MEDICARE HMOS: A CONSUMER PERSPECTIVE†

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INTRODUCTION

Medicare is the federal health insurance program for the elderly (those sixty-five or older), disabled (and receiving Social Security disability benefits), and those with end stage renal disease. Generally, the program provides comprehensive medical coverage excluding preventive care, prescription drugs, long-term care, and dental care. Since 1985, Medicare beneficiaries have had the option of using their Medicare coverage to enroll in a health maintenance organization (HMO) that contracts with the Health Care Financing Administration (HCFA).[1]

In recent years, the number of Medicare beneficiaries enrolled in Medicare HMOs has skyrocketed. Currently, Congress and other federal policy makers intend to increase dramatically the numbers of Medicare beneficiaries in managed care.

Ultimately, this shift towards managed care should succeed only if consumers feel that they have adequate access to quality medical care. Current law already provides many protections for Medicare HMO enrollees; however, it also leaves many gaps. After providing some background information, this Article explores three broad areas of consumer concern—marketing, access to and quality of care, and due process—explaining the range of protections afforded Medicare enrollees and discussing some gaps that need closing. The author also recommends some needed reforms within each area of concern to consumers.

I. BACKGROUND INFORMATION

An HMO often serves a number of different populations.

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[1] The Health Care Financing Administration (HCFA) is the federal agency that administers the Medicare program. Technically, HCFA is an operating division of the United States Department of Health and Human Services.

Most have a majority of "commercial enrollees"—that is, persons enrolled through their employer (or union or trade association) group health plan. Many also have contracts with HCFA to serve the Medicare population. Some HMOs also enroll Medicaid recipients through contracts with the state Medicaid agency.[2]

A. *Legal Framework for Medicare HMOs*

Under a Medicare HMO risk contract,[3] HCFA pays an HMO a set monthly fee for each Medicare beneficiary enrolled. The monthly fee is intended to equal ninety-five percent of the average amount HCFA would have spent on a beneficiary in the community (referred to as the "average adjusted per capita cost" or "AAPCC"), and varies by geographic area.[4] For example, in 1996, the monthly capitation fee ranges from $127.44 in Culebra, Puerto Rico, to $758.53 in Richmond, New York.[5] In return, the HMO agrees to provide each Medicare enrollee with at least all of the services covered by Medicare (except hospice care).[6] The HMO

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2 Medicaid is the federal health insurance program for those with low income. Within a basic federally established framework, Medicaid is governed and administered by the states. It is called Medicaid in every state except California, which has named it Medi-Cal.

See generally 42 U.S.C. § 1396 (1988). Section 1396 states the broad purpose of the Medicaid Assistance Program:

> For the purpose of enabling each State, as far as practicable under the conditions of such state, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care . . . .

Id. Although a state's participation in Medicaid's joint federal and state cost sharing system program is optional, once a state chooses to participate, full compliance with all federal statutory provisions is required. Connecticut Hosp. Ass'n v. O'Neill, 793 F. Supp. 47, 49 (D. Conn 1992); Rye Psychiatric Hosp. Ctr. Inc. v. Surles, 777 F. Supp. 1142, 1144 (S.D. N.Y. 1991) (citing Harris v. McRae, 448 U.S. 297, 301 (1980)).

3 When HCFA first began contracting with HMOs, the contracts could be either risk based (that is, on a capitated basis) or cost based (a permutation of traditional fee-for-service health care). However, nearly all current Medicare HMO enrollees are on a risk basis. Medicare HMOs with cost-basis contracts operate under a different set of rules than do those with risk contracts. This Article pertains to Medicare risk contract HMOs only.

4 42 U.S.C. § 1395mm(a) (1988); 42 C.F.R. §§ 417.584(a) and (b) (1995). HCFA computes the average adjusted per capita cost per enrollee by adjusting the U.S. per capita incurred cost by several factors including those based on geography, enrollment, age, sex, and disability, as well as other factors as appropriate. *See generally* 42 C.F.R. §§ 417.588(a)-(c) (1995).

5 HCFA, *HMO/CMP Release* (Nov. 2, 1995) (reprinted in Medicare & Medicaid Guide (CCH), ¶ 44, 038 (1996)).

6 42 U.S.C. § 1395mm(c)(2) (1988). *See also* 42 C.F.R. § 417.442 (1995) (regard-

receives the same monthly capitated fee regardless of the amount or frequency of services it actually provides. For example, the HMO receives the same monthly fee for an enrollee who undergoes heart bypass surgery as for an enrollee who does not need any services.

Medicare HMOs operate under a number of different laws. For all of their enrollees, whether commercial, Medicaid, or Medicare, HMOs must meet the statutory and regulatory requirements of the state(s) in which they operate.[7] For their Medicare enrollees, HMOs must also meet federal Medicare requirements, which are set forth in Title 42, Section 1395mm of the United States Code (Section 1876 of the Social Security Act) and in Title 42, Part 417 of the Code of Federal Regulations. In most states, federal Medicare law is more extensive than state requirements for a number of areas, such as marketing and due process.[8]

B. *Potential Advantages of HMOs*

HMOs typically stress preventive care and therefore usually cover many services not covered by Medicare, including routine physicals, and vision and hearing exams. In very competitive markets, like Southern California, HMOs also provide additional benefits, such as prescription drug coverage and dental coverage.

