue to struggle with health plan policies and procedures that make access to medically necessary GASC difficult. Further, the ERISA Industry Committee challenged the final rule in litigation filed on January 17, 2025, against the “tri-agencies”—Health and Human Services, the Department of Labor and the Internal Revenue Service—arguing the agencies exceeded their authority by fundamentally

112. Requirements Related to the Mental Health Parity and Addiction Equity Act, 89 Fed. Reg. 77586, 77597 (Sept. 23, 2024) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, and 45 C.F.R. pts. 146–147); see also *Fact Sheet: Final Rules under the Mental Health Parity and Addiction Equity Act (MHPAEA)*, DEP’T OF LAB., <https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/final-rules-under-the-mental-health-parity-and-addiction-equity-act-mhpaea> [https://perma.cc/VD5U-KQEJ] (last visited Oct. 20, 2025).

113. *Id.*

114. *Id.*

115. DEP’T OF LAB., *supra* note 112.

116. *Id.*

117. *Id.*

118. *Id.*; see also *Proposed Updates to 2020 MHPAEA Self-Compliance Tool: Request for Comments*, DEP’T OF LAB. 10, https://www.dol.gov/sites/dolgov/files/ebsa/pdf_files/compliance-assistance-guide-appendix-a-mhpaea-proposed-updates.pdf [https://perma.cc/4S7Z-MNXS] (last visited Oct. 20, 2025).

reshaping MHPAEA and its enforcement.¹¹⁹ The federal government responded in March that the administration would reconsider the regulations and requested a stay in the litigation, which was granted.¹²⁰ With the looming cuts in Medicaid and Affordable Care Act Marketplace Plans that will result from the recently passed tax and budget bill, many Americans believe their access to healthcare will become more difficult and more expensive.¹²¹ More can and must be done through statutory improvement in available remedies for patients denied medically necessary, standard of care services. Congress can help level the playing field for patients and clinicians through the reforms in the proposed Ramstad for All Care Act.

III. REMEDIES – AVAILABLE TO SOME, ACCESSIBLE TO FEW

Because of our disjointed health insurance system, just as enforcement varies from state to state and jurisdiction to jurisdiction, remedies available to patients denied care vary by plan, by funder, by state, and by jurisdiction. As a result of this complexity, many patients do not understand their rights or the provisions of their health policy and feel powerless to appeal denials.¹²² Many clinicians do not have the time, resources, or knowledge of the vast and complex system to navigate appeals.¹²³

For example, as more states outsource Medicaid to MCOs, beneficiaries face a complex system of appeals and fair hearing requirements.¹²⁴ If the patient is in a managed Medicaid plan, he must exhaust the plan's appeal process, which requires researching what that is, and sending the appeal to the correct company and address.¹²⁵ If denied by the Medicaid MCO, many states do not allow for an independent review of the MCO decision.¹²⁶ Only 11% of Medicaid enrollees

119. Complaint, *ERISA Indus. Comm. v. U.S. Dep't of Health & Hum. Servs.*, No. 25-CV-136 (D.C.C Jan. 17, 2025).

120. Lauren Clason, *Trump Weighs Axing Mental Health Rule With Lawsuit on Pause* BLOOMBERG LAW NEWS May 12, 2025, <https://www.bloomberglaw.com/product/blaw/bloomberglawnews/bloomberg-law-news/X3AOLA84000000> [<https://perma.cc/R7A8-PDJ7>].

121. See Noam N. Levey, *Trump Voters Wanted Relief From Medical Bills. For Millions, the Bills Are About To Get Bigger*, KFF HEALTH NEWS (July 25, 2025), <https://kffhealthnews.org/news/article/medical-debt-trump-policies-little-relief/> [<https://perma.cc/2D38-BZ9R>]; Craig Palosky, *Poll: New Tax and Budget Law Remains Largely Unpopular; Nearly Half Say It Will Hurt Their Families, though Republicans and MAGA Supporters Are More Optimistic*, KFF (Jul 24, 2025), <https://www.kff.org/affordable-care-act/press-release/poll-new-tax-and-budget-law-remains-largely-unpopular-nearly-half-say-it-will-hurt-their-families-though-republicans-and-maga-supporters-are-more-optimistic/> [<https://perma.cc/UJU9-YCXH>].

122. Pollitz et al., *supra* note 24; Rebecca Pifer, *Health Insurers Will Step Off the Roller Coaster in 2025*, DEEP DIVE (Jan. 8, 2025), <https://www.healthcaredive.com/news/health-insurer-2025-predictions/735966/> [<https://perma.cc/W3YN-XLTH>] (discussing insurers' need to regain patient trust because their administrative systems are viewed as barriers to care).

123. Turner, *supra* note 55, at 9 (Turner addresses the appeal process being long and complicated specifically); *see generally* Madhusoodanan et al., *supra* note 55.

124. *See* Grimm, *supra* note 9, at 11–16.

125. *Id.* at 2–3.

