

June 1998

INDEMNITY HEALTH PLANS

Key Features of Consumer Complaint and Appeal Systems



**Health, Education, and
Human Services Division**

B-280264

June 30, 1998

The Honorable Paul Coverdell
The Honorable Larry Craig
United States Senate

About one in every five Americans who obtain health coverage from their employers is enrolled in a traditional indemnity health plan.¹ In an indemnity plan, members choose their physicians, physicians provide care, and the insurer pays all or some portion of the resulting bills. Indemnity plans commonly require that elective hospitalizations and procedures be authorized before they occur. A plan could refuse to pay, or reduce payment, for a service on the grounds that it was not covered in the insurance contract, was not medically necessary, or was not properly authorized. It is in these areas, denial of payment or coverage of services, that disputes between the member and indemnity plan commonly arise. Under traditional indemnity plans, however, adverse determinations may have implications different from those under managed care plans, because claims are generally paid or denied after the service has been provided. In managed care plans, most coverage decisions are made prospectively through the utilization review process, which may lead some to believe that a denial of coverage by a plan is a denial of care.

In our recently issued report on health maintenance organization (HMO) complaint and appeal systems, we found that HMOs in our study incorporated most elements considered important for such systems but that consumer advocates thought that these systems might not be adequately meeting consumer needs.² In light of these findings, you asked us to perform a similar review of complaint and appeal systems in indemnity plans. On the basis of discussions with your offices, we examined (1) the elements that are considered important to a system for processing indemnity plan member complaints and appeals, (2) the extent to which indemnity plan complaint and appeal systems contain these elements, and (3) how indemnity plans compare with HMOs in the extent to which their complaint and appeal systems incorporate recommended elements.

¹According to a recent survey of firms of more than 200 employees, about 18 percent of American workers in such firms are enrolled in indemnity plans, down from 71 percent in 1988. In 1997, conventional plans had highest enrollments in the Southern region (25 percent) and lowest in the Western region (8 percent). Across economic sectors, these plans were most popular among state and local governments, where they accounted for more than one-third of enrollments. See KPMG Peat Marwick, *Health Benefits in 1997* (June 1997).

²The results of our HMO study are reported in *HMO Complaints and Appeals: Most Key Procedures in Place, but Others Valued by Consumers Largely Absent* (GAO/HEHS-98-119, May 12, 1998).

To determine the elements that are important to indemnity plan complaint and appeal systems, we identified organizations that have issued guidelines applicable to indemnity plans. Families USA (FUSA) and the National Association of Insurance Commissioners (NAIC) were the only groups we identified with criteria explicitly addressing indemnity plan systems.³ An official at the Health Insurance Association of America (HIAA), which represents indemnity plans, stated that HIAA has not promulgated its own set of recommended elements but generally supports the NAIC Health Carrier Grievance Model Act and its provisions regarding grievance procedures.

Because we wanted to compare indemnity plans' complaint and appeal systems with those of HMOs, we contacted the 38 insurance carriers in five states (Colorado, Florida, Massachusetts, Oregon, and Tennessee) that participated in our HMO study to determine whether these companies also offer indemnity plans.⁴ Thirteen of the 38 carriers reported that they offer indemnity plans. Of this number, 10 plans, including at least one from each of the five states, provided us with specific information. We interviewed these plans' officials and reviewed plan policy statements, member handbooks, letters sent to members, and other documentation. In our report, we discuss systems applicable to members of insured plans and, for some carriers, self-funded plans as well.⁵

We did not evaluate the extent to which plans follow their policies or the extent to which they meet consumers' needs; instead, we assessed whether the systems in place contain features considered important. Because of the small number of plans examined in this study, and the way

³FUSA is a national nonprofit consumer organization, working at national, state, and grassroots levels to advocate on health care issues. NAIC is a voluntary organization of insurance regulatory officials created to assist state insurance regulators in protecting consumers and helping maintain the financial stability of the insurance industry. Elements described in our report were taken from a December 1997 FUSA document entitled "Evaluation Tool," containing FUSA criteria for evaluating 12 consumer protection issues, and from two 1996 NAIC model acts: the Health Carrier Grievance Procedure Model Act and the Utilization Review Model Act.

