

**MEDICARE APPEALS AND
INTERPRETATION: MEETING THE
REASONABLE EXPECTATIONS OF
MEDICARE USERS THROUGH A
COMPARISON TO PRIVATE HEALTH
INSURANCE**

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After filing a claim for reimbursement, a patient with a health insurance plan expects that the insurance company will come through and pay the medical bill. However, more claims are being denied as private insurance companies face rising health care costs while trying to maintain a profitable business. Similar problems face the federal government as it grapples with a rapidly aging population and a Medicare system struggling to meet the needs of the baby boom generation. Based upon his analysis, Mr. DeJonker proposes changes in the Medicare appeals process through the adoption of some of the positive aspects of private health insurance jurisprudence. Specifically, Mr. DeJonker promotes the use of arbitration as a way of achieving efficiency and neutrality in the resolution of claims under Medicare. In addition, he advocates the application of the reasonable expectations doctrine to Medicare appeals in order to provide a more equitable evaluation of claims.

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I. Introduction

When someone reaches a state of discontent regarding a particular situation, it is human nature to consider the situation of a neighbor, who often appears to be faring much better. In other words, the age-old axiom “the grass is greener on the other side of the fence” instantly enters the mind of the dissatisfied. Of course, this feeling causes one to angrily mutter, “I wish I were in that person’s shoes,” and cry to anyone who can hear that the better situated should be happy that his or her particular predicament is not as bad as one’s own.

In much the same way, those who suffer under the appeals process of Medicare consider the seemingly more expedient system of appeal under private health insurance and wish for the “good life” of nearly immediate court supervision. Within its current structure, Medicare requires the individual who disagrees with a decision made by a Medicare review board to seek relief through an elaborate, multi-staged appeal process.¹ In contrast, the complainant under a private health insurance policy enjoys the benefits of a single review board and may also find relief in a process similar to that of a breach of contract claim.²

A comparison of Medicare and the private health insurance industry reveals another major difference between the average Medicare appeal and the average private health insurance appeal. Federal courts exercise jurisdiction over Medicare appeals, which are primarily federal claims, whereas state courts consider the average health insurance dispute.³ Federal courts tend to defer to the decisions made by the Department of Health and Human Services (HHS) in making decisions about Medicare, while state courts tend to favor the beneficiaries of health insurance contracts.⁴

This note examines the procedures, history, and courts’ treatment of the appeals process under Medicare Part B, as well as the general appeals procedures used by most private health insurance companies and followed in state courts. Through this examination, this note suggests solutions to combine the best of both processes to create a better appeals system for Medicare. Specifically, this note fo-

1. See *infra* Part IV.
2. See *infra* Part V.
3. See *infra* Part VII.
4. See *infra* Part VII.

cuses on Medicare Part B due to the increasing number of controversies under this section arising from the differences in claimant review under Part B as compared to Part A, as well as its more insurance-like nature as a supplemental health insurance plan.⁵

Part II provides a historical overview of Medicare in general and also considers the appeals process under Medicare Part B. Part III provides general information about private health insurance and the types and forms of health insurance contracts. Part IV outlines the average appeals process under Medicare, while part V similarly describes a private health insurance appeal. Part VI explores jurisprudence under Medicare versus health insurance contracts. Finally, parts VII and VIII suggest streamlining the Medicare appeals process and the application of the reasonable expectations doctrine to the interpretation of Medicare claims. This note concludes that the grass on one side of the fence is not really greener than the other side, with each “neighbor” facing peculiar pitfalls that stymie the appeals process. Each remains capable, however, of learning valuable lessons from its counterpart.

II. The Federal Government’s Side of the Fence: An Introduction to Medicare

A. An Overview of Medicare and Medicare Part B

Created by Congress in 1965 as an instrument to help the elderly pay for adequate health care,⁶ Medicare represents the first comprehensive effort by the U.S. government to provide federally funded health care.⁷ At its inception, Congress crafted Medicare into two parts: Medicare Part A and Medicare Part B.⁸ Part A provides funding to all eligible individuals for inpatient institutional services.⁹ These services include the costs of hospital procedures and stays, skilled nursing facilities, and hospice care.¹⁰ The majority of Part A’s funding

5. See *infra* notes 15–18 and accompanying text.

6. See Health Insurance for the Aged Act, Pub. L. No. 89-97, 79 Stat. 290, 290–360 (codified as amended at 42 U.S.C. §§ 1395–1396 (1994)).

7. In reality, the federal government barely funded health care prior to the passage of the Social Security Act of 1965. See Laura A. Mellas, *Adapting the Judicial Approach to Medical Malpractice Claims Against Physicians to Reflect Medicare Cost Containment Measures*, 62 U. COLO. L. REV. 287, 287 n.2 (1991).

8. See 42 U.S.C. §§ 1395–1396 (1994).

9. See *id.* § 1395c.

10. See *id.*

is provided by payroll taxes.¹¹ Part B addresses those health services not covered by Part A, helping to offset the costs associated with physician visits and various outpatient services through monthly premiums from enrollees and general government revenues.¹² Coverage provided under Part B includes payments for doctors, outpatient hospital care, and additional medical services that Part A fails to cover.¹³ Services include more than just those offered by doctors, as Medicare Part B, for example, also covers the costs of physical and occupational therapists.¹⁴ The primary stipulation, however, remains that all services covered under Part B must be “medically necessary,” a term which continues to trouble many experts.¹⁵ Medicare allows for services to be completed anywhere, including “a doctor’s office, clinic, nursing home, hospital, or at home.”¹⁶

Of course, because Medicare was created to cover the medical costs of a growing segment of the population, funding remains an issue.¹⁷ Principally, Part A continues to be funded by Social Security taxes, while Part B remains primarily a federally subsidized voluntary health insurance supplement.¹⁸ Part B places some of its financial

11. See 1 SPECIAL COMM. ON AGING, DEVELOPMENTS IN AGING: 1993, S. REP. NO. 103-403, at 146 (1994).

12. See 42 U.S.C. §§ 1395k, 1395x(s); 42 C.F.R. §§ 410.3, .10 (1998); 1 S. REP. NO. 103-403, at 146.

13. See *Medicare and You*, 2000 (visited Feb. 2, 2000) <<http://www.medicare.gov/publications/Mandy.pdf>> [hereinafter *Medicare and You*].

14. See *id.*

15. See *id.*

16. *Id.*

17. For example, all national health expenditures in 1967 totaled \$51 billion, which accounted for 6.3% of the gross national product. By 1995, Medicare expenditures totaled \$248.9 billion or 16.4% of the federal budget. In fiscal year 1996, HCFA (the Health Care Financing Administration) projects that nearly 62 million people will receive services paid for by Medicare or Medicaid. Nearly 20% of Medicare users, more than 11.7 million people, will require inpatient hospital services covered by Medicare or Medicaid during the same year. See *1996 HCFA Statistics*, (visited Oct. 17, 1998) <<http://www.hcfa.gov/stats/hstats96/blustcov.html>>.

18. See 42 U.S.C. §§ 1395j–1395w (1994). Part B remains a voluntary government service, where an individual is required to sign up either during the general enrollment period (January 1st through March 31st) or during a special enrollment period (if the individual failed to sign up for other reasons, like previous health care coverage). An individual is eligible under Part B if he/she is eligible under Part A (eligibility for Part A implies eligibility for Part B) or if he/she is a U.S. citizen or permanent resident age 65 or older. Under Part B, Medicare deducts a monthly premium (\$45.50 for 1999) from a person’s government retirement payments (e.g., Social Security, Railroad Retirement, or Civil Service Retirement payments), or bills the applicant directly every three months. See *Medicare and You*, *supra* note 13.

burden upon its beneficiaries, as it is supported by periodic premiums and supplemented by contributions from the federal government, with the combined capital held in the Federal Supplementary Insurance Trust Fund.¹⁹

As a result, Medicare Part A provides hospital service to all Americans,²⁰ while Part B is premised on prepayment by the user, serving as a kind of supplemental insurance designed to meet the nonhospital needs of elderly Americans. The individual prepays into the aforementioned trust fund and then receives a full range of services.²¹ Unlike private health insurance companies, the federal government, by its nature, does not seek to turn a profit. Minimizing costs, however, still remains an issue.

Medicare continues to be the largest source of funding for public health care services²² and historically suffers from funding difficulties.²³ Since its inception, Congress met these funding needs through a series of early amendments and statutes to provide for increased tax revenue²⁴ or to curtail costs.²⁵ However, congressional efforts proved rather unsuccessful in curtailing costs or creating a financially strong Medicare program, which resulted in further legislation.²⁶ In 1982,

19. See 42 U.S.C. §§ 1395l, 1395r, 1395t, 1395w.

20. See generally 42 U.S.C. § 1395c.

21. See generally *supra* notes 13 and 19 and accompanying text.

22. See *Nat'l Health Expenditures and Average Annual Percent Change, by Source of Funds: Selected Calendar Years 1970–2008* (visited Oct. 20, 1998) <<http://www.hcfa.gov/stat/NHE-proj1998/tables/table3a.htm>>.

23. See Eleanor D. Kinney, *Making Hard Choices Under the Medicare Prospective Payment System: One Administrative Model for Allocating Medical Resources Under a Government Health Insurance Program*, 19 IND. L. REV. 1151, 1163 (1986).

24. In Medicare's early stages, Congress passed two amendments to adjust the amount of money entering the fund via payroll taxes, the primary source of revenue for Medicare Part A. See Social Security Amendments of 1967, Pub L. No. 90-248, 81 Stat. 821, 835–37 (increasing payroll taxes for the first time to offset increased Medicare costs); Social Security Amendments of 1972, Pub L. No. 92-603, 86 Stat. 1329, 1362–64 (increasing payroll taxes for the second time to offset increased Medicare costs).

25. See Social Security Amendments of 1972, Pub L. No. 92-603, § 223, 86 Stat. at 1330. Congress attempted to constrain the rising costs of health care by authorizing the Secretary of Health, Education and Welfare to establish limits on hospital costs reimbursed by Medicare, as well as establishing organizations to determine whether hospital services were reasonable, medically necessary, and cost efficient. See *id.* § 249F(b). For a general analysis of the Social Security Amendments of 1972, see B.D. REAMS, *THE PROFESSIONAL STANDARDS REVIEW ACT: A LEGISLATIVE HISTORY OF TITLE XI OF THE SOCIAL SECURITY AMENDMENTS OF 1972* (1990).

26. See Timothy P. Blanchard, "Medical Necessity" Denials as Medicare Part B Cost-Containment Strategy: *Two Wrongs Don't Make It Right or Rational*, 34 ST. LOUIS U. L.J. 939, 974 (1990).

Congress passed the Tax Equity and Fiscal Responsibility Act (TEFRA)²⁷ and the Peer Review Improvement Act.²⁸ TEFRA further limited Medicare reimbursements for inpatient hospitalization²⁹ while the Peer Review Improvement Act established Peer Review Organizations (PROs) to monitor the efficiency of services provided under both Medicare Part A and Part B.³⁰

Under the Medicare Act, the Secretary of Health and Human Services (HHS)³¹ manages Parts A and B of the Medicare program.³² In the administration of Part B, the Secretary assigns private insurance carriers the task of paying Part B claims from the aforementioned trust fund.³³ Under this system, Medicare seeks to alleviate the difficulties in meeting the payment needs of the many beneficiaries under Part B.³⁴ To achieve this goal, Medicare places the responsibility for administration in the hands of “capable” private firms³⁵ who are in a better position to adequately meet these needs.³⁶ Medicare compensates physicians and their services in either of two ways: through direct compensation to the beneficiary or through an assignment from the beneficiary to the physician who furnished the services.³⁷

27. Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 101, 96 Stat. 324.

28. See Peer Review Improvement Act of 1982, Pub. L. No. 97-248, § 143, 96 Stat. 382, 385-88.

29. See Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 101, 96 Stat. 324.

30. See Peer Review Improvement Act of 1982, Pub. L. No. 97-248, § 143, 96 Stat. at 385-88.

31. Hereinafter referred to as the “Secretary.”

32. See 42 U.S.C. § 1395u(a) (1994).

33. See *id.* § 1395u(a) (authorizes the Secretary “to provide for administration of the benefits under [Medicare Part B] with maximum efficiency and convenience . . . for providers of services and other persons furnishing services to [Medicare participants]”).

34. See Blanchard, *supra* note 26, at 941-42.

35. The majority of these carriers are either subcontractors or affiliates of the Blue Cross and Blue Shield Association in Chicago, Ill. See *id.* at 955 (referring to HCFA Intermediary and Carrier Directory (Bureau of Program Operations (HID-1 Jan. 1, 1989)); see also The Medicare Handbook, Pub. No. HCFA-10050 (Jan. 1, 1989), Medicare & Medicaid Guide (CCH) ¶ 13,320).

36. See Blanchard, *supra* note 26, at 955.

37. See 42 C.F.R. §§ 424.50-.80 (1998); see also 42 C.F.R. 424.70-.90; MEDICARE CARRIERS MANUAL, Pt. 3 § 3045-3060.11. Part IV of this note explores what this means in terms of physician services and ultimately the review process.

