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Articles

HEALTH PLAN INTERNAL CONSUMER DISPUTE RESOLUTION PRACTICES: HIGHLIGHTS FROM A NATIONAL STUDY

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I. INTRODUCTION AND BACKGROUND

This article highlights selected results of an 18-month study¹ by the American Bar Association Commission on Legal Problems of the Elderly and its research partners² on managed care internal dispute resolution practices. The objective of the study was to identify and assess the internal practices of health plans for resolving enrollee-plan

1. The study was funded by the Robert Wood Johnson Foundation and the William and Flora Hewlett Foundation.

2. The Commission is a 15-member interdisciplinary group appointed by the ABA President, dedicated to examining the law-related concerns of older persons. Other members of the research team included The Economic and Social Research Institute, Health Care Strategy Associates, Inc. and Lake, Snell, Perry & Associates. While the study included an emphasis on disputes involving older people, this article is more generic. The Full Report addresses additional aspects of health plan dispute resolution practices not covered here, including customer service, the effect of state oversight and external review on internal decisions, the role of medical groups and physicians, plan practices in tracking data on grievances and appeals, and plan procedures or accommodations for serving older enrollees and enrollees with disabilities. The Full Report also includes lists of specific "promising practices" in use by health plans we interviewed. See NAOMI KARP & ERICA WOOD, AMERICAN BAR ASSOCIATION COMMISSION ON LEGAL PROBLEMS OF THE ELDERLY, UNDERSTANDING HEALTH PLAN DISPUTE RESOLUTION PRACTICES (2000).

disputes in the private commercial arena, as well as in Medicare and Medicaid, and to identify workable options for improving the process.

A. Overview and Study Rationale

Health maintenance organizations (HMOs)³ and other managed health care plans continue to capture a growing share of the health care delivery market. Between 1994 and 1998, the number of HMO plans climbed 62.2%, from 556 to 902; and between 1994 and 1999 HMO market penetration increased nearly 17% to reach 37.9%.⁴ At the same time, the number of government beneficiaries enrolling in managed care continues to grow.⁵

The growth of managed care has brought advantages in cost control, preventive care and the potential of coordinating treatment – a feature especially critical for members who are elderly, chronically ill or who have disabilities.⁶ However, the rise of managed care also raises compelling questions concerning the scope of coverage, authorization for services and the “gatekeeper” concept, physician/patient/plan communications, physician payment rates, quality of care – and how best to resolve plan-enrollee differences about care and payment.

3. A “health maintenance organization” (HMO) is “a type of managed-care plan that acts as both insurer and provider of a comprehensive set of health care services to an enrolled population. Benefits are typically financed through capitation with limited copayments, and services are furnished through a system of affiliated providers.” PHYSICIAN PAYMENT REVIEW COMMISSION, ANNUAL REPORT TO CONGRESS 487 (1997).

4. AVENTIS PHARMACEUTICALS, INC., MANAGED CARE TRENDS DIGEST 2000, slide 1 (2000), available at <http://www.managedcaredigest.com/edigests/tr2000/tr2000c01s01g01.html>; AVENTIS PHARMACEUTICALS, INC., MANAGED CARE TRENDS DIGEST 2001, slide 4 (2001), available at http://www.managedcaredigest.com/slides/2001trends/2001trends_04.shtml. Note that in 1999, however, the number of HMOs declined to 820. AVENTIS PHARMACEUTICALS, INC., MANAGED CARE TRENDS DIGEST 2001, slide 2 (2001), available at http://www.managedcaredigest.com/slides/2001trends/2001trends_02.shtml.

5. Currently, of nearly 40 million Americans in Medicare, about 5.6 million (15%) are enrolled in a Medicare+Choice managed care plan. See The Centers for Medicare and Medicaid Services at <http://www.hcfa.gov/medicare/medicare.htm> and <http://www.hcfa.gov/facts>. Medicaid enrollment in full-risk managed care organizations rose from 1997 through 1999 by 21.3%. SUZANNE FELT-LISK ET AL., KAISER COMMISSION ON MEDICAID AND THE UNINSURED, TRENDS IN HEALTH PLANS SERVING MEDICAID- 2000 DATA UPDATE 1 (2001). In 1999, 316 health plans served 11.4 million Medicaid enrollees in 45 states. SUZANNE FELT-LISK ET AL., KAISER COMMISSION ON MEDICAID AND THE UNINSURED, TRENDS IN HEALTH PLANS SERVING MEDICAID 2000 DATA UPDATE 3 (2001). See also HEALTH CARE FINANCING ADMINISTRATION, NATIONAL SUMMARY OF MEDICAID MANAGED CARE PROGRAMS AND ENROLLMENT (1999), available at <http://www.hcfa.gov/medicaid/trends99.pdf>. In 2001, 93% of people who were insured through their jobs were in some form of managed care. Robin Toner, et al. *Decade After Health Care Crisis, Soaring Costs Bring New Strains*, N.Y. TIMES Aug. 11, 2002, at A19.

6. See FELT-LISK ET AL., *supra* note 5, at 28.

While some surveys have found considerable satisfaction with managed care, enrollees nonetheless experience difficulties with their health plans, including delay or denial of care or payment, reduction or termination of ongoing treatment, billing problems and other complaints.⁷ Because the managed care landscape is so large, complex and rapidly changing, some amount of miscommunication and conflict is inevitable. The American Association of Health Plans has observed "the reality is that the delivery of health care is inherently complex, and disputes about coverage, treatment options, and similar issues are inevitable."⁸ The likelihood of disputes is aggravated with frequent health plan mergers and acquisitions, the proliferation of new modes of delivery, new drugs and technologies, the recent withdrawals of plans from Medicare,⁹ increased economic pressures on health plans, and the uneven public understanding of managed care rules and trade-offs.

All health plans have internal processes for addressing member problems, and states and the federal government have regulated these processes. Fair and efficient procedures can help members have timely access to health services thus improving their health, and can help health plans run more smoothly and give plans significant information on member needs.

7. In 2000, a Kaiser Family Foundation survey of 2,500 insured adults finds that one in two had a problem with their plan in the last year, and concluded that "most consumers are confused about where to turn for help in resolving problems with their health plans." Kaiser Family Foundation, *Most Consumers Generally Positive About their health plan, but fifty-one percent report having some problem in the past year* (June 7, 2000), available at <http://www.kff.org/content/2000/20000607a/>. Also, a 1997 random survey of persons in the Sacramento area conducted by The Lewin Group found that more than 29% of Sacramento-area households reported some problem with their health care in the previous twelve months. THE LEWIN GROUP, INC., *EVALUATION OF THE FIRST 18 MONTHS OF OPERATION OF THE HEALTH RIGHTS HOTLINE: A PILOT INDEPENDENT ASSISTANCE PROGRAM OF THE CENTER FOR HEALTH CARE RIGHTS* 5 (2000). Data collected from over 8,700 hotline calls from July 1997 through June 2000 were consistent with this, finding that "consumers have significant problems navigating the health care system and these problems have not changed much over three years." SHELLEY ROUILLARD ET AL., *HEALTH RIGHTS HOTLINE, THE IMPACT OF THE HEALTH RIGHTS HOTLINE: MAKING A DIFFERENCE FOR HEALTH CARE CONSUMERS THROUGH DIRECT SERVICE, ADVOCACY AND SYSTEMIC CHANGE* 5 (2001). In addition, Health Rights Hotline data from 1997 through 1999 showed that "consumers with different health conditions disproportionately encounter different problems with the health care system." J. BRIDGET SHEEHAN-WATANABE, *HEALTH RIGHTS HOTLINE, WHEN WHAT'S AILING YOU ISN'T ONLY YOUR HEALTH* 4 (2000). See also <http://www.hrh.org>.

8. Karen Ignagni & Kathryn Wilber, *Encouraging Innovation in Resolving Disputes Between Health Plans and Their Members*, 34 NAT'L. INST. DISP. RESOL. F. 1 (1997).

9. See <http://www.hcfa.gov>. See also *Medicare+Choice Doesn't Add Up for Seniors*, 7 THE COMMONWEALTH FUND QUARTERLY 3 (2001), available at <http://www.cmwf.org/publist/quarterly/fal01qrt.asp?link=6> (indicating that in 2001 13.6% of Medicare+Choice enrollees were affected by HMO withdrawals nationally).

In 1997, The President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry set out basic tenets on health plan dispute resolution in its "Consumer Bill of Rights and Responsibilities."¹⁰ The Commission report provided that "all consumers have the right to a fair and efficient process for resolving differences with their health plans, health care providers, and the institutions that serve them, including a rigorous system of internal review and an independent system of external review."¹¹ Recent reforms call for the use of independent review organizations that can overturn plan denials,¹² and the opportunity for such outside review is a critical protection for members. However, a basic premise of dispute resolution is that the bulk of conflicts should be settled at the earliest levels possible.¹³ For health plans, this means the *internal dispute resolution process*. Very little research has targeted internal plan dispute resolution. Therefore, our study aimed to examine how health plans internally respond to the range of disagreements with members, and to identify practical and imaginative solutions.

B. Existing Studies on Health Plan Dispute Resolution

Our study is set in the context of a substantial body of writings on the resolution of consumer disputes in managed care.¹⁴ In 1994, Susan Stayn gave an overview of the then-existing regulatory framework and proposed the creation of a uniform model of grievance and appeal procedures.¹⁵ In 1995, the Center for Health Care Rights developed a comprehensive review of consumer protections in state HMO

10. PRESIDENT'S ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY, CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES (1997), also published as Appendix A of the full Commission Report, PRESIDENT'S ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY, QUALITY FIRST: BETTER HEALTH CARE FOR ALL AMERICANS 57 (1998), available at <http://www.hcqualitycommission.gov/final>.

11. PRESIDENT'S ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY, QUALITY FIRST: BETTER HEALTH CARE FOR ALL AMERICANS 57 (1998).

12. KAREN POLLITZ ET AL., EXTERNAL REVIEW OF HEALTH PLAN DECISIONS: AN OVERVIEW OF KEY PROGRAM FEATURES IN THE STATES AND MEDICARE 14 (1998). See also TRUDY LIEBERMAN ET AL., KAISER FAMILY FOUNDATION, A CONSUMER GUIDE TO HANDLING DISPUTES WITH YOUR PRIVATE OR EMPLOYER HEALTH PLAN 1 (1998), available at <http://www.kff.org/consumer/guide/>.

13. See JAY E. GREINIG, ALTERNATIVE DISPUTE RESOLUTION §1.1 (2d ed. 1997).

14. See NAOMI KARP & ERICA WOOD, *supra* note 2, at App. C.

15. Susan Stayn, *Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures*, 94 COLUM. L. REV. 1674 (1994).

laws, including grievance and appeal processes.¹⁶ Families USA updated this information in 1998.¹⁷ Eleanor Kinney,¹⁸ Mark Rodwin,¹⁹ Tracy Miller²⁰ and others offered cogent explanations of the range of federal and state laws, and emerging issues in the implementation and regulation of plan grievance and appeal procedures. The American Association of Health Plans issued a policy regarding appeals in 1997.²¹ The Consumer Coalition for Quality Health Care and other consumer groups have issued reports and recommendations.²² Georgetown University Institute for Health Care Research produced a study of state external review laws.²³

In 1997, the American Bar Association Commission on Legal Problems of the Elderly convened a roundtable on the resolution of consumer disputes in managed care that produced a set of exploratory recommendations.²⁴ In 1998, the Robert F. Wagner Graduate School of Public Service at New York University sponsored an additional interdisciplinary session to explore managed care dispute reso-

16. GERALDINE DALLEK ET AL., CENTER FOR HEALTH CARE RIGHTS, CONSUMER PROTECTIONS IN STATE HMO LAWS (1995).

17. FAMILIES USA FOUNDATION, HIT AND MISS: STATE MANAGED CARE LAWS (1998).

18. Eleanor Kinney, *Tapping and Resolving Consumer Concerns About Health Care*, 26 AM. J.L. & MED. 335 (2000). Eleanor Kinney, *Consumer Grievance and Appeal Procedures in Managed Care Plans*, 10 HEALTH LAW. 17 (1998); See also NAOMI KARP & ERICA WOOD, *supra* note 2, at App. C (listing additional articles by Eleanor Kinney).

19. Marc Rodwin, *Consumer Protection and Managed Care: Issues, Reform Proposals, and Trade-Offs*, 32 HOUS. L. REV. 1319 (1996). See also MARC RODWIN, PROMOTING ACCOUNTABLE MANAGED HEALTH CARE: THE POTENTIAL ROLE FOR CONSUMER VOICE (2000) (maintaining that grievance and appeal procedures provide insufficient consumer input).

20. Tracy Miller, *Center Stage on the Patient Protection Agenda: Grievance and Appeal Rights*, 26 J.L. MED. & ETHICS 89 (1998).

21. American Association of Health Plans, Code of Conduct, *available at* http://www.aaahp.org/Content/NavigationMenu/About_AAHP/What_We_Stand_For/Code_of_Conduct/Code_of_Conduct.htm. This 1997 policy provides: "Health plans should explain, in a timely notice to the patient, the basis for a coverage or treatment determination with which the patient disagrees, accompanied by an easily understood description of the patient's appeal rights and the time frames for an appeal. An expedited appeals process should be made available for situations in which the normal time frame could jeopardize a patient's life or health. Appeals should be resolved as rapidly as warranted by the patient's situation." See *id.*

22. See, e.g., CONSUMER COALITION FOR QUALITY HEALTH CARE, THE QUALITY IMPERATIVE: MODEL STATE LEGISLATION FOR MANAGED CARE (1996). This and similar documents by consumer groups emphasizes the need for clarity and timeliness of notice, opportunity for members to submit evidence, and need for procedural safeguards and qualified reviewers.

23. POLLITZ ET AL., *supra* note 12.

24. THE COMMISSION ON LEGAL PROBLEMS OF THE ELDERLY, AMERICAN BAR ASSOCIATION, RESOLUTION OF CONSUMER DISPUTES IN MANAGED CARE: INSIGHTS FROM AN INTERDISCIPLINARY ROUNDTABLE (Naomi Karp & Erica Wood eds., 1997).

lution,²⁵ and in 2001 produced a dispute resolution assessment protocol for health plans.²⁶ The National Institute for Dispute Resolution devoted an issue of its journal to "Conflict Resolution and Managed Health Care: The Challenge of Achieving Both Equity and Efficiency."²⁷ Recently Lauren Randel, Ezekiel Emanuel and others examined managed care problems as ethical dilemmas,²⁸ and Clark Havighurst considered the implications of consumer class actions on the health care system.²⁹ In addition, a number of important writings have explored specific aspects of managed care dispute resolution including Medicare disputes,³⁰ Medicaid disputes,³¹ and the use of arbitration and other forms of dispute resolution.³²

25. This conference was convened in September 1998 by the Program on Negotiation and Conflict Resolution and the Health Policy and Management Program at the Robert F. Wagner Graduate School of Public Service, New York University.