⁴We asked the companies whether they offered an indemnity product, distinct from HMO, point of service (POS), and preferred provider organization (PPO) products. We consider such products to be forms of managed care because they use a network of physicians contracted with by the plan and because they offer incentives to plan members to use physicians in the network.

⁵Employment-based health coverage, whether fee-for-service or managed care, may be financed in one of two ways. Many employers choose to purchase health care coverage from an insurance company or other entity, paying a per-employee or per-beneficiary premium in exchange for this coverage. The insurance company or other entity then bears the cost of any health care services that the beneficiary incurs. Many other employers, however, choose to pay their employees' health care costs themselves, often hiring an insurance company to process claims and perform other administrative functions. Such firms are referred to as self-insured or, more accurately, self-funded, because no insurance element is actually present (the term insurance implying a transfer of risk).

in which these plans were selected, the results cannot be generalized to the universe of indemnity plans; however, they do indicate the extent to which plans incorporate elements considered important to complaint and appeal systems. We conducted our review between March and June 1998 in accordance with generally accepted government auditing standards.

Results in Brief

Guidelines issued by the regulatory and consumer advocacy groups in our study identified nine elements as important to indemnity plan complaint and appeal systems, falling into three general categories: timeliness, integrity of the decision-making process, and communication with members. Nearly all the recommended elements were present in the policies of at least half the plans in our study. Five elements—explicit time periods for resolving member appeals, appeal decisions made by medical professionals with appropriate expertise, provision of information on how to register a complaint or appeal, plan acceptance of oral complaints, and inclusion of appeal rights in notice of denial of coverage or payment—were included in the policies of a large majority of indemnity plans in our study. However, the remaining four elements—expedited review of appeals in urgent situations, appeal decisions made by individuals not involved in the initial decision, plan acceptance of oral appeals, and written notice of appeal denials including further appeal rights—were present in the policies of only two-thirds or fewer of the plans reporting. Taken together, a smaller proportion of indemnity plans in our study incorporated recommended elements in their complaint and appeal systems than did HMOs in our previous study. When compared with HMOs operated by the same carrier, indemnity plans generally incorporated about the same proportion of recommended elements as did HMOs.

Background

Under traditional indemnity plans, the physician has no legal relationship to the patient's health plan. The contractual relationships are between the patient and the physician—under which the patient is obligated to pay the physician a fee for service rendered—and between the patient and the plan—under which the plan is obligated to indemnify the patient for medical expenditures incurred according to the terms of the insurance contract. Although disputes between the patient and plan may arise over denial of payment, claims regarding the quality of services that result in medical injury are resolved in state common law tort systems under principles of medical malpractice law.⁶

⁶Eleanor D. Kinney, "Symposium: On Physician Decision-Making and Managed Care: Resolving Consumer Grievances in a Managed Care Environment," *Health Matrix: Journal of Law-Medicine*, winter 1996.

Complaint and appeal procedures are regulated by a patchwork of federal and state laws. No federal standards, however, prescribe how complaint and appeal systems are to be structured and administered. For example, the Employee Retirement Income Security Act of 1974 (ERISA), a federal law governing most employer-sponsored health plans, requires that all health plans provide a mechanism to permit participants and beneficiaries to appeal a plan's denial of a claim. Regulations promulgated pursuant to ERISA generally require that plans approve or deny appeals within 60 days. Some states may have statutes or regulations governing indemnity plan complaint and appeal procedures; however, under ERISA the states are prevented from regulating self-funded health plans, which enroll approximately 87 percent of indemnity plan members.⁷

Nine Elements Were Considered Important for Indemnity Plans

The groups we contacted identified 9 of the 11 elements recommended for HMO complaint and appeal systems as applicable to indemnity plans. The two HMO-related elements not considered applicable to indemnity plans were a two-level appeal process and the member's right to appear at one appeal hearing.⁸ The elements considered important to a sound complaint and appeal process for indemnity plans fell into three general categories—timeliness, integrity of the decision-making process, and effective communication—and included the following:

- explicit time periods, set out in plan policies, within which plans resolve complaints or appeals. Appeals, according to the criteria, were to be resolved within 30 days;
- expedited review of appeals in situations in which, were a plan to follow its usual time period for processing an appeal, the patient's health might be jeopardized. Such situations might include, for example, admission to, or discharge from, an acute-care hospital. Criteria called for expedited review to be completed within 72 hours or 2 business days of the appeal;
- appeal decisions made by medical professionals with appropriate expertise;
- appeal decisions made by individuals not involved in the initial decision;
- information provided about how to register a complaint or appeal;

⁷KPMG Peat Marwick, Health Benefits in 1997.

