

## MARKET WATCH

## Patients In Conflict With Managed Care: A Profile Of Appeals In Two HMOs

Contrary to popular belief, most appeals are not about insurers' denials of coverage for potentially life-saving care.

by Carole Roan Gresenz, David M. Studdert, Nancy Campbell, and Deborah R. Hensler

**ABSTRACT:** Despite speculation about the nature of disputes between managed care enrollees and their health plans over benefit denials, little empirical information exists about the details of such disputes and how they are actually handled. In this study we profile more than 11,000 appeals lodged between 1998 and 2000 by enrollees at two of the nation's largest health maintenance organizations (HMOs), to shed some preliminary light on the vast terrain of enrollee appeals. As many as half of appeals involved requests for reimbursement for costs of services already obtained ("retrospective" appeals), as opposed to services sought ("prospective appeals"). Enrollees won 36 percent of prospective appeals at Plan 1 and 70 percent at Plan 2, compared with 89 percent and 78 percent, respectively, of retrospective appeals. The success rate among retrospective appeals involving emergency room services—95 percent at both plans—was particularly striking.

PROCEDURAL MECHANISMS for reviewing benefit denials have emerged as the darling of federal and state efforts to protect the rights of patients in managed care plans.<sup>1</sup> Proposals to increase managed care organizations' (MCOs') exposure to civil litigation for wrongful benefit denial or delay have attracted much attention, but less controversial and considerably more common are reforms that improve the accessibility or functioning of administrative review processes, including internal "appeals" processes operated by health plans themselves and reviews conducted externally by independent review organizations.<sup>2</sup>

For the vast majority of enrollees who dispute a denial of coverage, an appeal to the health plan is the initial (and usually final) remedial step. Although other options for redress exist, their attractiveness to managed care enrollees is typically limited by considerations of accessibility, cost, timeliness, and effectiveness. For example, enrollees might seek assistance from their employer if they are in an employer-based group plan, but employers appear to have limited influence and may be reluctant to intervene because of liability concerns.<sup>3</sup> Alternatively, enrollees may seek independent review of a benefit denial, but such review mechanisms are not in place in all

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requirements for a specified set of services, coverage exclusions of or limitations on particular services and products, and coverage rules for emergency services. Thus, we expect a reasonable degree of commonality between the types of appeals we encountered and the wider corpus of managed care disputes.

A second limitation is that our analyses address appeals resulting from formal, explicit denials. Because managed care influences physicians' practice patterns, certain "implicit" denials may never be recognizable to patients as legitimate bases of appeal.<sup>12</sup> This type of care limitation warrants special mention in our study because the incentives for it to occur may be sharpest in fully delegated models. Similarly, incentives for physicians to act as advocates for enrollees in appeals are weakest in such models.

### Overview Of Appeals

■ **The process.** In the appeals processes in operation at each plan during the study period, enrollees who were formally denied insurance coverage for medical services (whether sought or already rendered) received a denial letter from their medical group notifying them of their opportunity to appeal the decision to the plan.<sup>13</sup> Once an appeal was initiated, its path differed between the plans in two main ways. Plan 1 offered enrollees three stages of appeal, and an active request for reconsideration from the enrollee (or his or her agent) was required to move the appeal to each successive stage. At Plan 2 all appeals resolved against the enrollee at stage one that involved "medically reviewable" issues received automatic reconsideration at a second and final stage of review; all other types of appeals terminated with the first-stage determination. In most other respects, however, the appeals processes were quite similar and exhibited the same core structural features as have been identified elsewhere.<sup>14</sup>

■ **Rates of appeal.** Rates of appeal were virtually identical at the two plans, with approximately 3.5 appeals per thousand enrollees per year. Similar rates of appeal have been reported by HMOs in other states.<sup>15</sup> Ex-

trapolating by commercial HMO enrollment alone, these rates suggest that approximately 250,000 appeals are processed at U.S. health plans annually. To put this caseload into context, it is nearly three times greater than the total volume of malpractice claims filed each year in the United States.<sup>16</sup>

■ **Types of appeals.** Although much of the anecdotal evidence about disputes in the managed care setting involves patients in conflict with their health insurers over denials of access to services ("prospective appeals"), a significant proportion of appeals involve disputes over payments for services already obtained ("retrospective appeals"). Retrospective appeals accounted for nearly 60 percent of appeals at Plan 1 and 32 percent at Plan 2; prospective appeals accounted for slightly more than 40 percent of appeals at Plan 1 and nearly 70 percent at Plan 2 (Exhibit 1).