26. PROGRAM ON NEGOTIATION AND CONFLICT RESOLUTION ET AL., *DISPUTE RESOLUTION IN MANAGED CARE: A MODULAR SELF ASSESSMENT PROTOCOL* (2001).

27. 34 NAT'L INST. DISP. RESOL. F. (Howard Newman ed., 1997).

28. Lauren Randel et al., *How Managed Care Can Be Ethical*, 20 HEALTH AFF. 43 (2001).

29. Clark C. Havighurst, *Consumers Versus Managed Care: The New Class Actions*, 20 HEALTH AFF. 8 (2001).

30. Jennifer Gladieux provided a detailed review of Medicare managed care appeals procedures and discussed the competing concerns of beneficiary due process rights and cost containment. Jennifer Gladieux, *Medicare+Choice Appeal Procedures: Reconciling Due Process Rights and Cost Containment*, 25 AM. J.L. & MED. 61 (1999). The Center for Health Dispute Resolution, which reviews Medicare managed care appeals under contract with The Centers for Medicare and Medicaid Services, has produced studies of denial disputes between Medicare beneficiaries and HMOs. DAVID RICHARDSON ET AL., HEALTH CARE FINANCING ADMINISTRATION, *A STUDY OF COVERAGE DENIAL DISPUTES BETWEEN MEDICARE BENEFICIARIES AND HMOs* (1993). The Medicare Rights Center, the Center for Medicare Advocacy, and the National Senior Citizens Law Center, and others have issued recommendations for improving the Medicare grievance and appeal system. See, e.g., MEDICARE RIGHTS CENTER, *MEDICARE APPEALS AND GRIEVANCES: STRATEGIES FOR SYSTEM SIMPLIFICATION AND INFORMED CONSUMER DECISIONMAKING* (1996), available at <http://www.medicarerights.org/maincontentpolicyappealsexecreport.html>, also available at <http://www.nslc.org>. The American Arbitration Association, American Bar Association and American Medical Association examined the use of alternative dispute resolution in external review. See AMERICAN ARBITRATION ASSOCIATION ET AL., *HEALTH CARE DUE PROCESS PROTOCOL: A DUE PROCESS PROTOCOL FOR MEDIATION AND ARBITRATION OF HEALTH CARE DISPUTES* (1998). Other sources specifically have analyzed the use of arbitration.

31. The Families USA Foundation and the National Health Law Program developed a guide to Medicaid managed care grievances and complaints. FAMILIES USA FOUNDATION & NATIONAL HEALTH LAW PROGRAM, *A GUIDE TO COMPLAINTS, GRIEVANCES, AND HEARINGS UNDER MEDICAID MANAGED CARE* (1998). For a comprehensive resource on the Medicaid fair hearing and grievance law and its implementation, see KRISTI OLSON & JANE PERKINS, *MEDICAID MANAGED CARE AND DUE PROCESS: THE LAW, ITS IMPLEMENTATION AND RECOMMENDATIONS* (2000) and KRISTI OLSON & JANE PERKINS *MEDICAID MANAGED CARE AND DUE PROCESS: A GUIDE FOR STATES AND HEALTH PLANS* (2000).

32. See Sec. G, *infra*.

Most of the existing literature focuses on the regulatory framework for resolving consumer disputes rather than plan policies and plan methods and extent of implementation. However, in 1996, *Consumer Reports* surveyed 51 health plans throughout the country on many aspects of consumer service, and reported that all had grievance and appeal processes.³³ Also in 1996, the Department of Health and Human Services Office of Inspector General issued an extensive set of reports on the Medicare managed care appeal and grievance processes, detailing deficiencies and making recommendations for the Health Care Financing Administration.³⁴ In 1998, the General Accounting Office (GAO) released a report on HMO complaint and appeal policies.³⁵ The GAO study surveyed 38 commercial HMOs to determine whether their grievance and appeals policies were consistent with elements of timeliness, integrity of the decision-making process and effective communication.

C. Background: Regulatory Framework

The internal health plan dispute resolution process comes into play when a member is dissatisfied with a plan, provider action or decision. The scenarios are limitless. For example, a plan physician denies authorization for an out-of-network cardiologist; a member disagrees with a bill for an emergency room visit; a member sees an internist without knowing the internist has left the plan; a member mistakenly gets a bill; a plan rejects a physician's request for durable medical equipment or for surgery for a patient; a member's request for treatment is delayed; a member receives notice that her home health services will no longer be covered; or a member finds a provider's office inaccessible or the wait too long.

In many cases, the health plan's initial determination about treatment or services is made through its "utilization review" or "utilization management" process. The member then may receive written or oral notification of a plan decision or action. The member may call the plan's customer service department to seek assistance. Plans may have one or several levels of formal review. There may be an opportunity for a face-to-face hearing with plan decision makers. Following this, there may be an opportunity for independent external review. A

33. *Consumer Reports, How Good Is Your Health Plan?*, 61 CONSUMER REP. 28 (1996).

34. OFFICE OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES, OEI-07-94-00280, *MEDICARE HMO APPEAL AND GRIEVANCE PROCESSES* (1996).

35. U.S. GENERAL ACCOUNTING OFFICE, GAO/HEHS-98-119, *HMO COMPLAINTS AND APPEALS: MOST KEY PROCEDURES IN PLACE, BUT OTHERS VALUED BY CONSUMERS LARGELY ABSENT* (1998).

member complaint also may go through a plan's quality improvement procedure.

This generic process is framed by a complex of rapidly changing federal and state laws and accreditation requirements. Licensed and accredited plans participating in public programs may simultaneously seek to comply with the dispute resolution mandates of state law, Medicare, Medicaid, the Employee Retirement Income Security Act (ERISA), and the National Committee for Quality Assurance. Moreover, large multi-state plans must meet the differing requirements of several jurisdictions.

1. *State Requirements.*

All states require health plans to have grievance and appeal procedures for members as a condition of licensure.³⁶ State laws vary in definitions of dispute, time frames, levels of review, notice and reporting provisions, and qualifications of reviewers.³⁷ The National Association of Insurance Commissioners (NAIC) developed the Health Carrier Grievance Procedures Model Act to guide state legislatures, and over 30 states have enacted variations, either by statute or regulation.³⁸ NAIC requires: (1) a first level review by the health plan, and a written decision (generally) within 20 days after receipt of the request; (2) notice of the decision that includes the rationale, the evidence used, a description of second level review and statement of the right to contact the state insurance commissioner; (3) a second level review process allowing members the option of appearing before an authorized representatives of the plan or participation by technological means such as a conference call or video conference within 45 days of the request, and a decision within 5 working days of the meeting; and (4) procedures for expedited review.³⁹ Recently many states have enacted new managed care laws, and a number of these set standards for grievances and appeals.⁴⁰ Currently 40 states plus the District of Columbia require external review.⁴¹

36. See GAO, *supra* note 35; DALLEK ET AL., *supra* note 16; Gladieux, *supra* note 30; and Kinney, *supra* note 18. See also ALLIANCE FOR HEALTH REFORM, RESOLVING HEALTH PLAN DISPUTES: THE ISSUE AND CHALLENGES (1999); LIEBERMAN ET AL., *supra* note 12.

37. See generally FAMILIES USA FOUNDATION, *supra* note 17.

38. NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (*hereinafter* "NAIC"), HEALTH CARRIER GRIEVANCE PROCEDURE MODEL ACT (1998).

39. *Id.*

40. FAMILIES USA FOUNDATION & NATIONAL HEALTH LAW PROGRAM, *supra* note 31. See also FAMILIES USA FOUNDATION, STATE MANAGED CARE PATIENT PROTECTIONS (2001), available at <http://www.familiesusa.org/media/updates/hitmisup.htm>.

41. See LIEBERMAN ET AL., *supra* note 12, and POLLITZ ET AL., *supra* note 12.

2. *The National Committee for Quality Assurance.*

Many health plans have applied for accreditation with the National Committee for Quality Assurance (NCQA). The NCQA standards include guidelines on both "member rights and responsibilities" and "utilization management."⁴² NCQA requires that plans have written policies and procedures for the timely resolution of member complaints.⁴³ Like NAIC, the NCQA standards set out a two-level internal appeals process.⁴⁴ At both levels, reviewers must not have been involved previously.⁴⁵ In at least one level, at least one of the reviewers for clinical issues must be "an actively practicing practitioner in the same or similar specialty" that typically provides the treatment under consideration.⁴⁶ The first level decision must be within 30 working days (with possible extension).⁴⁷ In the second level review, the member must have the right to appear before a panel, and the review must be within 30 working days of the request.⁴⁸ The plan must have an expedited process for acute or urgent conditions.⁴⁹ There must be "a procedure for providing independent, external review of final determinations."⁵⁰

3. *Medicare.*

Managed care organizations that participate in the federal Medicare program⁵¹ are bound by the program's regulations, and must comply with the policy guidelines of The Centers for Medicare and Medicaid Services (CMS)⁵² as well. Under Medicare regulations regarding the Medicare+Choice program,⁵³ beneficiaries must be in-

42. NATIONAL COMMITTEE FOR QUALITY ASSURANCE (*hereinafter* NCQA), STANDARDS FOR MEMBERS' RIGHTS AND RESPONSIBILITIES (2001) [*hereinafter* NCQA RR]; NATIONAL COMMITTEE FOR QUALITY ASSURANCE, STANDARDS FOR UTILIZATION MANAGEMENT (2001) [*hereinafter* NCQA UM]; and NATIONAL COMMITTEE FOR QUALITY ASSURANCE, SURVEYOR GUIDELINES FOR THE ACCREDITATION OF MANAGED CARE ORGANIZATIONS (2000) [*hereinafter* NCQA MCOs].

43. *See* NCQA RR; NCQA UM.

44. NCQA UM, at 7.

45. NCQA RR, at 3.2.4.1.

46. NCQA RR, at 3.5.

47. NCQA RR, at 3.2.4.2.

48. NCQA RR, at 3.3.3.2 and 3.3.3.3.

49. NCQA RR, at 3.3.3.5 and 4.2.

50. NCQA RR, at 3.6.

51. *See generally* 42 U.S.C. § 1396 (1991).

52. Formerly the Health Care Financing Administration (HCFA).

53. *See* MEDICARE+CHOICE Program, 42 C.F.R. §§ 422.560 - 422.622 (2000). As part of the Balanced Budget Act of 1997, Congress enacted Part C of the Medicare Program, including the Medicare+Choice Program (Medicare managed care). 42 U.S.C. § 1395w-21. In June 1998, HCFA promulgated interim final regulations for Medicare+Choice, including provisions for grievances and appeal. *See* 63 Fed. Reg. 34968, 35021 (June 26, 1998).

formed of their appeal rights at the time of initial enrollment,⁵⁴ upon every denial of service or payment,⁵⁵ in notices when they are admitted or discharged from the hospital,⁵⁶ and in the Evidence of Coverage (description of plan benefits).⁵⁷ Beneficiaries can file an appeal with the plan concerning a denial or termination of services or denial of payment.⁵⁸ The plan must then conduct an internal reconsideration.⁵⁹ If this reconsideration is not wholly favorable to the beneficiary, it is automatically transferred to the CMS contractor (currently the Center for Health Dispute Resolution) for independent review.⁶⁰ Following this, a beneficiary can appeal to an administrative law judge (if \$100 or more is at issue), the federal Departmental Appeals Board, and federal district court (if \$1000 or more is at issue).⁶¹ Health plans in the Medicare program vary in the ways they integrate these procedures with their appeal system for private commercial products regulated under state law.⁶²

4. Medicaid.

Because Medicaid⁶³ is a joint federal and state program, dispute resolution for Medicaid managed care is governed by multiple sources: (a) federal law and regulation;⁶⁴ (b) state law and regulation;

The final rule was published in the Federal Register in 2000. See 65 Fed. Reg. 40331, 40328 through 40332 (effective July 31, 2000). In January 2001, HCFA published a proposed rule on improvements to the Medicare+Choice grievance and appeals procedures. See 66 Fed. Reg. 7593 (Jan. 24, 2001).

54. MEDICARE+CHOICE Program, 42 C.F.R. § 422.562 (2000).

55. See 42 C.F.R. § 422.568 (d).

56. See 42 C.F.R. § 422.620.

57. See 42 C.F.R. § 422.100 (c) (2000).

58. See 42 C.F.R. § 422.564.

59. See 42 C.F.R. § 422.578.

60. See 42 C.F.R. § 422.590.

61. See 42 C.F.R. §§ 422.594, 422.600, 422.612.

62. See KARP AND WOOD, *supra* note 2, Chapter IX.

63. Center for Medicare and Medicaid Services. Medicaid information available at <http://www.hcfa.gov/mcicaid/mcicaid.htm>.

64. The process is presently in a state of flux. The Clinton Administration issued proposed rules for the Medicaid managed care, including dispute resolution, and these rules were finalized on January 19, 2001. 66 Fed. Reg. 6228 (January 19, 2001). The Bush Administration stayed the effective date of the Clinton rules three times. The Bush Administration issued its own proposed rules in August, 2001, expected to be finalized in 2002. 66 Fed. Reg. 43661 (August 20, 2001). While the issue has not been litigated, some argue that the Bush Administration's suspensions of the Clinton regulations fail to comply with the Administrative Procedures Act. See Memorandum of Staff of Congressional Research Service, "Validity of Suspension of Effective Date of HHS's Medicaid Managed Care Rule," October 11, 2001.

and (c) the contract between the state and the health plan.⁶⁵ Medicaid beneficiaries who are dissatisfied with health plan decisions or actions have two routes: the state fair hearing process and the internal plan grievance process.⁶⁶ Federal Medicaid law and regulations specify fair hearing rights for beneficiaries.⁶⁷

- Beneficiaries must receive written notice when a benefit is denied and generally at least 10 days before the date of a proposed termination or reduction in services.
- Beneficiaries have a right to a hearing before an impartial decision-maker concerning denials, reductions, termination, or delays in Medicaid benefits. They have a right to a written decision within 90 days of their hearing request.
- When a reduction or termination of care is involved, beneficiaries can get services continued pending the final hearing decision if they make a timely request for continued services.

