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Inside the Black Box of Managed Care Decisions

Understanding Patient Disputes over Coverage Denials

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Recent movies such as *John Q* and *The Rainmaker* dramatize a widespread public concern: that managed care organizations attempt to keep costs low by denying coverage for care that patients need. This concern stands at the heart of patients' rights proposals. A key focus of patient protection efforts has been establishing, standardizing, and improving processes to review coverage denials—including denial of coverage for medical services patients would like to receive or reimbursement for services already received. However, little is known about the characteristics of coverage denials by managed care organizations and what happens to such cases in health plans' reconsideration, or "appeals," processes.

Many millions of Americans with private health insurance are enrolled in managed health care organizations, and managed care enrollees file an estimated 250,000 appeals each year; however, little empirical information exists about why health insurance coverage disputes happen, what kinds of services they involve, and how they are resolved.

To begin to open the "black box" of coverage denials and appeals, Carole Roan Gresenz from the RAND Corporation, David Studdert of the Harvard School of Public Health, and colleagues from RAND conducted a series of studies on managed care coverage denials and the appeals system in which those denials are reconsidered. The research team gathered data from two large California health maintenance organizations (HMOs) and two large medical groups that contract with each of the HMOs,

Key findings:

- The two large medical groups in the study denied, on average, 9 percent of patients' requests for coverage.
- Denials of coverage were more frequent for post-service requests (reimbursement for medical services already obtained) than for pre-service requests (medical services sought but not yet received).
- Appeals frequently involved more than disputes about medically necessary care. Many involved contractual limits on covered services, coverage for out-of-network doctors, and emergency care that the health plan did not consider urgent.
- Enrollees won approximately half of all appeals, including more than three-fourths of all post-service appeals and nearly all appeals over emergency care.

providing some of the first empirical data on *utilization review*—the process in which initial coverage decisions are made—and patients' appeals of denials that result from utilization reviews. Among the studies' key findings:

- On average across the two medical groups, 9 percent of patient requests for coverage were denied in the utilization review process. Requests that were most commonly denied involved coverage for durable medical equipment (such as orthotics, power-operated

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vehicles, or other equipment intended for long-term use) and reimbursement for emergency care.

- Denials of coverage were more frequent among post-service requests (requests for reimbursement for medical services enrollees had already received) than among pre-service requests (patients' requests for authorization for medical services they wanted but had yet to receive).
- Appeals involved more than just disputes between patients and their managed care organizations about the medical necessity of services. Many appeals were sparked by contractual limits on covered services, by plans' restrictions on insurance coverage for doctors outside their provider network, and because enrollees received emergency care in situations the health plan did not consider urgent.
- Enrollees won more than three-fourths of all post-service appeals at both HMOs in the study. At both plans, patients were less likely to prevail in pre-service than in post-service disputes. One plan reversed approximately one-third of pre-service coverage denials, and the other plan reversed two-thirds of such denials.
- Patients won nearly all appeals over emergency care.

Utilization Review: Frequency and Nature of Coverage Denials

In California, most HMOs contract with medical groups to provide medical care to enrollees, and it is these medical groups that perform the initial utilization review. Kanika Kapur from RAND, along with Gresenz and Studdert, examined the outcomes of nearly one-half million utilization review requests to two large California medical groups. The analysis found that:

- Of the more than 476,000 coverage requests analyzed, approximately 41,000 were denied. The overall denial rate—8 percent at one medical group (Group 1) and 10 percent at the other (Group 2)—was substantially higher than rates of around 3 percent found in earlier studies.
- The types of requests most commonly denied were for durable medical equipment (23 percent of such requests were denied by Group 1 and 15 percent by Group 2) and emergency care (17 percent and 16 percent of these requests were denied). Denial rates were also relatively high for laboratory/pathology services, speech therapy, and chiropractic services.
- In contrast, requests for inpatient care, surgery, and obstetric care had low rates of denial at both medical groups.
- Post-service requests (for reimbursement) were denied four times more frequently (23 percent) than were pre-service requests (6 percent), based on data from one medical group.