This difference in the types of appeals each health plan received is puzzling. One possibility is that it reflects differences across medical groups in their UR practices. In turn, these practices may be fashioned by the experiences of medical groups as they learn the kinds of cases that the plans are likely to adjudicate for and against enrollees.

### Retrospective Appeals: Sources Of Conflict

Retrospective appeals can be broadly grouped into those that involve emergency room (ER) services and those that don't. The distributions of the retrospective appeals across these service types were similar, with ER services at issue in 48 percent of Plan 1's and 41 percent of Plan 2's retrospective appeals.<sup>17</sup> Appeals over ER services centered on differences among enrollees, medical groups, and plans in interpretation of the standard for determining when use of ER services is appropriate. Where non-ER services are at issue, the data highlight three key sources of conflict: (1) enrollees' failure to abide by specific plan procedures for obtaining care; (2) enrollees' misunderstanding of the contractual limits of coverage; and (3) delays or denials of care that enrollees believe are medically necessary and

**EXHIBIT 1**  
**Profile Of Appeals In Two California Health Plans**

	Retrospective appeals		Prospective appeals	
	Plan 1	Plan 2	Plan 1	Plan 2
Percent of appeals	58.9%	31.9%	41.1%	68.1%
Final level of appeal				
Level 1	97.8	95.9	90.3	93.5
Level 2	1.8	4.1	7.8	6.6
Level 3	0.0	— <sup>a</sup>	1.9	— <sup>a</sup>
Final outcome				
Resolved against enrollee	10.9	22.4	64.5	29.7
Goodwill paid	62.9	11.7	— <sup>a</sup>	— <sup>a</sup>
Other resolution in enrollee's favor	26.2	65.9	35.5	70.3
Resolution in favor of enrollee, by level <sup>b</sup>				
Level 1	88.2	75.2	32.8	67.4
Level 2	44.1	50.0	24.7	37.1
Level 3	0.3	— <sup>a</sup>	12.7	— <sup>a</sup>

**SOURCE:** Authors' tabulations of health plan data.

<sup>a</sup>Not applicable.

<sup>b</sup>Includes goodwill-paid (GWP) and non-GWP resolutions in favor of enrollee.

urgently needed.

■ **Emergency care.** Disputes over reimbursement of the costs for emergency care may sometimes involve issues of patient eligibility or coordination of benefits among multiple insurers, but most are likely to center on disagreements over the interpretation of the standard by which coverage for emergency services is determined. The standard is based on statutory language and is common across most health plans nationwide: namely, that coverage for emergency care cannot be denied based on lack of preauthorization (or any other access requirement) unless the enrollee did not require emergency treatment and should reasonably have known that.<sup>18</sup> The standard is commonly referred to as the "prudent layperson" or "reasonable person" standard. The specific clinical aspects of disputes over the necessity of emergency services are an area for future research.

■ **Nonemergency care.** *Failure to follow procedures.* Some disputes over nonemergency services that have been rendered arise because enrollees either are unaware of or do not fully understand the applicable rules of their cover-

age. In the majority of such appeals, issues of authorization are implicated: An enrollee failed to obtain the necessary authorization for care or failed to remain within the network of participating providers, or both. Enrollees' failure to fully follow health plans' procedures may signify a failure of plans and medical groups to articulate the procedures well; of enrollees to read, absorb, and recall the rules; and of providers to help patients abide by the rules. For example, health plans reported that doctors (often who contract with multiple health plans) may inadvertently direct a patient to a nonnetwork laboratory for a blood draw or radiology services. In other cases, authorization for a particular treatment may have been provided but had expired by the time the enrollee sought the service. A small portion of retrospective cases (5 percent at Plan 1 and 3 percent at Plan 2) involved nonemergency care received "out of area," such as when a member was traveling far from home. Members may believe that they are entitled to coverage for out-of-area care without authorization, but at both Plans 1 and 2 and many others, coverage for out-of-area services is limited to emer-

gency care.