In addition to the state fair hearing, beneficiaries can complain through the health plan's internal process.⁶⁸ Plans that contract with the state must establish and maintain an internal review process (termed a "grievance process") approved by the state Medicaid agency.⁶⁹ Under federal regulations, the in-plan process must provide for "prompt resolution" of grievances.⁷⁰ Some states require beneficiaries to exhaust the internal process before they can have a state-level hearing.⁷¹

5. ERISA.

The 1974 Employee Retirement Income Security Act (ERISA)⁷² sets out a review process for enrollees who obtain their health care

65. Sara Rosenbaum et al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts*, George Washington University Center for Health Services Research and Policy (last visited Jan. 31, 2002), available at http://www.128.164.127.251/~chsrp/MANGA/Overview_3.htm.

66. For a comprehensive resource on the Medicaid fair hearing and grievance law and its implementation, see KRISTI OLSON & JANE PERKINS, *supra* note 31.

67. 42 U.S.C. §1396a(a)(3) (1991).

68. See 42 C.F.R. § 434.32 (effective until August 16, 2002). New regulations are pending.

69. See *id.*

70. See 42 C.F.R. § 434.32 (b).

71. However, the entire resolution process from the time the beneficiary files a complaint with either the plan or the state to the fair hearing decision must be no more than 90 days. See *Daniels v. Wadley*, 926 F. Supp. 1305, 1311 (M.D. Tenn. 1996). See also FAMILIES USA FOUNDATION & NATIONAL HEALTH LAW PROGRAM, *supra* note 17, at 14.

72. See 29 U.S.C. §1133 (2000). Approximately one-third of individuals with employer-provided health coverage, about 51 million people, are in self-insured plans. However, ERISA's preemption of state laws is far broader concerning resolution of disputes. "Virtu-

coverage through an employer that self-insures. Under ERISA, plans must comply with Department of Labor regulations requiring notice of claim denial and giving a reasonable opportunity for review.⁷³ They must provide adequate written notice in language calculated to be understood.⁷⁴ The notice must include specific reasons for the denial, reference to the plan provisions on which the denial is based, a description of additional information needed, and an explanation of the steps for submitting the claim for review.⁷⁵ Recent DOL regulations strengthened the ERISA claims process, including provisions for expedited review, shortened time frames, requirements for more information to consumers on appeal rights, and involvement of an independent health care professional on benefit denials.⁷⁶ The ERISA claims process generally is viewed as pre-empting state regulation and blocking enrollee access to state courts, and this has been a major issue in Congressional consideration of a Patients' Bill of Rights.⁷⁷

D. Study Methodology

The ABA study aimed to examine how health plans respond to the range of disagreements with members, and to identify practical and imaginative solutions.⁷⁸ The study included:

ally everyone who receives health coverage from a private employer, whether the employer self-insures or purchases health insurance, is preempted by ERISA from receiving the remedial protections established by state law. Approximately 124 million Americans are affected by this broad preemption." *FAMILIES USA*, *supra* note 17, at 27, from tabulations by the Employee Benefits Research Institute.

73. See 29 U.S.C.A. § 1133.

74. *Id.*

75. *Id.*

76. 29 C.F.R. § 2560.503-1(f). See 65 Fed. Reg. 70, 24601 (Nov. 21, 2000) (the final DOL rule).

77. Congress has considered a number of bills that would change the ERISA process and allow patients to sue their health plans in state court. In June 2001, the Senate passed S. 1052, 107th Cong. (2001), which included right-to-sue provisions; and in August 2001 the House passed a compromise bill with more restrictive provisions, H.R. 2563, 107th Cong. (2001). Congress did not enact either bill. *Families USA Memo*, available at http://www.familiesusa.org/media/updates/patients_rights.htm (last visited Jan. 31, 2002).

78. While the study makes a significant contribution toward knowledge about internal managed care practices in resolving consumer disputes, readers should be aware of its limitations: (a) the study is qualitative in nature, not quantitative; (b) we did not examine the extent to which specific plan practices comply with state and federal law; (c) while the focus groups and interviews with advocates provided some consumer perspective, the bulk of our information came from plans; and (d) the "promising practices" presented in the full report have not been proven effective, and we have not estimated their cost or administrative burden. Also, the report was completed in early 2000, and health plan practices may have changed since that time.

- *In-depth telephone interviews* with representatives of 50 HMOs⁷⁹ (vice presidents, governmental program directors, Medicare directors, directors of grievances and appeals, directors of customer services, medical directors, quality improvement staff, others) in 27 states, ranging in size from 3,900 to 5 million members, and including 38 plans participating in Medicare and 26 in Medicaid.
- *Intensive site visits* with four health plans, including interviews with the medical director, director of the grievance and appeal division, Medicare director, and customer service staff; supplemented by interviews with regulators from the state departments of health and insurance, consumer advocates, health law attorneys, medical providers, and labor union representatives.
- *Focus groups*, three with managed care enrollees who had filed inquiries, complaints, grievances and appeals; and one with providers of geriatric care.

Each section below summarizes: (1) findings from the health plan interviews; and (2) any additional findings from the focus groups, as well as interviews with regulators and others.⁸⁰ While health plans and regulators vary in their definitions and classifications of “disputes,” in this article, we will use terms as follows:⁸¹

- *Complaint* – an oral or written expression of dissatisfaction by a plan member.
- *Appeal* – a request by a member for review of a previous plan decision about services or payment.
- *Grievance* – a complaint or dispute other than one involving a plan decision denying or limiting services or payment.

II. ABA FINDINGS ON ASPECTS OF HEALTH PLAN DISPUTE RESOLUTION

All health plans have a customer service unit that is truly the “frontline” of health plan dispute resolution. On average, the health

79. The study did not include other types of managed care such as preferred provider organizations or provider sponsored organizations. While some of the organizations interviewed had ERISA plans in which employers were self-insured, our interviews did not include specific questions about processes for resolving ERISA disputes, and we did not interview employers.

80. Some sections of the Full Report did not include findings from consumer focus groups or from regulator interviews.

81. Health plans use different terminology. What is called an “appeal” by one plan may be named a “grievance” or “complaint” or “reconsideration” by another in the same state. Moreover, states vary in their terminology, and federal programs offer their own sets of definitions. For example, the term “grievance” often means an appeal to change a plan denial. We use the terms as they are used in federal Medicare regulations.

plans we interviewed stated that between 80 and 90 percent of incoming calls to customer service are resolved at this level. If a problem cannot be addressed immediately, many plans have a "pre-grievance" or "pre-dispute" process in which customer service representatives investigate the issues and seek resolution before the level of a formal appeal.

However, a small percentage of enrollee problems, garnering the lion's share of press and public attention, cannot be solved by customer service or by "pre-dispute" resolution techniques and graduate to the health plan's formal internal appeals system. While our study showed a wide array of appeal mechanisms (and the complexity is intensified when the specific requirements of Medicare and Medicaid are added to the mix), tracing commonalities across a number of plans might give a rough composite picture of how internal appeals systems work. In this composite picture, a complaint about denial of services or payment that has not been resolved by customer services is forwarded, often by computer, to the plan's grievance and appeals unit – or arrives via appeal letter from the member. It reaches the desk of an appeals analyst who collects medical records and other evidence; and consults with a medical director, associate medical director or other clinicians if there are medical issues involved.

The analyst then might make a first level decision him/herself, make a decision jointly with the medical director, or might present the case to a first level appeals committee. Such a committee might be composed of a medical director, a quality assurance representative and other plan representatives, sometimes with outside consultation or peer review. Once the decision is made, the analyst sends the member a letter, typically within 30 days of the complaint, and if the plan does not find in favor of the member, the letter includes information on how to appeal further. In the small percent of cases where the member requests additional review, the dispute goes to a higher-level appeals committee. This is a more formal group that might include health plan departmental representatives, board members, consumers and/or outside experts. The member frequently has an opportunity to come in person to present his/her case, or to participate by teleconference. The committee asks questions, makes a decision, notifies the member, and provides instructions about any external review available in the state.

Quality concerns such as physician communication, quality of medical care, or excessive waiting time might be handled in the same way as denials, or might follow an entirely different path with the plan's quality assurance department.

A. *The First Level of Appeal*

1. *Findings from Health Plans.*

All health plans have a formal “first level of appeal,” a terrain that follows customer service, and constitutes the initial stage in a two- or three-step “grievance and appeal” system. However, a picture of this first formal level is clouded for several reasons. There may be more than one simultaneous “first level” – i.e., a separate process for clinical and contractual disputes; or separate processes for quality complaints and denials of services – or even a separate process for experimental procedures or transplant disputes. Moreover, exhaustion requirements differ. For example, Medicaid beneficiaries have a right to go directly to the state, bypassing this first stage. In some plans, pre-service disputes can skip level one and go directly to a second level appeal. Expedited disputes may enter the process at the second level or go directly to the medical director or an outside expert. Finally, the first level of review actually may take place in a delegated medical group.

a. *Kinds of Appeals.*

The health plans in our study named the most common appeals in order of frequency (with some overlapping): emergency room coverage, pharmacy issues concerning the formulary, coverage for referrals not authorized, questions of out-of-network coverage, contractual interpretation questions on benefit coverage, benefits excluded by contract but needed by the member, billing problems, and coverage for durable medical equipment. Besides drugs and durable medical equipment, specific coverage issues highlighted by the plans included chiropractic services, breast reduction mammoplasty, speech and physical therapy, cosmetic surgery, infertility treatments, psychiatry, ambulance denials, ophthalmologist care, hospital inpatient care, nursing home length of stay, and dental services. Plans named the most “troublesome” issues to resolve as: “misunderstandings between the member and the primary care physician;” “cases where there are not qualified providers in the geographic area;” “cases involving obtaining medical records from a number of separate providers;” “cases where there is ambiguity in coverage;” “situations where we have made an exception once and then another member asks for it;” “cases where there is an emotional response;” “complaints by Medicare members because they don’t always understand how HMOs work;” and “cases in the gray area between contractual and medical necessity.” Their answers underscore the complexity of managed care en-

rollee conflicts where medical, legal, interpersonal, bureaucratic and business concerns merge.

b. How the Appeals Process Begins.

There are two main portals for disputes to enter the first review level: Customer Service and Utilization Review. Utilization Review (UR) is the arm of the plan that makes clinical determinations about the authorization of services.⁸² It is staffed by physicians and nurses – or sometimes contracted out to medical reviewers. Some state laws regulate UR and designate time frames.⁸³ If a UR determination is adverse, the member may have received notice and may file an appeal, or may contact Customer Services and ultimately be referred to the appeals unit. Disputes also may come from other plan departments such as Claims and Sales, or from affiliated medical groups.

Generally, consumers begin the formal process by making an oral or written request for review. In the 1998 GAO report on HMO grievances and appeals, 36 of the 38 plans reporting accepted oral complaints.⁸⁴ For Medicare appeals, federal regulations require that standard appeals be in writing, but expedited appeals may be either oral or written.⁸⁵ For commercial cases, the method of request often is governed by state law. At least 17 of the 50 plans we studied accept appeals in either oral or written form. Some stated they would accept either written or oral requests but “encourage” written submissions. At least 12 require written appeals.

At least 12 of the 50 plans studied have a standard form for appeal requests. However, a number of plans pointed out that they do not limit requests to those on the standard forms, and accept all kinds of letters, while others prefer not to have a form at all. “There is not a set form for appeals,” one plan staff member explained, “and they come in crayon, handwritten, typed, sometimes illegible.” If there is a denial letter, the consumer often can simply write “I want to appeal this decision” on the letter and return it to the plan.

82. The National Association of Insurance Commissioners defines “utilization review” as “a set of formal techniques designed to monitor the use of, or evaluate the medical necessity, appropriateness, efficacy or efficiency of health care services, procedures, or settings.” NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, MODEL ACT, §3(BB). See also NCQA “Standards for Utilization Management,” 2001 *Surveyor Guidelines*. One large HMO, UnitedHealthCare, announced it intended to leave specified coverage determinations to physicians rather than requiring authorization from the plan’s UR department. David Hilzenrath, *HMO to Leave Care Decisions Up to Doctors*, WASH. POST, November 9, 1999, at A1.

83. FAMILIES USA FOUNDATION, *supra* note 17.

84. U.S. GENERAL ACCOUNTING OFFICE, *supra* note 35, at 14.

85. See 42 C.F.R. §§ 422.582, 422.584 (2000).

Once the plan's grievance and appeals department receives the request for review, staff date stamp it, log it in the computer, set up a file, and send an acknowledgment letter. Acknowledgment letters confirm that the request has been received, and often attach medical release forms. Plans reported that they send the letters between two and 15 days after receiving the request, most frequently "within three working days."

c. Who Decides?

The most typical scenario is that an appeals analyst ("complaint coordinator," "member advocate," "grievance specialist") researches the case. Sometimes these analysts previously have been customer service representatives, and in a number of plans they are nurses. If an issue of medical necessity is involved (and sometimes even if not) the case generally goes to a medical director – a physician employed by the plan. Our study identified six different *decisional patterns*:

(1) *Medical Director Solo*. The medical director may make the decision on whether to provide services or payment to the member. In at least ten health plans studied, this is specifically a medical director who was *not* involved in the case previously.⁸⁶ In three instances, plans stated it *could* be the same director who made the original decision or was involved previously, while other plans did not specify. One plan observed that "The medical director will talk to the treating physician and the member and resolve things pretty quickly."

(2) *Administrative Decision-Maker Solo*. The appeals analyst or the director of the appeals department makes the decision, at least for administrative, non-medical cases. As with customer service representatives, some plans have given the appeals staff latitude to make decisions themselves below a specified dollar amount.

(3) *Two-Person Team*. The medical director and the appeals analyst together may make the decision.

(4) *Committee Approach*. The case proceeds to a first level review committee, generally including representatives from a range of plan departments — Customer Service, Sales, Benefits, Quality Assurance, Pharmacy, Provider Relations, Medical Management and Utilization Review. Often, this internal committee meets weekly, and may hear a number of cases each week. The appeals analyst may facilitate the

86. Medicare regulations provide that the internal plan reconsideration must be by persons who were not involved in the original determination. See 42 C.F.R. § 422.590(g). NCQA requires first level review by a person or persons "who were not involved in the initial determination." National Committee for Quality Assurance, *supra* note 45, at RR 3.2.4.1.

meeting of the committee or may make case presentations. The medical director usually participates.