126. *Id.* at 11–12.

appealed an MCO prior authorization, and the MCOs upheld their own decision 64% of the time.¹²⁷ If an independent medical review is not available, the Medicaid enrollee's next step is a fair hearing, which must be requested, unlike additional levels of appeal that are offered automatically in Medicare and many private plans.¹²⁸ A fair hearing is not conducted by medically trained personnel or a practicing clinician who should be familiar with GASC; it is conducted by an administrative law judge who will determine if the plan followed Medicaid policies and procedures.¹²⁹ A Medicaid patient must wait up to ninety days from the date of request for the fair hearing decision.¹³⁰ Therefore, our most disadvantaged neighbors—the aged, disabled and the poor—have health inequities exacerbated by a complex system to navigate in order to access care in addition to social determinants of health challenges they already face.¹³¹ It is unreasonable that Medicaid enrollees cannot count on being able to access GASC. GASC is not the “best care money can buy” or cutting-edge; it is a *floor* below which a clinical practitioner may be committing *malpractice*.¹³²

For very different reasons, employer plans, especially under ERISA, lack reasonable remedies for patients denied care through medical review processes that do not reflect the GASC.¹³³ For fully-insured, state regulated employer plans, after researching their options on difficult to navigate insurer websites, enrollees must exhaust the health plan's appeal process or actively request an independent medical review.¹³⁴ If their state's insurance regulator is consumer-friendly, and adequately funded, they may be able to obtain assistance from the regulator to address the issue. Some regulators will not address medical review issues due to the clinical nature, or they only will review if the MCO followed the required process, not assess the quality of the review.¹³⁵ While most MCOs have timelines for medical review in their policies that appear to be timely, in reality, fighting an insurance denial may take several weeks or months.¹³⁶ If a state allows for bad faith claims against a health insurer, and the patient's plan

127. *Id.*

128. *Id.* at 12–13.

129. *Id.* at 11–16.

130. *Id.* at 15.

131. Khushbu Chelak & Swarupa Chakole, *The Role of Social Determinants of Health in Promoting Health Equality: A Narrative Review*, CUREUS 4–6 (Jan. 5, 2023), <https://pmc.ncbi.nlm.nih.gov/articles/PMC9899154/pdf/cureus-0015-00000033425.pdf> [<https://perma.cc/2BPB-TK95>].

132. Moffett & Moore, *supra* note 2, at 111.

133. Francis Beifuss, *Illusory Remedies: Why Lacking Oversight and Penalties Leave Half of the Country With Only a Shadow of Healthcare*, 62 UNIV. LOUISVILLE L. REV. 761, 779–83 (2024).

134. *Why Health Insurance Websites Challenge Patients Seeking Care*, REPUTATION, <https://reputation.com/resources/articles/why-health-insurance-websites-challenge-patients-seeking-care/> [<https://perma.cc/5627-3R66>] (last visited Mar. 7, 2025).

135. See Aaron Swartz et al., *Coverage Denials: Government and Private Insurer Policies for Medical Necessity in Medicare*, HEALTH AFF. 2 (Jan. 2022), <https://pmc.ncbi.nlm.nih.gov/articles/PMC9465897> [<https://perma.cc/HX27-26ZB>] (discussing the challenges of opacity in the medical necessity reviews for patients, clinicians, regulators, and policy makers).

136. Grimm, *supra* note 9, at 15–16.

is state regulated, he may have options to sue for damages beyond the cost of the care that was denied. If the state does not allow for bad faith claims, or the patient's health plan is federally regulated under ERISA, the patient is limited to suing for reimbursement for care that *should* have been covered, but only if the patient is able to pay out of pocket, get their care and sue later.¹³⁷ Clearly, the vast majority of patients cannot afford to private pay for care and then hire an attorney to seek reimbursement or seek reimbursement from the insurance company on their own.

Nationally, about 136 million people are covered by an ERISA-regulated health plan, making ERISA health insurance the largest segment of the U.S. health insurance market.¹³⁸ Limited options for enrollees in ERISA self-insured employer plans and states where bad faith claims are disallowed result from complex legal realities that must be addressed by Congress.

The confounding lack of remedy is due to a three-part wall. Each layer interlocks, reinforcing the others: (1) damages immunities – insurers of employer-sponsored plans are generally only subject to equitable remedies and are not exposed to consequential or punitive damages; (2) consulting physician malpractice immunity – the doctors that insurers hire to determine if a claim is medically necessary are treated solely as fiduciaries to the plan, avoiding any meaningful duty of care as a medical doctor to the patient/claimant; (3) and, finally a complex system of express, reverse, and implied preemption, where states are charged with creating insurance regulations and monitoring mechanisms but have no enforcement powers – resulting in an bizarre, rigid regulatory terrain.¹³⁹

ERISA health plans are immune from consequential and punitive damages for negligence and most state contract and tort laws are superseded by ERISA, leaving remedies most meaningful for physical, mental and economic harm unavailable.¹⁴⁰ Some state laws that regulate insurance, as opposed to insurance companies, may still apply to ERISA plans, such as the Ramstad Act for All Care ban on discretionary clauses.¹⁴¹ There was very little direction from

137. *A State-by-State Guide for Causes of Action for Bad Faith Claims*, CHARTWELL LAW, <https://www.chartwelllaw.com/bad-faith-claims-map> [<https://perma.cc/AK9V-8BHE>] (last visited Oct. 29, 2025); Peter K. Stris, *ERISA Remedies, Welfare Benefits, and Bad Faith: Losing Sight of the Cathedral*, 26 HOFSTRA LAB. & EMPL. L. J. 387, 394–395 (2009).

138. Bruce Telkamp, *What is ERISA Health Insurance?*, ASS'N HEALTH PLANS (June 30, 2020), <https://www.associationhealthplans.com/group-health/what-is-erisa-health-insurance/> [<https://perma.cc/FFT7-PNMC>].

139. Beifuss, *supra* note 133, at 784.

140. Lee Black, *ERISA: A Close Look at Misguided Legislation*, 10 J. OF ETHICS AMA, 307, 308–09 (2008) (on file with author).