**Medical necessity conflicts.** Some appeals involving members' request for reimbursement of unauthorized, nonemergency care arise from a conflict over the medical necessity of certain services. Actual or anticipated delays in receiving authorization for services lead some patients to acquire services they feel they urgently need without the required approval. In 11 percent of retrospective appeals at Plan 2, enrollees requested reimbursement of costs of services that were previously denied in (prospective) UR. In other cases, enrollees may either have anticipated or experienced a delay in the authorization process that kept them from waiting for approval. These appeals are akin to prospective appeals over medical necessity, except for patients' perception of the urgency of the need for services or their ability or willingness to bear financial risk for the costs of care.

**Prospective Appeals: Sources Of Conflict**

Prospective appeals center on three main issues: (1) the medical necessity of particular services; (2) the interpretation of specific coverage exclusions; and (3) the appropriateness of a particular physician to provide services.

■ **Medical necessity.** The medical necessity of services was the principal issue in dispute in 49 percent of all prospective appeals at Plan 2 (the only data that permitted this categorization). Although the prototypical medical necessity dispute pertains to whether a treatment or procedure should be covered at all, these disputes frequently hinged on whether an alternative or more conservative treatment should have been tried before the requested service or whether additional evaluation should have been obtained. Another common flashpoint was whether the duration or intensity of services—for example, more than five physical therapy sessions after sur-

gery—was clinically sufficient. Conflicts over notions of what constitutes medically necessary care seem inevitable. The challenge of developing descriptions of coverage limits that are more explicit and precise, yet still comprehensible to purchasers and enrollees, seems formidable.<sup>19</sup> Ongoing efforts by Sara Singer and Linda Bergthold to link coverage language to evidence-based medical practice represent one thoughtful attempt to achieve this goal.<sup>20</sup>

■ **Contractual disputes.** An additional 16 percent of prospective appeals involved disputes that were more closely tied to contractual than clinical considerations. At issue were administrative considerations, such as whether an individual's enrollment was active, and coverage exclusions, such as dental services, orthotics, or mental health services. In the latter category, however, certain types of services blend clinical and contractual

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considerations. For example, in determinations about whether a surgical procedure is cosmetic or reconstructive, the applicability of the coverage exclusion turns on medical necessity. Nonetheless, the fact that a nontrivial portion of disputes implicated contractual issues that appeared to be severable, wholly or partly, from clinical ones suggests that the “expertise” that many advocate for in the review of coverage decisions should come from persons who are versant not only in clinical medicine but also in contractual interpretation.

■ **Choice of physicians.** One in five prospective appeals related not to whether certain services should have been covered but to which physician should have provided services that the patient and health plan agreed should have been rendered. Some enrollees were seeking a particular kind of specialized provider, while the plan may have authorized services from a different type of specialist or the enrollee's primary care physician. In other cases, members requested an out-of-network provider. Leading reasons for these requests

for specific providers included that the authorized or in-network provider (1) was not "qualified" or specialized enough, (2) would not offer an objective second opinion, (3) would not offer the continuity of care that another provider could (in some cases, a provider who was formerly part of the plan's network), or (4) was inconveniently located.

### Outcomes Of Appeals

The outcomes of appeals varied greatly by type of appeal: Prospective appeals were less likely than retrospective appeals were to be resolved in enrollees' favor. Enrollees won 36 percent of prospective appeals at Plan 1 and 70 percent at Plan 2, compared with 89 percent and 78 percent of retrospective appeals, respectively (Exhibit 1). The success rate among retrospective appeals involving ER services—95 percent at both plans—was particularly striking (data not shown).

■ **Level of appeal.** More than 90 percent of appeals terminated at the first level (Exhibit 1). Higher-level considerations were more common among prospective appeals, although this propensity to persist with disputes is partly an artifact of the lower win rate in these appeals for enrollees at stage one. Overall, the sizable difference between plans in the outcome of prospective appeals is difficult to explain. Two possibilities are differences in the stringency of the plans' UR standards and in the plans' willingness to set aside denials for reasons other than merit (for example, to curry favor with employer-purchasers).