Furthermore, the beneficiary cost-sharing associated with HMOs is minimal. Most HMOs offer Medicare beneficiaries very small or no monthly premiums, and require only nominal copayments for HMO services. Although Medicare HMO enrollees still pay their monthly Medicare Part B premium ($42.50 per month in 1996),[9] Medicare deductibles and copayments, as well as charges beyond Medicare-approved amounts, are eliminated. Also, Medicare HMO enrollees do not need Medicare supplemental insurance (which costs $500 to $5000 per year in premiums).[10]

Another significant advantage is that, unlike health insurers in most states—including companies selling Medicare supplemental

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ing "additional benefits" and "supplemental benefits" for which Medicare enrollees may be eligible).

[7] Every state in the country has its own set of laws governing HMOs. However, the breadth and depth of state requirements vary dramatically. *See generally* GERALDINE DALLEK, CAROL JIMENEZ & MARLENE SCHWARTZ, CONSUMER PROTECTIONS IN STATE HMO LAWS (L.A. Center for Health Care Rights 1995).

[8] For a discussion of state law requirements, see *id.*

[9] 60 Fed. Reg. 53626 (Oct. 16, 1995).

[10] *See* I.R. Perkin, *Insurance covers "gaps" in Medicare*, SENIOR WORLD (May 1995) at 16-17.

insurance[11]—Medicare HMOs can not, by law, do any medical underwriting; that is, they can not discriminate in enrollment or coverage on the basis of health history or current health status.[12] Therefore, Medicare beneficiaries in need of extensive medical care can obtain comprehensive coverage at very little cost.

C. *Consumer Concerns*

The Center for Health Care Rights (CHCR) provides direct counseling, representation, and education to approximately 15,000 Los Angeles County Medicare beneficiaries each year. For at least the past five years, approximately forty percent of CHCR's legal cases have involved HMO issues. In addition, CHCR conducted an extensive study on Medicare risk contract HMOs in California[13] and the author is one of the counsel for a nationwide class of plaintiffs seeking to reform many of the problems in the Medicare HMO system.[14] CHCR staff has trained and assisted many attorneys and other advocates nationwide regarding Medicare HMO issues and advocacy.

Enrollees in Medicare HMOs have encountered problems related to a variety of areas including marketing, denials of and delays in obtaining needed medical care, payment of covered out-of-

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[11] Under federal law, Medicare supplemental insurance companies cannot medically underwrite only for the first six months after a person both attains age 65 and has Medicare Part B coverage. 42 U.S.C. § 1395ss (Supp. 1995). Some states, such as New York, have more extensive protections against medical underwriting. N.Y. INS. LAW § 3218 (McKinney 1985); *see also* N.Y. COMP. CODES R. & REGS. tit. 11, §§ 56.1 & 56.3 (1995).

[12] *See* 42 U.S.C. § 1395mm(c)(3)(D) (1988) (stating that the organization "must provide assurances to the Secretary that it will not expel or refuse to enroll . . . because of the individual's health status or requirements for health care services"). *See also generally* 42 C.F.R. §§ 417.426 and 417.428 (1995) (detailing, respectively, open enrollment requirements for HMOs and rules governing their marketing activities).

[13] *See* GERALDINE DALLEK, AILEEN HARPER, CAROL JIMENEZ & CHRISTINA NUNEZ DAW, MEDICARE RISK-CONTRACT HMOS IN CALIFORNIA: A STUDY OF MARKETING, QUALITY, AND DUE PROCESS RIGHTS (L.A. Center for Health Care Rights 1993).

[14] *See* Grijalva v. Shalala, No. CIV 93-711 TUC ACM (D. Ariz., nationwide class certified July 18, 1995), CCH Medicare & Medicaid Guide, Transfer Binder ¶ 43,523, at 45,474. In *Grijalva*, Medicare HMO enrollee plaintiffs challenged "the Secretary[of HHS]'s oversight of HMO[s] . . . because she allow[ed] HMOs to improperly deny their members Medicare covered services, and she has failed to establish adequate denial and appeal procedures for HMO [enrollees]." *Id.* at 45,478. The court certified two sub-classes: (1) those persons denied services by an HMO who "filed some form of a claim for benefits with the secretary" or the HMO; and (2) persons not given adequate notice of appeal or appeal rights. Class members must have been Medicare beneficiaries"enrolled in risk-based health maintenance organizations or competitive medical plans during the three years prior to filing" the law suit. *Id.* at 45,479.

plan claims, and the appeals processes. Other issues, such as financial risk arrangements and those concerning what information is publically available, also affect enrollees but are generally not raised by enrollees navigating the HMO system. The discussion below focuses on those issues most commonly raised by enrollees: marketing, quality of care (including access to care), and due process rights.