⁸In addition, we modified two guidelines slightly to facilitate comparison with the results of our HMO report. While FUSA and NAIC called for appeals to be resolved within 30 days, we used unspecified "time periods," in order to facilitate comparison with the results of our HMO study. Similarly, while guidelines used by FUSA and NAIC called for expedited appeals to be resolved within 72 hours, or up to 2 business days, we simply determined whether plans had procedures in place for expedited review, without specifying the time period in which such review must be completed, again in order to facilitate comparison with the results of our HMO study.

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- oral complaints accepted by the plan;
 - oral appeals accepted by the plan;
 - appeal rights included in notice of denial of coverage or payment of service; and
 - written notice of appeal denials, including further appeal rights where applicable. This standard would not apply in cases where members have no further appeal rights—for example, in plans that offered only one level of review.

Key Elements Were Present in at Least Half the Plans

Nearly all the recommended elements were present in the policies of at least half the plans in our study. As shown in table 1, five elements—explicit time periods for resolving member appeals, appeal decisions made by medical professionals with appropriate expertise, provision of information on how to register a complaint or appeal, plan acceptance of oral complaints, and inclusion of appeal rights in notice of denial of coverage or payment—were included in the policies of a large majority of the indemnity plans in our study. However, the remaining four elements—expedited review of appeals in urgent situations, appeal decisions made by individuals not involved in the initial decision, plan acceptance of oral appeals, and written notice of appeal denials including further appeal rights—were present in the policies of only two-thirds or fewer of the plans reporting.

Table 1: Number of Indemnity Plans With and Without Elements Identified as Important to a Complaint and Appeal System

Element	Plans with element	Plans without element	Plans not reporting
Timeliness			
Explicit time periods ^a	10	0	0
Expedited review ^b	6	3	0
Integrity of the decision-making process			
Appeal decisions made by medical professionals with appropriate expertise ^c	9	1	0
Appeal decisions made by individuals not involved in the initial decision	5	5	0
Effective communication			
Plan provides information about how to register a complaint or appeal	10	0	0
Oral complaints accepted	9	1	0
Oral appeals accepted	2	8	0
Appeal rights included in notice of denial of coverage or payment	7	2	1
Written notice of appeal denials, including further appeal rights	6	3	1

^aGuidelines called for appeals to be resolved within 30 days. However, we used unspecified "time periods" to facilitate comparison with the results of our HMO study.

^bGuidelines called for expedited appeals to be resolved within 72 hours, or up to 2 business days. However, we simply determined whether plans had procedures in place for expedited review, without specifying the time period in which such review must be completed, to facilitate comparison with the results of our HMO study. Further, one plan is omitted from the analysis of this element. An official from the plan stated that the plan does not require preauthorization of any procedures, and an expedited review process is unnecessary because all decisions regarding coverage are made after the care is received.

^cWe considered plans as having this element if medical personnel were included in the decision-making process. However, we were not able to determine whether individuals with clinical expertise were appropriately assigned to specific cases.

We asked plans to indicate whether the complaint and appeal policies they described applied to both insured and self-funded business. Four plans provided no information on this issue, while one stated that its indemnity plan had no self-funded members. Of the five remaining plans, three stated that the complaint and appeal policies they reported to us applied to all members, insured as well as self-funded, and two stated that most self-funded purchasers follow the plans' policies. Three plans stated that self-funded purchasers may become involved in the appeal process, generally after the member has exhausted the plan's standard appeal process. According to an official at one plan, because such purchasers are

actually responsible for the cost of care, they have the discretion to overturn denials made by the plan.

All 10 plans in our study had established time periods within which complaints and appeals were to be resolved. Two plans reported that their time period for resolving an appeal was 21 days; several allowed 30 days, and several others allowed 60 days.