B. A New Wrinkle in Time: Medicare + Choice Program

Through the Balanced Budget Act of 1997, Congress decided to throw a new option into the Medicare mix, introducing Medicare Part C or the Medicare + Choice Program.³⁸ Designed to provide the Medicare participant with an alternative to traditional Medicare Parts A and B, Part C gives the beneficiary a range of health insurance choices, including Health Maintenance Organizations (HMOs), Preferred Physician Organizations (PPOs), Physician Service Organizations (PSOs), medical savings accounts (MSAs), and private fee-for-service Medicare.³⁹ Medicare Part C plans provide basically the same services and benefits as traditional Medicare Parts A and B,⁴⁰ but give the participant more flexibility in tailoring a health insurance plan which best meets future needs.⁴¹

Medicare introduced these options to the public in November – 1999, and participants in the Medicare plan are now able to choose between traditional Medicare and Medicare Part C.⁴² Since only recently becoming an option, it is unclear at this point how this new program will affect the review process of Medicare claims, but it seems fair to assume that this new wrinkle will create more controversy. As one commentator noted, Medicare Part C includes “radical changes to the system”⁴³ and “confusing language and policies.”⁴⁴

III. Private Industry’s Side of the Fence: An Introduction to Basic Health Insurance

Providing for expenditures which account for over \$1 trillion, the medical health insurance industry supports the needs of millions of Americans.⁴⁵ As a result, the industry has developed a variety of

38. See Balanced Budget Act of 1997 § 1851(a), 111 Stat. 276, 276.

39. See *id.* §§ 1851–1859, 111 Stat. 276, 276–327.

40. See *id.* §§ 1859(b)(3)(i)–(ii), 111 Stat. 251, 326.

41. Medicare + Choice gives the patient a variety of choices in choosing how their medical bills will be paid. For a discussion of possible differences between the options introduced by Medicare Part C, see Karen Visocan, *Recent Changes in Medicare Managed Care: A Step Backwards for Consumers?*, 6 ELDER L.J. 31, 45–48 (1998).

42. See Balanced Budget Act of 1997, § 1851(e)(3)(B), 111 Stat. at 282.

43. Visocan, *supra* note 41, at 47.

44. *Id.*

45. See Health Care Financing Administration, *Medicaid Bureau Fraud and Abuse Information* (visited Oct. 28, 1999) <<http://www.hcfa.gov/medicaid/mbfraud.htm>>.

products to service different customers. This section explores the three major kinds of health insurance.

A. Traditional Medical Coverage

The health insurance industry has established two primary types of medical insurance coverage⁴⁶—base (basic) plans and major medical plans.⁴⁷ Basic plans generally provide coverage on a first-dollar (no deductible) basis and include a 100% reimbursement for all hospital expenses, surgical expenses, or both.⁴⁸ Similar to most car insurance plans, basic plans set maximum amounts of coverage, ranging from \$10,000 to \$100,000, which are significantly lower than most major medical plans.⁴⁹

On the other hand, major medical plans include a deductible for initial expenses.⁵⁰ Following the satisfaction of the deductible, the major medical insurer covers some percentage of medical bills (normally 80%) up to an increased maximum, which normally ranges from \$500,000 to \$1 million.⁵¹ Major medical plans provide the added bonus of a large variety of covered services, comparing favorably to basic plans.⁵² While major medical plans provide a broader base of coverage with higher limits, the major medical insurer also requires the insured to capture some of the costs, including deductibles and

46. This note focuses on private medical expense insurance, which can be differentiated from short-term medical (providing high-limit, short-term medical expense coverage on an indemnity basis) and long-term health care insurance (providing coverage for the cost of custodial and other types of extended care provided in a nursing home). For specific information on both topics and more distinguishing characteristics, see generally Info Web, *Frequently Asked Questions About Medical Expense Insurance* (visited Nov. 11, 1998) <<http://www.insweb.com/research/faq/stmedical-a.htm#1>> [hereinafter *Health Insurance FAQ*] (based on information provided by Georgia State University's Dep't of Risk Management and Insurance).

47. *See id.*

48. *See id.*

49. *See id.*

50. *See id.* Normally, the deductible will amount to an annual amount of \$100 to \$500 depending on the insurance provider. *See id.*

51. *See id.* These percentage of coverage and limits represent industry norms, as some major medical plans might reimburse eligible expenses at a lower percent (e.g., 70%) while others might provide unlimited lifetime benefits. *See id.*

52. *See id.* The possible list of covered services can be rather broad. Typically, services consist of "medical expenditures, including hospital expense, surgical expense, physician (non-surgical) expense, private duty nursing, diagnostic X-ray and laboratory services, prescription drug expense, artificial limbs and organs, ambulance services, and many other types of medical expenses when prescribed by a duly licensed physician." *Id.*

coinsurance (normally 20% to 30% of eligible expenses above a deductible amount).⁵³

At first glance, major medical plans may appear to be an ideal form of health coverage. However, there are a number of drawbacks with this type of plan. Specifically, major medical insurance contracts often contain an extensive list of excluded health care services.⁵⁴ In some ways, these exclusions mirror Medicare exclusions, as major medical plans also fail to provide for services like convalescent care and cosmetic surgery.⁵⁵ In addition, coinsurance reflects a cost-containment effort by insurance providers and is therefore an additional expense and drawback for the insured. Coinsurance (or “percentage participation”) forces the insured to share in medical costs, requiring the insured to pay any amount that the insurance provider does not fund based on its “percentage of coverage.”⁵⁶ For example, if the insurance provider offered 70%/30% coverage, then on a given claim, the insurance company would pay 70% of eligible medical charges above any deductible while the insured would have to pay the remaining 30% of the bill.⁵⁷

Those covered under a major medical insurance plan, with a coinsurance clause, are susceptible to severe financial hardship in the event of a medical catastrophe.⁵⁸ To meet this concern, many insurance providers add a coinsurance cap, or stop-loss limit.⁵⁹ The cap limits the insured’s out-of-pocket expenses in a given year as a result of a coinsurance clause.⁶⁰ When the insured reaches the coinsurance

53. *See id.*

54. *See id.*

55. *See id.* Typical insurance plans include an extensive list of exclusions, with most prohibiting

(1) convalescent or custodial care; (2) physical examinations, unless required for the treatment of an injury or illness (it should be noted that some plans now cover this expenditure); (3) cosmetic surgery unless required to correct a condition resulting from an injury or a birth defect; (4) occupational injuries and illnesses that are otherwise covered under a Workers’ Compensation law; and (5) routine dental and vision care (care required for treatment of an injury and dental and eye surgery are frequently covered, however).

Id.

56. *See id.* Percentage of coverage normally includes 70%/30% coverage, 80%/20% coverage, or 90%/10% coverage, depending upon the insurance provider. *See id.*

57. *See id.*

58. *See id.*

59. *See id.*

60. *See id.* Coinsurance caps generally range from \$2,000 to \$3,000, with limits as low as \$1,000 depending upon the insurance provider. *See id.*

cap, the insurance provider pays all remaining eligible expenses above this amount up to the plan's overall coverage limit.⁶¹

B. Managed Care and HMOs

Managed-care organizations (MCOs) encompass a significant force within the health industry, with over 120 million Americans enrolled as participants in these organizations.⁶² Dominating the industry are health maintenance organizations (HMOs), with over sixty million enrolled as of 1996.⁶³ Even more remarkable are the numbers of working insureds who participate in HMOs, which included over 75% of the work force in 1997.⁶⁴ Most of the growth in managed care occurred during the past two decades, with the number of people insured by HMOs rising from ten million in 1992 to 120 million in 1995.⁶⁵

With many people resorting to HMOs as their primary insurance provider,⁶⁶ the differences between HMOs and traditional insurance are critical. Normally, MCOs employ two distinct types of health insurance contracts, either: (1) indemnity contracts under normal insurance plans, or (2) HMO contracts to cut costs for larger servers.⁶⁷ The major difference between HMO and traditional, indemnity contract plans is the way in which claims are paid under the contracts.

1. INDEMNITY CONTRACTS

Indemnity contracts consist of basic and major medical expense plans.⁶⁸ These plans indemnify, or reimburse, the insured for medical

61. *See id.*

62. *See generally* Ryan Steven Johnson, *ERISA Doctor in the House? The Duty to Disclose Physician Incentives to Limit Health Care*, 82 MINN. L. REV. 1631, 1633 (1998). In considering MCOs, "the American Medical Association has defined managed care as '[t]he control of access to and limitation on physician and patient utilization of services by public or private payers . . . through the use of prior and concurrent review for approval of or referral to service or sit of service and financial incentives or penalties.'" *Id.* (quoting John K. Iglehart, *Health Policy Report: The American Health Care System*, 326 NEW ENG. J. MED. 962, 965 (1992)).

63. *See* Johnson, *supra* note 62, at 1638.

64. *See* Gail A. Jansen et al., *The New Dominance of Managed Care: Insurance Trends in the 1990s*, HEALTH AFF., Jan./Feb. 1997, at 125, 126.

65. *See* Carol J. Simon et al., *The Impact of Managed Care on the Physician Marketplace*, in U.S. DEP'T HEALTH & HUMAN SERV., PUBLIC HEALTH REPORTS 222 (1997).

66. *See supra* notes 62-63 and accompanying text.

67. *See Health Insurance FAQ*, *supra* note 46.

68. *See id.*

expenses incurred following the completion and filing of specific forms to establish a covered claim.⁶⁹ From their inception, insurance companies paid physicians for medical services on a fee-for-service or a percentage of charges basis.⁷⁰ The type of service offered under such a system allowed patients to choose physicians freely and gave physicians the opportunity to select the method of treatment and the cost for their patients.⁷¹ As a result, insurance companies carried the burden of health care expenses, which often grew beyond their control.⁷² Typically, an insurance company pays about 80% or 90% of any charges, with the remainder covered by the insured, subject to any additional deductibles or out-of-pocket annual expense limitations.⁷³ Most insurance companies limit their inquiries to coverage issues, deductibles, and preexisting conditions.⁷⁴ These increased costs to the insured⁷⁵ tended to be balanced by the ability to freely designate a physician of choice.⁷⁶

2. HMOS: THE METHODOLOGY OF LIMITING COSTS

The health care insurance industry established HMOs to curb rising costs and provide a better system for review of health care services.⁷⁷ With such a large group of Americans involved with MCOs, finding ways to cut costs appeared to be an easy way for MCOs to save money and therefore increase profits for most of these organizations.⁷⁸ Under an HMO plan, the MCO continues to be responsible for the delivery, management, and finance of health care services for enrollees which is similar to standard private health insurance.⁷⁹ To reduce overhead expenses, HMOs contract directly with

69. *See id.*

70. *See id.*; *see also* Johnson, *supra* note 62, at 1635.

71. *See* Johnson, *supra* note 62, at 1635.

72. *See id.* As one commentator noted, “[b]y insulating physicians and patients from health care costs, this system failed to provide either group with any incentive to minimize costly and unnecessary care, a system blamed for the skyrocketing health care costs of the last several decades.” *Id.*

73. *See* Marvis J. Oehm, *Hospital Cost Containment: A Health Law Symposium*, 14 U. PUGET SOUND L. REV. 527, 529–30 (1991).

74. *See id.* at 530.

75. *See supra* notes 41–46 and accompanying text.

76. *See Health Insurance FAQ*, *supra* note 46.

77. *See* Johnson, *supra* note 62, at 1638–41.

78. *See generally* Oehm, *supra* note 73.

79. *See* Allison Faber Walsh, *The Legal Attack on Cost Containment Mechanisms: The Expansion of Liability for Physicians and Managed Care Organizations*, 31 J. MARSHALL L. REV. 207, 207 n.2 (1997).

health care providers to offer cost-effective care to enrollees.⁸⁰ As a result, HMOs often exercise control over medical treatment options, “an area traditionally left to the clinical judgment of physicians.”⁸¹

Compared to traditional medical insurance, HMO plans tend to emphasize comprehensive and preventive care, including little or no exclusions, minimal deductions, and greatly decreased copayments.⁸² Along with these benefits, however, HMO plans provide less freedom of physician choice, requiring a primary care physician who acts as a “gatekeeper” to approve additional medical services.⁸³ Normally, an individual will choose a primary care physician from a number of available professionals.⁸⁴ The primary care physician holds the power of referral, a dominant form of specialist access that gives the physician the ability to determine whether or not a patient should see a medical specialist or undergo specific procedures.⁸⁵ As a result, this physician control might prevent a patient from receiving services that she might feel are necessary, but that the physician concludes are unnecessary, too costly, or too dangerous. The patient is often unable to afford these specialized services on her own due to their high cost.⁸⁶ To combat this perceived weakness in this system, HMOs may offer a point-of-service option, allowing the insured to seek indemnity type coverage (with a deductible and coinsurance) when receiving medical treatment outside the HMO network.⁸⁷ HMOs find this process necessary to limit patient access to the expensive medical services of specialists.⁸⁸

C. The Denial of Claims: A Question of Motive

Claim denials by insurance companies, recently brought to the public’s attention in the movie based on John Grisham’s novel *The*

80. See *id.* at 215.

81. Johnson, *supra* note 62, at 1633 n.15 (commenting on Jack K. Kilcullen, *Groping for the Reins: ERISA, HMO Malpractice, and Enterprise Liability*, 22 AM. J.L. & MED. 7, 25–28 (1996)).