(5) *Delegation to a Specific Department.* The appeals analyst sends the case to one or more appropriate plan departments for review and input, and sometimes for a decision. For instance, a case might go to the Utilization Review physicians and nurses, or to Provider Relations, or to several departments and then back to the appeals department for a final decision.

(6) *Outside Medical Expert.* Finally, in at least five of the plans studied, outside medical “peer reviewers” were involved. The medical director can call on a physician with the appropriate specialty either from the plan panel of providers, or outside of the panel.⁸⁷ One plan uses 100 experts from throughout the state to review for medical necessity. Another uses independent review organizations.

d. Collecting the Evidence.

In preparation for these decisions, the appeals analyst drafts a chronology and case summary, collects medical records and other evidence. Several of the plans we studied commented that “the member is always allowed to submit evidence to support the dispute at any time, and most members do.” Other plans stated that it is “uncommon” to get additional evidence from members, and that consumers are “less likely” to submit evidence than providers. The plans did not describe any specific protocol for ensuring member input beyond the request for review.

Many plans commented that it is often difficult to get information from physicians within the required time frame: “The key challenge is medical record retrieval, especially with providers outside the service area.” Several plans have devised methods of encouraging timely submission – including allowing physicians to bill the plan for administrative time in transferring records, providing copy service for physicians, offering financial incentives, writing a timeline into the provider contract, and picking up medical records from provider offices.

87. The National Committee for Quality Assurance *2001 Surveyor Guidelines* require that “in at least one level of internal appeal, at least one of the people appointed to review an appeal involving clinical issues is an actively practicing practitioner in the same or a similar specialty who typically treats the medical condition, performs the procedure or provides the treatment.” National Committee for Quality Assurance, *supra* note 44, at UM 7.

e. Behind the Decision.

Health plan personnel expressed pride in a fair process, concern about their community reputation, desire to resolve issues short of what must be officially documented by state or federal law, need to achieve consistency, need to avoid “costly, lengthy disputes,” hopes for moving the process along in a timely way, and in some cases desire to use an effective appeals process as a competitive edge. Some plans have constructed decision protocols or checklists to help guide decision-making. Interviews with plan staff brought out the following perspectives about the decision-making process:

(1) *Member Understanding: “Pay & Educate.”* A repeated lament was that many of the “garden variety” disputes come about because members don’t understand the rules of the health plan. In response, many plans have established “pay and educate” programs. For example, if a member goes to a non-participating provider without a referral and then questions the denial of the claim, plan staff make a one-time exception, approving payment of the claim, and educating the member on the correct procedure for getting referrals in the future. Some plans call this a “goodwill” determination, noting it is “for business purposes and also for what’s right for the member.” At least 10 plans in our study indicated frequent use of “pay and educate” decisions, with one plan noting that “pay and educate” accounts for about 25 percent of first level determinations.

(2) *Referral Systems and Snafus.* Some disputes at the first level of review stem from glitches in the referral system. The referral may be slow in coming through, and the provider’s computer spits out a bill ahead of time. In one plan, this was common: “The most common types of appeals are referral issues. These are sometimes situations in which the claim arrives before the referral form.” Or in other instances the provider simply didn’t process the referral at all: “A lot of concerns relate to coverage/claims payment denial cases where the primary care physician approved a referral but forgot to put through the referral paperwork.” Referral problems also may be generated around “point of service” (POS) options, in which the member is free to go outside the plan’s network but may not realize this incurs a higher co-pay.

(3) *Challenging Exclusions.* Some plans perceived a rising number of member appeals about services clearly excluded under the contract. Staff in one interview felt that members, especially Medicare beneficiaries, had unrealistic expectations that “everything will be covered.” An additional viewpoint was that because of “the information age” members “hear about things and see if they can get them, like

Viagra.” Sometimes plans pay for services that clearly are not covered benefits because “it is not worth arguing about and it is fair to the member.”

(4) *Medical Criteria.* A number of plans indicated they use specific criteria and clinical practice guidelines in making medical review decisions. Others mentioned peer-reviewed literature, medical societies, informal consultation with colleagues, and use of the Internet. One medical director described reliance on a range of authorities – calling a specialist in the area, calling the hospital center to gauge the community norm, and researching issues on the “Medline” Web site of the National Institutes of Health. There is no uniform set of guidelines or agreed-upon standards for “medical necessity.” Medical directors in different plans appear to abide by different criteria – and to vary in adherence to written criteria versus more flexible exercise of independent medical judgment.

(5) *Regulatory Influence.* Finally, recent state legislation can steer the course of review decision-making. Perhaps the most visible example in our study was the “prudent layperson” rule many states have adopted concerning emergency room visits. This appears to generate more appeals in some plans (“Since the state changed the ER coverage requirements, many members think they can get covered for things they can’t.”) and fewer appeals in other plans. (“Since the state passed the prudent layperson rule, [the plan] is not making as many ER denials.”)

f. Time Frames.

Time frames for review are governed by a host of regulations, including state insurance law, Medicare, Medicaid and accreditation standards by the NCQA. Multi-state and multi-product plans we interviewed took three approaches to grappling with differing time requirements. First, some plan policies set out an elaborate matrix of review levels, federal mandates and differing state laws, to ensure strict compliance with each. Second, some plans used such a matrix to identify the most stringent time frames, and conformed their entire review system to meet these requirements. Thus, if state law allowed 45 days for first level review of commercial cases and the Medicare program allowed 30, these plans took 30 days as a base for all their cases. Finally, a few plans identified time frames that are stricter than required by law, hoping to boost consumer satisfaction by fast turnaround.

The dominant template for commercial cases appears to be the NCQA requirement for first level review within 30 working days, with

an additional 15 working days if there are “circumstances beyond [the plan’s] control” and if the plan “provides notice to the member with the reasons for the delay before the 30th working day.”⁸⁸ Altogether, about 30 of the 50 plans in our study approximate the 30-day requirement, with some differentiating between “administrative” and “medical necessity” cases.⁸⁹ Nine of the plans in our study use a standard of 20 days, with others specifying timelines such as 21 days or 14 days in their written policies.

The extent to which the plans in our study follow these written policies on timeliness is not known. A few plans indicated they had “performance standards” for gauging their own compliance with corporate and state time requirements.

g. The Outcome.

In our study, only 11 of the 50 plans interviewed gave disposition rates for this stage. These ranged from a low of approximately 33 percent to a high of 90 percent overturned in favor of the consumer. About half the plans providing overturn rates noted they reverse and find for the consumer about 40 percent to 50 percent of the time.

2. Findings from Enrollees and Regulators

Consumers in our focus groups described the kinds of disputes involved in their appeals — disputes about referrals to out-of-network specialists, prescription drugs, billing problems, and specific coverage issues. Participants in our geriatric physician focus group had a similar list of common appeal issues—out-of-network care, drug formularies, emergency care, and coverage issues including rehabilitation services, durable medical equipment, and podiatry. Focus group participants and regulators had the following comments:

a. Utilization Review.

Two regulators discussed the difficulty that consumers may have in moving from the utilization review process to the appeal process. One said plan members may be “stuck in UR” at length and not realize there is a whole separate appeals process; while another remarked that “one problem is that the UR process is not part of the grievance process, and members might not understand the difference. They

88. See NCQA RR, *supra* note 45, at 3.2.4.2.

89. This is similar to the 1998 GAO finding in which “many HMO . . . time periods called for resolution of complaints or appeals within 30 days at each level.” U.S. GENERAL ACCOUNTING OFFICE, *supra* note 35, at 12. Yet the GAO also found considerable variation, and we did as well.

think they are in the grievance process, but in the UR process there is no notice. One [case] was in the UR process for 120 days. Valuable time can be lost in UR.”

One participant in our focus groups agreed, and told of her difficulty in getting a UR decision: “My daughter needed a second opinion from a neurologist. The doctor had no problem. Our first initial call to get the referral was not a problem. We set up the appointment. It was six months away and then as the time got closer, we still hadn’t gotten the letter. We kept calling and then it became this frantic thing of calling and getting someone else. One person says you are covered; another person says you are not covered for this.”

b. Standard Forms.

Consumers in the focus groups welcomed the idea of appeals forms, but suggested that they be more readily available. One suggestion was a tear-out form in the member handbook. Focus group participants also said they would find it helpful to have an organizational chart of the plan with names and phone numbers of contact people.

c. Evidence from Enrollees and Providers.

Several participants in our focus groups were not aware that once they filed a request for review, they could submit evidence to the record to support their case. A regulator commented on the difficulty health plans sometimes have in getting timely evidence from providers for appeals. He said the plans “should have had that information to begin with at earlier levels in order to make the initial decision.”

d. Time Frames.

While some state regulators observed that generally plans seem to be meeting the complaint and appeal time frames, a few of the consumers in our focus groups had to postpone medical treatment until their dispute was resolved: “I waited four months . . . I was doing myself more harm than good for four months.” Most of the focus group participants believe the appeals process should move more quickly to respond to a member’s health. They question why it might take 30 days to review a denial when “it should only take a few days.”

B. Additional Levels of Appeal: The Face-to-Face Meeting

A very small percentage of disputes — both payment and pre-service problems — graduate from the first internal health plan review to a higher level of appeal in which the member may participate in a meeting or hearing before a designated committee. A participatory

face-to-face process can offer significant benefits. The appeals director of one plan observed that “the verbal is much more powerful than the written, [and] face-to-face meetings usually open up a lot of things, usually positive for both the member and the plan.” Members have a chance to interact directly with the decision-makers, and to present any new evidence or different perspectives.

The model grievance act of the NAIC has both a first and second level appeal process (“grievance review”), and at the second level “a covered person [may request] the opportunity to appear in person before authorized representatives of the health carrier.”⁹⁰ Similarly, the NCQA requires that accredited health care plans have a second level of review in which “the member has a right to appear.”⁹¹ The 1998 GAO report on grievances and appeals found that 36 of the 37 plans responding had a face-to-face appeals committee meeting.⁹²

1. Findings from Health Plan Interviews

Almost all of the plans in our study permit members to attend and participate in an appeals hearing, often, but not always called the second level of review. These hearings or meetings show a wide variation in the qualifications and impartiality of the decision-makers, member participation, structure of the hearing process, and outcome.

a. The Decision-Makers.

NCQA requires that accredited plans appoint “a panel for the second level review composed of representatives who were not involved in any previous decisions regarding the appeal,” and specifies that “in at least one level of internal appeals, at least one of the persons who is appointed to review an appeal involving clinical issues is an actively practicing practitioner in the same or a similar specialty” as the matter in question, and “who did not participate in the plan’s initial decision.”⁹³ We found a substantial portion of plans that aim to comply with NCQA standards. We also found a range of practices concerning extent of involvement of outside practitioners, other experts and consumers.

The great majority of the plans studied have *physicians or nurses* on the appeals committee, and many indicated that they include a specialist in the field in question. In some instances, these physicians are

90. NAIC Model Act, *supra* note 38, at 9.

91. NCQA, *supra* note 42, at UM 7.

92. GENERAL ACCOUNTING OFFICE, *supra* note 35, at 12.

93. NCQA, *supra* note 42, at UM 7.

always outside peer reviewers – “docs from the community.” In other cases the medical professionals are plan employees. In 11 of the plans, the committee appeared to be entirely composed of plan management staff. In a few additional plans, the committee is drawn from the plan’s board of directors. At least 18 of the plans specifically noted that the committee is made up of some or all members who have not previously been involved in the case.

At least 14 of the plans studied include consumer representatives on the committee – usually one or more plan members who have volunteered to serve in that capacity. In two plans, the committee is made up entirely of plan members elected by other plan members – “consumer elected subscribers.” In another, 50 percent of the committee is composed of members, including the principal of a public school, retired executives, corporate officers, hospital workers and others. A few plans have representatives of employer groups, one has a standing “senior advocate” and another has a nun to “look at the ethical side.” The remaining majority has no consumer participation.

b. Member Participation.

Members have the opportunity to come and present their case in-person or by teleconference in the great majority of the plans studied. Of the 27 plans commenting on how often members attend, answers ranged from “almost 100 percent of the time” to “none have ever come.” Many plans reported that “members usually come,” or that “a good percentage come,” but a few plans stated that members “rarely” appear in person or “usually don’t come.” One plan candidly explained, “Not many choose to attend – but that may be because historically we haven’t advertised that option as well as we do now.” In a couple of instances, the teleconference option was the top choice.

c. The Hearing Process.

Plan interviews and written policies describe the hearing process as an uncertain hybrid with both formal and informal, adversarial and mediative approaches. Generally the member gets about 20 minutes to present his/her case, the committee asks questions, the member leaves, and the committee deliberates and decides.

(1) *Member Representation.* Plans we interviewed explained that members often bring family, usually a spouse or adult child “for moral support at least.” Sometimes they bring physicians to support their case. In one instance, a member brought his dentist, and in another a union benefit representative assisted.

Beyond this is the question of counsel. While the NCQA standards do not mention legal representation, the NAIC model act strongly supports the member's right to an attorney. In the NAIC model, not only does the member have a right to "be assisted or represented by a person of his or her choice,"⁹⁴ but if the plan will have an attorney present, it must notify the member 15 days in advance and must suggest "that the covered person may wish to obtain legal representation of his or her own."⁹⁵ State laws vary. In the GAO study, 16 of 36 HMOs permitted members to be accompanied by a representative, "such as a friend or a lawyer."⁹⁶

The majority of plans indicated that members "can bring an attorney, but this is rare." One noted that of 50 to 60 cases this year, there was only a single case in which the member had an attorney present. Another plan does not allow attorneys to come, and a third limits the attorney's time to 15 minutes and prohibited attorney questions. Several said that if the member brings an attorney, then the plan will have an attorney present as well, and one required the member to notify the appeals department in advance.

Many of the plans in our study see the hearing as an informal discussion rather than an adversarial process. One clearly states in its written policies that "the proceedings of the committee are non-adversarial." Most of the plans emphasized informality: "The hearing is a very informal process. It is not at all intimidating." Yet one took an opposite approach, providing "presentation guidelines" for members, and stating clearly that the format is "presentation as opposed to dialogue." The role of the appeals staff in the hearing seems to vary considerably. Often, appeals staff serve as the coordinator or facilitator. In some plans they assist the member in presenting the case. Three plans noted that they offer the option of having plan staff serve as advocate for the member, although one plan staff recognized this is a role fraught with conflict. In at least one plan, the staff presents the plan's case, opposing the member.