II. Marketing Issues

Marketing issues are intertwined with enrollment and disenrollment issues. Marketing abuses do not have as adverse ramifications for beneficiaries if sufficient enrollment and disenrollment protections are available. Conversely, if tight control is exerted over marketing so that uninformed enrollment is rare, beneficiaries do not need as much protection and flexibility with respect to enrollment and disenrollment. The following discussion separates marketing from enrollment and disenrollment issues as much as possible, but because of their interwoven nature, does not do so completely.

A. *Marketing Practices and Requirements*

Medicare beneficiaries enroll in HMOs as individuals, unlike commercial enrollees who are part of group plans. In geographic areas where there is significant competition, HMOs aggressively market their Medicare plans.[15] Common marketing practices include television, radio, and newspaper advertisements; mass mailings; telemarketing to obtain permission to send a marketing representative to the home; community presentations at restaurants, senior centers, and other locations; and visits to Medicare beneficiaries' homes.[16]

Required and prohibited marketing activities for Medicare HMOs are governed by the Code of Federal Regulations[17] and are further explained in HCFA's HMO/CMP Manual.[18] Federal law requires that HMOs provide to beneficiaries interested in enrolling

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[15] *See generally* Dallek, et al., *supra* note 13.

[16] *See generally id.*

[17] *See generally* 42 C.F.R. § 417.428 (1995).

[18] HCFA informally publishes manuals explaining rules of operation for the Medicare program. As a practical matter, HMOs, other providers, and those dealing with the Medicare program look to these manuals for guidance. However, the manuals are not promulgated pursuant to the Administrative Procedures Act (APA) and therefore do not have the force of law. *See, e.g.*, Linoz v. Heckler, 800 F.2d 871 (9th Cir. 1986) (holding that a provision of the Medicare Carrier Manual, restricting cov-

"adequate written descriptions" of the HMO's rules, procedures, benefits, fees, and other information "necessary for beneficiaries to make an informed decision" about whether or not to enroll in the HMO.[19] HMOs must submit all marketing materials to HCFA for approval at least forty-five days before their intended use.[20] HCFA's failure to disapprove of marketing materials is deemed approval.[21] Also, Medicare HMOs must have an open enrollment period for Medicare beneficiaries for at least thirty consecutive days each year and must notify the general public of its enrollment period.[22] At the time of enrollment and at least annually thereafter, each HMO must provide a copy of its rules to each Medicare enrollee.[23] This written information must include all benefits provided under its risk contract; how and where to obtain services from the HMO; restrictions on coverage for out-of-plan services, other than emergency services and out-of-area urgently needed services; the HMO's obligation to provide reasonable reimbursement for out-of-plan emergency services and out-of-area urgent services; information regarding services from outside the HMO; premium information; grievance and appeal procedures; and disenrollment rights.[24]

The types of practices that are considered marketing abuses and violative of federal law are fairly broad. Medicare HMOs may not engage in discriminatory practices that discourage enrollment on the basis of health status.[25] Further, any activities that could mislead or confuse Medicare beneficiaries or misrepresent the HMO or HCFA are also prohibited.[26] HMOs may not offer gifts or payment as inducement for enrollment.[27] Finally, federal law bans

erage of ambulance trips, was invalid because such provision constituted a "substantive rule" and was not promulgated pursuant to the APA (5 U.S.C. § 553)).

19 42 C.F.R. § 417.428(a)(1) (1995).

20 *Id.* § 417.428(a)(3).

21 *Id.* § 417.428(b)(5) (proscribing the "distribution of marketing materials, if before the expiration of the 45 day period . . . the HMO . . . receives written notice from HCFA that HCFA has disapproved the material").

22 *Id.* § 417.426(a). *See also id.* § 417.428(a)(2) (requiring that potential enrollees be notified of the open enrollment period "through appropriate media").

23 42 C.F.R. § 417.436(b) (1995).

24 *Id.* §§ 417.436(a)(1)-(8).

25 *Id.* § 417.428(b)(1). The rule offers an example of such behavior, stating that the HMO may not "engage in any activity intended to recruit Medicare beneficiaries from higher income areas (usually an indicator of better health) without making a comparable effort to enroll Medicare beneficiaries from lower income areas." *Id.*

26 *Id.* § 417.428(b)(2). *See id.* (noting that for the HMO to state that HCFA recommends or endorses the particular HMO constitutes an example of such prohibited confusing or misleading activity).

27 *Id.* § 417.428(b)(3).

door-to-door solicitation of Medicare beneficiaries.[28]

B. Marketing Problems and Recommended Solutions

Many marketing abuses exist despite legal requirements for disclosure of full, accurate, and nondeceptive information about many aspects directly affecting enrollees, the requirement of advance government approval of marketing materials, and the bans on discriminatory practices and door-to-door solicitation. Medicare beneficiaries' experience shows that most marketing problems surface in newly competitive markets.[29]

Consumer groups have documented many instances of HMO marketing agents enrolling seniors who clearly are mentally confused or monolingual in a language other than English. Additionally, agents have advised beneficiaries to sign or initial documents to indicate they spoke with each other without informing them that they were actually enrollment applications. Further, there have been instances where HMO agents have misrepresented the nature of the HMO as supplemental to Medicare and have falsely inflated Medicare's traditional beneficiary cost-sharing requirements to scare beneficiaries into enrolling. Also, a great number of HMOs send marketing agents to beneficiaries' homes. Often, they have obtained the beneficiary's permission to do so, so their visit does not technically constitute door-to-door solicitation. Marketing agents commonly are compensated in part based on the number of enrollments they obtain for the HMO. This method of compensation and the wide range of marketing problems appear to be related.