82. See Johnson, *supra* note 62, at 1633 n.15.

83. See *id.*

84. See Deven C. McGraw, *Financial Incentives to Limit Services: Should Physicians be Required to Disclose These to Patients?*, 83 GEO. L.J. 1821, 1823–25 (1995) (mentioning that most plans allow patients to select from a group of physicians).

85. See *id.*

86. See *id.*

87. See *Health Insurance FAQ*, *supra* note 46.

88. See *id.*

Rainmaker,⁸⁹ continue to draw scrutiny. As for-profit businesses, insurance companies continue to seek methods to control or decrease costs.⁹⁰ Obviously, by denying claims, insurance companies lower costs by avoiding payment for the health care services utilized by their customers.

The growing number of health insurance companies,⁹¹ coupled with the rising costs faced by the industry, leads many to question the motives behind claim denials on an individual basis. Under the pre-HMO system, medical treatment decisions were made between physicians and patients.⁹² The intervention of third-party payers, including organizations like private HMOs and Medicare, drives a wedge between the primary relationship between doctors and patients.⁹³ HMOs utilize language similar to the Medicare Act, prescribing that patients will only be compensated for procedures deemed “essential.”⁹⁴ HMOs do not consider their denials of coverage as limiting how physicians should practice medicine, but rather as “setting limits on the medical treatment for which they are willing to reimburse the physician or hospital.”⁹⁵

1. THE FEDERAL GOVERNMENT MOVES INTO THE ARENA

In response to increasing questions about the methodology used by the health insurance industry, several interests within the federal government plan to enter the field and propose sweeping health care reform.⁹⁶ Much of the reform centers on three different proposals:

89. See generally JOHN GRISHAM, *THE RAINMAKER* (1995).

90. See *supra* notes 77–81 and accompanying text.

91. With regard to medical health insurance, the industry provides a number of different types of insurance companies based on their ownership and the services they provide. Included within the health insurance industry today are Blue Cross/Blue Shield insurers (normally nonprofit, community-oriented health insurance providers) and typical HMO insurance companies. See generally *Health Insurance FAQ*, *supra* note 46.

92. See Jeffrey P. Phelan, *Two Hot Areas in Medical Malpractice for the 1990s*, 24 CREIGHTON L. REV. 1261, 1264 (1991).

93. See *id.*

94. See *id.* Compare with basic Medicare regulations, which require that the health care providers, normally physicians, offer medically necessary services in an economical manner. See 42 C.F.R. § 1004.10 (1998).

95. Phelan, *supra* note 92, at 1265.

96. See generally Eleanor D. Kinney, *Protecting Consumers and Providers Under Health Reform: An Overview of the Major Administrative Law Issues*, 5 HEALTH MATRIX 83 (1995) (discussing issues in administrative law and health insurance reform); Jack A. Rovner, *Federal Regulation Comes to Private Health Care Financing: The Group Health Insurance Provisions of the Health Insurance Portability and Account-*

managed competition, single-payer systems, and reform through federal tax and other incentives.⁹⁷ These plans remain in the developmental stage and are under consideration by a number of members of Congress who are trying to rein in the power of the health insurance industry.⁹⁸ The first plan, managed competition, would maintain the status quo by retaining the current “employer-based, private health insurance system while reforming the private health insurance market,” an area formerly left to state regulation.⁹⁹ Single-payer models, the second alternative, would involve creating a government insurance program that would cover everyone, similar to the current Medicare program.¹⁰⁰ Finally, the third approach, utilizing taxes and other incentives, would expand coverage and promote efficiency by relying on private companies to make decisions based on tax breaks created by the federal government.¹⁰¹ In other words, by placing tax incentives in certain areas, the government would seek to steer private insurance companies in the direction which Congress feels will most benefit the average American.¹⁰²

In passing the Kassebaum-Kennedy Bill,¹⁰³ or the Health Insurance Portability and Accountability Act (HIPAA),¹⁰⁴ the federal government instituted its first attempt at health care reform.¹⁰⁵ Under the Act, Congress seeks to “guarantee continued availability of health care coverage to employees and their spouses and dependents who have group health insurance, without regard for medical condition and without additional periods of preexisting condition exclusion.”¹⁰⁶ The Act creates a number of federally mandated criteria for the health insurance industry, affecting almost every health benefit plan and every

ability Act of 1996, 7 ANN. HEALTH L. 183 (1998) (discussing the Health Insurance Portability and Accountability Act of 1996).

97. See Kinney, *supra* note 96, at 85.

98. See *id.*

99. *Id.*

100. See *id.* at 86.

101. See *id.* at 85–86.

102. See *id.*

103. H.R. 3103, 104th Cong. § 2 (1996).

104. In actuality, the Act is a series of three different amendments to three different acts: the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1936 (1996) (amending Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001–1461 (1994)), Public Health Service Act, 42 U.S.C. §§ 201–299 (1994), and the Internal Revenue Code of 1986, 26 U.S.C. §§ 1–9806 (1994 & Supp. 1996).

105. See Rovner *supra* note 96, at 184–85.

106. *Id.*

health insurance company.¹⁰⁷ Notably, HIPAA instituted the following changes: limitations on preexisting condition exclusions; enrollment rights for spouse and dependent coverage; minimum hospital stay periods for childbirth; parity in mental health benefits; and small group/individual standards for issuance and renewal of health care insurance.¹⁰⁸

2. THE IMPORTANCE OF HIPAA

While sweeping legislation like the Health Insurance Portability and Accountability Act may not have much impact on the appeals process under standard insurance contracts, the legislation tends to demonstrate congressional ability to force regulation on an industry previously dominated by individual state regulation.¹⁰⁹ In the areas listed above, HIPAA preempts any state law, allowing only those state laws that impose stricter restrictions upon insurance companies.¹¹⁰ HIPAA is the result of congressional determination to address health insurance problems with national solutions.¹¹¹ Such efforts, however, often lead to higher costs for the insured and greater complexity for multistate insurance companies.¹¹² Overall, the possibility that Congress could impose far-reaching overhauls in the private health insurance industry may lead to some interesting developments in the future.

IV. Dissecting the Medicare Apparatus

A. The Development of a Process for Settling Claims: A Brief History of Claim Review Under Medicare Part B

Consider an unrealistic or “perfect” Medicare world. Every citizen using Medicare to cover medical bills goes through a simple process, merely going to a physician and receiving the necessary treatment. Later, Medicare notifies the patient that Medicare Part B covers the majority of the bill and requires only that the patient pay a \$100 deductible, standard for all treatments under Plan B.¹¹³ However, the

107. *See id.* at 184.

108. *See id.*

109. *See id.* at 214.

110. *See id.* at 210.

111. *See generally id.* at 214–15.

112. *See id.*

113. *See* NATIONAL ASS’N OF INS. COMM’RS & HEALTH CARE FIN. ADMIN., 1998

reality is that the system of appeals is far more complicated, resulting in a long and difficult process to resolve contested claims.¹¹⁴

The Medicare program requires health care providers who participate in the program to meet certain requirements to assure that their services are properly administered.¹¹⁵ Ultimately, the physician makes decisions as to whether a service is required or “necessary” for the survival of the patient.¹¹⁶ Under this type of system, there are normally two avenues of appeal.¹¹⁷ The first involves a physician seeking relief from a decision by a Peer Review Organization (PRO) that he failed to meet statutory requirements.¹¹⁸ As mentioned previously,¹¹⁹ Congress created PROs to monitor the effectiveness and efficiency of health care providers utilizing Medicare to pay for their services.¹²⁰ In this case, the PRO decides whether or not the physician’s treatment was “medically necessary” and therefore whether the physician should be reimbursed.¹²¹ The second claims appeal is brought by the individual patient denied coverage, who typically argues that a physician’s decision to provide treatment was “medically necessary” and therefore should have been covered by Medicare.¹²²

Traditionally, Medicare conducts patient reviews through a series of administrative steps,¹²³ with the Social Security administrative review scheme incorporated into the Medicare claims process.¹²⁴ Un-

GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE 3 (1997).

114. See *supra* notes 35–37 and accompanying text.

115. See 42 U.S.C. § 1320c–(5)(a) (1994); see also 42 C.F.R. § 1004.10 (1998). Medicare requires that the health care providers, normally physicians, offer services which:

will be provided economically and only when, and to the extent, medically necessary; will be of a quality which meets professionally recognized standards of health care; and will be supported by evidence of medical necessity and quality in such form and fashion and at such time as may reasonably be required by a reviewing peer review organization in the exercise of its duties and responsibilities.

42 U.S.C. § 1320c-5(a).

116. See 42 U.S.C. § 1320c-5(a).

117. See Blanchard, *supra* note 26, at 957–58.

118. See *id.*

119. See *supra* text accompanying note 30.

120. See Peer Improvement Act of 1982, Pub. L. No. 97-248, § 143, 96 Stat 385, 385–88.

121. Although this procedure is important and deserves consideration, it is beyond the scope of this note and therefore will remain largely ignored.

122. See Blanchard, *supra* note 26, at 964–65.

123. See 42 U.S.C. § 1320c-4 (1994).

124. See 42 U.S.C. § 1395ff(b) which incorporates 42 U.S.C. § 405(g) of the Social Security Act into the Medicare review process.

der Part A and Part B, Medicare and the HHS have established completely different procedures for claimant review.¹²⁵ Over the years, Part A review has received much less criticism than Part B review for a variety of reasons.

Prior to 1986, the Medicare Act required only a fair hearing by the carrier “in any case where the amount in controversy [was] more than \$100.”¹²⁶ Any final determination by the carrier was beyond review at this stage, regardless of the expense of the claim submitted.¹²⁷ In other words, although the carrier needed to give some type of review to the claimant, the carrier had little or no incentive to do an adequate job because no one was checking over its shoulder.¹²⁸ Part A, on the other hand, allowed claims equal to or more than \$100 to receive direct review from an HHS administrative law judge (ALJ), with an appeal of an adverse decision to a federal district court for claims of \$1000 or more.¹²⁹ Noting these deficiencies in the system, or “Part B and its asymmetry with Part A,”¹³⁰ various groups stepped forward to argue for a new system of review for Part B.¹³¹ Congress noted the shortcomings within the general infrastructure of the appeals process; specifically, the conflicts of interest between fair hearing officers and the carrier that employed them¹³² and the absence of review beyond the fair hearing stage.¹³³ As summarized by Congress in a House Report attached to the Amendments of 1986, “[n]umerous concerns have been expressed by beneficiaries about the fairness and adequacy of [the] Part B appeals process.”¹³⁴

125. See 42 C.F.R. §§ 405.701–.753 (1998) for the appellate process for Medicare Part A and 42 C.F.R. §§ 405.801–.877 for Medicare Part B.

126. 42 C.F.R. § 405.801.

127. See *Isaacs v. Bowen*, 865 F.2d 468, 471 (2d Cir. 1989) (citing *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 678 (1986) and *United States v. Erika, Inc.*, 456 U.S. 201, 206–08 (1982)).

128. See *id.*

129. See 42 U.S.C. § 1395ff(b)(2)(A) (1994).

130. *Isaacs*, 865 F.2d at 471.

131. See MEDICARE APPEALS PROVISIONS: HEARING ON S. 1158 BEFORE THE SUBCOMM. ON HEALTH OF THE SENATE COMM. ON FIN., 99th Cong. 188–391 (1985).

132. See *id.* at 188–94 (John H. Pickering on behalf of the American Bar Association stating that many of these fair hearing officers owed their salaries to the same organization against whom they might be forced to bring an adverse judgment).

133. See *id.* at 229–33 (statement of Arlene Lapp, Medicare Part B participant) and 385–91 (statement of National Association of Medical Equipment Suppliers).

134. H.R. REP. NO. 99-727 at 95 (1986), reprinted in 1986 U.S.C.C.A.N. 3607, 3685. This report notes a number of problems with the old system. In particular, the report discusses the fact that hearing officers do not meet proper qualifications or fail to remain objective. Further, the hearings themselves are in some ways

To address the problem of a lack of subsequent review under Medicare Part B, Congress introduced the 1986 Amendments to the Medicare Act, shoring up some of the deficiencies in the program but introducing additional gray areas.¹³⁵ Maintaining the idea of “fair hearings,” Congress changed the amount in controversy requirement to include a minimum and a maximum.¹³⁶ Specifically, Congress stated that “an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is at least \$100, but no more than \$500.”¹³⁷ Congress also added an additional level of appellate review to an adverse decision by allowing a formal hearing before an administrative law judge, followed by review by a district court.¹³⁸ The ALJ is granted authority to review the decision “if the amount in controversy is less than \$500,”¹³⁹ and the district court may review the decision if the controversy is less than \$1000.¹⁴⁰ To clear up the question of whether Congress authorized a fair hearing for controversies greater than \$500 but less than \$1000, Congress amended the wording in 42 U.S.C. § 1395u(b)(3)(C) in 1987 to change “not more than [\$500]” to “less than [\$500].”¹⁴¹ These congressional changes, however, failed to resolve controversies regarding conflict of interest between fair judgments in internal hearings and the hearing officers’ known affiliation and employment by the health carriers.¹⁴²

conducted improperly, especially based on the “beneficiaries’ inability to produce evidence or to challenge the hearing officers’ decisions, rules, or his reliance on unidentified experts and consultants.” *Id.* It should be noted, however, that many of these problems are not limited to Medicare Part B, and would appear to be problematic in other government organizations that rely on internal review of decisions.