141. John Morrison & Jonathan McDonald, *Exorcising Discretion: The Death of Caprice in ERISA Claims Handling*, 56 S.D. L. REV. 482, 482–83 (2011) (“Challenged by the insurance

Congress about how ERISA was to regulate health plans.¹⁴² As a result, courts have responded with dramatically different interpretations over the years. The law on MCO liability under ERISA is not settled, but currently substantially favors protecting insurers.¹⁴³ This is contrary to ERISA's primary goal "to protect the interests of *participants and their beneficiaries* in employee benefit plans" (emphasis added).¹⁴⁴

Consulting physicians employed by the MCOs make clinical and diagnostic decisions that determine if a patient will be able to access their prescribed treatment; they can effectively override the patient's treating clinicians without the personal, ethical, or legal accountability of malpractice exposure because they are considered fiduciaries only to the *plan*, not the *plan's beneficiaries*.¹⁴⁵ This defies reality. Patients should be able to expect insurer clinicians to make medical review decisions based upon the patients' long-term health optimization and what a minimally competent clinician would do—that is to follow the GASC. Many subscribers do not have a high level of trust in their health insurance company; one representative survey shows a little more than half of patients expect their health plan to "do the right thing."¹⁴⁶ But, subscribers, patients and funders, whether employers or the taxpayers, *should* expect that their health plan holds some responsibility for the medical reviewer's decisions and behavior. After all, the health plan sets the terms of coverage and the guidelines under which the medical reviewers can approve coverage. Without coverage, patients often postpone or forgo care.

However, in *Pegram v. Herdrich*, the Supreme Court determined that, unless a physician fiduciary to a health plan is also directly treating the *actual* patient (as in a Health Maintenance Organization or HMO), then the physician is not exposed to malpractice, even though the Court recognized "decisions of treatment and eligibility are 'inextricably mixed' de facto medical determinations."¹⁴⁷ Further, as described above, the idea that an insurer is "denying coverage, not denying care" is often a fiction.¹⁴⁸ As discussed, unless a patient is wealthy, he is not going to be able to access medical care that is not going to be covered by insurance without significant financial difficulty, including bankruptcy from medical debt. Additionally, coverage determinations

industry, states have prevailed in two key legal battles. In *Standard Insurance Co. v. Morrison* and *American Council of Life Insurers v. Ross*, the federal courts ruled that ERISA does not preempt the power of state insurance regulators to prohibit discretionary clauses from insured group health and disability insurance policies.").

142. COLLEEN E. MEDILL, INTRODUCTION TO EMPLOYEE BENEFITS LAW: POLICY AND PRACTICE 267 (Mark C. Alexander et al. eds., 6th ed. 2024).

143. Black, *supra* note 140, at 309.

144. *History of EBSA and ERISA*, DEP'T OF LAB., <https://www.dol.gov/agencies/ebsa/about-ebsa/about-us/history-of-ebsa-and-erisa> [<https://perma.cc/R9BG-UY24>] (last visited Jan. 30, 2025).

145. *Pegram v. Herdrich*, 530 U.S. 211, 225–26 (2000).

146. Pifer, *supra* note 122 (discussing that only 56% of patients believe their insurance company will "do the right thing").

147. Beifuss, *supra* note 133, at 783–84.

148. *See* Appendix A.

are frequently made by individuals acting in administrative or fiduciary capacities rather than as treating clinicians, even though ERISA requires fiduciaries to act solely in the interests of plan beneficiaries when making benefit determinations.¹⁴⁹ However, if a court determines that the *insurer* denies benefits for a particular treatment, claims filed by insureds remain primarily subject to state law.¹⁵⁰ How patients are supposed to understand this distinction and pursue their limited available remedies without the assistance of expensive legal professionals is unclear. This complex system of preemptions and limitations leaves states without enforcement powers to protect consumers, employers or taxpayers from bad actors, even if they repeatedly violate the law or deny medically necessary care.¹⁵¹ The *Wit* litigation and the struggles gynecologic cancer patients face are good examples of the significant challenges any individual patient experiences to secure what is widely recognized as the standard of care treatment if the insurance company resists coverage for whatever reason.¹⁵²

A. Rationale for a Ramstad for All Care Act

General principles of insurance law support this Note thesis. Health insurance contracts are contracts of adhesion, especially for the patient who may be offered only one plan option by their employer. They are also contracts of adhesion for most employers and clinical providers, with only the largest among them having any ability to negotiate in any meaningful way.¹⁵³ There is a power and information asymmetry that is heavily in favor of the insurer or TPA. For patients, it is especially asymmetric, as evidenced by how few patients appeal denied care and how few feel they understand and can navigate their insurance.¹⁵⁴ In other lines of insurance, an insurer is liable if it fails to act in “good faith and fair dealing”—if it unreasonably delays or denies coverage. Other types of insurance carriers are also liable for the physical and mental harm proximately caused by their decisions, or compensatory damages.¹⁵⁵ Exemplary or punitive damages are also available in the event of malice, fraud, or egregious conduct, such as knowingly, repeatedly violating the law.¹⁵⁶ ERISA health plans and the insurance companies and TPAs that managed them are not subject to these damages. The ERISA remedies patients can receive, that would amount to millions of dollars of liability exposure in other cases, are reduced dramatically

149. *Pegram v. Herdrich*, 530 U.S. 211, 225 (2000).

150. Black, *supra* note 140, at 309.

151. *Id.*

152. See Appendix A.

153. See generally Chris Stanton, *The Confessions of Insurance Executives*, NEW YORKER, (Mar. 28, 2025), <https://nymag.com/intelligencer/article/insurance-health-care-executives-wendell-potter-whistleblowers.html> [<https://perma.cc/W3P5-XKVZ>].

154. Pollitz et al., *supra* note 24.

155. KENNETH S. ABRAHAM & DANIEL SCHWARCZ, *INSURANCE LAW AND REGULATION CASES AND MATERIALS* 85–98 (Saul Levmore et al. eds., 7th ed. 2020).