Unfortunately, experience shows that such problems will continue unabated unless the government intervenes. For example, from 1988 to 1991, in Southern California, disenrollment data, consumer complaint information, and HCFA monitoring uncovered significant marketing problems by one particular HMO. These problems continued without improvement for several years until HCFA finally took enforcement action against the HMO and refused to approve geographic expansion until its marketing problems were rectified.[30]

Furthermore, it is not unusual for HMO community presentations to be given at restaurants, which generally results in a more healthy population turning out for the presentation. Also, many

[28] *Id.* § 417.428(b)(4).
[29] *See* DALLEK ET AL., *supra* note 13.
[30] *Id.*

Medicare HMOs, by the very nature of their name and their advertisements, market almost exclusively to the senior population and not to the Medicare disabled population, who also may enroll. For example, some Medicare HMOs in Southern California are called CareAmerica 65, Secure Horizons, FHP Senior Plan, Kaiser Senior Advantage, and Health Net Seniority Plus. These HMOs advertise heavily in senior newspapers, but not in publications disabled persons might be more likely to read. Their advertisements and enrollment materials generally show only active, healthy elderly people.

Many of the marketing abuses that occur can be prevented. Not only should marketing activities be regulated, but so too should the training and compensation of HMO marketing agents. For example, agents should be required to have adequate training both with respect to their HMO and the Medicare fee-for-service program and its cost-sharing features. Also, HCFA should randomly monitor marketing agents' presentations to groups of potential enrollees. In addition, HMOs should not be allowed to pay commissions to marketing agents until the Medicare beneficiary has been enrolled in the HMO a minimum of three months, as disenrollment in the first three months of enrollment may be a sign of marketing problems.[31] In order to ensure informed enrollment, each HMO should be required to call each new enrollee to confirm that the enrollment was voluntary and informed. The use of in-home marketing should be strongly discouraged, perhaps with a certain ratio of in-home visits to numbers of enrollees creating a presumption of impermissible door-to-door solicitation. HCFA should take a stronger stance on what constitutes discriminatory practices and should be more aggressive in enforcing the prohibition against discrimination. HMOs should not be allowed to call their Medicare plan a name that itself potentially discriminates and HMOs marketing materials should be required to show enrollment of a cross-section of the Medicare population. Marketing materials should be required to make much clearer and more prominent that all Medicare beneficiaries may join.

C. *Enrollment and Disenrollment Practices and Requirements*

The most important enrollment rules directly affecting beneficiaries—the open enrollment period with no medical underwriting and the information that must be provided to potential enrollees—

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31 *See generally* DALLEK ET AL., *supra* note 13.

are discussed above. Problems with enrollment occur most frequently as a result of marketing violations.[32]

A Medicare beneficiary may disenroll from an HMO at any time and for any reason.[33] Accomplishing disenrollment is a simple process for the beneficiary. Disenrollment can be accomplished either by submitting a written request to the HMO or by filling out a very simple one-page form (HCFA Form 566) at any Social Security office.[34] By law, disenrollment is effective the first of the month following the written disenrollment request. Therefore, disenrollment should take no longer than thirty days.[35] For example, if a beneficiary disenrolls on either the first or the twenty-ninth of December, disenrollment from the HMO should be effective on the first of January. Until the effective date of disenrollment, beneficiaries must continue to use the HMO's services and providers.

If a Medicare beneficiary has out-of-plan claims as a result of uninformed enrollment in an HMO, he or she has two options. A policy called "retroactive disenrollment" allows beneficiaries to disenroll from an HMO with a retroactive effective date.[36] Once retroactive disenrollment has been approved, Medicare will pay for all of the beneficiary's claims from the effective date forward.[37]

As a practical matter, HMOs and HCFA often offer retroactive disenrollment instead of addressing the underlying marketing problems.[38] For beneficiaries, the advantage of retroactive disenrollment is that it is accomplished fairly quickly and assures them that their out-of-plan claims will be covered. In contrast, ben-

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[32] *Id.*

[33] *See* 42 C.F.R. § 417.461(a) (1995) (stating that the request for disenrollment may be made "at any time").

[34] *See* 42 C.F.R. § 417.461(a)(1) (1995) (requiring that the beneficiary/disenrollee provide the HMO with "a signed, dated request in the form and manner prescribed by HCFA" in order for the disenrollment to become effective); *see also id.* § 417.461(a)(2); 42 U.S.C. § 1395mm(c)(3)(B) (requiring that the HMO provide the disenrolled beneficiary with a copy of the request for disenrollment, as well as a "written explanation" of the period (ending on the effective date of the termination) during which the individual continues to be enrolled with the organization).