135. See Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9313(a), 100 Stat. 2037 (1986) (codified at 42 U.S.C. § 1395ff (1994)).

136. See 42 U.S.C. § 1395u(b)(3)(C).

137. *Id.*

138. See 42 U.S.C. § 1395ff(b)(2)(D).

139. See *id.* § 1395ff(b)(2)(B).

140. See *id.*

141. 1987 Amendments, Pub. L. No. 100-203, § 4805(i)(5), 101 Stat. 1330-32 (1987).

142. See generally *infra* notes 299-300 and accompanying text.

B. The Road to Redemption: A Typical Claimant Under Medicare Part B and Private Health Insurance

To highlight the similarities and differences between the appeals processes, consider the example of a typical dissatisfied claimant who seeks review of a denied claim under Medicare Part B.

1. THE PATH WITHOUT COUNSEL

Turning to Medicare, meet William Black, who seeks to have his carrier's decision to deny payment of his claim under Medicare Part B reviewed.¹⁴³ For the sake of this example, the specific claim that Mr. Black is making is irrelevant, but assume that the decision of the physician was borderline or questionable, allowing Mr. Black's claim to proceed through the entire review process.¹⁴⁴ Prior to the 1996 class action against the Secretary of HHS in *Grijalva v. Shalala*,¹⁴⁵ HCFA could withhold pertinent information from the patient regarding his denied claim. For example, HCFA was not required to inform the claimant about the reasons for his claim denial, provide additional evidence needed to support an appeal, or give an explanation of the process for obtaining a second review.¹⁴⁶ Following the *Grijalva* decision, Medicare was forced to send all such information to a Part B user if his claim was denied.¹⁴⁷ Following *Grijalva*, Mr. Black has some basis upon which to begin his quest for redress.

Mr. Black first makes a request to his carrier, asking the carrier to reconsider its initial decision on the claim.¹⁴⁸ While Mr. Black believes a hearing is ultimately unavoidable, he realizes that at this juncture a hearing will probably not be available.¹⁴⁹ Instead, Mr. Black prepares

143. It should be noted that under 42 U.S.C. § 1395pp(d) (2000), a physician may also bring suit on behalf of a patient from whom he has accepted assignment (given the claim is denied as not "reasonable" or "medically necessary"). Also, he may represent a beneficiary in an appeal if no charge is made for the representation and the physician waives all right for a charge. See 42 U.S.C. § 1395ff(b). For simplicity's sake, this option will not be discussed within the William Black example.

144. The assumption is made that his claim was questionable in order to eliminate any needed discussion of Mr. Black's case being promptly dismissed during the early stages of the process.

145. 946 F. Supp. 747 (D. Ariz. 1996).

146. See Visocan, *supra* note 41, at 43.

147. See *id.*

148. See 42 C.F.R. §§ 405.801–.806 (1998); MEDICARE CARRIERS MANUAL, Pt. 3, § 12010.

149. See 42 U.S.C. § 1395u(b)(2)(B)(i) (1994); MEDICARE CARRIERS MANUAL, Pt. 3, § 12010.

for the inevitable response from his carrier, who considers his case based specifically on written evidence that its agents have gathered and prepared.¹⁵⁰ Following a period of review,¹⁵¹ the carrier responds, concluding that the original decision either needs to be affirmed, modified, or reversed.¹⁵² For the sake of this example, assume that the decision in Mr. Black's case has been summarily upheld.¹⁵³

Dissatisfied with the carrier's decision, Mr. Black decides to bring his controversy before a carrier-hearing officer for a fair hearing.¹⁵⁴ The hearing officer asks Mr. Black to telephone him first and engage in an "on the record" fair hearing, occurring sometime before an in-person hearing.¹⁵⁵ Following this brief telephone discussion, Mr. Black remains dissatisfied and therefore appears in person and produces his written evidence. After hearing Mr. Black's testimony, the hearing officer reviews the case, focusing on coverage, reasonable charge, and any possible waivers of liability issues.¹⁵⁶

2. ADDING AN ATTORNEY TO THE MIX

Despite Mr. Black's good faith efforts to vindicate his claim, the hearing officer ultimately upholds the carrier's decision rejecting payment. Angered at his lack of success, Mr. Black vows to continue, and consults his attorney, George Evenhand, about the chances of success at the next stage of the appeal process. Attorney Evenhand seems less than enthusiastic about the case, mentioning that Mr. Black

150. See 42 U.S.C. § 1395u(b)(2)(B)(i). Due to the nature of review, the term "inevitable response" is employed. Under such, Medicare forces carriers to respond within 45 days of receiving the request for 95% of the cases. See *id.*

151. See *id.*

152. See 42 C.F.R. §§ 405.807–810 (1998); MEDICARE CARRIERS MANUAL, Pt. 3, § 12010.

153. If a ruling has been reversed or modified, what occurs next is the subject of some debate. For instance, one commentator has noted that upon a reversal decision, many carriers neglect to send a determination letter "to explain the basis for reversal even though several grounds may have been advanced in the request for review." Blanchard, *supra* note 26, at 966. As he later explains, such denials appear to go against rules specifically made by Medicare, which require the carrier to notify the claimant about the basis for its determination. See *id.* at 966 n.141 (mentioning 42 C.F.R. § 405.834).

154. See 42 U.S.C. § 1395u(b)(3)(C) (1994); 42 C.F.R. §§ 405.811–835.

155. See MEDICARE CARRIERS MANUAL, Pt. 3, § 12021.

156. See *id.* The hearing officer is required to reach a conclusion "within the framework of applicable statute, regulations, and guidelines," *id.* § 12016B, which will normally be composed of the Medicare statute, regulations, national coverage determinations, and *Medicare Carriers Manual* provisions. See Blanchard, *supra* note 26, at 967–68.

will “not get services while the appeals process winds on, and the case drags on for years as it ascends the various levels of appeal.”¹⁵⁷ Although this will undoubtedly lead to increased fees for Attorney Evenhand, it may fail to produce a satisfied client, based on the amount of time and money required to mount an effective appeal. Undaunted, Mr. Black asks Attorney Evenhand what avenues of recourse he has available. Attorney Evenhand replies that one option is for Mr. Black to request a reopening of his claim denial, meaning that he can request that his case be reviewed by the hearing officer.¹⁵⁸ However, Attorney Evenhand quickly advises against this option.¹⁵⁹ Instead, Attorney Evenhand suggests that Mr. Black request an appeal to an administrative law judge,¹⁶⁰ which is Mr. Black’s best route to recovery because his claim is more than \$500.¹⁶¹ Had Mr. Black’s claim been less than \$500, Mr. Black could only seek review through his Medicare contractor.¹⁶²

At this point, Attorney Evenhand consults his copy of the *Medicare Carriers Manual*.¹⁶³ Realizing the tremendous delays that his client will be forced to experience, Attorney Evenhand decides that his best course of action is to place Mr. Black’s appeal before The Office of Hearing and Appeals Medicare Part B Development Center.¹⁶⁴ Following an unnecessary delay, Attorney Evenhand presents Mr. Black’s case before an administrative law judge, who dutifully listens to Mr. Black’s case, considering all relevant information and testimony given by Mr. Black and his attorney. After careful deliberation, the

157. Cynthia L. Barrett, *Retiree Health Insurance Problems*, SB90 ALI-ABA 1389, 1395-96 (1997). In her article on advocacy for the elder law attorney, Ms. Barrett goes on to suggest limiting the number of Medicare appeals cases that the attorney takes. *See id.* at 1395-97.

158. *See* 42 C.F.R. §§ 405.835-.850; MEDICARE CARRIERS MANUAL, Pt. 3, § 12100.

159. As one commentator has described it, “[r]eopening, however, is within the Hearing Officer’s discretion, and is strongly discouraged by HCFA.” *See* Blanchard, *supra* note 26, at 1040 n.148 (describing a hearing officer’s review of a past decision under *Medicare Carriers Manual*, § 12100).

160. *See* 42 U.S.C. § 1395ff(b)(2)(B) (1994).

161. In order to qualify for review by an administrative law judge, the claimant’s amount in controversy must be greater than \$500. *See id.*; *see also* 42 U.S.C. § 405(b).

162. *See* 42 U.S.C. § 1395u(b)(3)(c); 42 C.F.R. § 405.801.

163. MEDICARE CARRIERS MANUAL, Pt. 3.

164. *See id.* § 12027. Attorney Evenhand realizes that he had better get the claim in front of the Center as soon as possible, as “Medicare Part B appeals have been misrouted because of confusion arising under [Medicare Carrier’s] instructions, further delaying payment on erroneous Medicare Part B coverage denials.” Blanchard, *supra* note 26, at 969.

ALJ finds insufficient evidence to overturn the original decision of the carrier, and Mr. Black's journey has apparently ended without victory.

Returning to Attorney Evenhand's office, Mr. Black prepares to pay the inevitable bill from his already depleted bank account. Attorney Evenhand graciously asks Mr. Black to put his checkbook away.¹⁶⁵ For while his case may appear hopeless, a variety of options remain open to Mr. Black. Attorney Evenhand tells Mr. Black that he will prepare another appeal at once, this time to the SSA Appeals Council.¹⁶⁶ "But be warned," Attorney Evenhand cautions, "the Appeals Council normally limits its jurisdiction, only considering those cases which might amount to an abuse of discretion by the ALJ, significant errors of law, an absence of substantial evidence to support the ALJ's decision, or those cases it considers to be within the public interest."¹⁶⁷

As a result, although another level of review remains available to Mr. Black within the Medicare review structure, the possibility that the average person will be allowed an opportunity to be heard is remote. In the interest of completing this example, assume that the Appeals Council believes that there is some merit in Mr. Black's claim for further appeal and decides to let Mr. Black and his attorney present the case. Although the Appeals Council finds some evidence supporting a reversal of the original denial of claim, it ultimately concludes that the evidence is insufficient for reversal. After this long process of review under Medicare Part B, Mr. Black has heard the final decision of the Secretary of Health and Human Services.¹⁶⁸

3. SEEKING RELIEF THROUGH THE COURTS

Returning to his home away from home, the office of Attorney Evenhand, Mr. Black dejectedly prepares to end his fight. In retrospect, Mr. Black is prepared to write off his monetary loss from the denial of his claim to an unreasonable government unwilling to com-

165. Not before he is able to see how much money Mr. Black has in his account, however. Mr. Black might be a longtime customer, but a longtime customer without any money is soon only a longtime acquaintance.

166. See 20 C.F.R. § 404.969 (1999); see also 53 Fed. Reg. 20,023 (June 1, 1988), General Notice Regarding Part BE Appeals Jurisdiction, [1988-2 Transfer Binder] Medicare & Medicaid Guide (CCH) ¶ 37,119. By motion, Appeals Councils are also allowed to elect a review of an ALJ's decision within 60 days after the issuance of an ALJ decision. See 20 C.F.R. §§ 404.969-976.

167. Blanchard, *supra* note 26, at 969-70.

168. See 20 C.F.R. §§ 404.979-981. In the average claimant case, the final decision of the Secretary would be that made by the ALJ. See *id.*

pensate its citizens for federally regulated and medically necessary services.¹⁶⁹ Again, Attorney Evenhand prevents Mr. Black from quitting prematurely, noting that one more step remains in the appeals process. Mentioning that Mr. Black's claim amounts to more than \$1000, Attorney Evenhand correctly observes that Mr. Black can appeal to a federal district court.¹⁷⁰ Gathering all of the materials and evidence gained through the first four steps of the appeals process, Attorney Evenhand prepares himself for the final leg of the appeals journey.

Perusing Medicare case law, Attorney Evenhand learns to his surprise that the option of review before a federal district court did not become available until 1986. In that year, the Supreme Court decided *Bowen v. Michigan Academy of Family Physicians*,¹⁷¹ which overturned prior decisions preventing district court review.¹⁷² Medicare limits a plaintiff's ability to find redress in the federal district courts by placing conditions on the district courts' capacity to rule in certain cases.¹⁷³ For example, Medicare requires federal courts to remand cases back to the Secretary of Health and Human Services when it has determined that the outcome of the administrative hearing is not supported by substantial evidence.¹⁷⁴ Medicare also denies the court the ability to make a decision involving Medicare coverage until it has had an opportunity to review the supplemented record.¹⁷⁵ Sections 1395ff(b)(3)¹⁷⁶ and 1395ff(b)(4)¹⁷⁷ outline other limits on district court review, all of which tend to hamper the review process and make it

169. Although Mr. Black was not in a position to fight for his rights during the 1960s, he has always sympathized with those who sought an end to oppression and a dismantling of "big brother."

170. See 42 U.S.C. §§ 1395(ff), 405(g) (1994).

171. 476 U.S. 667 (1986).