156. *Id.*

to minimal fines, creating the perverse incentive of making it more profitable to deny care in many instances, especially in the short term for publicly traded, for profit MCOs.¹⁵⁷ Would insurers, like United Healthcare and its subsidiaries, UBH and Optum, continue to use medical review processes deemed illegal in four states across their other markets if viable remedies were available to protect ERISA participants and beneficiaries?¹⁵⁸

Congressional intent when passing ERISA also supports this Note thesis. ERISA's primary goal is "to protect the interests of *participants and their beneficiaries* in employee benefit plans"(emphasis added).¹⁵⁹ Additional goals for ERISA include plan uniformity, participant access to information, and fiduciary trust accountability.¹⁶⁰ If the TPAs and their medical reviewers are not required to protect participants and beneficiaries as fiduciaries, are the employers ultimately responsible for demanding GASC and quality care? A recent survey asked fifty executives from fifty ERISA employers about their decision-making pertaining to health benefits for cancer treatment, where treatment delays and denials can reduce survival.¹⁶¹ The 2022 survey revealed 94% of the survey participants said organizational health care costs were the most influential factor in their health benefit design, and 98% responded that direct cost was the most important information source in their benefits decision-making.¹⁶² This survey suggests employers are not considering the unintended, long-term consequences to health care costs and employee health that may result from MCO cost control measures that delay or deny GASC.¹⁶³ If employer fiduciaries are not protecting participants and beneficiaries' health, Congress must provide the guardrails. "ERISA has the effect of diminishing liability . . . for health plans and, along with it, the responsible decision making that medical malpractice is intended to encourage. . . . [It is] up to Congress to provide more specific guidelines. In an industry as heavily regulated as health care, it takes more than the basic standards provided in ERISA to ensure the safe and effective care of patients."¹⁶⁴ The control health plans exert over determining care is not matched by their level of accountability for poor clinical decision-making.¹⁶⁵ While beyond the scope of this Note, employers must consider whether the health care "cost problem" stems from MCOs' failure to coordinate care,

157. Beifuss, *supra* note 133, at 774.

158. Annie Waldman, *How UnitedHealth's Playbook for Limiting Mental Health Coverage Puts Countless Americans' Treatment at Risk*, PROPUBLICA (Nov. 19, 2024), <https://www.propublica.org/article/unitedhealth-mental-health-care-denied-illegal-algorithm> [<https://perma.cc/58H4-Q4YA>].

159. DEP'T OF LAB., *supra* note 144.

160. *Id.*

161. Matthew Gavidia, *Employer Utilization Management Prioritizes Health Benefit Cost Over Patient Care, Survey Finds*, AM. J. OF MANAGED CARE (Apr. 13, 2022), <https://www.ajmc.com/view/employer-utilization-management-prioritizes-health-benefit-cost-over-patient-care-survey-finds> [<https://perma.cc/DX3L-ZWJW>].

162. *Id.*

163. *Id.*

164. Black, *supra* note 140, at 310.

165. *See supra* Section IV.

conduct value-added activities, and promote long-term health while promoting short-term profit-making activities, their own bloated corporate bureaucracies and related middlemen, such as pharmacy benefit managers.¹⁶⁶

Further MCO and health plan discriminatory practices have led to piecemeal amendments to ERISA and other Congressional acts to protect discrete patient groups—mothers and newborns, women with breast cancer, people with mental health conditions, and people with genetic conditions.¹⁶⁷ Perhaps such piecemeal legislation would not be necessary if all health plans, including ERISA plans, were required to follow GASC, and were held liable for compensatory and punitive damages when appropriate. To control costs, ERISA plans may rely on exclusions and restrictive coverage decisions that encourage patients to enroll in public health plans and Affordable Care Act state and federally subsidized Marketplace plans. By making their medically necessary treatment inaccessible, these practices perpetuate inequities and discrimination by proxy. State laws like Illinois's may not be able address this issue in most ERISA plans.¹⁶⁸ Again, Congressional action to improve enforcement and accountability for ERISA plans and their TPAs will go a long way to prevent such costs being transferred to taxpayers.

Congressional action is also needed to clarify ERISA law for the courts, given the conflicting decisions and erosion of intended protections that have resulted.¹⁶⁹ An analysis of ERISA reveals Congress's purposeful choice to apply existing trust law remedies to ERISA employee pension and welfare plans, including the traditional make-whole principle of trust remedy law.¹⁷⁰ While providing multi-state employers with uniformity, predictability and flexibility in designing and administering their employee benefits plans is an important ERISA goal, the main purpose of ERISA is beneficiary protection from pension default risk and administration risk in both pension and welfare (health, disability, and other benefits) plans.¹⁷¹ Administration risk refers to the danger that plan managers may abuse their authority and discretion when making decisions about investments, plan assets, and *paying claims*.¹⁷² Thus, Congress

166. PETER G. PETERSON FOUND., *supra* note 20; see *Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies*, FED. TRADE COMM'N 1 (July 2024), <https://www.ftc.gov/reports/pharmacy-benefit-managers-report> [<https://perma.cc/7RSV-7SJ2>].

167. SEAN ANDERSON ET AL., *PENSION AND EMPLOYEE BENEFIT STATUTES AND REGULATIONS: SELECTED SECTIONS*, 495–504 (Foundation Press, 2017 ed.); ERISA §§ 701, 702, 711–13 (sections added to ERISA to limit exclusions on preexisting conditions, prohibit discrimination based on health status, limit plans' ability to request or require genetic testing, require minimum lengths of hospital stays for newborns and mothers, require mental health and substance use disorder parity, and to require coverage for reconstructive surgery after mastectomy for breast cancer).

168. Generally Accepted Standards of Behavioral Health Care Act of 2021, Pub. Act No. 102-0579, 2021 Ill. Laws 10633.

169. John H. Langbein, *What ERISA Means by "Equitable": The Supreme Court's Trail of Error in Russell, Mertens and Great-West*, 103 COLUM. L. REV. 1317, 1365 (2003).