(2) *Presentation of Evidence.* Several plans studied said members "can and do" submit evidence at the hearing stage, and some "encourage this." Others noted that by this point, members "usually already have" submitted their evidence. Evidence might include updated medical reports or additional physician letters, and in a growing number of cases health information from the Internet. Many

94. NAIC, *supra* note 38, at 10.

95. *Id.*

96. GAO, *supra* note 35, at 12.

plans send the case file or a summary to the committee in advance, but it is unclear to what extent the file also goes to the member. In one plan, the member can "make a written request to review all relevant documents, and can submit comments in writing." At least two plans stated clearly that routinely and without request the member is sent the same case file received by the committee. At the other extreme, one plan policy states that "the panel will not provide copies of any medical information to the complainant."

d. Time Frame.

The NCQA requires a second level review within 30 working days, and a notification to the member within five working days of the review.⁹⁷ The model grievance act of the NAIC requires that the second level appeal hearing be within 45 days of the plan's receipt of the request, and that the member be notified of the result within five days of the meeting.⁹⁸ State law requirements vary.

At least six of the plans studied use a 45-day requirement. At least 13 of the plans hold a hearing within 30 days of the request, although some allow plans to extend the time frame if needed. Some have different time frames for administrative and clinical cases.

As with the first level of appeal, our study sought to look behind the paper policy, and determine how fast the hearings actually are held. Only three plans reported this information, with one stating it takes "about two months depending on the case," a second estimating 15 days, and a third boasting that while their policy called for 20 days the hearing usually is held in "about nine days."

e. The Outcome.

The overturn rates for the 12 plans responding to this question in the interviews ranged from a low of 19 percent to a high of 70 percent, with an average of 45 percent. Several plans reported that if there is a tie in the voting of the appeals committee, it goes to the member.

2. Findings From Interviews with Consumers and Regulators

No consumers in our focus groups had gone through a face-to-face level of appeal, but when asked, most said they would like an opportunity to talk with the plan's decision-makers in person: "If they turn you down, I think you should have a face-to-face [meeting]."

97. NCQA, *supra* note 42, at UM 7.

98. NAIC, *supra* note 38, at 9-10.

One participant lamented that she had not yet had a chance to talk directly to plan decision-makers: “Why can’t I speak to someone there myself, and let them know what [my condition] is.” Consumer advocates we interviewed stressed the importance of the opportunity for representation to ensure compliance with patients’ rights and to “level the playing field.” Participants in the focus groups felt that it is important to have an advocate, but said the advocate need not always be an attorney.

C. Expedited Appeals

All of the health plans in our study had a process for expedited appeals in urgent situations, but the time frames, criteria and procedures differed. Plans with Medicare products are governed by federal regulations,⁹⁹ and some plans had extended the Medicare requirements to commercial members as well. In other instances, state insurance law, state Medicaid law or NCQA accreditation requirements dictated standards for expedited appeals.

1. Findings from Health Plan Interviews

a. Time Frame for Expedited Appeals.

In the 1998 GAO study on grievances and appeals, the length of time plans allow for resolution of an expedited appeal “varied considerably,” with the most common period being 72 hours.¹⁰⁰ Our findings substantiate this. Over half the plans we interviewed use a 72-hour time frame, although in some cases this was only for Medicare. For example, of three plans that use the required 72-hour limit for Medicare, one uses four business days for commercial members; one uses five business days for commercial and 48 hours for Medicaid; and one uses 48 hours for commercial members, but three hours if it is an emergency room pre-service case. Three plans reported that while their policy calls for expedited appeals within 72 hours, they usually make a decision more quickly – often within 24 hours. Nine plans use an overall time frame of 48 hours, and three use 24 hours.

b. Who Decides to Expedite?

Under the Medicare regulations, a plan must expedite a case if a physician requests it, and may expedite it if the member (or the plan) perceives that his/her health is at risk.¹⁰¹ Six plans in our study have a

99. CMS Medicare+Choice Program, 42 C.F.R. §§ 422.584, 422.590(d) (2002).

100. GAO 1998, *supra* note 35, at 3.

101. 42 C.F.R. § 422.584 (2001).

similar provision for commercial and/or Medicaid members, specifying an automatic expedited appeal if a physician determines it is necessary. In most of the plans, however, the medical director decides whether a case should be expedited, either alone or in conjunction with other plan personnel such as a case manager, a nurse, the grievance unit manager or the quality improvement manager.

c. What Criteria?

State insurance and federal Medicare laws define an "urgent" case requiring expedited review.¹⁰² Plans described disparate triggers for expedited review, stating that these are cases in which use of the standard time frame: "may be detrimental to the life of a member" "would pose a serious risk to the member's health;" "would pose a serious risk and a life/death/limb situation is involved;" "would impair the member's health;" "would acutely jeopardize their life." Three plans indicated that if a skilled nursing facility is terminating care, the case is automatically expedited. One plan reported expediting all pre-service cases.

d. Decisional Process.

Plans outlined four ways of making a speedy determination on the merits. First, the case may go directly to a medical director. Second, the case may be decided by an outside expert: "The case is referred to a licensed physician outside the plan with an appropriate specialty." Third, the plan uses a special "Expedited Appeals Committee." Fourth, and most common in our sample, the case goes through a truncated version of the standard appeals process, perhaps skipping a level, speeding each level up, or making do without full committee representation: "We hold a grievance committee hearing but the member typically participates by phone rather than in person," "if the grievance committee is not scheduled to meet, the coordinator tries to pull together as many committee members as possible;" "an ad hoc meeting of the Level One committee is scheduled."

102. Under Medicare regulations, a case must be expedited if "the standard time frame for reconsideration could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function," 42 C.F.R. §422.584(c). The NAIC language is the same, except it uses "would" jeopardize rather than "could" jeopardize the person's health and ability. NAIC, *supra* note 38, at 11. NCQA requires an expedited process for "acute or urgent conditions," *2001 Surveyor Guidelines* at UM 7.

e. Infrequent Use.

The plans interviewed use expedited appeals rarely. Of those commenting on frequency, one plan reported five expedited appeals in the past year, with two being Medicare appeals; and three plans each said they had three expedited appeals. Others said they had *few pre-service appeals* at all, and the need for an expedited review had not come up.

At least two plans had protocols for addressing cases in need of urgent attention that might not meet the requirements for expedited review. One plan in our study had a “rapid resolution” team ready to address serious or aggravating cases quickly, but without the urgency of a formal expedited review. Another had an “expedited intervention process” in which a CSA supervisor or appeals analyst can request a meeting with the medical director to help a member get services they need right away.

2. Findings from Interviews with Enrollees and Regulators.

Regulators we interviewed offered no specific comments on expedited review. Some of the senior health insurance counseling (“SHIP”) programs¹⁰³ concurred that expedited review is not often used. They were unable to determine whether this is due to plans’ interpretations of the criteria for expediting review or because some members at risk of serious health problems may seek medical help first, and argue about coverage later. One SHIP counselor observed that health plans generally grant requests for expedited review “unless it is clearly not an emergency,” but he said physicians do not often request it “because the standards are so high.” Another said most of his cases were post service billing problems rather than pre-service appeals.

D. Notice: The Trigger for Appeals

Notice of plan determinations are critically important because they inform enrollees that a decision about treatment or payment has been made, and how to seek redress. By notifying the member of the decision and its rationale, the plan enables the enrollee to decide whether to seek further recourse. Notice is the trigger for member

103. State Insurance Counseling and Assistance Programs (SHIP) have been funded by the Health Care Financing Administration (currently the Centers for Medicare and Medicaid Services) and established in each state since 1990. They help older persons to understand and exercise their rights concerning Medicare and other insurance options. See generally Medicare, *Helpful Contacts*, available at <http://www.medicare.gov/contacts/related/ships.asp>.

action. Many states require health plans to provide written notice when a service is denied, reduced, or terminated. The Medicare program has specific notice requirements for managed care plans.¹⁰⁴

We examined the actions that trigger denial notices, the persons or entities issuing the notices, and the notice content. We focused on notice of the original plan determination, rather than notice of the first level review determination.

1. Findings from Health Plan Interviews

a. Providing Written Notices

(1) *Do Plans Regularly Give Notice?* Our interviews with health plans suggested that the plans regularly give enrollees written notice of service denials. Health plan representatives in our study uniformly stated that they provide written notices when denying a requested service that requires prior authorization by the plan (e.g. referrals to specialists, referrals to out-of-network providers, surgery, therapy, durable medical equipment, home health services, skilled nursing care or

104. In public programs such as Medicare and Medicaid, receiving a written denial has been deemed by the courts to be so important that it comes under the umbrella of constitutionally guaranteed due process rights. The landmark case of *Goldberg v. Kelly*, 397 U.S. 254 (1970) set out a requirement for written notice for Medicaid recipients.

More recently, the crucial role of notice for Medicare beneficiaries in managed care was highlighted in a nationwide class action, *Grijalva v. Shalala*, 946 F. Supp. 747 (D. Ariz. 1996) challenging the failure of the U.S. Department of Health and Human Services to implement and enforce effective notice, hearing and appeals procedures for Medicare HMOs. In the *Grijalva* case, the District Court cited the failure of notices to give adequate reasons for denial and information about the right to present additional evidence for reconsideration. The Court ordered that timely notice be given for all denials of services and stated that the notice must be readable and must clearly state the reason for denial. It should inform the enrollee of all appeal rights, the right to present evidence and the right to a hearing on reconsideration. It should explain how to obtain supporting evidence. *Grijalva v. Shalala*, 946 F. Supp. 747 (D. Ariz. 1996), *aff'd*, 152 F. 3d 1115 (9th Cir. 1998), *vacated Shalala v. Grijalva*, 119 S. Ct. 1573 (1999). The Ninth Circuit remanded *Grijalva v. Shalala* to the District Court for further consideration in light of *American Mfrs. Mut. Ins. Co. v. Sullivan*, 119 S. Ct. 977 (1999), the Balanced Budget Act (BBA) of 1997, and regulations implementing the BBA. 185 F. 3d 1075 (9th Cir. 1999). The case subsequently was settled in 2000, and the Health Care Financing Administration agreed to amend its regulations. HCFA already had changed some aspects of the notice requirements in its regulations pursuant to the Balanced Budget Act. See 42 C.F.R. § 422.568. Proposed rules were published in January, 2001 further to revise the notice requirements. 66 Fed. Reg. 7593 (January 24, 2001).

Requirements for Medicaid managed care plans, including notice requirements for the internal grievance process, have a tortured recent history. See *supra* note 64, describing the issuance of Clinton Administration rules that were stayed by the Bush Administration, and the subsequent issuance of Bush Administration proposed rules, currently pending. The new proposed provision on notice, 42 C.F.R. § 438.404, has fewer requirements than the Clinton rule.

other kinds of care). Generally, a primary care physician or other provider requests the service, and the health plan's utilization review (UR) department reviews the authorization request. The UR department makes a decision, based on either medical necessity or coverage grounds, and then generates the denial notice.

In some plans, enrollees may not get a denial notice until they have initiated a "complaint" or have exhausted the first level of appeal. The physician may tell the patient that the requested care is inappropriate or that the health plan would not approve the request. The patient then may call or write the health plan to complain that the treatment was not provided. In some plans, that complaint would trigger the written notice. Some plans commented that they might not otherwise know that a provider denied a service until the member called to complain. At that point the issue would be escalated to the appeals stage, and the first written notice the member would receive would follow the appeals decision.

Several health plans noted that payment claims do not trigger notification. The member would simply get a bill for the denied service without a written explanation of the specific reason for the service or payment denial.

(2) *Do Delegated Medical Groups Give Notice?* Some health plans delegate the responsibility for giving notice to medical provider groups.¹⁰⁵ It then becomes critical for the plan to monitor the notice practices of each individual medical group with which it contracts.¹⁰⁶ At least seven of the plans we interviewed have delegated responsibility for the denial notice to providers, but we have no specific findings on this issue.

105. Our study found that the growing role of medical groups, both locally organized multi-specialty group practices and national physician practice management companies, impacts the utilization review (UR) and dispute resolution arenas. See NAOMI KARP & ERICA WOOD, *supra* note 2, at 73-8. Our study identified a number of HMOs delegating varying amounts of financial risk and utilization review responsibility to medical groups and integrated medical systems. These UR arrangements can be fragmented and convoluted, and in some cases health plans appear not to oversee these functions fully as required by state law. When UR and dispute resolution functions are divided or duplicated between health plans and medical groups, consumers may be confused and procedures may fail to comply with state grievance and appeal procedures. The picture is further complicated when medical groups contract with numerous health plans, each with disparate UR, grievance and appeal processes. See *id.*

106. This issue was highlighted in a 1999 report by the General Accounting Office, which found that some Medicare plans had delegated the notice function to medical groups without sufficient oversight. U.S. General Accounting Office, *Medicare Managed Care: Greater Oversight Needed to Protect Beneficiary Rights*, GAO/HEHS-99-68, 19 (April 1999). See also NCQA 2001 Standards, RR 8 on "Delegation of Members' Rights and Responsibilities."

(3) *Do Physicians Give Notice?* While plan practices concerning delegation and monitoring of notice may be inconsistent, the real “sticky part,” as one plan administrator put it, comes when the member asks the primary care physician for a service and the physician decides not to request plan authorization. In that case, plan administrators acknowledged, physicians usually do not give notices to enrollees, nor do they communicate with health plan administrators so the plan can issue the notice.¹⁰⁷ Moreover, physicians often deny care or treatment that does not require authorization, and in those situations likely are not giving notice to members. In an independent practice association (IPA) model health plan, the difficulty in ensuring notice is exacerbated, as physicians may be providers for many different plans with distinct utilization review and grievance and appeals systems.

Numerous health plans in our study confirmed that the plan generally does not give notice when the provider directly denies a service, because the plan is not aware of the service request. “Members always get notice as long as we know about it,” said one regulatory compliance administrator, but she doesn’t always know about the denial. Several plans expressed uncertainty about whether notice should be provided upon a provider’s denial of a service that does not require authorization. In one large metropolitan area, health plans worked together to decide when written notices should go out. They decided that “a conversation between a physician and a patient in the exam room stays there,” but if the service requires a referral, enrollees should be given their appeal rights.

b. Timing of Notice.