172. See *id.* at 677 n.7.

173. See 42 U.S.C. § 1395ff(b)(3)(C); see also Blanchard, *supra* note 26, at 970–71.

174. See Blanchard, *supra* note 26, at 970–71.

175. See *id.*

176. 42 U.S.C. § 1395ff(b)(3). This section prevents judicial review of any determination regarding "national coverage determinations under section 1395y(a)(1)" of the Medicare Act in determining whether or not "a particular type or class of items or services is covered" by Medicare. *Id.*

177. 42 U.S.C. § 1395ff(b)(4). Section 1395ff(b)(4) prevents the judicial review of any "regulation or instruction which relates to a method for determining the amount of payment" under Medicare Part B or any determination "issued before January 1, 1981." *Id.* While the first part of this section is of obvious relevance to any person seeking review, it is rather dubious that any person would be prevented review under the second part. Some might argue, however, that the long period of time required for a claim might still involve some cases who are only now seeking review in a federal court after beginning their claim in 1985.

more difficult for the average claimant to obtain review of denials of Medicare coverage.¹⁷⁸

Preparing a detailed complaint for court, Attorney Evenhand and Mr. Black prepare to travel through the long and torturous journey called “litigation.” Suffice it to say, Mr. Black’s journey began several months previously, and could continue for several more months or even years depending upon his resolve to pursue a judicial decision.

V. Testing the Waters of Private Health Insurance Appeals

The appeals process via an average health insurance contract is relatively short when compared to that of Medicare,¹⁷⁹ primarily due to the more limited number of steps involved.¹⁸⁰

A. The Appeals Process

1. FEE-FOR-SERVICE INSURANCE

The typical health insurance contract involves a signed agreement between the insurance company, the person being insured, and in many instances, the health insurance plan sponsor, typically the individual’s employer or employee union.¹⁸¹ Consider the example of an average insurance claimant, Michael Black, the son of our Medicare claimant, William Black. After suffering injury from an accident, the younger Mr. Black receives treatment from his physician, who invokes a questionable clause in his insurance contract by providing treatment not specifically covered by his insurance provider.

Before taking Michael Black through a hypothetical insurance claim, several elements of the health insurance claims process should be highlighted. Michael’s insurance company and choice of plan will determine the type of adjudication procedure available. As mentioned previously, most private disputes between commercial health insurers and the claimant occur in state courts, with these courts making decisions based on state regulation of health insurance plans.¹⁸² However, various factors tend to affect the process. In real-

178. See Blanchard, *supra* note 26, at 971–73.

179. See *supra* Part IV.

180. See *infra* Part VIII for an analysis of these differences.

181. See Kinney, *supra* note 96, at 88.

182. See *id.* at 95.

ity, few insurance claims are ever litigated and, of those cases that are litigated, most never reach state appellate courts.¹⁸³ Some argue that this is due to increased informal negotiation or formal arbitration of health insurance claims,¹⁸⁴ while others point to the relatively limited amount of damages available under contract claims. Therefore, litigation expense is often greater than possible contract damages.¹⁸⁵ It should be noted, however, that an attached tort claim for punitive damages may increase the available damages.¹⁸⁶

For the moment, Michael Black's case involves an average, state-regulated health insurance plan. Under such a plan, Michael must first file a claim against his insurance carrier with a claims examiner for the medical service that he received.¹⁸⁷ Then, should his claim be denied, the insurance company allows the claimant to appeal to a secondary insurance examiner, sometimes referred to as a technical assistant—"someone who is higher in the chain of command."¹⁸⁸ Here, Michael filed his first claim in a timely manner, yet his insurance company rejected that claim. Michael then appealed to a technical assistant and that assistant subsequently denied this first appeal.¹⁸⁹

Taking issue with the decision of his health insurance company to withhold payment for a specific medical treatment suggested by his physician, Michael Black speaks with his father and learns of the service provided by George Evenhand, Attorney at Law. Following a consultation with Attorney Evenhand, Michael learns that controversies under state-regulated health plans fall within the reach of state courts via state contract law.¹⁹⁰ Some states provide for additional claims review prior to court action.¹⁹¹ For example, Nebraska created a Department of Insurance to evaluate the decisions of insurance

183. See Mark R. Fondacaro, *Toward a Synthesis of Law and Social Science: Due Process and Procedural Justice in the Context of National Health Care Reform*, 72 DENV. U. L. REV. 303, 345 (1995).

184. See *id.* (noting that arbitration of coverage or eligibility disputes are often required by the policy itself).

185. See GEORGE J. ANNAS ET AL., *AMERICAN HEALTH LAW* 157 (1990).

186. See *id.*

187. See Fondacaro, *supra* note 183, at 346.

188. *Id.*

189. Many times, the insurance company provides additional avenues of appeal to the insured within the company, allowing him to appeal to a claims manager and then a branch manager. See *id.*

190. See Kinney, *supra* note 96, at 96. See generally ROBERT KEETON & ALAN I. WIDISS, *INSURANCE LAW: A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES, AND COMMERCIAL PRACTICES* (2d ed. 1988).

191. See Fondacaro, *supra* note 183, at 346.

companies and to provide an impartial assessment of the insurance company's decision.¹⁹² Prior to entering state court, Michael Black and his attorney consult with the state's branch of administrative review,¹⁹³ which decided that the insurance company's decision was fair.

Attorney Evenhand carefully examines the contract, trying to find some basis for a contract remedy. Consulting case law on the subject, Attorney Evenhand finds another possible avenue for resolution—"bad faith breach" of the insurance contract.¹⁹⁴ Normally, under a "bad faith breach," the insured has many available remedies, allowing him to bring his suit via contract law and through a tort claim.¹⁹⁵ In this case, Michael, through consultation with Attorney Evenhand, decides to bring his suit under both a tort claim for "bad faith breach" and a normal breach of contract claim. When his case finally reaches the trial court setting, Michael finds himself mired in the litigation process for several months. The insurance company, holding far greater financial resources and a desire to prevent future litigation of the same kind,¹⁹⁶ parades before the court a number of expert witnesses to demonstrate that the procedure lies outside of the coverage of its medical plan and that the company's actions therefore fall outside of the reach of a "bad faith breach" claim.

Despite the advantage of a sympathetic jury, Michael ultimately loses, and prepares to liquidate many of his assets to cover his increased medical bills, not to mention his attorney's fees. However, Attorney Evenhand quickly counsels Michael to hold on to his money, for two additional state levels of review remain available, and Attorney Evenhand shows a willingness "to fight this all the way to the Supreme Court!"¹⁹⁷ Assume that Michael and Attorney Evenhand ap-

192. See Unfair Insurance Claims Settlement Practices Act, NEB. REV. STAT. §§ 44-1536 to 44-1544 (1993); NEB. ADMIN. R. & REGS., T. 210, Ch. 61, §§ 001-011 (1992).

193. See Fondacaro, *supra* note 183, at 346.

194. See Kinney, *supra* note 96, at 96. See generally *Taylor v. Prudential Ins. Co. of Am.*, 775 F.2d 1457 (11th Cir. 1985).

195. See Kinney, *supra* note 96, at 96.

196. For the sake of this hypothetical, young Mr. Black's case involves a treatment which is definitely borderline in terms of coverage and is also quite costly, but also represents a procedure which could be rather useful to a large number of future patients. As a matter of common financial sense, the insurance company, to minimize costs, seeks to deter the future use of this procedure.

197. In his statement, it continues to be unclear as to whether Attorney Evenhand is referring to the Supreme Court of the United States or the State Supreme Court. Either way, Attorney Evenhand desires to make a name for himself in the

peal to both the state appellate courts and the state supreme court and continue to remain unsuccessful.

Sharing the same thirst for justice that his father demonstrated during his appeals process with Medicare, Michael Black vows to continue his fight.¹⁹⁸ Turning to federal law,¹⁹⁹ Attorney Evenhand notes that the final avenue of recourse available to Michael is the U.S. Supreme Court.²⁰⁰ As a result, Michael lacks the opportunity to present his case before the same courts where his father was ultimately unsuccessful.²⁰¹ Noting the limited number of cases that tend to reach the Supreme Court on a yearly basis, Michael Black's claim most likely ended with his appeal within the state court appellate structure.²⁰²

2. HMOS AND THE APPEALS PROCESS

HMOs have a different structure than fee-for-service health insurance,²⁰³ and therefore there are variations in the appeals process under HMOs. As mentioned earlier, HMOs suffer from one obvious drawback, an "inherent tendency towards underservicing enrollees" due to their "financial interest in minimizing the total costs of the

elder law field and hopefully collect some impressive attorney's fees along the way.

198. Perhaps Attorney Evenhand lacks the good counsel that is required, because he probably should have dissuaded both members of the Black clan for shamelessly wasting money on long appeals processes. Then again, some might argue that Attorney Evenhand shows remarkable ability as an attorney, able to hoodwink a father and son with relative ease. This issue remains beyond the scope of this note.

199. See 28 U.S.C. § 1257 (2000) (casting the Supreme Court as the only recourse for the final judgments of the highest court in a given state).

200. See generally *Parker v. Illinois*, 333 U.S. 571 (1948) (noting that an individual may bring a claim to federal court after adjudicating it via a state court unless the individual waives his claim by failing to follow proper state procedure); see also *Thompson v. City of Louisville*, 362 U.S. 199 (1960) (determining the U.S. Supreme Court may hold jurisdiction over only those state cases which raise a federal constitutional question).

201. See *Kinney*, *supra* note 96, at 96 (mentioning that U.S. district and appellate courts lack jurisdiction to review state agency decisions regarding insurance law absent a specific congressional mandate). One example of a federal mandate is HIPAA, which calls for HCFA to fine previously state-regulated insurance companies if the state fails to meet the applicable standards of the federal government on a consistent basis. See *supra* notes 80-92 and accompanying text; see also *Rovner*, *supra* note 96, at 211. Because this action would be undertaken by a federal agency, that could tend to represent a congressional mandate for district court review should the insurance company decide to appeal.

202. See generally *Parker*, 333 U.S. 571; *Thompson*, 362 U.S. 199.

203. See *supra* Part III.

services rendered.”²⁰⁴ To encourage the development of HMOs, Congress passed the Health Maintenance Organization Act of 1973,²⁰⁵ establishing strict guidelines for the “hearing and resolving of grievances” between the insured and the organization.²⁰⁶

While every plan will vary in terms of its appellate procedure, a typical plan includes the following steps. The plan first attempts to informally resolve the claim through a member services department, which must receive the complaint within ninety days of the denial giving rise to the grievance.²⁰⁷ After review by this department, the plan allows the member to request a written appeal to a higher review board.²⁰⁸ During this review, the second tier appellate council may call for an adjudicatory-type hearing, but is not required to do so in all cases.²⁰⁹ Either way, the plan requires the council to reach their decision within sixty days of a formal written request for review.²¹⁰

Following a denial at this level, the plan might allow the member to appeal to the plan’s board of directors, which will either review the denial or pass the claim on to a designated grievance committee.²¹¹ The board of directors represents the final stage of appeal within the organization and will ultimately deliver the organization’s final opinion.²¹² Many plans require the appealing member to exhaust internal grievance procedures before pursuing outside legal action.²¹³

Both Medicare and private health insurance claims involve numerous stages of bureaucracy, all meant to keep the claimant from reaching a federal or state court, which tends to be a costly and time-consuming process. To prevent this “disastrous” occurrence, both Medicare and health insurance companies have established multiple

204. Fondacaro, *supra* note 183, at 343 (quoting Andreas G. Schneider & Joanne B. Stern, *Health Maintenance Organizations and the Poor: Problems and Prospects*, 70 Nw. U. L. REV. 90, 97-98 (1975) (footnotes omitted)).

205. 42 U.S.C. §§ 300e to 300e-17 (1988 & Supp. V 1994).

206. *Id.* The statute forces the plan to assure its members that complaints will be transferred to the appropriate HMO decisionmaking levels with the authority to take corrective action. Any action taken must be prompt and include a full investigation if necessary and notification to all concerned parties regarding the investigation’s results. See 42 U.S.C. § 300e(c)(5) (1988).

207. See Fondacaro, *supra* note 183, at 346.

208. See *id.* Normally, this group will be designated with an appropriate title, like the Member Satisfaction Committee. See *id.*

209. See *id.*

210. See *id.*

211. See *id.*

212. See *id.*

213. See *id.*

levels of review, purportedly meant to ensure that the claimant receives as much review as needed to settle upon a just resolution.²¹⁴ However, these same levels of review also foster two significant problems. First, the claimant will often muddle around for long periods of time, fighting the claim before an often unsympathetic audience. Second, bias may exist, as the same company who denied the claim in the first place often employs the reviewing individuals. These questions deserve consideration in creating a better system of Medicare review.

VI. Jurisprudence in the Appeals Process: The Courts' Reactions to Medicare Versus Private Health Care Insurance

The stories of William Black and his son Michael leave out an important ingredient. The structure of the court system and the standard of review applied by the judiciary play a key role in the adjudication of a claim brought against an insurance company or Medicare. Seeking alternative ways to improve Medicare through a study of private health care insurance requires an examination of the jurisprudence in both areas, particularly the courts' deference (or lack thereof) to the administrative agencies or insurance companies. As mentioned previously,²¹⁵ some differences naturally occur due to the change in venue between Medicare litigation, occurring in federal courts, and private insurance cases, taking place in state courts.

A. The Federal Courts and Medicare

Courts tend to give federal agencies the benefit of the doubt regarding the majority of their decisions, especially following the Supreme Court decision in *Chevron U.S.A., Inc. v. Natural Resources Defense Council*.²¹⁶ In this landmark administrative law decision, the Supreme Court instructed lower federal courts to defer to an agency's interpretation of a statute if it appears reasonable or involves a permissible construction of the statute.²¹⁷

214. *See id.*

215. *See supra* Parts IV, V.