170. *Id.* at 1317.

171. *Id.* at 1322.

172. *Id.* at 1323.

intended to subject the welfare plans to fiduciary law by bringing them under ERISA, while specifically exempting the welfare plans from other ERISA rules, such as vesting and termination insurance.¹⁷³

The erosion of beneficiary protections began with *Russell* (1985), where Justice Stevens, denied “extracontractual” relief—rather than “consequential damages,”—for a severe delay in paying plan benefits, reasoning that ERISA contained no *express* statutory regulation addressing the “possible consequences of delay . . . in processing of a disputed claim,” even though such a delay would constitute a routine breach of fiduciary practice under trust law.¹⁷⁴ As a result, “[t]he consequence has been that the Court has been treating ordinary applications of traditional fiduciary and remedy law as impermissible extensions of the statute.”¹⁷⁵

The *Russell* decision also influenced the Court in *Mertens*, where Justice Scalia asserted the meaning of the word “equitable” in ERISA § 502(a)(3) precludes monetary damages for consequential injury despite the make-whole principle of trust and equity and the fact that courts routinely award monetary damages when providing equitable relief.¹⁷⁶

By treating relief for consequential injury as an excluded category that Congress must have disapproved by not specifically scheduling it, Justice Scalia closed off the court from the trust law tradition on which ERISA’s drafters relied to give meaning to their grant of “other appropriate equitable relief.” Because both the substantive and the remedial provisions of ERISA arise from trust law, the likely meaning of “appropriate equitable relief” in ERISA is the panoply of remedies, specific and monetary, including make-whole damages for consequential injury, which courts of equity have for centuries applied to correct breaches of trust, and which are “other” than the “benefits due” and injunctive relief that the statute expressly authorizes earlier in section 502(a).¹⁷⁷

As discussed throughout, when patients cannot secure damages beyond the mere cost of their denied medical test or service, they are not made whole when they have suffered real physical, mental, and economic damages from lost function, lost work and out of pocket costs. Congress must correct the Supreme Court error in *Russell* and *Mertens* to re-establish causes of action under ERISA for consequential and punitive damages as are available for other types of insurance. Given the special nature of health insurance—and its fundamental role in survival, liberty, ability to work, and quality of life—physicians who

173. *Id.* at 1323–24.

174. *Id.* at 1328, 1345–47 (employing the term “extracontractual” damages, which predated the decision, to describe relief beyond benefits due under ERISA).

175. *Id.* at 1329.

176. *Id.* at 1336.

177. *Id.* at 1355.

make administrative decisions regarding welfare plan claims payment should be expressly named as fiduciaries. Those fiduciaries must act solely in the interests of plan participants and beneficiaries, consistent with the role of a “disinterested intermediary,”¹⁷⁸ bound by the traditional trust duties of loyalty and prudence.

As the *Wit* case and the ProPublica investigation of United Healthcare clearly document, for-profit MCOs and their medical review processes can be infused with conflicts of interest and perverse incentives to delay or deny care to increase profits and decrease costs without regard to the beneficiaries’ best interests or the long-term health of workers.¹⁷⁹ The HHS-OIG reports on inappropriate denials of medically necessary treatments in Medicaid and Medicare reinforce that deficiencies in MCO medical review processes and clinical guidelines are a system-wide problem.¹⁸⁰ Discretionary clauses allowing the plan’s administrators and fiduciaries discretionary authority to determine benefits and interpret the terms of the plan are key to allowing these conflicts and perverse incentives to flourish. To achieve ERISA’s purpose, Congress must follow the lead of several states and prohibit these clauses to ensure beneficiaries a de novo standard of review in court, should a plan dispute be litigated. Currently, under *Firestone*, the courts will employ a deferential arbitrary and capricious standard of review if the plan language contains a discretionary clause.¹⁸¹ The proposed Ramstad for All Care Act would prohibit such clauses for health and welfare plans.

B. The Proposed Ramstad for All Care Act

With the Jim Ramstad Model Legislation for States, quoted in Appendix A, as a basis, language changes to create a Ramstad for All Care Act (RACA) should include the following provisions:

Section 1 – Statement of Congressional intent and rationale

- a. Over the past 40 years, managed care has moved away from, and eventually abandoned, its roots as clinician-driven entities focused on improving individual patient’s health and thereby reducing costs by optimizing value. As MCOs changed from non-profit to profit driven, they prioritized cost control over quality leading to perverse incentives, bloated bureaucracies engaging in administratively redundant or wasteful processes, and spiraling costs with decreasing population health.
- b. Reform is crucial to maintaining military readiness, worker productivity, the health and welfare of our citizens, and the ability to care for our most vulnerable citizens. Reform must restore managed

178. *Id.* at 1327–28.

179. *See generally* *Wit v. United Behav. Health*, No. 14-CV-02346-JCS, 2019 WL 1033730 (N.D. Cal. Mar. 5, 2019).

180. *See generally* Grimm, *supra* note 9.

181. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) (discussing conflict of interest and evaluating plan administrator abuse of discretion under ERISA).

care's primary focus—quality care and patient health—by requiring all U.S. health plans to cover GASC or minimally competent care.