[35] *See generally* 42 C.F.R. § 417.461(a)(2) (1995); 42 U.S.C. § 1395mm(c)(3)(B) (1988).

[36] HCFA, HMO/CMP MANUAL, § 2002.3 (1992) (reprinted in Medicare & Medicaid Guide (CCH), ¶ 13,955, at 5719-8 (1992)). Situations where "retroactive disenrollment" is available include erroneous enrollments due to systems problems; Social Security district office errors, failure of employers to notify plan, and a showing of the beneficiary's "lack of intent to enroll." *See id.*

[37] *See id.*

[38] *See* CAROL JIMENEZ & LENORE GERARD, MEDICARE ADVOCACY & APPEALS, CALIFORNIA ELDER LAW—AN ADVOCATE'S GUIDE (Cal. CEB, June 1995).

eficiaries would otherwise use the lengthy and cumbersome Medicare appeals process in order to obtain HMO payment for out-of-plan claims. The disadvantage of retroactive disenrollment is that beneficiaries then have the traditional Medicare cost-sharing for such claims, which they generally would not have if the HMO covered the claim.

D. *Enrollment/Disenrollment Problems and Recommended Solutions*

Many enrollment and disenrollment problems reflect another side of marketing abuse. Therefore, the recommended solutions to marketing abuse apply equally to enrollment and disenrollment issues.

Often, a Medicare beneficiary who enrolls in an HMO, but soon changes his or her mind, finds it difficult to cancel the enrollment. There is no formal mechanism other than disenrollment for canceling enrollment. As a practical matter, it sometimes takes two to three months for an HMO enrollment to become effective (depending on the workload of the HCFA Regional Office processing the enrollment). Because disenrollment takes effect much more quickly, disenrolling before the effective date of enrollment may have no effect on a subsequent enrollment date. This results in a situation in which the Medicare beneficiary believes that he or she has canceled the HMO enrollment and uses fee-for-service medical providers, but HCFA records indicate HMO enrollment and the beneficiary's Medicare claims are denied on that basis.

In addition, it is not unusual for Medicare beneficiaries to experience trouble with processing disenrollment requests submitted directly to the HMO. This may be caused by the beneficiary being falsely informed by an HMO representative that his or her oral request to be disenrolled is sufficient, or else by an HMO failing to forward the beneficiary's written request for disenrollment to HCFA (who is responsible for processing such requests). This also results in a beneficiary believing he or she has been disenrolled from the HMO and using out-of-plan providers, when, in fact, disenrollment has not occurred.

The options of quick, easy disenrollment and retroactive disenrollment should continue and should not be abrogated. Such options provide beneficiaries an avenue for addressing individual problems with marketing, enrollment, access to care, and quality of care. Without these vehicles, beneficiaries would have no real remedy for halting the adverse effects of HMO problems that they cannot resolve informally.

In addition, beneficiaries should be provided a simple, but formal, mechanism for canceling HMO enrollment within a certain amount of time, such as fifteen days, after signing an enrollment application. HMOs should also be required to provide enrollees, at the time of enrollment and annually thereafter, and to display prominently in the lobbies of all HMO providers' offices, a specified page of easy-to-read instructions on how to disenroll from the HMO.

III. ACCESS TO CARE AND QUALITY OF CARE ISSUES

A. *HMO Practices and Requirements*

Medicare risk contract HMOs must provide or arrange for at least all of the services covered by Medicare (except hospice care).[39] Many Medicare HMOs also provide additional services—such as routine physical examinations, prescription drug coverage, vision and hearing care, and dental care—as part of their basic benefit package. For Medicare-covered benefits, such as skilled nursing home care or rehabilitation services, HMOs must follow Medicare coverage regulations and guidelines, even if the HMO does not cover such care or uses more restrictive guidelines for its other enrollees. For example, an HMO must provide home health aide services to its Medicare enrollees (when Medicare coverage criteria are met) even if such services are excluded from the benefits it provides to its commercial enrollees.

Medicare HMOs are required to cover out-of-plan care only in limited circumstances: when the enrollee needs emergency care; when the enrollee is out of the HMO's geographic service area and needs urgent care; and when the HMO fails to provide Medicare-covered services.[40] Emergency care is defined as any time a member's life is endangered, such as shock, unconsciousness, difficulty in breathing, symptoms of a heart attack, and severe bleeding.[41]

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39 *See generally* 42 U.S.C. § 1395mm(c) (1988); 42 C.F.R. §§ 417.440(b), 417.442 (1995). *See also* 42 C.F.R. § 417.440 (c) (1995) (stating that Medicare enrollees electing to receive "hospice care under § 418.24 of this chapter waive[ ] the right to receive from the HMPO or CMP any Medicare services (including services equivalent to hospice care) that are related to the terminal condition for which the enrollee elected hospice care, or to a related condition"). *See generally* 42 C.F.R. §§ 418 (1995) (detailing the circumstances and procedures for Medicare hospice care enrollments).

40 *See* 42 C.F.R. § 417.420(c)(2) (1995).