■ **Goodwill-paid decisions.** In retrospective appeals, decisions in favor of the enrollee come in two forms: reversals of the medical group's denial based on an evaluation of the appeal's merits, and "goodwill payments." In the latter, the health plan chooses to pay a non-meritorious claim or to pay a claim without assessing its merits, and to bear financial risk for the cost of the disputed services. Officials at Plans 1 and 2 articulated similar motivations for their goodwill-paid decisions, namely (1) to engender the goodwill of the enrollee or the enrollee's employer; (2) to avoid processing appeals when adjudication costs greatly exceed

the disputed costs; and (3) to recognize that in special circumstances plan rules may have been confusing, especially for new enrollees. At Plans 1 and 2, 63 percent and 12 percent, respectively, of retrospective claims generally and 65 percent and 8 percent, respectively, of ER claims specifically were goodwill-paid.<sup>21</sup>

■ **Noteworthy issues.** The outcomes we observe among retrospective appeals raise two noteworthy issues. First, the large proportion of ER claims that are overturned on their merits suggests either that a major problem exists with the interpretation of the standard used to determine coverage for this type of service or that inappropriate denials of emergency services are common. Inappropriate denials are not necessarily the result of deliberate "gaming" on the part of medical groups; there may be delays in obtaining relevant medical records from hospitals or a lack of an administrative infrastructure to evaluate claims appropriately. Further research is needed to discern between these competing explanations.

Second, although goodwill payments of certain nonmeritorious claims may help to protect consumers from financial burdens associated with ambiguous or confusing procedures or standards for obtaining care, the short-term gains to beneficiaries of such payments may be outweighed by systemic losses. If goodwill payments introduce an incentive for medical groups to inappropriately deny claims, enrollees who do not appeal such denials lose out. Moreover, failure to adjudicate appeals on their merits represents a missed opportunity to educate medical groups and consumers on the plan's view of acceptable behavior. This educative function is especially important for emergency services, for which the standard for appropriateness appears to be relatively ambiguous.

### Framing A Research Agenda

Attention to conflicts in managed care from media, political, and even entertainment circles has tended to converge on a particular kind of dispute: legal wrangling over health insurers' denials of coverage for potentially life-saving care on the grounds that it is not

medically necessary. The focus on these particular kinds of cases reflects the potential seriousness of their health consequences, but context is important: Our research shows that these cases do not make up the corpus of disputes, but rather that the terrain of disputes handled through administrative means is vast. As many as half of appeals involve requests for reimbursement for costs incurred for services already obtained, and half of those involve situations where a member has obtained emergency care. Among appeals over prospective access to service, at least one in five involved issues unrelated to medical necessity, such as which physician was to provide a covered medical service. Although the outcomes of these disputes are typically less dramatic, they are still likely to have important cost and access implications for enrollees. Research and policy should not ignore the "silent mainstream" of these thousands of disputes that arise and get adjudicated at health plans each year. There is a pressing need to learn more about them.

Our findings on the sources and outcomes of appeals suggest some general directions for policy research. Creative approaches are needed to help enrollees better understand the rules to which they are expected to adhere. A particular area of concern is emergency services, where the prevalence of disputes and the apparent schism between medical groups' and health plans' views of the merits of these disputes point to a need for efforts to decrease ambiguity in the contractual language describing coverage. Dissemination of specific clinical examples by plans that illustrate acceptable and unacceptable uses of emergency services could help to clarify the rules for both consumers and medical groups. Information systems must be designed to permit timely and secure sharing of patient data so that adjudicators of coverage disputes can make fully informed decisions about the merits of the appeals before them.

The findings also speak to a better understanding of how health plan resolutions influence the behavior of consumers and medical groups alike. Finally, much more needs to be

known about the epidemiology of benefit denial disputes—including who does (and does not) bring them forward, what specific services are involved, and what factors bear on their resolution. Our study should help to translate some of these general queries into a more specific set of front-line research questions.

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**NOTES**

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2. C.R. Gresenz et al., "A Flood of Litigation? Predicting the Consequences of Changing Legal Remedies to ERISA Beneficiaries," RAND Institute for Civil Justice Issue Paper 184 (Santa Monica, Calif.: RAND, July 1999); D.M. Studdert et al., "Expanding Managed Care Liability: What Impact on Employment-Based Health Coverage?" *Health Affairs* (Nov/Dec 1999): 7-27; D.M. Studdert and T.A. Brennan, "The Problems with Punitive Damages in Lawsuits against Managed-Care Organizations," *New England Journal of Medicine* 342, no. 4 (2000): 280-284; and U.S. Department of Labor, "Employee Retirement Income Security Act of 1974; Rules and Regulations for Administration and Enforcement; Claims Procedure," *Federal Register* 65, no. 225 (November 2000): 70245-70271.
3. Studdert et al., "Expanding Managed Care Liability."
4. W.K. Mariner, "What Recourse? Liability for Managed-Care Decisions and the Employee Retirement Income Security Act," *New England Journal of Medicine* 343, no. 8 (August 2000): 592-596.
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6. American Arbitration Association, American Bar Association, and American Medical Association, "Commission on Health Care Dispute Resolution: Interim Progress Report," 20 January 1998.