- c. Professional clinical societies have been engaged in evidenced-based practice guideline and standard of care study for decades; there is no need for insurance company committees or contractors to duplicate or taint this process with profit motives.¹⁸² Clinical societies are poised to distinguish among GASC (minimally competent care), clinically effective care, and best practice, and to establish guidelines that meet recommended standards of trustworthiness.¹⁸³ Clinical societies consider costs in standard development—in terms of *value* not corporate *profit*.
- d. Congress must reaffirm the primary purpose of ERISA, to protect plan participants and beneficiaries, and amend ERISA to expressly include consequential and punitive damages where appropriate.
- e. To ensure our most vulnerable citizens enjoy similar protection from MCO care delays and denials, automatic independent medical reviews for Medicaid shall be offered as it is for Medicare enrollees.
- f. Medical reviewers shall be fiduciaries, disinterested intermediaries, to all U.S. health plans' *covered lives/beneficiaries*, like trust officers are fiduciaries to the trust beneficiary, not the bank or financial institution.¹⁸⁴
- g. Resources wasted on flawed medical review processes and procedures can be redirected to value-added activities like patient education, care coordination, and patient time with clinical providers.¹⁸⁵
- h. Distinguishing mental health care and physical care is artificial, and results in suboptimal care, increased stigma, and health inequities.¹⁸⁶

Section 2 – Definitions

(a) The following definitions apply for purposes of this Act:

- (1) “Generally accepted standards of care” means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties for the condition being reviewed. Valid, evidence-based sources reflecting generally accepted standards of care include peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including but not limited to patient placement criteria and clinical practice guidelines, recommendations of

182. See *Wit*, 2019 WL 1033730.

183. INST. OF MED., *supra* note 18, at 5–9.

184. Langbein, *supra* note 169, at 1365 (explaining the importance of trust principles applied to ERISA).

185. Madhusoodanan, *supra* note 55 (finding that prior authorization processes impose substantial administrative and opportunity costs on clinicians without improving approval rates, diverting clinical time from patient care).

186. See Osborn, *supra* note 83, at 330 (explaining that separating mental and physical health care obscures their interdependence, contributes to poorer health outcomes, and reinforces stigma against psychiatric patients).

federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(2) “Medically necessary treatment” means a service or product addressing the specific needs of that patient, for the purpose of screening, preventing, diagnosing, managing or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

- (i) In accordance with the generally accepted standards of care.
- (ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.
- (iii) Not primarily for the economic benefit of the insurer, purchaser, or for the convenience of the patient, treating physician, or other health care provider. . . .

(3) *omitted*

(4) “Utilization review” means either of the following:

- (i) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to insureds.
- (ii) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in an insurance policy is covered as medically necessary for an insured.
- (iii) “Utilization review criteria” means any criteria, standards, protocols, or guidelines used by an insurer to conduct utilization review.

Section 3 – Medical Necessity Determinations Must Follow Generally Accepted Standards

(a) An insurer that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the insurer, and any entity acting on the insurer’s behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of all covered conditions on current generally accepted standards of care as defined in Section 1 of this Act. All denials and appeals shall be reviewed by a professional with the same level of education and experience of the provider requesting the authorization.

(b) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of conditions in children, adolescents, and adults, an insurer shall apply the level of care placement criteria and practice guidelines set forth in the most recent versions of such criteria and practice guidelines, developed by the nonprofit professional association for the relevant clinical specialty.

(c) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subdivision (b), an insurer shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. For all level of care placement decisions, the insurer shall authorize placement at the level of care consistent with the insured's score using the relevant level of care placement criteria and guidelines as specified in subdivision (b). If that level of placement is not available, the insurer shall authorize the next higher level of care. In the event of disagreement, the insurer shall provide full detail of its scoring using the relevant level of care placement criteria and guidelines as specified in subdivision (b) to the provider of the service. . . .

(d) To ensure the proper use of the criteria described in subdivision (b), every insurer shall do all of the following:

- (1) Sponsor a formal education program by nonprofit clinical specialty associations to educate the insurer's staff, including any third parties contracted with the insurer to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.
- (2) Make the education program available to other stakeholders, including the insurer's participating providers and covered lives.
- (3) Provide, at no cost, the clinical review criteria and any training material or resources to providers and insured patients.
- (4) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process.
- (5) Conduct interrater reliability testing to ensure consistency in utilization review decision making covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review as defined in paragraph (3) of subdivision (f).
- (6) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.
- (7) Achieve interrater reliability pass rates of at least 90% and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(e) This section applies to all health care services and benefits for the diagnosis, prevention, and treatment of conditions covered by an insurance policy, including prescription drugs.

(f) This section applies to an insurer that covers hospital, medical, or surgical expenses and conducts utilization review as defined in this section, and any entity or contracting provider that performs utilization review or utilization management functions on an insurer's behalf.

(g) If the [state commissioner, EBSA, CMS, other relevant federal regulator] determines that an insurer or third party administrator (TPA) has violated this section, the [regulating entity], after appropriate notice and opportunity for

hearing in accordance with *[relevant section of state and/or federal code]*, by order, assess a civil penalty not to exceed *[five thousand dollars (\$5,000)]* for each violation, or, if a violation was willful, a civil penalty not to exceed *[ten thousand dollars (\$10,000)]* for each violation. The civil penalties available to the [regulator] pursuant to this section are not exclusive and may be sought and employed in combination with any other remedies available to the [regulator] under this code.

(h) An insurer shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

3. Section 4 – Discretionary Clauses Prohibited

(a) If an insurer contract offered, issued, delivered, amended, or renewed on or after *[effective date]*, contains a provision that reserves discretionary authority to the insurer, or an agent of the insurer, to determine eligibility for benefits or coverage, to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state, that provision is void and unenforceable.

(b) For purposes of this section, the term “discretionary authority” means a contract provision that has the effect of conferring discretion on an insurer or other claims administrator to determine entitlement to benefits or interpret contract language that, in turn, could lead to a deferential standard of review by a reviewing court.