A Profile of Patient Appeals of Coverage Denials

The main recourse for HMO enrollees who are denied insurance coverage for a medical service in the utilization review process is to file a request with their HMO for reconsideration of the decision. Reconsiderations are handled through an appeals process run by the HMO, not by the medical group. Researchers examined more than 11,000 appeals of coverage denials filed between 1998 and 2000 by patients enrolled at two large HMOs. They examined grounds for appeals and their outcomes.

Rate of appeals. Appeal rates were similar for the two HMOs: about 3.5 appeals per 1,000 enrollees per year. This rate suggests that more than 250,000 appeals are filed each year among all privately insured HMO enrollees in the United States.

Sources of disputes. A substantial fraction of appeals involved post-service disputes—nearly one-third at Plan 1 and over one-half at Plan 2. At both plans, post-service appeals most commonly involved emergency care. In these cases, the initial coverage denial usually reflected a judgment that the services were not urgent and could reasonably have been provided in a different setting at a later time.

Among pre-service appeals, three principal reasons were given for denials of coverage: (1) The type of care at issue was excluded in the individual's insurance contract; (2) the care was not medically necessary; and (3) the requested provider was outside the HMO provider network. Disputes over care that fell outside the bounds of the insurance contract were sometimes straightforward coverage issues—for example, an enrollee wanted coverage for acupuncture, but acupuncture was not a covered benefit. In other cases, the disputes involving contractual exclusions also involved interpretation of *medical necessity*—for example, cosmetic services are explicitly excluded from coverage by many health plans (and such denials are classified as contractual denials), but clinical judgment is required in determining what is or is not a cosmetic service.

Success rate for appeals. Enrollees won more than three-fourths of all post-service appeals at both Plan 1 and Plan 2. Patients at both plans were less likely to prevail in pre-service than in post-service disputes: over one-third of patients in Plan 1 and slightly more than two-thirds at Plan 2, in pre-service appeals.

When enrollees won post-service appeals (i.e., the health plan agreed to provide reimbursement for the costs of services received), it was either on the basis of merit or resulted from a decision by the health plan to “goodwill pay” the claim, meaning that payment was made to engender the goodwill of the enrollee or the enrollee's employer, to avoid the cost of

reviewing the appeal, or to recognize that in some circumstances plan rules may have been confusing, especially for new enrollees.

The HMOs differed with respect to their use of this kind of decision: Of decisions on post-service appeals, 67 percent were goodwill payments at Plan 1 but only about 13 percent at Plan 2. To better understand the specific nature of disputes, researchers conducted in-depth analyses of more than 3,500 appeals at the two HMOs. They performed detailed studies of pre-service appeals of a varied nature and of post-service appeals over emergency care.

Pre-Service Appeals

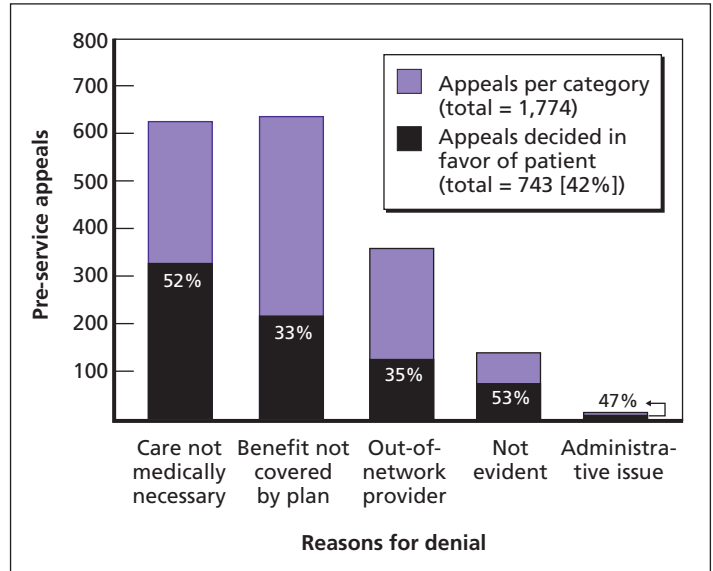
In a detailed study of pre-service appeals, researchers found that approximately 20 percent involved patients' desires to obtain care from a provider outside the HMO's network of doctors. One-third of pre-service appeals involved issues of medical necessity alone (see the figure). Another one-third of appeals related to a contractual coverage exclusion, sometimes involving a combination of contractual and medical-necessity issues, but at other times directly challenging stated exclusions in the insurance contract. The remainder involved either an administrative issue, such as whether the patient was an eligible enrollee, or a reason for denial that could not be ascertained. Researchers sought a clearer picture of what was going on inside each of these categories.

