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# HMO COMPLAINTS AND APPEALS

## Plans' Systems Have Most Key Elements, but Consumer Concerns Remain

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# HMO Complaints and Appeals: Plans' Systems Have Most Key Elements, but Consumer Concerns Remain

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Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss our recent report on health maintenance organization (HMO) complaint and appeal procedures.<sup>1</sup> As you know, our health care financing and delivery system has undergone major changes in the past decade. With the growth of managed care, health plans have increased controls on patients' access to and use of costly services. On the one hand, these controls have helped slow the growth of health care spending but, on the other hand, they have added to consumers' confusion and dissatisfaction. A health plan's complaint and appeal system can provide a means for enrollees to signal their dissatisfaction and challenge denials of coverage or payment. It is not well known, however, what procedures HMOs have to handle members' complaints and appeals.

At your request, we examined the extent to which HMOs have procedures with which enrollees can raise concerns and resolve disputes. We focused on (1) the elements that are considered important to a system for processing HMO members' complaints and appeals, (2) the extent to which HMOs' complaint and appeal systems for members contain these elements, (3) the concerns that consumers have regarding HMO complaint and appeal systems, (4) the information that is available on the number and types of complaints and appeals HMOs receive from their members, and (5) how, if at all, HMOs use their complaint and appeal data.

To address these issues, we obtained information from 38 HMOs in five states on the policies and procedures established for their complaint and appeal systems.<sup>2</sup> The criteria for assessment were derived from national standards developed by the Joint Commission on Accreditation of Healthcare Organizations and the National Committee for Quality Assurance (NCQA), as well as policies outlined by the American Association of Health Plans, Families USA, and the National Association of Insurance Commissioners. Of the elements these organizations consider to be key to complaint and appeal systems, 11 that are common to at least two groups address timeliness, the integrity of the decision-making process, and effective communication with members. (See the appendix.) These criteria allowed us to develop some sense of whether plans have important features for responding to members' concerns. Although we did not

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<sup>1</sup>HMO Complaints and Appeals: Most Key Procedures in Place, but Others Valued by Consumers Largely Absent (GAO/HEHS-98-119, May 12, 1998).

<sup>2</sup>Our report discusses systems in Colorado, Florida, Massachusetts, Oregon, and Tennessee applicable to HMO members not enrolled in Medicare and Medicaid. Although a small proportion of enrollees in HMOs were in self-insured plans, we did not focus on the procedures applicable specifically to self-insured members.

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determine how well these systems are working, our review indicates the policies of the 38 HMOs in our review.

In brief, we found that the HMOs in our study have most elements identified as important by regulatory, consumer, and industry groups. However, we found (1) considerable variation in how the HMOs specify certain policies, (2) poor understanding of HMO systems by members, and (3) a lack of consistency in the way the HMOs define, collect, and maintain data on complaints and appeals.

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**HMOs Have Most**  
**Elements Considered**  
**Important, Although**  
**Two Elements Are**  
**Commonly Lacking**

The HMOs in our study have most of the policies and procedures identified as important to complaint and appeal systems. Much of the uniformity exhibited by HMOs may be attributed to the influential role played by NCQA, which includes all 11 elements in its accreditation standards. HMOs recognize that NCQA accreditation is important to purchasers, who view it as an indicator of plan quality. A growing number of plans have obtained or are seeking accreditation, reflecting an apparent trend toward standardization within the HMO industry in this area.

We examined HMOs’ time periods, decision-making processes, and communication with members regarding their complaints and appeal systems. Consistently, the plans have 9 of the 11 key elements in their policies and procedures. Of the HMOs providing data, 89 to 100 percent reported that they

- have explicit time periods for responding to complaints and appeals,
- have an expedited appeal process available under certain circumstances,
- have a two-level appeal process,
- allow a member to attend at least one appeal hearing,
- involve medical professionals with appropriate expertise in appeal decisions,
- provide understandable written information about how to voice a complaint or appeal,
- accept oral complaints,
- provide a description of a patient’s appeal rights in the denial notice, and
- provide written notice of appeal denials, including further appeal rights.