41 The federal regulations define "emergency services" as:

> covered inpatient or outpatient services that are furnished by an appropriate source other than the HMO or CMP and that meet the following conditions: (1) Are needed immediately because of an injury or sudden illness; (2) Are such that that the time required to reach the HMO's or

Urgent care is care needed to prevent a serious deterioration of health which cannot be delayed until the enrollee returns to the HMO's service area.[42] Because of limited coverage of out-of-plan claims, enrollees who reside away from the HMO's service area for ninety consecutive days or more per year may not join an HMO without specifically arranging for coverage.[43]

Federal law clearly allows HMOs to control costs and utilization by sharing the financial risk of providing care with the actual medical providers, through mechanisms such as risk sharing and financial incentives.[44] The Medicare statute restricts compensation arrangements between an HMO and a physician or physician group, causing the direct or indirect effect of reducing or limiting services provided to enrollees. However, HMOs with such arrangements must simply comply with other requirements such as having stop-loss protection and conducting enrollee satisfaction surveys.[45] Furthermore, in recent regulations, HCFA has so narrowly defined which arrangements fit the statutory restriction as to effectively exempt almost all existing financial risk arrangements.[46] Despite such meaningless restrictions on financial risk arrangements, federal law makes clear that an HMO which contracts with others to provide care for its enrollees is still liable for such care.[47]

> CMP's providers or suppliers (or alternatives authorized by the HMO or CMP) would mean risk of permanent damage to the enrollee's health.
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> Once initiated, the services continue to be considered emergency services as long as transfer of the enrollee to the HMO's or CMP's source of health care or authorized alternative is precluded because of risk to the enrollee's health or because transfer would be unreasonable, given the distance and the nature of the medical condition.

42 C.F.R. § 417.401 (1995); *see also* 42 U.S.C. § 1395mm(c)(4) (1988) (requiring that the HMO pay for services provided to a beneficiary "other than through the organization, if (i) the services were medically necessary and immediately required because of an unforseen illness, injury, or condition and (ii) it was not reasonable given the circumstances to obtain the services through the organization").

[42] *See* 42 C.F.R. § 417.401 (1995).

[43] *See generally id.* §§ 417.448(c), 417.460(f)(2).

[44] 42 U.S.C. § 1395mm (1988); 42 C.F.R. § 417.103(b) (1995).

[45] 42 U.S.C. §§ 1395mm(i)(8)(A)(ii)(I) & (II) (1988) (detailing the required controls for HMOs to operate under "physician incentive plans"). "Physician incentive plans" are defined as "any compensation agreement between an eligible organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization." 42 U.S.C. § 1395mm(i)(8)(B) (1988).

[46] *See generally* 61 Fed. Reg. 13,430 (Mar. 27, 1996), publishing final regulations regarding physician incentive plans, adding 42 C.F.R. § 417.479 and amending 42 C.F.R. § 417.500. The new § 417.479(h)(3) requires HMO disclosure to any Medicare beneficiary of the types of financial incentive arrangements used by the HMO.

[47] *See generally* 42 C.F.R. §§ 417.100, 417.101(a), 417.103(a)(1), 417.104(a)(2) (1995). *See also* § 417.401 (stating that an HMO may provide or arrange for other

B. Problems and Recommended Solutions

Medicare beneficiaries in need of high cost medical care, such as skilled nursing home care, rehabilitation services, home health care, and specialty care, often report difficulty in obtaining it. It is not unusual for beneficiaries to be told that a particular type of care, such as home health aides, is not a covered service despite the fact that it is a Medicare covered benefit. HMOs sometimes limit the amount of care they will provide, such as a ten-day limit on skilled nursing facility care, despite no such limit in the Medicare program. In other cases, an HMO may acknowledge that the care needed is a covered benefit, but may simply use criteria that is more restrictive than that used in the Medicare program to deny care. In a legal challenge to HCFA's failure to enforce the requirement that Medicare HMOs provide all Medicare covered benefits (among other issues), a nationwide plaintiff class of Medicare HMO enrollees who have been denied services by an HMO has recently been certified.[48]

A common frustration among HMO enrollees denied particular services is the difficulty in determining who is responsible for the denial and who has the authority to overturn the denial. In mature HMO markets, the primary care medical group commonly bears the financial risk of at least all outpatient care provided to enrollees, and sometimes that of inpatient care as well. When a medical group denies a service, the HMO often refuses to intervene. Although this HMO position can be challenged legally, it presents an almost insurmountable barrier to an enrollee trying to obtain immediately needed medical care.

Some of these problems can be addressed fairly simply. HMOs should be required to supply each of their medical providers and employees/agents responsible for patient care with a prescribed information packet regarding Medicare HMO rules. This would minimize providers' unfamiliarity with the requirement that all Medicare covered care be covered, as well as with the scope of Medicare covered benefits. In addition, HCFA should annually review each HMO's internal coverage guidelines and those of its contracting medical groups, to ensure that they are not more restrictive than Medicare coverage rules. HCFA should implement the statutory prohibition on substantial financial risk in a meaning-

entities to provide services to its Medicare enrollees, as long as the HMO still "retains responsibility for those services").