Medical necessity. Surgical procedures, office consultations, and diagnostic tests accounted for nearly 75 percent of pre-service appeals in which the central issue was the medical necessity of services. Of these appeals, 40 percent involved one of six specific services—surgery for obesity or an obesity-related condition, breast alteration, varicose-vein removal, bone density study, sleep study, and treatment of a scar or benign lesion. Patients prevailed in 52 percent of all medical-necessity cases. The success rates for cases involving gastric bypass surgery and varicose-vein removal were significantly lower than the average for all medical-necessity appeals (26 percent and 32 percent were overturned, respectively).

Plan coverage. Taken together, foot orthotics, speech therapy, physical therapy, dental care, alternative-medicine treatments, investigational therapies, and infertility treatments accounted for 61 percent of pre-service appeals in which the dispute was related to a specific exclusion in the insurance contract. Patients were less likely to prevail in these contractual coverage cases (33 percent resolved in enrollees' favor) than in cases involving only medical-necessity issues (52 percent resolved in enrollees' favor).

Provider choice (out-of-network care). Although enrollees sought authorization for insurance coverage for care

Types and Outcomes of Pre-Service Denials



from an out-of-network provider for a number of reasons, the main reason (60 percent of these cases) was that enrollees believed that the out-of-network provider was of higher quality than any provider available within the network. Other frequent motivations were having to travel too far to see an in-network provider or a desire for continuity of care with a specific clinician, who may either have ended his/her contract with the HMO or who may have been the enrollee's provider in a different insurance plan. With only 35 percent of these appeals resolved in enrollees' favor, patients were also less likely to prevail in provider-choice cases than in medical-necessity cases.

Emergency Department Appeals

Disputes over emergency department care accounted for a sizable share of post-service appeals: 52 percent at Plan 1 and 34 percent at Plan 2. In a subsequent analysis, Gresenz and Studdert took a closer look at appeals of denials of payment for emergency department services. They studied a sample of more than 400 such appeals from the two HMOs. The table describes the most common reasons for emergency department visits in cases in which insurance coverage was being contested. Patients most often sought emergency department care for symptoms related to illness (64 percent) and to injury (22 percent), and for disease-related services (8 percent). The remaining 6 percent of cases involved specific therapeutic procedures (e.g., 1 percent for removal of sutures) or were uncodable (5 percent). The average bill for services in dispute was just over \$1,100.

The most striking finding: Patients prevailed in over 90 percent of appeals involving emergency department care.

Most Common Reasons for Emergency Department Visits Resulting in Appeals

Emergency Room Appeals	Total cases	Percentage of cases	Most common conditions
Symptoms of illness	254	64	abdominal pain, cramps, spasms; earache; gastrointestinal infection; vertigo; leg symptoms; back symptoms; headache, pain in head; sinus problems
Injuries and adverse effects	87	22	lacerations and cuts; sprains
Disease	44	8	diseases of esophagus, stomach, and duodenum (including stomach ulcer and gastritis)

Decisions in enrollees’ favor were made on the basis of merit or were “goodwill payments” by health plans. In the latter case, the plan either pays the claim after concluding that it has no merit or pays the claim without judging its merit. At Plan 1, 60 percent of emergency department appeals were goodwill paid, whereas only 7 percent fell into this category at Plan 2. The difference in the plans’ use of goodwill payments may simply reflect a difference in nomenclature—how each plan categorizes outcomes—but could also represent a behavioral difference in the way different plans determine when a case will undergo a full review for merit.