But 2 of the 11 important elements have not been adopted by most of the HMOs in our study. Of the HMOs providing data, only 32 to 41 percent reported that they

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- bar decisionmakers who had previous involvement in a case from hearing an appeal and
- accept oral appeals of adverse determinations. (Some HMO officials told us that they prefer members to submit appeals in writing in order to ensure that their concerns are accurately characterized. Of the plans requiring written appeals, however, three told us they provide writing assistance to members who request it.)

Even where we found a policy or procedure to be common across HMOs, plans exhibit considerable variation in the specifics of certain policies, as illustrated below.

- Although many HMOs’ time periods call for resolution of complaints or appeals within 30 days at each level, other HMOs’ time periods vary considerably. One HMO’s policy calls for complaints to be resolved immediately, another HMO’s within 24 hours; another allows up to 60 days to resolve complaints. Time periods for first-level appeals vary from 10 to 75 days; for second-level appeals, from 10 days to 2 months.
- HMOs also vary considerably in the length of time they allow for the resolution of an expedited appeal, used when the health of the patient might be jeopardized by following normal time periods. While the most common time period among the HMOs in our study is 72 hours, two HMOs’ policies call for resolution within 24 hours, while two others allow up to 7 days for resolution.
- All HMOs in our study reported using a committee to resolve second-level appeals. Half the plans also use a committee at the first level, while the other half use individuals, including grievance coordinators or appeal coordinators, medical directors, or other plan officials such as the plan president. Most HMOs told us that they include medical professionals among the appeal decisionmakers; some plans use physicians not employed by the plan to review appeals. Many plans involve staff of various plan departments, such as marketing, claims, and medical management, in making appeal decisions. Some plans use the board of directors, or a subset, as a decision-making committee; some include plan enrollees as committee members. One plan reported that of its 10-member second-level appeal committee, half are plan enrollees and the other half plan physicians.
- Of the HMOs allowing a member to attend at least one appeal hearing, less than half explicitly permit members to be accompanied by a representative, such as a friend or a lawyer. In instances in which the member cannot attend the meeting in person, fewer than one-third have

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explicit provisions for members to attend the meeting by telephone or videoconference.

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**Consumer Groups  
Expressed Concerns  
Regarding Conflict of  
Interest and  
Communication  
Difficulties**

Although the majority of HMOs' complaint and appeal systems include most of the important elements, consumer advocates expressed concern that such systems are not fully meeting the needs of enrollees. Advocates specifically noted the lack of an independent, external review of plan decisions on appeals and noted members' difficulty in understanding how to use complaint and appeal systems. This latter issue, however, may be part of a broader lack of understanding about health insurance in general and managed care in particular.

Consumer advocates contend that member disputes may not be resolved equitably. Advocates told us that regardless of the particular mechanisms plans use to resolve appeals, plan employees' reviewing the decisions made by other plan employees suggests a conflict of interest. Accordingly, consumer advocates and other groups believe that review by an independent third party is essential to ensuring integrity in decision-making. Among its criteria for external review, the President's Quality Commission states that such review should (1) be available only after consumers have exhausted all internal processes (except in cases of urgently needed care), (2) be conducted by health care professionals who have appropriate expertise and who were not involved in the initial decision, and (3) resolve appeals in a timely manner, including provisions for expedited review. The Commission notes, however, that several issues—including mechanisms for financing the external review system, sponsorship of the external review function, consumer cost-sharing responsibilities (for example, filing fees), and methods of overseeing and holding external appeal entities accountable—must be analyzed to identify the most effective and efficient methods of establishing the independent external appeal function.<sup>3</sup>

The Medicare population has had experience with external appeals for several years. The Health Care Financing Administration (HCFA) requires that appeals by Medicare HMO enrollees be reviewed by an independent party if the initial appeal is denied by the HMO. A HCFA contractor, the Center for Health Dispute Resolution, hires physicians, nurses, and other clinical staff to evaluate beneficiaries' medical need for contested services and make reconsideration decisions. As of July 1997, nearly one-third of

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<sup>3</sup>Advisory Commission on Consumer Protection and Quality in the Health Care Industry, "Consumer Bill of Rights and Responsibilities: Report to the President of the United States," Nov. 1997.

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the denials that Medicare HMOs upheld in their grievance proceedings were overturned; for some categories of care, that rate was 50 percent.