[48] *See* Grijalva v. Shalala, No. CIV 93-711 TUC ACM (D. Ariz. nationwide class certified July 18, 1995).

ful manner and should strictly limit the amount of financial risk that may be borne by those authorizing or denying medical care. In addition, it should be made much clearer to HMOs that they are legally liable for the decisions and actions of their contracting medical providers. As a back-up to increased monitoring and enforcement of existing rules regarding access to care, HCFA should impose significant fines and should suspend enrollment for HMOs failing to provide needed care.

IV. Due Process Issues

A. *Medicare Requirements*

For Medicare HMO enrollees, there are two mutually exclusive processes for resolving disputes with the HMO: the HMO's grievance process and the Medicare appeals process. The appeals process covers all claims involving an "organization determination."[49] An organization determination is defined as a determination regarding services that would be covered by Medicare, reimbursement for emergency or out-of-area urgent care services, and any other medical services that the beneficiary believes are covered by Medicare and should have been provided by the HMO (whether or not the beneficiary has obtained them out of plan).[50] The appeals process for organization determinations is spelled out explicitly by law and is discussed below.

For claims that do not require an organization determination, such as issues relating to waiting time at an appointment and a doctor's demeanor, the enrollee must go through the HMO's own grievance process.[51] Medicare does not mandate any specific due process requirements for an HMO's grievance process. Fortunately for enrollees, most enrollee claims fall within the appeals process rather than the grievance process.

B. *Organization Determinations*

When an HMO denies an enrollee's request for medical services or for payment of out-of-plan claims, the HMO must do so in writing. This written notice is called an "organization determina-

49 42 C.F.R. § 417.604 (a)(1)(i) (1995).

50 *Id.* § 417.606(a).

51 *See id.* § 417.436(a)(7) (requiring that the HMO maintain written rules governing the organization's grievance procedures); *see also* 42 C.F.R. §§ 417.604(a)(1)(ii) & 417.606(c) (1995); 42 U.S.C. § 1395mm(c)(5)(A) (1988) (mandating that the HMO provide "meaningful procedures" for resolving enrollee grievances).

tion" and must be given within twenty-four calendar days from the time of a clean claim (that is, a claim with no defects or other special circumstances requiring special treatment) involving issues other than payment of out-of-plan claims, and within sixty days of all other claims.[52]

The organization determination must clearly specify the reason the HMO has denied or terminated a service or denied payment for out-of-plan claims.[53] A general statement that Medicare does not cover the service is not sufficient to meet this requirement. Furthermore, the notice must inform the HMO enrollee of his or her appeal rights including where and how to appeal and the time frame for appeal.[54] An HMO's failure to provide a written organization determination constitutes an adverse determination that can itself be appealed.[55]

1. Reconsideration

There are two parts to the reconsideration phase of the appeals process. In the first part, the HMO reviews its organization determination. An enrollee must file his or her request for reconsideration within sixty days from receipt of the organization determination.[56] However, if the HMO has not issued an organization determination, the sixty-day time limit does not apply.[57] Based upon its review of its own organization determination and any other evidence submitted, the HMO must make its reconsideration determination within sixty days from the request for reconsideration.[58] The HMO must provide the enrollee with the opportunity to present evidence in person and in writing.[59] In the second stage of the reconsideration phase, if the HMO does not make a decision fully favorable to the enrollee within the sixty-day time limit, it must forward the case to HCFA for further review.[60] The HMO is not required to notify the enrollee that the case has been forwarded to HCFA.

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52 *See generally* 42 U.S.C. §§ 1395h(c)(2), 1395u(c)(2) & 1395h(f) (1988); 42 C.F.R. § 417.608(a) (1995).

53 42 C.F.R. §§ 417.608(a) & (b) (1995).

54 *Id.* § 417.608(b).

55 *Id.* § 417.608(c).

56 *Id.* § 417.616(b). The HMO may extend the 60-day time limit "for good cause shown." *Id.* § 414.616(c).

57 *See generally* 42 C.F.R. §§ 417.608(a) & 417.616(a)(1) (1995).

58 42 C.F.R. § 417.624 (c) (1995). *But see id.* § 417.624(d) (wherein HCFA may extend the 60-day deadline "[f]or good cause shown" by the HMO).

59 42 C.F.R. § 417.618 (1995).

60 *Id.* § 417.620.

HCFA contracts with a private company, Network Design Group (NDG), to conduct all of its HMO reconsiderations nationwide.[61] NDG must process and reach a decision on each reconsideration within sixty days. There is no formal procedure by which enrollees may participate in the HCFA reconsideration review.

2. Administrative Law Judge Hearing

If a beneficiary is still dissatisfied with the outcome after the reconsideration stage, he or she may request a hearing before an administrative law judge (ALJ) as long as at least $100 is still at issue.[62] An ALJ hearing must be requested in writing within sixty days after receipt of the reconsideration decision.[63] Beginning with this stage of appeal, the appeals process for Medicare HMO enrollees is the same as for those pursuing Medicare Part B claims.[64]

3. Appeals Council

A Medicare HMO enrollee dissatisfied with the outcome of an ALJ hearing may appeal to the Social Security Appeals Council. A request for this review must be filed within sixty days from the ALJ decision.[65]

4. Federal District Court

The last available avenue of appeal is federal district court; however, at least $1000 must be in controversy. The complaint must be filed within sixty days of the Appeals Council decision.[66] The standard of review is de novo for issues of law. For issues of

[61] HCFA, HMO/CMP MANUAL § 2405.3D (1992) (reprinted in Medicare & Medicaid Guide (CCH), ¶ 13,985.35 (1992)).