Six plans (of nine included in this analysis) reported that their policies contained expedited appeal processes for use in circumstances in which delay in care might jeopardize the patient's health.⁹ One plan's policies called for appeals involving admission to, or services from, an acute-care hospital in a life-threatening or other serious injury situation to be resolved within 3 hours, while other types were to be resolved within 2 business days. Another plan's policies called for expedited appeals to be resolved within 72 hours. Two plans allowed up to 3 business days, while another allowed up to 7 days. The remaining three plans stated that they did not have such expedited review policies. The final plan is excluded from our analysis of this element; an official from this plan stated that the plan does not require preauthorization of any procedures and that an expedited review process is unnecessary because all decisions regarding coverage are made after the care is received.

Nine plans reported that they included doctors or nurses on their appeal committees. We did not, however, analyze individual appeal cases and so were unable to determine whether doctors and nurses with appropriate expertise made appeal decisions in cases of denials resulting from medical necessity decisions. Five plans, out of 10 reporting, required that persons reviewing appeals not be the same individuals involved in the case earlier.

All 10 plans in our study reported that they provide written information to members describing the complaint and appeal process. We reviewed the materials provided to members—including member handbooks, member contracts, newsletters, and other forms of communication—and judged them to be clear and understandable.

Nine plans accepted oral complaints from members, while one plan required members to put complaints in writing. Only two plans, however, accepted oral appeals from members; the remaining eight required members to file appeals in writing. One plan that accepted oral appeals,

⁹We did not obtain information from plans about who decides whether the patient's health is at risk—the plan, the physician, or the patient.

however, noted in its policy that oral appeals must be filed in person. In our prior study of HMOs, some plan officials told us that they prefer members to submit appeals in writing in order to ensure that members' concerns are accurately characterized.

Seven plans, out of nine responding, described member appeal rights when informing members of a denial of payment or authorization. Regarding denials of members' appeals, six plans (of nine providing data) reported that they included further appeal rights, where applicable, in written notices of denial. Further appeal rights might include additional levels of appeal within the plan or the right to appeal to a state organization or the member's employer. Two of the remaining three plans provided written notice of appeal denials but did not include further appeal rights despite offering additional internal levels of appeal, while one plan responded to members only if the appeal was resolved in the member's favor.

Indemnity Plans Were Less Closely Aligned With Certain Key Elements Than Were HMOs

Compared with the 38 HMOs in our previous report, a smaller proportion of the 10 indemnity plans' policies and procedures included the recommended elements. However, the disparity in the number of HMOs and indemnity plans participating in our studies might account for some of the noted differences. At the individual carrier level, in most cases, the prevalence of recommended elements was nearly the same in the indemnity plan and HMO operated by the same carrier, but several carriers had less conformance in their indemnity plan.

As shown in table 2, on the whole, a smaller percentage of indemnity plans than HMOs had the nine recommended elements applicable to both indemnity and HMO plans. Four elements were incorporated by a similar, and relatively high, proportion of plans of each type. Large differences were evident in two elements—expedited review and written notice of appeal denials, including further appeal rights—where a substantially lower proportion of indemnity plans included the elements than did HMOs. We found smaller differences in three elements: a slightly higher percentage of indemnity plans than HMOs specify that appeal decisions must be made by individuals not involved in the initial decision, and a slightly higher percentage of HMOs than indemnity plans accept oral appeals and explain appeal rights in denial notices. Regarding the remaining four elements, we noted only slight differences.