216. 467 U.S. 837 (1984).

217. *See id.* at 843.

A series of Supreme Court decisions helped to establish the jurisdiction of federal courts with regard to Medicare decisions. In 1975, the Supreme Court considered *Weinberger v. Salfi*,²¹⁸ ruling that federal courts lacked jurisdiction to hear constitutional claims against the Social Security Administration, unless the claimant had proceeded through all available administrative remedies.²¹⁹ In allowing for judicial review of administrative decisions, Congress has required that all claimants exhaust administrative remedies prior to seeking relief before a federal court.²²⁰ Following the *Bowen v. Michigan Academy of Family Physicians*²²¹ decision, Congress decided to expressly provide judicial review of Part B claims, constructing a system comparable to that of Part A claims.²²²

The Supreme Court, in deciding *Mathews v. Eldridge*,²²³ established a series of factors that needed to be evaluated in determining whether a procedural review process by an administrative agency passed constitutional muster.²²⁴ Promoting a kind of balancing test, the Court set out a series of three elements to determine whether a system satisfied the requirements of due process.²²⁵ First, the Court considered the effect of the appeals system on the private interest.²²⁶ Second, the Court looked at whether a risk of erroneous deprivation existed through the procedures used and the usefulness of any additional or alternative safeguards.²²⁷ Finally, the Court analyzed the government's interest in maintaining the current system, including the fiscal and administrative costs of any new or additional procedural requirements.²²⁸ All of these factors need to be weighed against one another, in effect meaning that an HHS policy decision could outweigh an adverse effect on an individual.²²⁹

218. 422 U.S. 749 (1975).

219. *See id.*

220. *See Kinney, supra* note 96, at 94.

221. 476 U.S. 667, 674 (1986) (ruling that section 205(h) of the Social Security Act failed to prevent claimants from challenging Medicare policies determining the payment of Medicare claims).

222. *See* 42 U.S.C. § 1395ff (1994).

223. 424 U.S. 319 (1976). In this case, the Court analyzed the termination of disability benefits under the Social Security Act.

224. *See id.* at 341–49.

225. *See id.* at 335.

226. *See id.*

227. *See id.*

228. *See id.*

229. *See id.* at 348–49.

Overall, the federal courts tend to pay great deference to the decisions reached by HHS in their Medicare determinations, especially when dealing with national coverage issues. Several U.S. circuit court cases, particularly *Friedrich v. Secretary of Health & Human Services*²³⁰ and *Wilkins v. Sullivan*,²³¹ demonstrate the federal courts' willingness to allow HHS to determine its own national policy of uniformity in the administration of Medicare.

B. State Review of Private Health Insurance

Insureds, contesting decisions made by private health insurance companies to deny payment of health insurance claims, bring their suits through state causes of action. Specifically, most cases involve contract, tort, or other claims of state law in state courts.²³² While many of these claims may appear to be uniform among the states, some states, through the use of constitutional provisions, statutes, and common law, foreclose some claims.²³³ In fact, the federal government gives state courts the power to hear many federal claims, even to the point of requiring state courts to hear some claims in particular instances.²³⁴

1. THE RULE OF CONTRA PROFERENTEM AND INSURANCE CONTRACTS

Claims brought in state courts revolve around several key issues, specifically "coverage of services, liability for provided services that are not covered benefits, co-insurance issues, and payment issues."²³⁵ As one commentator aptly described them, insurance contracts tend to exhibit "[an] inefficient use of individual resources in addition to promoting wasteful technologies,"²³⁶ due to their use of broad language and, therefore, overbroad coverage.²³⁷ Inconsistencies in con-

230. 894 F.2d 829, 837 (6th Cir. 1990) (finding in favor of HHS and determining that deference should be paid to their need to establish uniformity and equality in the administration of Medicare).

231. 889 F.2d 135, 139 (7th Cir. 1989) (courts should tend to defer to the Secretary's decisions in interpreting and applying the SSA).

232. See Kinney, *supra* note 96, at 105.

233. See *id.*

234. See *id.*

235. *Id.* at 125.

236. Paul E. Kalb, Note, *Controlling Health Care Costs by Controlling Technology: A Private Contractual Approach*, 99 YALE L.J. 1109, 1116 (1990).

237. See *id.*

tract interpretation develop for a variety of reasons, primarily due to the many common law rules of interpretation.²³⁸ For example, contracts should be construed against the person who writes them, as that party is in a better position to write the terms in his own favor.²³⁹ Applying this standard, courts interpreting insurance contracts are willing to rule on the side of claimants when faced with difficult cases, especially when dealing with “borderline” technology.²⁴⁰ Proving that a given treatment has been beneficial might be rather simple under most insurance contracts, because the claimant need only show a small improvement in condition, which often favors the insured because most insurance contracts contain ambiguity.²⁴¹ As a result, application of the aforementioned interpretative rule only helps the insured in his fight for claim compensation.

Courts also apply another rule of contract interpretation in order to favor the insured over the insurance company. Based on the theory of adhesion, courts read insurance contracts as against the insurance company and in favor of the insured.²⁴² Under common contract interpretation, courts presuppose that both parties to the contract hold equal bargaining power.²⁴³ When interpreting insurance contracts, however, courts dispense with this rule, holding that insurance companies have superior bargaining power because the insured often has no choice but to accept the whole policy.²⁴⁴ In other words, “un-negotiated contract terms and unequal bargaining power between parties demand that the law tip interpretation against the more sophisticated insurer, and in favor of the insured.”²⁴⁵ Called the rule of

238. *See id.* at 1117.

239. *See id.*

240. *See id.*; *see also* *McLaughlin v. Connecticut Gen. Life Ins. Co.*, 565 F. Supp. 434 (N.D. Cal. 1983) (ruling that a lack of FDA approval for treatment was not sufficient to find treatment beyond the terms of the insurance contract); James S. Cline & Keith A. Rosten, *The Effect of Policy Language on the Containment of Health Care Cost*, 21 *TORT & INS. L.J.* 120 (1985) (describing how broad policy language frustrates insurers' cost-containment efforts).

241. *See* *Kalb*, *supra* note 236, at 1117 n.40. An experimental surgery or treatment might result in favorable results, even when medical experts would deem the treatment a failure. “Because of coincidence or the placebo effect, for example, a patient might improve after administration of an unsafe or ineffective technology.” *Id.*

242. *See* Peter Nash Swisher, *Symposium Introduction*, 5 *CONN. INS. L.J.* 1, 4 (1998).

243. *See id.*

244. *See id.*

245. Mark Traynor, *Kunin v. Benefit Trust Life Insurance Co.: Protecting Employees Under ERISA by Construing Ambiguous Plan Terms Against the Insurer*, 77

contra proferentem,²⁴⁶ both federal and state courts utilize this rule to interpret insurance contracts due to their adhesive nature,²⁴⁷ especially where the insured contracts directly with the insurer.²⁴⁸ Additionally, courts apply contra proferentem to insurance contracts based on the difficulty in reading them, the lack of sophistication of the reader, and the simple fact that most insurance contracts are never read by the insured.²⁴⁹

2. EXPLORING REASONABLE EXPECTATIONS

Expounded by Judge Robert E. Keeton, the “reasonable expectations” doctrine represents a more recent development in insurance contract jurisprudence.²⁵⁰ Judge Keeton promulgates a reading of insurance contracts in favor of the insured, based on their lack of sophistication and unequal bargaining position.²⁵¹ Often described as a functionalist reading of contracts,²⁵² those employing the Keeton philosophy apply two primary tenets.²⁵³ First, these scholars and judges feel that insurance companies should not gain an “unconscionable advantage” in the interpretation of the contract.²⁵⁴ Second, courts must apply the reasonable expectations of the insureds and their intended beneficiaries when they interpret the contract.²⁵⁵ Although this theory has yet to gain nationwide acceptance, some courts have adopted this

MINN. L. REV. 1219, 1222 (1993).

246. See BLACK’S LAW DICTIONARY 327 (6th ed. 1990) (“Used in connection with the construction of written documents to the effect that an ambiguous provision is construed most strongly against the person who selected the language.”).

247. Because most insurance contracts include standard forms that force the insured to accept terms without negotiation, scholars continue to consider insurance contracts as adhesion contracts. See ALLAN D. WINDT, INSURANCE CLAIMS AND DISPUTES § 6.02 (1988).

248. See Traynor, *supra* note 245, at 1222–24.

249. See *id.*

250. See Swisher, *supra* note 242, at 4–5.

251. See generally Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions*, 83 HARV. L. REV. 961 (1970); Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions: Part Two*, 83 HARV. L. REV. 1281 (1970).

252. See Swisher, *supra* note 242, at 6.

253. See Keeton, *supra* note 251, at 964–65. Legal functionalism is the idea that “a logical and socially neutral legal framework is rarely attainable and may be undesirable in a changing society, and the paramount concern of the law should not be logical consistency, but socially desirable consequences.” Swisher, *supra* note 242, at 5.

254. Keeton, *supra* note 251, at 965.

255. See *id.* at 967.

doctrine, often making decisions in direct opposition to the more traditional approach to contract interpretation.²⁵⁶

3. LEGAL FORMALISM AS A RESPONSE TO REASONABLE EXPECTATIONS

Courts apply legal formalism as a contrast to the idea of the reasonable expectations doctrine in contract interpretation.²⁵⁷ Legal formalism, according to the standard rules of contract law, advocates that courts must avoid the temptation to reinterpret or modify the straightforward meaning of the plainly written and often unambiguous language of insurance policies.²⁵⁸ Formalism suggests that the interpretation of contracts should be viewed as judicial jurisprudence coupled with legislative precedent, forming a separate system of logical and neutral rules and laws.²⁵⁹ In the late 1980s and early 1990s, those courts influenced by the Supreme Court moved back towards formalism,²⁶⁰ especially in the interpretation of insurance contracts.²⁶¹

Formalism is applied in order to increase the uniformity and predictability in insurance contract suits, allowing those seeking relief to have a better idea of how the court will make its final decision.²⁶² In other words, those who advocate a formalist approach would prefer that court decisions not be influenced by the unwritten needs of the insured. On the surface, this view appears to favor the larger, more financially stable insurance companies. Formalist critics of functionalism (reasonable expectations) argue that the problem with the reasonable expectations doctrine is that it provides no specific factors to

256. See Swisher, *supra* note 242, at 6. Some states which have approved the use of this doctrine include Alabama, Alaska, Arizona, California, Iowa, Montana, Nebraska, Nevada, New Hampshire, and New Jersey. Colorado, Delaware, Hawaii, North Carolina, Pennsylvania, and Rhode Island apply a hybrid of the "reasonable expectation" doctrine. See Roger Henderson, *The Doctrine of Reasonable Expectations in Insurance Law After Two Decades*, 51 OHIO ST. L.J. 823, 829-34 (1990).

257. See Swisher, *supra* note 242, at 5.

258. See *id.* The author identifies the foremost scholar in terms of insurance contract formalism as Professor Samuel Williston. See *id.*

259. See Swisher, *supra* note 242, at 5.

260. See, e.g., *Schultz v. Hartford Fire Ins. Co.*, 569 A.2d 1131, 1134 (Conn. 1990) (construing a contract based on the simple language and standard interpretative devices in contract law); *American Family Mut. Ins. Co. v. National Ins. Ass'n*, 577 N.E.2d 969, 971 (Ind. Ct. App. 1991); *Hybrid Equip. Corp. v. Sphere Drake Ins. Co.*, 597 N.E.2d 1096, 1102 (Ohio 1992).

261. See Peter Nash Swisher, *Judicial Rationales in Insurance Law: Dusting Off the Formal for the Function*, 52 OHIO ST. L.J. 1037, 1047 (1991).

262. See Swisher, *supra* note 242, at 4.

use in determining when coverage should be deemed “reasonable.”²⁶³ Some courts agree with this critique and reject functionalist arguments.²⁶⁴

In the wake of such criticism, some courts combine elements of functionalism with other contract doctrines, including the ambiguity doctrine, promissory and equitable estoppel, and unconscionability, to find in favor of the insurance company.²⁶⁵ Commentators also favor this “middle ground,” finding it to be a viable way to find in favor of the insured without completely rejecting the language of insurance contracts.²⁶⁶

VII. Recommendations to Streamline the Process: Applying Medical Insurance Procedures and Contract Interpretation to the Medicare Appeals Process

An attempt to synthesize the appeals process and jurisprudence of Medicare and private health insurance would fail, largely due to the complexity of each system and the inability of significant segments of each to coexist. Perhaps Congress, however, in its continuing drive to reform Medicare, might draw from some actions of the states and the courts to improve the appeals system under Medicare.

A. Evaluating the Appeals Process

1. THE COMPONENTS OF A SUCCESSFUL APPEALS SYSTEM

In providing a more efficient system, Congress must find a way to promote an administrative system that provides accuracy of judgment in a cost-effective and timely manner.²⁶⁷ Judging success, how-

263. See generally Kenneth S. Abraham, *Judge-Made Law and Judge-Made Insurance: Honoring the Reasonable Expectations of the Insured*, 67 VA. L. REV. 1151 (1981); Mark C. Rahdert, *Reasonable Expectations Reconsidered*, 18 CONN. L. REV. 323 (1986); Stephen Ware, *A Critique of the Reasonable Expectations Doctrine*, 56 U. CHI. L. REV. 1461 (1989).