(c) This section does not prohibit an insurer from including a provision in a contract that informs an insured that, as part of its routine operations, the plan applies the terms of its contracts for making decisions, including making determinations regarding eligibility, receipt of benefits and claims, or explaining policies, procedures, and processes, so long as the provision could not give rise to a deferential standard of review by a reviewing court.

4. Section 5 – Severability Clause

The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.¹⁸⁷

C. Counter Analysis

Based upon past responses to reform efforts, it is expected insurance companies, and their investors, will resist the proposed Ramstad for All Care Act because they believe these reforms will decrease their profits.¹⁸⁸ However, if the insurer has been acting in good faith and following GASC in its medical review processes, its profits and investor dividends did not depend upon denying

187. Lloyd, *supra* note 14.

188. Choi & Evers-Hillstrom, *supra* note 74.

or delaying medically necessary treatment.¹⁸⁹ The nation must confront the debate about whether basic health care is a right or a commodity and design our health insurance system to support that framework. There is much evidence the health care “market” does not respond to traditional market forces or behave like a regular commodity market.¹⁹⁰ Insurers and politicians have encouraged the concept of “consumer driven care.”¹⁹¹ Given the power and information asymmetry between the patient and insurer, if consumers have little real remedy and cannot be made whole when insurers act in bad faith, consumer driven health care simply is not achievable.

As previously discussed, MCOs have not delivered the lower cost or better outcomes they have promised employers and the government over the past 30 years, and there is no magic wand or incremental tweak of the system that will change this situation. Managed care has increased administrative costs through utilization management and medical review processes that do not deliver value.¹⁹²

Bold reform that re-focuses the system on quality and health outcomes is required. Reform must include insurer accountability, which is sorely lacking under Medicaid and ERISA health plans. Congress must enact legislation to allow for bad faith damages across the board to ensure MCOs comply with existing law and GASC when making coverage decisions.

Some may say this proposed act goes too far. Some employers may balk at the ERISA reforms; however, they are fully in line with Congressional intent, ERISA language, and general principles of insurance and trust law. Further, the reforms benefit employers by delivering better transparency and accountability for one of their major expenses, health insurance costs. Congressional partisanship, inaction, and special interest dominance of the political process will surely provide barriers to enacting reforms. On the other hand, mental

189. Beifuss, *supra* note 133, at 809 (“Although, premiums are determined on the pretext of normal risk, these solutions *will* impact net profits for insurers. Despite the inevitable criticism that these proposed changes will make health insurance less affordable, if the market operated in good faith it should not. Because these changes simply hold welfare benefits insurers accountable for not honoring their obligations, as every other type of insurer already must. For insurers who do not act in bad faith, these changes should have little to no impact on their profitability. In fact, such changes would provide a market advantage for lawful insurers because they could underwrite premiums without the level of consideration for litigation as their dubious competition would have to.”).

190. *Id.* at 775–76.

191. Song G. Yi, *Consumer-Driven Health Care: What Is It, and What Does It Mean for Employees and Employers?*, BUREAU OF LAB. STATS. 4, (Oct. 25, 2010), <https://www.bls.gov/opub/mlr/cwc/consumer-driven-health-care-what-is-it-and-what-does-it-mean-for-employees-and-employers.pdf> [<https://perma.cc/K2G4-NX8E>].

192. PETER G. PETERSON FOUND., *supra* note 20; *see also Connecticut Medicaid Prospers Post Capitated Managed Care*, HEALTH JUST. MONITOR (Mar. 25, 2022), <http://healthjusticemonitor.org/2022/03/25/connecticut-medicaid-prospers-post-capitated-managed-care/> [<https://perma.cc/7RL5-PPYS>].

health parity protections have long enjoyed bi-partisan support.¹⁹³ American families and employers cannot afford to have Congress uphold the status quo in our health insurance system. This proposed legislation leaves the private-public partnership system intact. It continues to provide significant employer control over health insurance options. Congress must acknowledge and address how stigma around mental health, substance use disorder, eating disorders, autism, and developmental and intellectual disabilities result in bias and discrimination in benefit design in all types of health plans. Congress also must acknowledge and address barriers to coverage that notions about “the deserving sick” and “the deserving poor” interject into policymaking. The proposed act is not socialized medicine, a single-payer system or a radical departure from our current structure.

For some, this proposal will not go far enough. Advocates of a single payer system will likely say piecemeal reform does not serve the American public well or move the system closer to treating health care as a human right. Those who believe health insurance companies are profiteering at patients’ expense, damaging our population health and our national economy through ever climbing costs may argue insurers cannot be controlled by reform at all—they will find loopholes to exploit.¹⁹⁴ Some genuinely believe, after experiencing decades of reforms, that only a systems change to universal coverage under a one-payer system will finally address cost and quality issues. Perhaps more robust regulation, ERISA reform through recommitting to trust law remedies, and required reliance on non-profit medical societies to establish the floor of care that must be covered by all health plans will bring us closer to an effective health care system while maintaining the more politically viable public-private health insurance system America has today.

IV. CONCLUSION

Congressional action to better regulate health plan medical review processes is long overdue, especially in ERISA and Medicaid health plans. Such action is paramount in making progress toward consumer driven health care, health equity, and greater patient protection in our disjointed, complex health insurance system. Congress should heed the message from several states and ban discretionary clauses in all types of health plans to level the playing field of remedies for patients harmed by bad actors in the managed care industry. As discussed above, this type of reform should not harm the profitability of insurers acting in good faith. Rather, it would help level the playing field and improve fair competition in the industry. Federal legislation like the proposed Ramstad for All Care Act, with its ban on discretionary clauses and the requirement that all health plans cover GASC as a floor, would go a long way in preventing

193. Sarah Fioroni, *Bipartisan Support for Improving Mental Healthcare Access*, GALLUP (Oct. 24, 2024), <https://news.gallup.com/poll/652079/bipartisan-support-improving-mental-healthcare-access.aspx> [<https://perma.cc/N7T5-MPLU>].