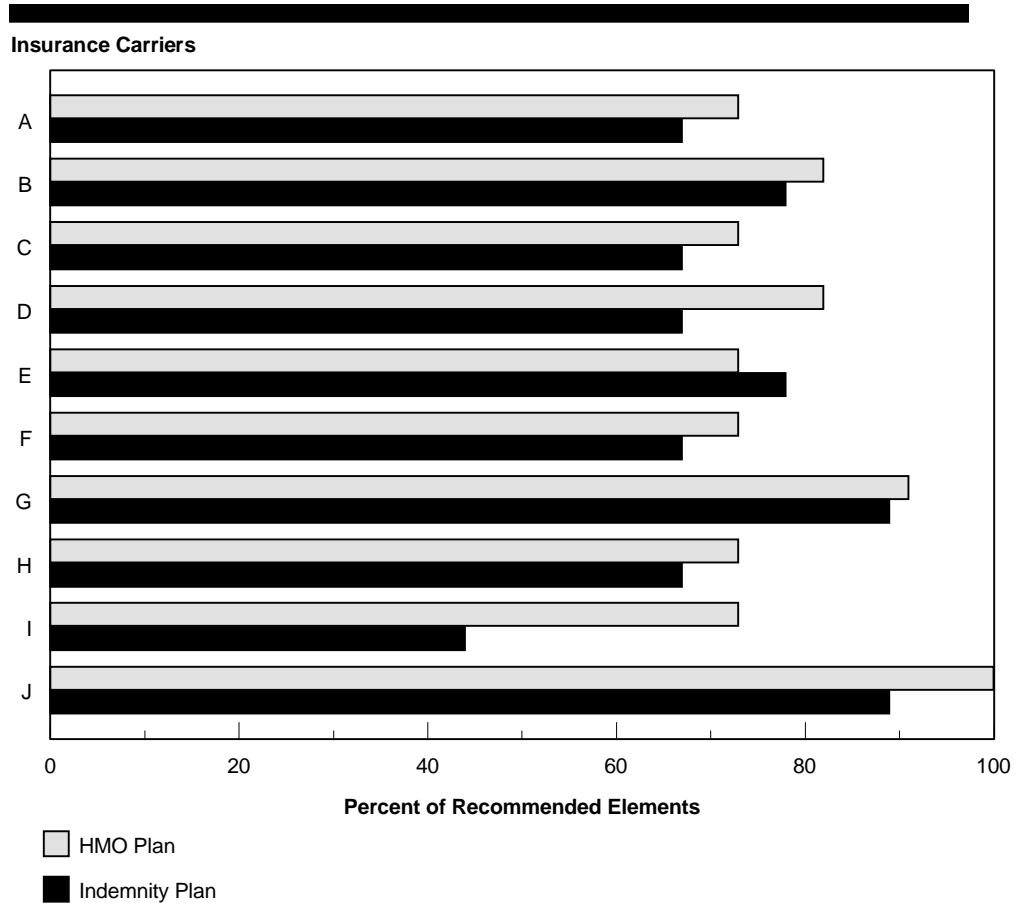
Table 2: Percentage of HMOs and Indemnity Plans With Elements Identified as Important to a Complaint and Appeal System

Element	Percentage of HMOs with element	Percentage of indemnity plans with element
Timeliness		
Explicit time periods	97	100
Expedited review	94	67
Integrity of the decision-making process		
Appeal decisions made by medical professionals with appropriate expertise	89	90
Appeal decisions made by individuals not involved in the initial decision	41	50
Effective communication		
Plan provides information about how to voice a complaint or appeal	94	100
Oral complaints accepted	95	90
Oral appeals accepted	32	20
Appeal rights included in notice of denial of coverage or payment	91	78
Written notice of appeal denials, including further appeal rights	97	67

Note: Percentages are based on the number of plans providing data on each element (up to 38 HMO and 10 indemnity plans).

We also examined the extent to which individual insurance carriers offering both indemnity and HMO plans included recommended elements in the complaint and appeal systems for each type of plan. Figure 1 compares the prevalence of recommended elements in indemnity plans with those in place in the HMO offered by the same carrier. For 7 of the 10 carriers in our study, the indemnity plan and HMO had nearly the same proportion of recommended elements. At the remaining 3 carriers, the HMO included the greater proportion of elements, with 1 carrier showing substantial differences across plans.

Figure 1: Percentage of Recommended Elements in Individual Carriers' HMOs and Indemnity Plans



Note: HMO data indicate the proportion of 11 key elements present in plan policies; indemnity plan data indicate the proportion of 9 key elements present.

Comments and Our Evaluation

In commenting on a draft of our report, NAIC officials stated that we had accurately characterized their criteria governing consumer complaint and appeal systems for indemnity health plans.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. We will then send copies to those who are interested and make copies available to others on request. Please call me on (202) 512-7119 if

you or your staff have any questions. Major contributors to this report include Rosamond Katz and Steve Gaty.

A handwritten signature in black ink, reading "Bernice Steinhardt". The signature is written in a cursive, flowing style.

Bernice Steinhardt
Director, Health Services Quality
and Public Health Issues

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