Some state laws specifically address the timing of notice, as do Medicare and Medicaid regulations.¹⁰⁸ Plan staff in our study stated

107. The Medicare+Choice (M+C) regulations now require that “at each patient encounter with an M+C enrollee, a practitioner must notify the enrollee of his or her right to receive, upon request, a detailed written notice from the M+C organization regarding the enrollee’s services. . . .” 42 C.F.R. §422.568(c). This notice of denial of service must use approved language, state the specific reason for the denial, and inform the enrollee of reconsideration rights. 42 C.F.R. § 422.568(e).

108. Medicare regulations state that when an enrollee or provider has requested a service, the health plan must notify the enrollee of its determination as expeditiously as the enrollee’s health condition requires, but no later than 14 calendar days after the date the organization receives the request, 42 C.F.R. § 422.568(a), or 72 hours in expedited cases, 42 C.F.R. §§ 422.570-572. Medicaid regulations require that notice be “timely” and that beneficiaries get a 10-day advance notice of a health plan’s decision to reduce or terminate services. 42 C.F.R. § 431.211.

that they comply with legal standards for the timing of notices. We had no way to verify this.

c. Content of Written Notices.

Ten health plans reported using a standardized notice form or standardized language in their notices. Sometimes this is a computer-generated notice. As one plan administrator explained, they “plug in the variables,” such as the patient name, the referral request, the doctor’s name, four or five lines with descriptive language, and a reason for the denial.

The biggest influence on the form and content of denial notices appears to be state¹⁰⁹ and HCFA¹¹⁰ (currently CMS) requirements. Several plans mentioned that their notices are “HCFA-approved denial letters”¹¹¹ or letters approved by the state Medicaid agency. Many plans said their notices include detailed explanations of appeal rights. One Medicare plan noted that initial denials include “three pages of instructions on how to appeal, including an invitation to submit supporting information.” In one plan, an official conceded that notices lacked specificity in detailing the reasons for denial, and that he had requested a change in the plan’s practice of keeping explanations “brief and general.”

An examination of the few sample notices provided us by plans and consumers illustrates inconsistent content. Explanations of the reasons underlying care denials often are brief, e.g. “These services are not urgent/emergent,” or “You need custodial care which does not require the skills of a registered nurse or licensed therapist.” Some sample notices are in a more personal format, are more individualized, and refer more specifically to contract provisions or Medicare guidelines – for instance, “Although I understand you are experiencing symptoms related to the varicose veins and the information submitted in Dr. X’s letter supports the treatment of sclerotherapy, Plan A cannot authorize this form of therapy when other medical therapies have not been tried first. This includes the use of 30 weight, or greater stockings for a minimum of 60 days.”

109. Some state laws and regulations set out requirements for notice content. *See, e.g.*, CODE ME. R. Ch. 850 § 9 (C) (1998).

110. 42 C.F.R. § 422.568(e).

111. *See* MEDICARE & MEDICAID PROGRAM MANUALS, HCFA HMO/CMP Manual (*hereinafter* “HCFA HMO/CMP Manual”), *Notice of an Initial Determination*, § 2403.4 (2002). This includes sample language for stating specific reasons for the determination as well as sample language to avoid. *Id.*

2. *Findings from Interviews with Enrollees and Regulators*
a. *Providing Written Notices.*

Some SHIP counselors, regulators, and legal services attorneys stated that members do not always receive appropriate and timely notice. One consumer attorney said that in her experience, most Medicare consumers get no notice unless it's a termination of skilled nursing or hospital care.¹¹² Other SHIP counselors, however, observed that they have heard of only a few cases in which notice was not provided.

Observations about lack of notice have been confirmed in recent government studies in the Medicare context. According to a 1999 GAO study on oversight of beneficiary rights in Medicare managed care, "HCFA monitoring reviews indicate that some denial notices were not issued. . ."¹¹³ The report said HCFA performed 90 monitoring visits to health plans in 1997, and about 13 percent of the plans reviewed were cited for failing to issue denial notices. Two studies by the Department of Health and Human Services' Office of the Inspector General also found that Medicare beneficiaries do not always receive notice.¹¹⁴

Our focus group participants received written notices of plan decisions in some instances, while in others they did not. One waited many months before finally getting a referral, receiving no denial notice in the interim. Another sought coverage for out-of-area services, received many bills, and only knew that the plan had finally paid the claim when the provider's bills stopped coming.

b. *Content of Notices.*

Several consumers in our focus groups noted insufficient explanations of the reasons for the denial.¹¹⁵ They remarked that after

112. Some consumer advocates have stated that managed care organizations are not consistently giving timely notice before services are reduced or terminated. See Gordon Bonnyman, Jr. & Michele Johnson, *Unseen Peril: Inadequate Enrollee Grievance Protections in Public Managed Care Programs*, 65 TENN. L. REV. 359, 379-80 (1998). Moreover, health plans with Medicaid contracts may not interpret "termination of services" to include instances in which a plan has certified a specific number of treatments, and the treatments end. See FAMILIES USA FOUNDATION & NATIONAL HEALTH LAW PROGRAM, *supra* note 17, at 12-13.

113. GAO/HEHS-99-68, *supra* note 106, at 15.

114. HHS/OIG, *Medicare HMO Appeal and Grievance Processes, Review of Cases*, OEI-07-00283 (Dec. 1996); & HHS/OIG, *Medicare HMO Appeal and Grievance Processes, Beneficiaries' Understanding*, OEI-07-96-00281 (Dec. 1996).

115. Both the 1999 GAO report and the District Court in *Grijalva* found that many notices fail to give sufficient explanations of the reasons for denial. The GAO report states that "most notices we reviewed contained general, rather than specific, reasons for the

reading the denial letter they did not understand why the care was denied, and asserted that a more informative denial letter would probably avert more appeals. Some regulators also found notice content lacking. "Denial notices usually are very general," one said. "The reason given may be 'not medically necessary.' Although consumers and physicians can request more information, they don't get the criteria for decision-making. The HMOs don't even release the criteria to the Department of Health, but they do have specific criteria." Some SHIP counselors agreed that many notices are deficient, and one commented that some plans issue lengthy notices containing too much boilerplate, but no detail on the specific reason for the denial.

E. Addressing Non-Appealable "Grievances"

This section covers disputes that in Medicare are called "grievances" – defined in the Medicare+Choice regulations as "any complaint or dispute other than one involving an organization determination."¹¹⁶ "Organization determinations" include denials and discontinuations of service and denials of payment, and are subject to appeal.¹¹⁷ Therefore, "grievances" are a catch-all category of non-appealable disputes or complaints – including those involving quality of care, physician behavior, waiting time for services, and other problems – that cannot be resolved by ordering a service or payment.¹¹⁸ Examples of grievances include:

- "I got poor medical care from the doctor/nurse/ambulatory care center/hospital."
- "I had to wait too long at the doctor's office."
- "I couldn't get an appointment for a month."
- "All of the providers in the network are too far from my house."
- "My doctor misdiagnosed my condition."
- "The office staff was rude."
- "I use a wheelchair and the doctor's office was not accessible."

Medicare regulations that cover grievances are brief: "Each Medicare+Choice organization must provide meaningful procedures for timely hearing and resolution of grievances between enrollees and the organization or any other entity or individual through which the or-

denial . . . [T]he notices simply said that the beneficiary did not meet the coverage requirements or contained some other generic reason." GAO/HEHS-99-68, *supra* note 106, at 16.

116. CMS Medicare+Choice Program, 42 C.F.R. § 422.561 (2002).

117. 42 C.F.R. §§ 422.561, 422.566 (2002).

118. Under Medicare regulations, a health plan decision not to expedite an organization determination or a reconsideration is also subject to the grievance process. CMS Medicare+Choice Program, 42 C.F.R. §§ 422.570(d)(2)(ii), 422.584(d)(2)(ii) (2002).

ganization provides health care services under any Medicare+Choice plan it offers.”¹¹⁹ The regulations include no specific time frame for the resolution of grievances, nor do they specify the necessary elements of a meaningful grievance procedure, whether a grievance may be expedited, or whether there should be further review of grievances.

One area of difficulty in the Medicare+Choice program is distinguishing grievances from appeals. Incorrect categorization of service or payment denials as grievable issues may deny beneficiaries due process and remedies to which they are entitled.¹²⁰

State laws regulating commercial plans often do not distinguish between appeals and grievances. States mandate an internal review process, but generally encompass all disputes in one process. For example, the Texas law requires: “Every Health Maintenance Organization shall establish and maintain a complaint system to provide reasonable procedures for the resolution of oral and written complaints initiated by enrollees concerning health care services.”¹²¹ Michigan’s internal grievance procedure likewise is all-encompassing, defining “grievance” as a complaint regarding: “(i) The availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (ii) benefits or claims payment, handling, or reimbursement for health care services; (iii) matters pertaining to the contractual relationship between an enrollee and the organization.”¹²² This language

119. 42 C.F.R. § 422.564. See also *HCFA Guidelines for Health Plans on Grievances*, HCFA HMO/CMP Manual (HCFA-Pub.75) which provides that health plans should maintain an internal grievance procedure and that this should “transmit timely grievances and complaints to appropriate decision making levels in the plan;” take “prompt, appropriate action, including a full investigation if necessary;” and notify concerned parties of investigation results.” §§ 2410-2411. HCFA, currently The Centers for Medicare and Medicaid Services (CMS), has issued a proposed rule on improvements to the Medicare+Choice grievance procedures. 66 Fed. Reg. 7593, *supra* note 104.

120. In 1996, the Office of the Inspector General (OIG) of the Department of Health and Human Services found that Medicare HMOs frequently miscategorize appeals and grievances. Fifty percent of the 132 Medicare risk-based HMOs the OIG surveyed miscategorized appealable issues as grievances, 36 percent categorized grievance issues as appeals, and 10 percent incorrectly processed cases with both appealable and grievable issues. Department of Health and Human Services, Office of the Inspector General, *Medicare HMO Appeal and Grievance Processes: Survey of HMOs* (December 1996). In another portion of the OIG study involving the on-site review of 144 appeals and 148 grievance files at ten HMOs, 26 percent of the cases processed as grievances actually presented appeals issues.

121. TEX. INS. CODE ANN. § 20A.12 (2001).

122. MICH. COMP. LAWS § 333.21035 (1998).

comes from the National Association of Insurance Commissioners' model act,¹²³ and has been adopted by a number of states.¹²⁴

The National Committee for Quality Assurance Standards also does not separate grievances from appeals. They define "complaints" as "oral or written expressions of dissatisfaction," without limiting the subject of the complaint or the type of remedy available. A complaint can progress to become an "appeal" – "a formal request by a practitioner or member for reconsideration of a decision," including a decision about "an administrative action or a quality-of-care or service issue."¹²⁵

Many grievances involve *quality of care issues*. There are several remedies external to health plans for handling quality complaints. State agencies, such as departments of insurance and departments of health, have complaint processes in place to address quality concerns.¹²⁶ Medicare beneficiaries may file quality of care complaints with "peer review organizations" (PROs).¹²⁷ PROs are physician-sponsored or physician-access organizations under contract with HCFA to determine whether the quality of services to Medicare beneficiaries meets professionally recognized standards of health care.¹²⁸ This complaint process is separate from the Medicare grievance procedure.¹²⁹

In addition, health plans must engage in broad-based quality assurance activities under state and federal laws, as well as under accreditation standards.¹³⁰ Plans participating in Medicare must have quality

123. NAIC, *supra* note 38, at § 3 (Q).

124. See *Testimony of the National Association of Insurance Commissioners' Special Committee on Health Insurance Before the Select Committee on Labor and Human Resources of the United States Senate*, 106th Cong (1999) (statement of Kathleen Sebelius, Secretary-Treasurer, National Association of Insurance Commissioners and Commissioner of Finance, State of Kansas).

125. NCQA 2001 *Surveyor Guidelines*, *supra* note 42, at Glossary.

126. Also, the Joint Commission on the Accreditation of Health Care Organizations has a complaint investigation process for complaints concerning quality of care issues, including "issues such as patient rights, care of patients, safety, infection control, medication use and security." JCAHO will investigate and may incorporate the complaint in its quality monitoring or accreditation survey process. See JOINT COMMISSION ON ACCREDITATION OF HEALTH CARE ORGANIZATIONS, *Report a Complaint about Health Care Organization* (Jan. 30, 2002), available at <http://www.jcaho.org/compl.html>.

127. Peer Review of Utilization and Quality of Health Care Services, 42 U.S.C. § 1320c-3(a)(14) (2001).

128. See generally HEALTH CARE FINANCING ADMINISTRATION, *Quality of Care – Peer Review Organizations* (Jan. 30, 2002), available at <http://www.hcfa.gov/quality/5b.htm>.

129. See U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF INSPECTOR GENERAL, *The Beneficiary Complaint Process of the Medicare Peer Review Organizations*, OEI-01-93-00250 (November 1995); U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF INSPECTOR GENERAL, *The Medicare Beneficiary Complaint Process: A Rusty Safety Valve*, OEI-01-00-00060 (August 2001).

130. Kinney, *supra* note 18, at 349.

assurance programs that measure performance in specified clinical and non-clinical areas, and must contract with HCFA-approved (currently CMS) independent quality review and improvement organizations to perform quality review functions.¹³¹ For the Medicaid program, the Balanced Budget Act requires that states develop and implement a quality assessment and improvement strategy for Medicaid managed care plans.¹³² For commercial plans, some states have passed statutes requiring the creation of quality assurance programs.¹³³ These activities include, but go beyond the handling of individual members' quality complaints.

1. Findings from Health Plan Interviews

In our interviews with health plans, we could not ascertain the frequency with which members file grievances, or the most common kinds of grievances. This difficulty was due to variations in terminology, threshold questions, such as whether the plan only counts written grievances, and ambiguity between grievances and appeals.

Moreover, many plans do not have a separate process for resolving grievances. Frequently, they provide the same opportunity for initial review and in-person hearing for grievances and appeals. There are two exceptions to this: (1) most plans have distinct procedures for dealing with disputes over quality of care and/or service; (2) plans may separate Medicare grievances.¹³⁴

a. Responding to Quality Complaints.

Health plans vary in how they define a "quality" complaint. Some plans we interviewed narrowly define quality to include issues involving medical care or treatment by a provider. Others have a broader definition encompassing both quality of medical care and quality of services. Quality cases usually are shifted away from the customer services or appeals staff, and are handled by a department responsible

131. Nicole Tapay et al., *Protection for Consumers in Managed Care Plans: A Comparison of Medicare, Medicaid and the Private Insurance Market* (1998); 42 U.S.C. § 1395w-22(e)(3)(A) (2001); 42 C.F.R. § 422.154 (2000).