However, there is limited experience with external review for commercial HMO members. According to the National Conference of State Legislatures, legislation or regulation mandating external review has been enacted by 16 states.<sup>4</sup> In Florida, one of the states included in our review, the program consists of a statewide panel made up of three Florida Department of Insurance representatives and three representatives from Florida's Agency for Healthcare Administration. The process is available to any enrollee who has exhausted the HMO's internal appeals procedure and is dissatisfied with the result. According to Florida officials, from 1991 to 1995 an average of 350 appeals per year were heard under the program: Issues included quality of and access to care, emergency services, unauthorized services, and services deemed not medically necessary. About 60 percent of the appeals were resolved in favor of members, about 40 percent in favor of HMOs.

In addition, consumers find it difficult to understand complaint and appeal systems. Despite the fact that most HMOs provide information about plan procedures to members, communication difficulties were noted by HMO officials, consumer advocates, and others. Several HMO officials told us that most members do not read their handbooks carefully; officials also told us that members are not familiar with the requirements of managed care and that many complaints and appeals stem from this lack of understanding. Consumer advocates we spoke with echoed these statements, consistently noting that HMOs' complaint and appeal systems are not well understood by members. A 1995 national survey supports these views, stating that half of insured respondents merely skim—or do not read at all—the materials about their health plans and that many consumers do not understand even the basic elements of health plans.<sup>5</sup> Consumer advocates cited a variety of reasons why many HMO members, even if they understand how to use complaint and appeal systems, are reluctant to access such systems. In some cases, members are incapacitated and have neither the time nor the energy to navigate the HMO's complaint and appeal system. Advocates told us that in other instances, members are intimidated by the formality and size of the HMO.

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<sup>4</sup>Arizona, California, Connecticut, Florida, Michigan, Missouri, New Hampshire, New Jersey, New Mexico, North Carolina, Ohio, Pennsylvania, Rhode Island, Tennessee, Texas, and Vermont all require that plan decisions be externally reviewed in certain instances.

<sup>5</sup>The results of the Louis Harris and Associates "Navigating the Changing Healthcare System" probability survey, covering 1,081 adults nationwide, are reported in Stephen L. Isaacs, "Consumers' Information Needs: Results of a National Survey," *Health Affairs*, Vol. 15, No. 4 (Winter 1996).

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Greater plan efforts to encourage enrollees to understand these policies could serve to prevent misunderstandings between patients and the plans and avoid later appeal proceedings. For example, three of the HMOs in our study do not give enrollees a written explanation of their appeal rights when denying a service or payment. Further, plans might revise written material to make it easier to understand; studies have found that plan material is written at the level of college or graduate school, while writing directed at the general public should be at the seventh or eighth grade level.<sup>6</sup>

Alternatively, ombudsman programs designed to facilitate consumer understanding about health plan processes, including the complaint and appeal systems, can provide an independent external resource for health plan information and consumer assistance. Florida, for example, has established ombudsman committees to act as volunteer consumer protection and advocacy organizations on behalf of managed care members in the state and may assist in the investigation and resolution of complaints. Members of the committees include physicians, other health care professionals, attorneys, and consumers, none of whom may be employed by or affiliated with a managed care program.

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**Complaint and Appeal  
Data Are Neither  
Comparable Nor  
Accessible**

We asked HMOs to provide us with the number of complaints and appeals received from commercial members in 1996 and the nature of the complaints and appeals. The number of complaints and appeals that HMOs reported to us varied widely. In 1996, complaints ranged from 0.5 per 1,000 enrollees to 98.2 per 1,000 enrollees, while the number of appeals ranged from 0.07 to 69.4 per 1,000 enrollees. According to the HMOs, complaints and appeals covered a variety of issues: The most common complaints were about medical or administrative services, quality of care, and claims issues; the most common appeals were appeals of benefits issues, denial of payment for emergency room visits, and referral issues.

However, these data may not be very meaningful, because HMOs differ in the ways they define complaints and appeals and in the ways they count the complaints and appeals they receive. For example, HMOs may use different terms—such as complaint, appeal, grievance, inquiry, or reconsideration—to describe the same or very similar events. HMOs also do not count complaints and appeals consistently. One HMO, for example, told us that it does not count oral complaints that are immediately resolved by

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<sup>6</sup>M. Hochhauser, "Letter to the Editor," *Health Affairs*, Sept.-Oct. 1997, p. 220. I. S. Kirsch and others, *Adult Literacy in America: A First Look at the Results of the National Adult Literacy Survey* (Washington, D.C.: U.S. Dept. of Education, 1993).