[62] 42 U.S.C. §§ 1395mm(c)(5)(B) & 1395u(b)(3)(C) (1988); 42 C.F.R. §§ 417.624(b)(2) & 417.630 (1995).

[63] 20 C.F.R. §§ 404.933(a) & (b) (1995); *see also id.* §§ 417.628, 417.632(a) & (b) (1995).

[64] *See* 42 C.F.R. §§ 417.628 to 417.636 (1995).

[65] 20 C.F.R. §§ 404.967 to 404.983 (1995); 42 C.F.R. § 417.634 (1995). The Appeals Council will only review cases if:

> (1) There appears to be an abuse of discretion by the administrative law judge;
> (2) There is an error of law;
> (3) The action, findings or conclusions of the administrative law judge are not supported by substantial evidence; or
> (4) There is a broad policy or procedural issue that may affect the general public interest.

20 C.F.R. § 404.970(a)(1)-(4) (1995).

[66] 20 C.F.R. § 422.210 (1995); 42 C.F.R. § 417.636 (1995).

fact, however, the reviewing court must accept HCFA's determination if supported by substantial evidence.[67]

C. Problems and Recommended Solutions

For a variety of reasons, it is very common for HMOs to fail to issue a written organization determination. Often, contracting providers are not aware of the requirement to issue an organization determination and HMOs are not aware when particular services or claims are being denied. It is sometimes difficult for an HMO to know when an enrollee believes he or she is being denied a medically necessary service. Even when an organization determination is given, it often fails to include the reason for the denial or the enrollee's appeal rights. Therefore, enrollees often lack adequate information to know that they can challenge an HMO denial.

As discussed above, HMOs often deny services and claims based on overly restrictive criteria. For instance, HMOs often deny claims for out-of-area urgent care services based on their assessment that they were not emergency services, failing to recognize that they must also by law cover urgently needed care. This results in Medicare HMO enrollees being forced to go through a time-consuming appeals process for what should be clearly covered claims.

Even if HMOs and HCFA adhere to all legal requirements of the appeals process, it can take a very long time for an enrollee to obtain a determination from someone not affiliated with the HMO that denied the care in the first place. If all time frames are met, it can still take six months for an enrollee to obtain a determination by NDG, the first line of review independent from the HMO. This time frame is essentially meaningless for enrollees who have been denied needed care. By the time they obtain a favorable decision, their health may be permanently and irrevocably deteriorated.

The long and drawn-out appeals process is grossly inadequate to meaningfully address quality of care and access to care problems and claims. There must be an expedited appeals system available to address denials of care which could result in significant harm to

67 42 U.S.C. § 405(g) (1995); *see also* Friedman v. Secretary of Dep't of Health & Human Servs., 819 F.2d 42, 44 (2nd Cir. 1987). In *Friedman*, the Second Circuit, addressing a question of Medicare coverage, explained that they were required to "uphold the Secretary's findings 'if a reasonable mind reviewing the evidence in the record as a whole, could accept it as adequate to support his conclusion.'" *Id.* (quoting Rodriguez v. Secretary of Dep't of Health & Human Servs., 647 F.2d 218, 222 (1st Cir. 1981) (citing Consolidated Edison Co. v. NLRB, 305 U.S. 197, 229 (1938))).

the enrollee. In addition, enrollees must have more rights to participate in the appeals process. They should be granted the right to review the HMO's organization determination and reconsideration files, should be provided copies of any procedures, guidelines, protocols, etc., used by the HMO as a basis to deny their claim, and be allowed the right to submit evidence at each stage of review. To make sure that enrollees are aware of their rights, HMOs and all of their provider groups should be required to post, in all facility and provider waiting rooms, a prescribed notice that enrollees may obtain a copy of their appeal rights upon request. Furthermore, HMOs should be required to provide, at least annually and upon request, a prescribed notice explaining enrollees' appeal rights. An HMO's failure to comply with the required time frames and enrollee appeal rights should automatically result in a decision in favor of the enrollee.

CONCLUSION

Federal Medicare law affords many protections for HMO enrollees. For example, an enrollee's ability to disenroll at any time allows some protection against marketing abuses, enrollment problems, and problems obtaining needed medical care. The extensive appeals process makes it likely that enrollees will eventually obtain reimbursement for covered out-of-area care.

Despite Medicare's solid basic framework of protections, many gaps leave Medicare beneficiaries vulnerable to HMOs' cost-savings efforts. If implemented, the recommendations in this Article would allow Medicare beneficiaries to more effectively obtain the Medicare covered services they need and would result in a system in which the enrollees themselves can hold HMOs accountable for the services and benefits they are required to provide.