132. See Tapay, *supra* note 131, at 26.

133. For instance, Minnesota's detailed regulations mandate that health plans implement written quality assurance plans addressing who evaluates quality of care, how data collection and reporting are handled, how the plan will monitor complaints, and how plans select providers. See FAMILIES USA FOUNDATION, *supra* note 31. See also NCQA, *supra* note 42.

134. For example, if a plan terms all disputes involving commercial enrollees "appeals," they may still have a separate category called "grievances" for the cases Medicare classifies as grievances.

for quality concerns – often called “Quality Management,” “Clinical Quality Improvement,” or “Quality Assurance.”

When members file grievances about the quality of care or service, they often receive no notice of the specific outcome. While health plans may notify the member that an investigation has been undertaken or completed, most do not specify their findings or decisions. Several health plans asserted that state “peer protection laws” or confidentiality statutes regarding internal quality investigations by hospitals, HMOs and other health care providers prevent them from sharing the outcomes of quality complaints. For example, under New York law, proceedings or records relating to medical or quality assurance review are not subject to disclosure under civil practice rules, and committees or individuals involved in such review may not be liable for their actions.¹³⁵

However, some plans do share brief information in a written communication to the member.¹³⁶ One plan commented, “we do give feedback to the member, but we are careful about what information we share.” Another plan responds in writing, but may not give the member all of the information about the findings. The plan’s member services manager stated that “this makes it difficult for the member to understand, and it seems like we’re hiding something.”

b. Addressing Medicare Grievances.

(1) *Distinguishing Grievances from Appeals.* Several health plans in our study recognized the difficulty in drawing lines between Medicare grievances and appeals. Some noted that a major challenge is training front-line staff to distinguish between them. A few conceded that they need to clarify the definition of a grievance so cases are not handled as appeals when they really don’t belong in that category.

Staff of one health plan gave an example of how they draw the line: “We would consider a complaint about a choice of providers to be a grievance, not an appeal, because it is not considered a denial of service. An appeal would be when the enrollee didn’t get a referral. But it would be a grievance if they got a referral but not necessarily to the provider they wanted or to an out-of-network provider they wanted.” Yet, arguably the question of whether a member was re-

135. N.Y. EDUC. LAW § 6527 (McKinney 2001).

136. HCFA guidelines on grievances procedures specify that Medicare plans should “notify concerned parties of investigation results.” MEDICARE & MEDICAID PROGRAM MANUALS, HCFA HMO/CMP Manual (*hereinafter* “HCFA HMO/CMP Manual”) (HCFA-Pub.75) § 2411.

ferred to an appropriate provider could be viewed as an appeal, because it could be a denial of the appropriate service.¹³⁷

Another plan recognized that cases can be both appeals and grievances.¹³⁸ The plan's medical director gave an example of a case that could actually follow three tracks at once. A member might complain that a medical group denied service, and that the group's staff was rude and used a poor process for responding to the member. The benefit coverage decision would be treated as an appeal; the complaint about the quality of service would go to the Quality Improvement Department; and the issue of the staff's rudeness would be treated as a grievance. Plan staff stated that by processing cases as grievances and appeals simultaneously, members get "the best of both worlds."

c. Remedies for Grievances.

Unlike appeals involving denials of care or payment many grievances have no clear individual remedy. For example, if a member complains that she received poor service from a plan's call center, was treated rudely by a physician, or was scheduled for an appointment at an inconvenient facility, there may be no readily apparent way to "make the member whole." A plan may investigate and make systemic changes, such as improving the efficiency of a call center or requesting changes in the practices of a provider. But the member herself may not be helped by such future changes, and in many cases the member may not even be informed of the outcome.

Some plans recognize that not all grievances are "fixable" but that creative remedies may be devised. One plan tries to handle these member concerns in the clinical setting. For instance, if a member complains of having to wait too long, a staff clinic manager may listen, offer an apology, waive a co-payment, or offer to have the member go to a different pharmacy. Staff said this allows members to air their complaints and express their thoughts on what the plan can do to "make it better."

137. HCFA HMO/CMP Manual §§ 2400, 2400.4. HCFA guidelines for health plans give examples of grievances, such as complaints about waiting times, physician demeanor and behavior, adequacy of facilities or involuntary disenrollment issues. *Id.* HCFA specifies that plans should "use the grievance procedure for all complaints which do not involve an initial determination. *Id.*

138. *See* HCFA HMO/CMP Manual § 2400.1 (provides that if an enrollee addresses two issues in one complaint, process each issue separately and simultaneously under the proper procedure). In addition, the manual states that not to process these complaints first through the grievance procedures, and then through the appeals procedures. *Id.*

G. *Alternative Dispute Resolution: Complementing the Appeals System*

All of the foregoing sections describe a process that is basically administrative in nature. The member proceeds from customer service to the first level of appeal, and may in a fraction of cases participate in an in-person or telephone hearing after that. Often these administrative and informal systems work. But when they don't, there may be ways to supplement the traditional process and involve the member more directly.

Proponents of "alternative dispute resolution" (ADR) maintain that it could be a useful resource for managed care dispute resolution, supplementing traditional channels.¹³⁹ The American Association of Health Plans has stated that "because ADR relies on comparatively informal and non-adversarial techniques, and thus contributes to preserving partnerships between health plans and their members, ADR offers significant promise for resolving health plan-consumer disputes."¹⁴⁰

"Alternative dispute resolution" refers to "a broad range of mechanisms and processes designed to assist parties in resolving differences."¹⁴¹ These mechanisms "interrupt the escalation . . . [and offer] the parties a structured, monitored framework to air and possibly resolve the dispute."¹⁴² Arbitration and mediation are perhaps the most common forms of ADR.¹⁴³ Others include ombudsman programs, fact finding and facilitated consensus building.¹⁴⁴

ADR methods "are now being explored for their application to health care-related dispute resolution." Recent efforts have examined the use of ADR in disputes between medical product manufacturers and medical providers, intellectual property disputes over high-tech medical equipment, physician disputes with hospitals and health

139. LEONARD J. MARCUS ET AL., *RENEGOTIATING HEALTH CARE: RESOLVING CONFLICT TO BUILD COLLABORATION* 317-24, 360-63 (1995) (Consumer advocates may be wary that consumers could compromise their rights in ADR. They caution that "alternative dispute resolution techniques should not be presented as supplanting procedural rights. Rather, they offer preliminary channels that often result in constructive and creative solutions.) *See also* ROBERT HOFFMAN & ERICA WOOD, *MEDIATION: NEW PATH TO PROBLEM SOLVING FOR OLDER AMERICANS*, AARP SENIOR CONSUMER ALERT: A SPECIAL BULLETIN FOR COMPLAINT HANDLERS (1992).

140. Ignagni & Wilber, *supra* note 8, at 5.

141. AMERICAN BAR ASSOCIATION, *ALTERNATIVE DISPUTE RESOLUTION: AN ADR PRIMER* 1 (1989).

142. MARCUS ET AL., *supra* note 139, at 318.

143. *Id.*

144. AMERICAN BAR ASSOCIATION, *supra* note 141, at 2-5.

plans, hospital staff disputes;¹⁴⁵ patient-physician disputes;¹⁴⁶ acute care bioethical disputes;¹⁴⁷ nursing home care conflicts,¹⁴⁸ a range of Medicare beneficiary complaints,¹⁴⁹ and external review for health plan-member conflicts.¹⁵⁰

1. Findings from Health Plan Interviews

a. Arbitration.

Arbitration is an adjudicative process outside of court in which a dispute is submitted to a neutral third party who makes a decision after hearing arguments and reviewing evidence.¹⁵¹ Arbitration can be binding or non-binding,¹⁵² and an agreement to arbitrate can be pre-dispute or post-dispute.¹⁵³ Pre-dispute arbitration agreements can be treacherous for all parties since they are signed before knowing the facts of the case and limit available remedies to resolve disputes. "Pre-treatment agreements can be adhesive because they hook consumers into arbitration before they know if and how they may be injured."¹⁵⁴

Courts generally have enforced arbitration agreements in the managed care setting, but in a 1997 case, *Engalla v. Permanente Medical Group*,¹⁵⁵ the court declined to do so, finding that an HMO had fraudulently induced an enrollee to agree to arbitrate.¹⁵⁶ Kaiser Permanente has included the use of arbitration in its enrollment contracts since 1972, and revised its procedures in 1998 to make the process more independent from the plan. A recent study of health care

145. CATHERINE CRONIN-HARRIS ET AL., HEALTH INDUSTRY DISPUTE RESOLUTION: STRATEGIES AND TOOLS FOR COST-EFFECTIVE DISPUTE MANAGEMENT 1-11 (1993).

146. MARCUS ET AL., *supra* note 139, at 317-24, 360-63.

147. NANCY N. DUBLER & LEONARD J. MARCUS, MEDIATING BIOETHICAL DISPUTES: A PRACTICAL GUIDE 1-11 (1994).

148. NAOMI KARP & ERICA F. WOOD, KEEP TALKING, KEEP LISTENING: MEDIATING NURSING HOME CARE CONFLICTS 1-44 (1997).

149. CMRI, THE MEDICARE BENEFICIARY COMPLAINT ALTERNATIVE METHODS STUDY 1-3 (1999) (A follow-up study by the Center for Social Redesign is assessing the potential for physicians and other providers to accept mediation as an alternative to traditional complaint processes.).

150. AMERICAN ARBITRATION ASSOCIATION ET AL., COMMISSION ON HEALTH CARE DISPUTE RESOLUTION 9 (1998) (These recommendations from the AAA/ABA/AMA Commission on Health Care Dispute Resolution have been endorsed by the ABA House of Delegates as Association policy.).

151. AMERICAN BAR ASSOCIATION, *supra* note 142, at 1.

152. *Id.*

153. Amy E. Elliot, *Arbitration and Managed Care: Will Consumers Suffer If the Two Are Combined?* 10 OHIO ST. J. ON DISP. RESOL. 417, 423-24 (1995).

154. *Id.* at 434-35. See also AMERICAN ARBITRATION ASSOCIATION ET AL., *supra* note 151, at 10 (setting out procedural due process rights for external use of ADR in managed care).

155. *Engalla v. Permanente Medical Group, Inc.*, 938 P.2d 903 (Cal. 1997).

156. *Id.* at 908.

arbitration agreements in California concluded that “few disputes are on the arbitration track. . . [and that] private, binding arbitration of health care disputes is not commonplace.”¹⁵⁷ A 1997 study on “alternative dispute resolution in managed care plans” found that 34 of the 75 plans studied use arbitration, but this includes providers and vendors as well as consumers.¹⁵⁸

Fourteen of the plans in our study said they use arbitration. In many if not most of these instances, the arbitration option seems to come after internal grievance and appeals processes have been exhausted, although this was not always clear. In most instances, plans that use arbitration follow the guidelines of the American Arbitration Association and/or draw arbitrators from the AAA-approved list of names.

Several plans with an arbitration option commented that they use it infrequently: “Formal arbitration rarely if ever occurs, though it is an option in the state;” “the plan has entered into binding arbitration in one case;” “cases don’t go to arbitration very often.” These comments substantiated the California finding that health plan-member arbitration is rare.

b. Mediation.

Mediation is a process in which a trained neutral third party enhances communication between disputing parties and acts as a catalyst for settlement.¹⁵⁹ The mediator helps the parties to reframe issues, develop options, clarify choices and consequences, and reach mutually acceptable agreement. But it is the parties themselves who shape the agreement. Mediation is confidential and (usually) voluntary.

In the state of Washington, legislation provides for non-binding mediation as a form of external review, after exhaustion of internal health plan processes.¹⁶⁰ A 1997 study of ADR in managed care found that 29 of 75 plans examined use mediation, but this includes processes for providers and vendors as well as consumers.¹⁶¹ A recent

157. Elizabeth Rolph et al., *Arbitration Agreements in Health Care: Myths and Reality*, 60 *LAW & CONTEMP. PROBS.* 153, 180 (1997).

158. Joan M. Gibson, *ALTERNATIVE DISPUTE RESOLUTION IN MANAGED CARE PLANS* (1997).

159. AMERICAN BAR ASSOCIATION, *supra* note 141, at 2.

160. WASH. REV. CODE § 48.43.055 (2001) (“A complaint that has been rejected by the health carrier may be submitted to non-binding mediation. Mediation shall be conducted pursuant to mediation rules similar to those of the American Arbitration Association, the Center for Public Resources, the Judicial Arbitration and Mediation Service, RCW 7.70.100, or any other rules of mediation agreed to by the parties.”).

161. Gibson, *supra* note 158.

study examined the potential applicability of mediation to a specified set of managed care disputes.¹⁶²

Our study showed virtually no use of formal mediation. However, some health plans expressed interest in the potential of mediation. In one plan, the director of member services had taken mediation training and aimed to put together a training for the appeals staff. Another plan mentioned it has a mediation option but has not used it yet. This plan has provided mediation training for dispute resolution staff that "was helpful and included role plays." A third plan reported that staff had talked about mediation, but have not yet used it.

Several plans noted that while staff are not strictly in neutral roles, they frequently use an informal "mediative approach." One plan said staff do face-to-face mediative sessions in several contexts – during an informal complaint negotiation, a case management meeting, and an emergency room "pay and educate" session. Staff sometimes get training sessions on communications and facilitation. The director of the appeals department explained that "90% of the time, the member wants somebody to listen, to air concerns, to have a chance to be heard."

c. Ombudsman Programs.

"Ombudsman" is a Swedish term dating back to the 19th century.¹⁶³ "The classic ombudsman was a government official with a high personal prestige and independence who investigated and resolved citizen complaints in an impartial manner and acted as mediator between the government and private citizens."¹⁶⁴ The classic ombudsman has three essential features: independence; mission to deal with specific complaints of individuals; and power to investigate, criticize and publicize but not to make decisions."¹⁶⁵ Today ombudsman programs (especially those for vulnerable populations) sometimes are viewed as including an advocacy mission as well.¹⁶⁶

A 2001 national survey by Families USA¹⁶⁷ identified several types of consumer health assistance/ombudsman programs:

162. DUBLER, *supra* note 147.

163. INSTITUTE OF MEDICINE, REAL PEOPLE, REAL PROBLEMS: AN EVALUATION OF THE LONG-TERM CARE OMBUDSMAN PROGRAMS OF THE OLDER AMERICANS ACT 42 (Cattoll Estes, Jill Freasley & Jo Harris-Wheeling eds. 1995).