Apart from the goodwill payments, a significant proportion of denials of coverage for emergency department services—at least one in three at Plan 1 and five in six at Plan 2—were overturned on merit grounds. These outcomes indicate explicit disagreement about the appropriateness of emergency department use between coverage decisionmakers at health plans—who make the appeal decision—and coverage decisionmakers at medical groups—who make the utilization-review decision.

These disagreements arose despite the fact that California, like most other states, has a legally binding standard for determining when use of emergency services is appropriate. The “prudent layperson standard” says that health insurers must cover emergency services obtained by patients if a reasonable layperson would have interpreted the symptoms as requiring such care. The high rate of overturn on merit suggests that health plan officials apply the standard in a different way than do decisionmakers at the medical groups.

The results point to two conclusions. First, despite widespread use of the prudent layperson standard, that standard is ambiguous and therefore imperfect as a way of regulating coverage of emergency services. Second, patients who do not appeal rulings on emergency care may be forced inappropriately to bear the costs of that care.

Implications

These studies are based on data from two HMOs and two

medical groups in California. Therefore, they cannot be generalized to the country as a whole. However, they provide the clearest picture to date of coverage decisionmaking in managed care organizations. Journalists, policy advocates, and politicians tend to portray health insurance coverage disputes as legal wrangling over health insurers’ denials of potentially life-saving care on the grounds of medical necessity. However, it is important to put life-or-death cases in perspective and to realize that the terrain of health insurance coverage disputes is varied:

- As many as half of the appeals involved requests for reimbursement for services already obtained. Often, the enrollee obtained such services from an emergency department.
- Among appeals over insurance coverage for those services that enrollees have yet to receive, one in five involved a dispute about which provider is to render services and one in three involved either a contractual coverage issue alone or a combination of medical-necessity and contractual issues.
- Disputes that involved only the medical necessity of services constituted another one-third of appeals. Most of the medical-necessity cases examined did not involve life-sustaining services. Rather, they clustered around services that straddle the line between treatment—preventing, curing, or ameliorating an impairment—and enhancement—improving normal human functioning.
- In a nontrivial fraction of all appeals, resolutions favored enrollees, especially for post-service requests for reimbursement.

Further Study

Internal HMO appeals are not usually a patient’s last resort for receiving authorization for a desired service or reimbursement for a delivered service. In almost every state, including California, patients may appeal the denial of health insurance coverage to a state-run dispute resolution program, commonly known as “external review.” The next stage of research, an examination of appeals to external review, will shed more light on the dynamics and impacts of patient-HMO disputes. ■

This research brief summarizes research from RAND's Law & Health Initiative reported in the following publications:

Gresenz, Carole Roan, and David M. Studdert, "Disputes over Coverage of Emergency Department Services: A Study of Two HMOs," *Annals of Emergency Medicine*, February 2004.

Gresenz, Carole Roan, David M. Studdert, Nancy Campbell, and Deborah R. Hensler, "Patients in Conflict with Managed Care: A Profile of Appeals in Two HMOs," *Health Affairs*, Vol. 21, No. 4, July/August 2002, pp. 186–196.

Kapur, Kanika, Carole Roan Gresenz, and David M. Studdert, "Managing Care: Utilization Review in Action at Two Capitated Medical Groups," *Health Affairs*, Web exclusive, June 18, 2003.

Studdert, David, and Carole Roan Gresenz, "Enrollee Appeals of Preservice Coverage Denials at 2 Health Maintenance Organizations," *Journal of the American Medical Association*, Vol. 289, No. 7, February 19, 2003, pp. 864–870.

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