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8. H.H. Schaufler et al., "Differences in the Kinds of Problems Consumers Report in Staff/Group HMOs, IPA/Network HMOs, and PPOs in California," *Medical Care* (January 2001): 15-25. In this survey of a random sample of Californians, 42 percent reported one or more problems with their MCO in the past year. Among HMO enrollees, approximately 12 percent reported billing/payment problems, and 4 percent reported denials of care or treatment.
9. D.A. Richardson, J. Phillips, and D. Conley Jr., *A Study of Coverage Denial Disputes between Medicare Beneficiaries and HMOs* (Pittsford, N.Y.: Center for Health Dispute Resolution, Network Design Group, September 1993).
10. Data on pharmacy appeals were either limited or unavailable and thus are not included in our analysis. Prior to 1 January 2000, Plan 2 delegated authority over both initial UR and first-stage appeals to medical groups. For comparability to Plan 1, we use Plan 2 data from 2000 only. We limit the analysis to appeals lodged at least one month prior to the end date of the data at Plan 2 and at least three months prior to the end date of the data at Plan 1. Appeals come to closure more quickly at Plan 2 because reconsideration at Plan 2 is automatic (or not offered) after an appeal is denied at the first level and because there are only two levels of appeal.
11. M.B. Rosenthal et al., "Scale and Structure of Capitated Physician Organizations in California," *Health Affairs* (July/Aug 2001): 109-119; J.C. Robinson, "Health Care Purchasing and Market Changes in California," *Health Affairs* (Winter 1995): 117-130; J.C. Robinson and L.P. Casalino, "Vertical Integration and Organizational Networks in Health Care," *Health Affairs* (Spring 1996): 7-22; and M.R. Gold, R. Hurley, and T. Lake, "Provider Organizations at Risk: A Profile of Major Risk-Bearing Intermediaries," *Health Affairs* (Mar/Apr 2001): 175-185.
12. E.A. Kerr et al., "Quality Assurance in Capitated Physician Groups: Where Is the Emphasis?" *Journal of the American Medical Association* (16 October 1996): 1236-1239; and E.A. Kerr et al., "Managed Care and Capitation in California: How Do Physicians at Financial Risk Control Their Own Utilization?" *Annals of Internal Medicine* (1 October 1995): 500-504.
13. Enrollees also are informed of their appeal rights in the health plan literature provided to them when they enroll.
14. See GAO, *HMO Complaints and Appeals*; and ABA, "Understanding Health Plan Dispute Resolution Practices." It is worth noting that a number of features of the appeals processes are shaped heavily by state regulation.
15. Without UR data, we are not able to calculate the rate of appeal conditional on receiving a UR denial. Data available on UR requests, denials, and appeals are limited. See Gresenz et al., "A Flood of Litigation?"
16. P.C. Weiler et al., *A Measure of Malpractice* (Cambridge: Harvard University Press, 1993).
17. At Plan 2, 8 percent of appeals are classified as out-of-area, and whether they involve ER services cannot be distinguished. At Plan 1, 61 percent of out-of-area claims involve ER services. We apply that percentage to the Plan 2 data to calculate the percentage of appeals involving ER (5 percent) or non-ER (3 percent) services.
18. *California Health and Safety Code*, sec. 1371.5.
19. Studdert et al., "Expanding Managed Care Liability."
20. S.J. Singer and L.A. Bergthold, "Prospects for Improved Decision Making about Medical Necessity," *Health Affairs* (Jan/Feb 2001): 200-206.
21. The difference between the plans in the rate at which appeals are goodwill-paid may reflect some differences in how goodwill-paid versus merit overturns are distinguished, but also may reflect true behavioral differences. For example, Plan 1 may have a higher cost threshold for paying claims to avoid administrative review costs.