194. *See generally* Stanton, *supra* note 153.

improper care delays and denials. This reform would serve to improve outcomes and reduce costs in the short term by reducing barriers to needed care and reducing the need for insurer and provider staff hours to process and re-process authorizations and appeals. It will serve to improve outcomes and reduce costs in the long run by preventing worsening conditions, treatment interruption and abandonment. Further, by clarifying trust remedies in ERISA and removing immunities for medical reviewers in favor of direct fiduciary responsibility to beneficiaries, patients, employers and taxpayers will be better protected from bad actors and perverse incentives. The high cost of health care in the U.S. does not translate into health care value. In the long run, diminishing administrative burdens and eliminating valueless managed care activities will allow resources to be shifted to value-added activities that do improve individual and population health. Maybe then Americans will start getting real value from their health insurance and experiencing the long-promised lower costs and improved health outcomes.

APPENDIX A: RAMSTAD MODEL ACT RELEVANT LANGUAGE¹⁹⁵

Section 1 – Definitions

(a) The following definitions apply for purposes of this Act:

(1) “Generally accepted standards of mental health and substance use disorder care” means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including but not limited to patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(2) “Medically necessary treatment of a mental health or substance use disorder” means a service or product addressing the specific needs of that patient, for the purpose of screening, preventing, diagnosing, managing or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the generally accepted standards of mental health and substance use disorder care.

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(iii) Not primarily for the economic benefit of the insurer, purchaser, or for the convenience of the patient, treating physician, or other health care provider. . . .

(3) *omitted*.

(4) “Utilization review” means either of the following:

(i) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to insureds.

(ii) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in an insurance policy is covered as medically necessary for an insured.

(iii) “Utilization review criteria” means any criteria, standards, protocols, or guidelines used by an insurer to conduct utilization review.

195. *Jim Ramstad Model Legislation to Advance Mental Health and Addiction Equity By Requiring Compliance with Generally Accepted Standards of Care*, THE KENNEDY FORUM, <https://www.thekennedyforum.org/app/uploads/2021/05/Ramstad-Model-Legislation-May-2021.pdf>, [https://perma.cc/L32K-3WBY] (last visited Feb. 3, 2026).

Section 3 – Medical Necessity Determinations Must Follow Generally Accepted Standards

(a) An insurer that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the insurer, and any entity acting on the insurer's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care as defined in Section 1 of this Act. All denials and appeals shall be reviewed by a professional with the same level of education and experience of the provider requesting the authorization.

(b) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, an insurer shall apply the level of care placement criteria and practice guidelines set forth in the most recent versions of such criteria and practice guidelines, developed by the nonprofit professional association for the relevant clinical specialty.

(c) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subdivision (b), an insurer shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. For all level of care placement decisions, the insurer shall authorize placement at the level of care consistent with the insured's score using the relevant level of care placement criteria and guidelines as specified in subdivision (b). If that level of placement is not available, the insurer shall authorize the next higher level of care. In the event of disagreement, the insurer shall provide full detail of its scoring using the relevant level of care placement criteria and guidelines as specified in subdivision (b) to the provider of the service. . . .

(d) To ensure the proper use of the criteria described in subdivision (b), every insurer shall do all of the following:

(1) Sponsor a formal education program by nonprofit clinical specialty associations to educate the insurer's staff, including any third parties contracted with the insurer to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.

(2) Make the education program available to other stakeholders, including the insurer's participating providers and covered lives.

(3) Provide, at no cost, the clinical review criteria and any training material or resources to providers and insured patients.

(4) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process.

(5) Conduct interrater reliability testing to ensure consistency in utilization review decision making covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review as defined in paragraph (3) of subdivision (f).

(6) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.

(7) Achieve interrater reliability pass rates of at least 90% and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(e) This section applies to all health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders covered by an insurance policy, including prescription drugs.

(f) This section applies to an insurer that covers hospital, medical, or surgical expenses and conducts utilization review as defined in this section, and any entity or contracting provider that performs utilization review or utilization management functions on an insurer's behalf.

(g) If the commissioner determines that an insurer has violated this section, the commissioner may, after appropriate notice and opportunity for hearing in accordance with *[relevant section of code]*, by order, assess a civil penalty not to exceed *[five thousand dollars (\$5,000)]* for each violation, or, if a violation was willful, a civil penalty not to exceed *[ten thousand dollars (\$10,000)]* for each violation. The civil penalties available to the commissioner pursuant to this section are not exclusive and may be sought and employed in combination with any other remedies available to the commissioner under this code.

(h) An insurer shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

Section 4 – Discretionary Clauses Prohibited

(a) If an insurer contract offered, issued, delivered, amended, or renewed on or after January 1, 2022, contains a provision that reserves discretionary authority to the insurer, or an agent of the insurer, to determine eligibility for benefits or coverage, to interpret the terms of the contract, or to provide standards of interpretation or review that are inconsistent with the laws of this state, that provision is void and unenforceable.

(b) For purposes of this section, the term “discretionary authority” means a contract provision that has the effect of conferring discretion on an insurer or other claims administrator to determine entitlement to benefits or interpret contract language that, in turn, could lead to a deferential standard of review by a reviewing court.

(c) This section does not prohibit an insurer from including a provision in a contract that informs an insured that, as part of its routine operations, the plan applies the terms of its contracts for making decisions, including making determinations regarding eligibility, receipt of benefits and claims, or explaining policies, procedures, and processes, so long as the provision could not give rise to a deferential standard of review by a reviewing court.

Section 5 – Severability Clause

The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.