164. PETER LEE & CAROL SCOTT, MANAGED CARE OMBUDSMAN PROGRAMS: NEW APPROACHES TO ASSIST CONSUMERS AND IMPROVE THE HEALTH CARE SYSTEM (1996).

165. See INSTITUTE OF MEDICINE, *supra* note 163.

166. See INSTITUTE OF MEDICINE, *supra* note 163, at 70-71.

167. FAMILIES USA, CONSUMER HEALTH ASSISTANCE PROGRAMS: REPORT ON A NATIONAL SURVEY 1-6 (June 2001).

- Long-term care ombudsman programs operating in each state and many localities under the Older Americans Act, that investigate and resolve complaints.¹⁶⁸
- State health insurance assistance programs (SHIPs), funded by the Centers for Medicare and Medicaid Services and established in each state since 1990, helps older persons to understand and exercise their rights concerning Medicare and other insurance options.¹⁶⁹ SHIP staff and volunteers increasingly address managed care issues.
- Protection and Advocacy Programs, authorized under five federal laws to protect and advocate for the rights of persons with disabilities.¹⁷⁰
- Medicaid ombudsman programs. A 1996 study by the Center for Health Care Rights identified 14 managed care ombudsman programs for Medicaid beneficiaries.¹⁷¹ The Center now operates a Managed Health Care Consumer Ombudsman Program in the greater Sacramento area in California, serving commercial, Medicare and Medicaid enrollees.¹⁷²
- General health care ombudsman programs. A few states specifically have established managed care ombudsman programs for all members.¹⁷³
- In addition, many hospitals have “patient representatives” to help patients navigate the hospital system and seek resolution of problems.

The Consumer Bill of Rights and Responsibilities of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry found that health plan “consumers and other stakeholders would benefit from greater availability of consumer assistance programs” that “inspire confidence;” “provide a safety valve;” and “foster

168. *Id.* at 2. See also 42 U.S.C.A. § 3058g (2001). See ADMINISTRATION ON AGING: LONG-TERM CARE OMBUDSMAN PROGRAM, available at <http://www.aoa.gov/ltcombudsman>; see also National Citizen's Coalition for Nursing Home Reform, available at <http://www.nccnhr.org/>.

169. FAMILIES USA, *supra* note 167, at 2-5. See also HEALTH CARE FINANCING ADMINISTRATION, THE STATE HEALTH INSURANCE ASSISTANCE PROGRAM: PROFILES OF THE 53 SHIP GRANTEES, iii-iv (2000).

170. FAMILIES USA, *supra* note 167, at 3. See also 42 U.S.C.A. § 6042 (2001); 42 U.S.C.A. § 10801 (2001); 29 U.S.C.A. § 794e (2001). See also PROTECTION & ADVOCACY: THE NATION'S DISABILITY RIGHTS NETWORK, available at <http://www.protectionandadvocacy.com>.

171. FAMILIES USA, *supra* note 167, at 5-6. See also LEE & SCOTT, *supra* note 164.

172. ROUILLARD ET AL., *supra* note 7, at 133-35.

173. FAMILIES USA, *supra* note 167, at 6. See also VA CODE ANN. § 38.2-5904 (2001) (For example, Virginia established a managed care ombudsman program in the state Bureau of Insurance. In addition, a Medicare Managed Care Ombudsman Program in Northern Virginia helps beneficiaries to resolve a range of problems with their health plans. Arlington Agency on Aging, *Northern Virginia Medicare Managed Care Ombudsman* (2001), unpublished manuscript.).

collaboration.”¹⁷⁴ In 1997, a study of ADR in managed care found that 12 of the 75 plans examined said they used ombudsmen, but did not specify whether this was internal, external or both.¹⁷⁵

We asked the health plans in our study if they have an internal ombudsman. In a strict sense, none do. Several said their customer services staff “function in that role.”¹⁷⁶ In one plan, the head of customer services is called a “customer ombudsman.” However, a staff member commented that “this position has not yet evolved into being a true ombudsman but I hope it will.” Another plan has a “patient representative.” A third reported that “patient care coordinators” in their medical group offices perform some of the functions of an ombudsman. A fourth has an “Internal Quality Assessment Unit that functions almost like an external ombudsman” since the medical groups bear the risk and perform the utilization review. The rest of the plans said they do not have an internal ombudsman.

III. CONCLUSIONS

Our study sought to identify and assess the internal practices of health plans for resolving enrollee-plan disputes. At its conclusion, we sought to assess what we learned and translate our findings into practical guidance for the future. This section covers selected cross-cutting

174. PRESIDENT'S ADVISORY COMMISSION ON CONSUMER PROTECTION AND QUALITY IN THE HEALTH CARE INDUSTRY, CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES, *supra* note 10, at 1-48.

175. Gibson, *supra* note 158.

176. See A.B.A. Annual Report, *Recommendation on Use of an Ombudsman in State and Local Government* 94 A.B.A. 152 (1969). (To be true ombudsmen, health plan staff would need independence from plan administrators and officers. American Bar Association policy on ombudsman programs in state and local government, based in part on the work of Walter Gellhorn, who authored the Model Ombudsman Statute, includes among essential features: authority of the ombudsman to criticize agencies, officials and employees; independence from control by any other officer; independence through a long-term appointment; a high salary; freedom to employ assistants; freedom to investigate any act or failure to act; access to records; and authority to inquire into “fairness, correctness of findings, motivation, adequacy of reasons, efficiency, and procedural propriety of any action or inaction . . .”). See A.B.A., 2001 Annual Meeting, *Reports with Recommendations to the House of Delegates* #107D, 1-6 (2001). (In July 2001, the American Bar Association House of Delegates approved a recommendation supporting “the greater use of ‘ombuds’ to receive, review and resolve complaints involving public and private entities. The recommendation endorsed a set of standards for the establishment and operation of ombuds offices naming the essential characteristics of an ombuds as independence, impartiality in conducting inquiries and investigations, and confidentiality.)

themes we identified and offers suggestions for strengthening health plan dispute resolution.¹⁷⁷

A. Cross-Cutting Themes

1. *All health plans have policies and internal guidelines on dispute resolution that seek to comply with regulatory and often accreditation requirements.*

All plans in the study described institutional practices that make up the internal process for resolving disputes. These practices regarding complaints, grievances and appeals generally are outlined in written policies. While the policies range in format, detail and length, all document an apparently systematic approach to dispute resolution. Health plan staff who were interviewed consistently referred to laws, regulations and standards with which they aim to comply.

2. *Within the regulatory framework, there is much diversity in health plans' dispute resolution systems and practices.*

Through our interviews and site visits, we observed many similarities throughout the country, particularly due to the influence of the National Committee for Quality Assurance standards, as well as Medicare requirements. However, we also found tremendous diversity. This diversity can allow for experimentation and innovation if information about dispute resolution systems is shared and effective practices promoted.

3. *Customer service is the frontline of health plan dispute resolution, where the bulk of conflicts are raised and addressed. Plans vary significantly in the organization and management of their customer service departments.*

All plans have a customer service (CS) unit with trained staff. On average, plans in the study stated that 80 to 90 percent of member inquiries are resolved at the CS level. Yet enrollees in our focus groups did not always receive timely assistance from CS staff, and many expressed frustration. These findings highlight the critical importance of these services to the dispute resolution process. Since the operation of customer service is largely unregulated, plans have the freedom to be innovative and test new approaches.

177. NAOMI KARP & ERICA F. WOOD, *supra* note 2, at 85-9 (2000) (Our complete report includes a broader array of cross-cutting themes and suggestions for the future. See Chapter XIII of the Full Report.).

4. *Health plans have different approaches for making decisions on appeals, but generally involve a clinical practitioner in medical cases.*

The study identified six patterns of decision-makers for appeals. Plans vary markedly in: (1) whether decision-makers have been involved in the case previously; (2) whether experts in the relevant medical specialty are involved; (3) how "medical necessity" determinations are made; (4) whether objective medical practitioners outside the plan are involved; and (5) whether consumers are involved at some level.

5. *Health plans rarely use alternative dispute resolution.*

A number of health plans have arbitration options and agreements in their contracts with members, but use arbitration infrequently. While some plans incorporate elements of informal mediation into dispute resolution, none of the plans studied use formal mediation. While several states and independent local agencies have set up external managed care ombudsman programs, none of the plans studied have an internal ombudsman.

6. *Many health plans have developed promising consumer-responsive practices to address various facets of the dispute resolution process.*

Whether motivated by a desire to increase member satisfaction, be more competitive in the marketplace, conserve resources, or deliver better health care, many health plans have developed innovative approaches to resolving consumer disputes. Yet many of these practices have not been shared among plans or tested on a broad scale.

7. *Health plan members sometimes cannot or do not understand or use the grievance, appeal and dispute resolution process.*

Despite many health plans' efforts to implement effective grievance and appeal mechanisms, some members express uncertainty about the process and feel ill-prepared to advocate for themselves. Consumers in our focus groups often did not understand how grievance and appeals procedures worked or what steps they should follow. Even after receiving enrollment materials and denial letters, some lacked understanding or stamina to pursue their requests or claims.

8. *Health plan members sometimes wait long periods for the resolution of their disputes.*

Health plans seek to meet regulatory time frames, and some have developed workable means of hastening resolution for certain categories of cases. Yet some enrollees and regulators said member requests may be held up in utilization review or at the customer service level, and consumers expressed dismay at administrative delays and appeal time frames, especially those that caused them to postpone treatment in pre-service cases.

9. *When members appeal, health plans overturn their initial decisions in a substantial portion of cases.*

While our figures are incomplete, a substantial number of plans studied reverse their initial denials in 40 percent or more of cases at both the first and second level of appeal.

10. *Expedited appeal cases are infrequent.*

Health plans, regulators and consumer representatives noted the infrequency of expedited cases, but the study did not ascertain the cause.

11. *Health plans report that compliance with multiple regulatory requirements is the primary challenge they face in implementing dispute resolution systems.*

Disparate requirements on notices, time frames, levels of review, identity of decision-makers and other critical factors challenge plans offering multiple product lines. Some plans reported that they attempt to meet the most stringent requirements across product lines and jurisdictions, while others implement differing processes for each member population. Variations and discrepancies appear to hamper health plans from instituting one streamlined system.

12. *Disputes between health plans and members frequently arise from misunderstandings, lack of communication and lack of coordination among plan departments, medical groups, participating providers and members.*

Providing an opportunity for early and open communication and clear explanations may enable plans and members to resolve their conflicts at an early stage, for example, through personalized customer services practices, "pay and educate" programs, timely and understandable notices, early opportunities for in-person review, internal ombudsman programs and other means.

13. *Some health plans do not consistently give timely written notice of their initial decision to deny services or payment, or of a decision to terminate or reduce services. Some notices lack clarity and the full information necessary for an effective appeal, including information on how to submit additional evidence.*

Health plans in the study stated that they give notices of denials of requested services that require prior authorization. However, a variety of difficulties with notices of denials, reductions and terminations of service or payment impede members' ability to contest plan decisions.

14. *Members generally receive little information about the outcome of non-appealable grievances concerning quality of care or services.*

Most health plans studied indicated that state confidentiality statutes prevent them from reporting the results of quality investigations to the member who initiated the grievance. Yet, some plans do share brief information. Moreover, some Medicare plan staff need guidance in distinguishing grievances and appeals, especially since an appeal processed as a grievance will deny the beneficiary procedural protections and full notice of the outcome.

B. Suggestions for the Future

1. *Evaluate and promote promising practices.*

Many health plans have developed fair and effective practices in customer service, grievances and appeals. Industry and governmental leaders should play a role in identifying, testing and promoting these practices through conferences, materials, studies, listserves, newsletters, training and incentive programs. Plans could evaluate the practices, make cost estimates, and share information about the results to advance the health plan dispute resolution field. The managed care industry should consider convening a commission to seek dispute resolution improvements, and should ensure consumer representation, involvement, and feedback in this effort.

2. *Move toward regulatory uniformity, with consumer protection and consistent enforcement.*

Plans named lack of uniformity in regulatory and accreditation standards as their greatest challenge. More uniformity would not only aid plans in compliance, but would help consumers and community

agencies to better understand, explain and pursue the process. The Centers for Medicare and Medicaid Services, the Department of Labor, the National Committee for Quality Assurance, the National Association of Insurance Commissioners, and consumer advocacy groups should initiate a dialogue on conforming regulatory requirements on dispute resolution, consistent with consumer protection. Federal and state insurance regulators should have sufficient resources to allow for consistent enforcement.

3. *Strengthen customer service and appeals staff development.*

Health plans should establish a career path for customer services and appeals staff that promotes professional development and high quality service. Plans should use compensation, benefits, job incentives, opportunities for cross-training, and mentoring programs to recognize the central frontline role of these employees. Industry and governmental leaders should encourage training programs

4. *Ensure consistent, timely and understandable notification of initial decisions.*

Health plans and regulators should place more emphasis on the original notice of denial, reduction or termination of treatment, or denial of payment, since this notice is the trigger for the appeals process. Health plans and the managed care industry should re-examine forms and compliance procedures for the original notice. Federal and state regulators should be engaged in a broad effort to improve the notice process.

5. *Ensure qualified appeal decision-makers.*

Laws and regulations should require that plan appeal decision-makers have appropriate expertise and no previous involvement in the case. To increase objectivity and consumer confidence, plans should be encouraged to involve outside medical professionals, and to consider consumer involvement at least at the second level of review.

6. *Strengthen the grievance process.*

Government and health policy experts should examine regulatory constraints on giving outcome information to members who file non-appealable grievances about the quality of care or services. Health plans should test mediative approaches for addressing grievances about plan services through direct member involvement.

7. *Support members in the dispute resolution process.*

Government and industry leaders should encourage community resources to help consumers throughout the complaint, grievance and appeals process. The federal and state governments should devote increased funding to the SHIP program, as well as to external consumer assistance programs, and SHIP programs and health plans should work to enhance member awareness of the service.

8. *Educate members and the public on health care dispute resolution.*

Health plans, government agencies and consumer groups should increase efforts to educate members and the professionals with whom members interact about the dispute resolution process

9. *Test alternative dispute resolution.*

Health plans should offer training in mediation, negotiation and facilitation for their customer service and appeals staff. Plans could test the use of mediation in appropriate settings and could consider developing internal ombudsman offices, investing these offices with authority and independence.