264. Idaho, Illinois, Massachusetts, North Dakota, Ohio, Oklahoma, South Carolina, Washington, and Wyoming all explicitly reject the reasonable expectations doctrine in the interpretation of insurance contracts. See Henderson, *supra* note 256, at 834 n.68.

265. See Jeffrey W. Stempel, *Reassessing the “Sophisticated” Policyholder Defense in Insurance Coverage Litigation*, 42 DRAKE L. REV. 807, 827–29 (1993).

266. See Peter Nash Swisher, *Judicial Interpretations of Insurance Contract Disputes: Toward a Realistic Middle Ground Approach*, 57 OHIO ST. L.J. 543 (1996).

267. See JERRY L. MASHAW, *BUREAUCRATIC JUSTICE: MANAGING SOCIAL*

ever, requires a thorough analysis, focusing on three different elements.

a. Consistency First, consistency remains important and requires an analogy to demonstrate its significance. In the restaurant industry, every restaurant seeks to provide consistent service, always meeting the desires of its customer in the same way on every occasion. Even if the restaurant sometimes provides poor service or food quality, so long as it always provides consistent service or taste, it can survive. At first glance, this appears strange, but one must evaluate the needs of the customer.

If the customer receives inconsistent service or food quality, his expectations constantly change and will never be met. Consumer X enters the restaurant, never knowing if the food will be good or if the service will be bad, or vice versa. Because cost often plays an important part in the consumer's decision, if she knows the service or the food will always meet a certain level, she will be willing to pay a certain price for that degree of quality.²⁶⁸ Therefore, if the restaurant always delivers the same product at the same price, the consumer will be more likely to continue his patronage, even if the final product is something less than the work of Wolfgang Puck or Emeril Lagasse.²⁶⁹

Similarly, if the Medicare user knows that the system will respond in a certain manner consistently, she will be more willing to file a claim and see the result. However, if the claimant knows that sometimes Medicare and HHS will respond in one manner and sometimes in another, then she will be less likely to utilize the system.

Therefore, HHS needs to establish a Medicare Appellate System that yields consistent results, even if they are generally one-sided (either in favor of the claimant or HHS). If the patient knows that her claim will always be denied, she can attempt to create alternative courses of action to avoid the predictably unnecessary review process. For example, she might seek alternative insurance or utilize preven-

SECURITY DISABILITY CLAIMS 79-85 (1983).

268. Thus, the popularity of sayings like "you get what you pay for."

269. The law of economics demonstrates that an individual will pay a certain price for something's perceived quality, but expects to receive equal quality for equal payment. Therefore, although one product might be better than another, so long as the person receives appropriate value for a given price, the rational consumer will be satisfied. *See generally* ROBERT COOTER & THOMAS ULEN, *LAW & ECONOMICS* 17-34 (3d ed. 1999).

tive medicine to avoid noncompensable procedures. Obviously, producing accurate and fair results is also very important, because a consistently poor system is still a failure.

b. Accuracy and Justice Producing accurate and equitable decisions form a second aspect of a successful appeals system.²⁷⁰ Therefore, HHS needs to promote a system that provides relief for those with valid claims. Because no system is ever foolproof, the system needs to be able to quickly identify and rectify improperly denied claims. If the claimant knows that the claim evaluators produce impartial and objective decisions, there will be a greater willingness to accept an adverse determination as a just result.

c. Fair Opportunity Finally, every claimant desires the ability to voice concerns and to express feelings about the previous claim denial and why that claim decision was wrong.²⁷¹ In other words, the average person, even if a claim is denied, will feel better about the process if the system in place gave her a fair opportunity to be heard and present her case.

2. EVALUATING THE MEDICARE APPELLATE PROCESS

Utilizing the Medicare example, the ultimate decision in William Black's case was not as important as the steps that he followed. The length and difficulty of the process cause some to describe it as a "pentathlon"²⁷² and others to openly question whether such claims are worth pursuing from an economic standpoint.²⁷³ Before William Black reached judicial review, he experienced five time-consuming steps, including two steps by in-house carrier officials,²⁷⁴ two steps before an ALJ, and a final step of judicial review. In fact, depending upon the financial wherewithal of the claimant, the federal court system makes

270. See Jerry L. Mashaw, *The Management Side of Due Process: Some Theoretical and Litigation Notes on the Assurance of Accuracy, Fairness, and Timeliness in the Adjudication of Social Welfare Claims*, 59 CORNELL L. REV. 772, 775 (1974).

271. See Rand E. Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach*, 88 YALE L.J. 243, 264 (1978).

272. Blanchard, *supra* note 26, at 970.

273. See Barrett, *supra* note 157, at 1395-96.

274. Some might argue that under the MEDICARE CARRIERS MANUAL, Pt. 3, § 12021, the claimant actually undergoes three stages of review by a carrier, including the "on the record" prereview meeting with the fair hearing officer.

more steps available if the claimant is unsuccessful. For example, a claimant seeking review under Medicare might have his claim heard before a federal district court, be granted review before a federal court of appeals, and finally even reach the Supreme Court with a grant of certiorari.

Determining whether there is a need for this process remains a difficult task. If we consider the average claimant, who probably lacks the financial strength of William Black, undergoing this entire process appears quite daunting. Further, William Black was able to pay for the necessary medical treatment. In some cases, however, elderly individuals may experience a dangerous health condition and not be able to cover the costs of medically necessary treatment.

In the 1997 Balanced Budget Act,²⁷⁵ Congress attempted to rectify this problem by adding an expedited appeals process,²⁷⁶ which limits the number of steps required before the claimant reaches federal court review as well as limiting the number of days within which the carrier can review the case.²⁷⁷ Medicare grants the expedited appeals process to those claimants who could have their lives, health, or ability to maintain "maximum functioning" seriously threatened by a given condition.²⁷⁸ While this process was added to meet perceived problems with Medicare HMOs,²⁷⁹ it is not difficult to imagine this process being applied to general Medicare claims. Imagine if a patient has his first medical care under Medicare Part B and later is admitted into a hospital due to a life-threatening condition under Part A. Would this expedited appeals process apply to him if his first claim under Part B were denied?

3. ADDING ARBITRATION: COMPARING HEALTH INSURANCE MECHANISMS TO MEDICARE APPEALS

Comparing the Medicare process to the private health insurance appeals process, one notices specific trends between the two different fields. First, grievance procedures under both systems tend to be somewhat long and arduous, with most HMO plans calling for multiple in-house review steps and fee-for-service plans requiring at least

275. Pub. L. No. 105-33, 111 Stat. 251 (1997).

276. See 42 C.F.R. §§ 417.600-.694, 473.10-.48 (1997).

277. See *id.* §§ 417.620, 473.20.

278. See *id.* § 417.617(b).

279. See Visocan, *supra* note 41, at 38-45.

two levels of review before court action becomes a possibility.²⁸⁰ Second, much like the internal steps under Medicare, the internal review under private health insurance allows considerable deference to the insurance companies themselves, who often lack the need or the desire to be impartial.²⁸¹ In fact, it can be argued that more pressure is on the health insurance company to cut costs than Medicare, because the possibility of a company going out of business due to rising costs remains far greater than Medicare and the federal government becoming insolvent.²⁸²

All of this leads the observer to wonder if any system of grievances can ever satisfy the average claimant while still balancing the needs of the federal government. Obviously, court costs provide a substantial reason for HHS to limit court proceedings, resulting in numerous levels of review within the organization to cut costs. For the same reasons, health insurance providers establish a series of procedures to give the claimant the “perception of review” while keeping their actual costs to a minimum.

The review process under Medicare and HMOs differs from the review process under fee-for-service private health insurance in the number of cases actually brought to trial. While Medicare or an HMO might see several court cases during the average year, the average fee-for-service insurance company faces a negligible amount of actual court cases.²⁸³ As mentioned previously, this is probably due to arbitration requirements, as well as the nature of damages under most fee-for-service health insurance claims.²⁸⁴

Formal arbitration involves the use of third-party professional arbitrators to hear both sides of a case and ultimately reach a conclusion.²⁸⁵ At its best, arbitration serves as “a substitution, by consent of the parties, of another tribunal for the tribunal provided by the ordi-

280. See *supra* Part IV.A.

281. See Fondacaro, *supra* note 183, at 347.

282. Some might disagree on this point, based on the ever rising federal deficit and the growing number of elderly persons making demands on the Medicare system.

283. See generally *supra* Part IV (discussion of Medicare claims) and Part V (discussion of private health insurance claims).

284. See *supra* notes 185–88 and accompanying text.

285. This generally refers to out-of-court hearings in which one or more independent persons, the arbitrator(s), decide who wins and what is won, and that result is, as a practical matter, final. See generally MELLINKOFF'S DICTIONARY OF AMERICAN LEGAL USAGE 33 (1992).

nary process of law”²⁸⁶ that will result in a “final disposition, in a speedy, inexpensive, expeditious and perhaps less formal manner, of the controversial differences between the parties.”²⁸⁷ Arbitration normally proves to be faster than adjudication.²⁸⁸ Payment comes not from one particular side or the other, but is a result of a decision that is rendered, regardless of who “wins” the case.²⁸⁹

Arbitration offers other advantages besides a quick solution. Generally, arbitration offers fewer levels of review, as the decision of the arbitrator can be final and binding upon both parties if agreed upon prior to the beginning of the procedure.²⁹⁰ Attorneys will normally be given less time to prepare their case, and will not need to file the various briefs and motions required in a court case.²⁹¹ Taken together, the finality of decisions and less procedural steps results in both decreased court costs and attorney fees.

In fact, Congress attempted to include provisions for the use of alternative dispute resolution (ADR) when it passed the Administrative Dispute Resolution Act.²⁹² Under the Act, Congress tried to influence various administrative agencies to voluntarily use various ADR techniques.²⁹³ The process might result in more creative solutions to disputes based on the emphasis away from formal, court-ordered resolutions and towards more balanced outcomes.²⁹⁴ In arbitration, with a deemphasis on the role of attorney, the average claimant probably feels that the judgment involves a heightened level of im-

286. Michael Hunter Schwartz, *From Star to Supernova to Dark, Cold Neutron Star: The Early Life, the Explosion and the Collapse of Arbitration*, 22 W. ST. U. L. REV. 1, 10–11 (1994) (quoting *Barcon Assoc. v. Tri-County Asphalt*, 430 A.2d 214 (N.J. 1981)).

287. *Id.*

288. See Schwartz, *supra* note 286, at 12. See also generally Judge Robert M. Parker & Leslie J. Hagin, “ADR” *Techniques in the Reformation Model of Civil Dispute Resolution*, 46 SMU L. REV. 1905, 1908 (1993). This greater speed is attributed to “the availability of more arbitrators than judges, the lack of discovery, and the informality of arbitration.” *Id.*

289. See Schwartz, *supra* note 286, at 12.

290. See Cynthia B. Dauber, *The Ties That Do Not Bind: Nonbinding Arbitration in Federal Administrative Agencies*, 9 ADMIN. L.J. AM. U. 165, 182 n.95 (1995).

291. See *id.* at 179 n.73 (citing CRAIG A. PETERSON & CLAIRE MCCARTHY, *ARBITRATION STRATEGY AND TECHNIQUE* 129 (1986)).

292. Pub. L. No. 101-552, 104 Stat. 2736 (codified as amended at 5 U.S.C. §§ 571–583 (1990)). See generally ADMINISTRATIVE CONFERENCE OF THE U.S., *FEDERAL ADMINISTRATIVE PROCEDURE SOURCEBOOK* § 3 (2d ed. 1992) (discussing the general terms of the Act and how it would be applied).

293. See Dauber, *supra* note 290, at 167.

294. See Jane Byeffer Korn, *Changing Our Perspective on Arbitration: A Traditional and a Feminist View*, 1991 U. ILL. L. REV. 67, 71 (1991).

partiality, because the arbitrator has no vested interest in either side winning and the parties themselves are more involved in the decision.²⁹⁵ Persons chosen as arbitrators normally include practicing or semi-retired attorneys or retired judges.²⁹⁶ The same people may also have more expertise in the specific area of concern, developed through prior legal practice and experience in similar arbitration procedures.²⁹⁷ The arbitrator's continued presence in the community as a certified arbitrator compels impartiality. In other words, to find continued employment, it is in the arbitrator's best interests to remain impartial and objective.²⁹⁸

Internal review under Medicare lacks the perceived sense of objectivity because the average claim reviewer has a vested interest in the outcome. Even ALJs may come under suspicion since their role involves work not as a judge in an adversarial hearing but as a non-partisan examiner.²⁹⁹ Further, the ALJ has full responsibility for developing the record, a responsibility of counsel in a conventional adjudicative proceeding.³⁰⁰

From the analysis of reviews under Medicare and private health insurance, it is apparent that both suffer many of the same disadvantages. For example, both continue to struggle in resolving claims in an expedient manner and both suffer from a perceived lack of fairness in review decisions.³⁰¹ However, the small portion of the health insur-

295. *See id.*

296. *See* JEROLD S. AUERBACH, JUSTICE WITHOUT LAW? 110–11 (1983).