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plan representatives; another HMO reported that it may count one member’s contact, such as a letter or telephone call, as several complaints if the contact involves several different issues.

Public records of complaints and appeals could be useful sources of information about problems in HMOs and help purchasers and consumers select and monitor health plans. In addition, if the nature and frequency of complaints were made public, HMOs might be more motivated to make systemwide improvements. A uniform set of definitions and categorizations would be required for public disclosure of complaints and appeal information. Without such consistency, a prospective purchaser or consumer would not be able to compare plans in a meaningful way. To this end, HCFA intends to require contracting health plans to submit standardized, plan-level appeal data. Although HCFA and accrediting bodies such as NCQA recognize that reporting simple complaint and appeal rates on individual plans may not be a good indicator of members’ relative satisfaction with HMOs, such information might prove beneficial when used in conjunction with other performance indicators.

Documenting and analyzing complaints and appeals can help plans deal with chronic problems by informing management about various elements of plan performance, both clinical and administrative. Resolution of problems brought to a plan’s attention, if widespread or recurring, can lead to improvements in access to care, physician issues, or quality of care, as well as changes in plan policies and procedures. All HMOs in our study told us that they analyze complaint and appeal data to identify systemic problems and opportunities for improvement. HMOs use complaint and appeal data, together with data from other sources, to make changes to benefits or plan processes, to change members’ behavior, and to change providers’ behavior. For example,

- Three HMOs reported adding a drug to their formularies; another added Weight Watchers coverage.
- Several HMOs reported changes to their system for processing and paying emergency room claims. Two HMOs, for example, increased the number of emergency room diagnoses that they would automatically pay without reviewing a claim. Claims that would previously have been denied were thus paid.
- Many HMOs reported using complaint and appeal data about specific providers as part of their processes for recredentialing providers; one HMO reported terminating a provider as a direct result of a member’s complaint. A few HMOs reported establishing peer review panels, in which providers

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would review information, including complaints and appeals, to evaluate the performance of HMO providers.

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## Conclusions

Although the HMO policies generally include most elements considered important to complaint and appeal systems, the systems may not be working as well as they could to serve enrollees' interests. Better communication and information disclosure could improve the complaint and appeal process for the benefit of HMO members and plans.

Even though HMO enrollment materials generally described complaint and appeal systems in accurate detail, many members may not know of their right to complain or appeal or might not understand how to exercise that right. Members' inability to navigate the complaint process results in little formal tracking of the patterns of problems that are encountered. Improved consumer knowledge might lead to more appropriate use of complaint and appeal systems and thus might provide more information to HMOs wishing to identify and address plan problems. Finally, consumers lack the information they need to compare plans in a meaningful way. Publicly available information on the numbers and types of complaints, the outcomes of the dispute resolution process, and actions taken by HMOs to correct problems would provide information about not only members' satisfaction but also plan responsiveness to problems raised by members. Consumers' demand for and use of such information could have a positive influence on plan operations and quality through market competition.

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Mr. Chairman, this concludes my statement. I would be happy to answer any questions from you and other members of the Committee. Thank you.

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# Number of HMOs With and Without Elements Identified as Important to a Complaint and Appeal System

<b>Element</b>	<b>HMOs with element</b>	<b>HMOs without element</b>	<b>HMOs not reporting</b>
<b>Timeliness</b>			
Explicit time periods	36	1	1
Expedited review	34	2	2
<b>Integrity of the decisionmaking process</b>			
Two-level appeal process	38	0	0
Member attendance permitted at one appeal hearing	36	1	1
Appeal decisions made by medical professionals with appropriate expertise	31	4	3
Appeal decisions made by individuals not involved in previous denials	15	22	1
<b>Effective communication</b>			
Written information provided, in an understandable manner, about how to register a complaint or appeal	34	2	2
Oral complaints accepted	36	2	0
Oral appeals accepted	12	25	1
Appeal rights included in notice of denial of care or payment of service	31	3	4
Written notice provided of appeal denials, including further appeal rights	36	1	1

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