297. *See* Korn, *supra* note 294, at 71.

298. Although formal arbitration might cost more as a single step, its ability to replace multiple steps in the reviewing process could eventually lead to cost savings. A final concern might be that the arbitrators, after establishing a position in the community as “Medicare arbitrators,” might develop the same type of relationships as ALJs. However, because their compensation comes from both sides of the dispute, developing a bias on behalf of Medicare seems less likely.

299. *See* Eleanor D. Kinney, *The Medicare Appeals System for Coverage and Payment Disputes: Achieving Fairness in a Time of Constraint*, 1 ADMIN. L.J. 1, 42 (1987). Many analysts question the independence of ALJs within the administrative agencies and the existence of significant safeguards to promote their independence in decision making. *See generally* R. Terrence Harders, *Striking a Balance: Administrative Law Judge Independence and Accountability*, 19 J. NAALJ 1 (1999); Victor G. Rosenblum, *Toward Heightening Impartiality in Social Security Agency Proceedings Involving Administrative Law Judges*, 18 J. NAALJ 58 (1998). Also, the administrative agency and the claimant will normally have very different goals: “The plaintiffs seek large jury awards, and the administrative agencies wait for the litigant to exhaust his resources.” Dauber, *supra* note 290, at 177 n.64.

300. *See* Eleanor D. Kinney, *The Medicare Appeals System for Coverage and Payment Disputes: Achieving Fairness in a Time of Constraint*, 1 ADMIN. L.J. 1, 42 (1987).

301. *See supra* notes 216–49 and accompanying text.

ance industry that remains fee-for-service holds some hope for both Medicare and HMOs. Although both the ALJ and the internal review procedures under Medicare carry a suspicion of double-dealing, the average person perceives the formal arbitrator as an outsider. This “outsider” tag carries with it a perception of objectivity and fairness, something that is needed in the Medicare system. Medicare needs to consider the example of fee-for-service health insurance and include outside arbitration in its steps for review. Instead of moving from internal review to an ALJ, Medicare should consider outside arbitrators who lack the perceived taint of partisanship. Otherwise, not only will Medicare continue to be bogged down with an incredibly detailed system of review, but it will also continue to suffer from a perception of bias.

B. Medicare Interpreted via Health Insurance Contracts

1. SUPREME COURT REVIEW REGARDING ADMINISTRATIVE DECISIONS

In its decision in *Chevron U.S.A., Inc. v. Natural Resources Defense Council*,³⁰² the Supreme Court outlined a two-step approach for evaluating decisions of law made by administrative agencies, especially when encountering unclear statutory language.³⁰³ The court must consider whether ambiguity exists in the text of the statute, and then decide whether the agency’s construction or interpretation of the statute is permissible.³⁰⁴ In other words, “the farther removed one becomes from the text of a statute in determining the legality of agency action, the more likely a court will defer to an agency’s interpretation.”³⁰⁵ Adding to the desire for fairness in review, the Supreme Court broadened this rule in 1987, deciding that the Court only defers to agency interpretation if other tools of statutory construction fail to provide an adequate answer.³⁰⁶ Taken together, these cases delineate a need for legislatures to clearly establish their objectives and desires within statutory language,³⁰⁷ or else find their statutes subject to the whims of administrative agencies.

302. 467 U.S. 837 (1984).

303. *See id.* at 843.

304. *See id.*

305. ALFRED C. AMAN, JR. & WILLIAM T. MAYTON, *ADMINISTRATIVE LAW IN A GLOBAL ERA* § 13.7.2 (1993).

306. *See INS v. Cardoza-Fonseca*, 480 U.S. 421, 446–48 (1987).

307. *See Rosenblatt, supra* note 271, at 336 n.421.

2. INTERPRETING MEDICARE: ADDING A REASONABLE EXPECTATION

Drawing from state decisions concerning health insurance contracts, the inclusion of reasonable expectations provides a means to give the Medicare user some say in Medicare decision making. State courts use reasonable expectations to meet the needs of the insured by adjusting the policy provisions to meet the reasonable expectations of the insurance purchaser.³⁰⁸ In effect, the doctrine of reasonable expectations is an aid to a court attempting to interpret often difficult and complex insurance policies in a way that ultimately benefits an insured over the insurance company.³⁰⁹

In his discussion of reasonable expectations, Professor Mark Rahdert discusses four specific ways courts use reasonable expectations as an interpretive device.³¹⁰ Two of these views, ambiguity and unconscionability,³¹¹ better lend themselves to statutory interpretation and deference to the needs of the claimant under Medicare Part B.

a. Ascertaining the Meaning of Policy Language In interpreting statutes, federal courts rely first on the statutory language of the Social Security Act, and second, on HHS policy regarding the statute when the language is ambiguous or missing.³¹² As a result of the reasonable expectations doctrine, the court would be forced to view an ambiguous term in favor of the claimant, applying the maxim *contra proferentem* to prioritize the needs of the patient-claimant over the desire for cost containment.³¹³ In the case of the insurance contract, the insurer normally drafts policy language,³¹⁴ and therefore the assumption of the risk must be borne by the insurer.³¹⁵ In effect, the insurer has a legal duty to communicate its policy in a manner that leads to understanding and not confusion.³¹⁶

Both Congress and HHS remain in a better position to craft the terms of Medicare in their favor and meet societal needs as they seem

308. See Mark C. Rahdert, *Reasonable Expectations Revisited*, 5 CONN. INS. L.J. 107, 108 (1998).

309. See *id.*

310. See *id.* at 111.

311. See *id.* at 115, 126.

312. See *supra* notes 258–64 and accompanying text.

313. See Rahdert, *supra* note 308, at 115.

314. See *id.* at 116.

315. See *id.*

316. See *id.*

fit. As a result, Congress, together with HHS, enjoys a super-bargaining position and therefore should be held to a legal duty to provide a comprehensive and simple health plan and process.³¹⁷ By reading complex and unclear provisions against the federal government, the courts would advance the reasonable expectations rationale, and also the use of plain language in Medicare statutory construction. As Rahdert describes the need for clarity, Medicare can “[c]over what [it] wants[s]. Exclude what [it] want[s]. But make sure [Congress and the HHS] [does] it clearly. Sloppy drafting could cost [Congress and the HHS] something.”³¹⁸

As mentioned earlier, providing for consistency should be one of the main goals of an appeals system,³¹⁹ and it should also be a goal of statutory interpretation. Congress, in drafting the statutes, often writes with broad, uncertain language that leads to ambiguity in its interpretation and therefore affects the well-being of the average citizen.³²⁰ Such ambiguous language, affecting the decisions of doctors in treating patients, should not result in injury to the patient. This language should be read against the government. Furthermore, although the average citizen enjoys the power of the “vote,” in reality, they lack the capacity to influence the specific language that ultimately shapes the interpretation of statutes.³²¹ These same people affected by the statutory language probably lack sufficient understanding of relevant statutes to help their physician make a decision or to insist on a less ambiguous construction.

As a result, the average Medicare user remains in a position where she is forced to rely on Medicare services to meet medical needs, but lacks the ability to shape the structure of the system. Instead, the user must rely on a physician’s interpretation of the statute to decide whether treatment needs can be met under Medicare’s provisions. With all of these factors weighing against the Medicare patient, the patient bears the risk of ambiguous language, which can neither be influenced nor predicted. The doctrine of reasonable ex-

317. *See id.*

318. *Id.*

319. *See supra* Part VI.A.1.a.

320. *See generally* Deanell Reece Tacha, *Judges on Judging: Judges and Legislators: Renewing the Relationship*, 52 OHIO ST. L.J. 279, 294 (1991).

321. *See generally* William N. Eskeridge, *Overriding Supreme Court Statutory Interpretation Decisions*, 101 YALE L.J. 331, 354–58 (1991).

pectations would force Congress and HHS to eliminate ambiguities or suffer the consequences of rising and unpredictable health care costs.

The elimination of ambiguous language will also help promote consistency within the Medicare structure, which is another goal of statutory interpretation.

b. Unconscionability in Statutory Interpretation While federal courts probably consider the idea of fairness within their evaluations of Medicare decisions, ultimately the federal courts must balance one or two specific instances of unfairness against the overriding costs to the Medicare system as a whole. In insurance contracts, courts also must balance the need to follow the terms of a contract against the need to prevent a blatantly unjust result.³²² To prevent these unjust results, state courts apply the theory of unconscionability to circumvent clear policy language.³²³

To support a holding of unconscionability, some state courts define health insurance contracts as adhesive.³²⁴ Adhesive contracts often include terms prescribed by the party who holds stronger bargaining power. This superior party demands “adhesion” to the terms of the contract or else the offer will be withdrawn.³²⁵ Under insurance contracts, the insurer holds even greater superiority than the average party to a contract because: (1) many of the contract terms are standardized by the entire industry, (2) the company has vast superior knowledge and resources compared to the insured, (3) the insured’s lack of understanding of the contract, and (4) high levels of consumer reliance on insurance due to the increased costs of medical service.³²⁶

As mentioned previously, the federal government and the physicians it employs hold many of these same advantages. First, HHS standardizes the terms of Medicare, preventing the Medicare user from shopping around or finding a better deal. Although some individual choice may exist, much of this choice is foreclosed by congressional decisions. Second, most Medicare users lack specific knowledge of how Medicare works or the basics of how claims are met.³²⁷ Third, Medicare users remain in an inferior bargaining position be-

322. See Rahdert, *supra* note 308, at 126.

323. See *id.*

324. See *id.*

325. See *id.* at 127.

326. See *id.*

327. See *id.* at 108.

cause of this lack of knowledge. Besides being unable to influence the mechanics of Medicare, the average Medicare user probably lacks the financial wherewithal to find a better source of medical insurance.³²⁸ Finally, by not standardizing costs or promoting less expensive health care, Congress and HHS indirectly cultivate high levels of Medicare reliance.

These characteristics lead to the conclusion that Congress constructed a Medicare system that is unconscionable. Under contract law, the “courts cannot depend on the usual practices of bargaining to produce a fair outcome, they must themselves police the fairness of the arrangement.”³²⁹ Similarly, the federal courts must be willing to monitor the efforts and decisions of HHS more closely.

In a perfect world, HHS considers the needs of the patient and strives to meet these needs in an efficient and cost-effective manner as prescribed by law. In reality, because the patient lacks an alternative, HHS can make its decisions in whatever manner it chooses and could ultimately decide to promote cost efficiency over the needs of claimants, especially when faced with the dilemma of limited funding or budgetary constraints. Courts must be willing to prevent these systemic decisions from harming Medicare participants who lack any other alternative.

c. The Result of Reasonable Interpretation and Unconscionability The idea of taking devices from contract law and importing them into statutory interpretation is not a new idea. In fact, two prominent scholars, Professor McNollgast³³⁰ and Professor Farber,³³¹ recently wrote articles applying contract law and its interpretation to Medicare jurisprudence.

Some courts may defer to administrative agencies or legislative intent displayed in legislative history. Applying contract theories advocated above involves a certain degree of judicial activism, as well as an eye toward more legislative care. The reasonable expectations doctrine should lead to the use of clear language. As a result, this doctrine might force the hand of Congress or other legislative bodies

328. *See id.*

329. *Id.*

330. *See* Matthew D. McCubbins et al., *Positive Canons: The Role of Legislative Bargains in Statutory Interpretation*, 80 GEO. L.J. 705 (1992).

331. *See* Daniel A. Farber, *Legislative Deals and Statutory Bequests*, 75 MINN. L. REV. 667 (1991).

and mandate well-constructed statutes. If not, litigants may take advantage of ambiguous language without judicial repercussion.

Applying unconscionability, however, will result in courts looking at the possible ramifications of applying a statute's plain language against a beneficiary. In other words, if the interpretation of a passage under Medicare might result in a bad outcome due to lack of care, then a court applying unconscionability might disregard the statutory provision and allow that beneficiary to receive benefits.³³² Unconscionability requires a deeper analysis by a court of not only the language of the statute, but also the conditions under which the statute was written.³³³ Lacking an alternative to the Medicare program, the beneficiary of such a program is obligated to enter into the only available "contract" and accept the consequences. In exchange, the government receives payment in the form of taxes or other earmarked contributions.

Both the doctrines of unconscionability and reasonable expectations require the courts to favor the individual over the government in interpretation. Placing the courts in a difficult position is not the point of this application. Instead, the use of contract law in statutory interpretation is meant to force legislatures to become more aware of what they write and how it might affect the average person who is dependent on the government to meet needs that are unattainable elsewhere. The awareness of the need for clarity and the proposed use of contract law in Medicare interpretation should ultimately lead to less judicial intervention and more consistent interpretation.

VIII. Conclusion

Medicare and the health insurance industry stand at a crossroads, seeking answers to the problems of rising costs and the inability of many Americans to receive proper medical care. Perhaps through congressional streamlining of the Medicare appeals process and the application of the reasonable expectations doctrine, people will encounter a more reasonable and effective Medicare appeals system. In order to effectively meet the needs of the growing number of elderly Americans, Medicare and the HHS must promote consistency, fairness, and accuracy in its decisions.

332. See McCubbins, *supra* note 330, at 711.

333. See *id.*