

RECENT CHANGES IN MEDICARE MANAGED CARE: A STEP BACKWARDS FOR CONSUMERS?

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Medicare, the largest payer of health care costs for individuals over sixty-five, has recently taken steps backward in the consumer protection arena. In this article, Karen Visocan outlines the inherent conflict between Medicare and managed care. Ms. Visocan details the inadequacy of the Medicare appeals process which further exacerbates the managed-care conflict. She then examines how these realities have led participants to challenge Medicare processes and procedures. She points out that although participants have been successful in securing consumer protections in recent court battles, Congress has failed to incorporate similar protections into recent federal legislation governing appeals processes, hearings, and review procedures. Ms. Visocan also outlines a new, recently introduced Medicare program which also fails to incorporate consumer protections. Throughout this article, she emphasizes how the complicated nature of Medicare and the consistent lack of consumer protection imperils our senior citizens. In conclusion, Ms. Visocan calls for the rigorous examination and public debate of both new and existing Medicare programs by senior advocates so that participants will be informed as to the full extent of benefits to which they are entitled.

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Medicare is the largest public payer of health care services and supplies for Americans.¹ Created by Congress in 1965, the program now covers roughly thirty-eight million Americans: thirty-three million age sixty-five and over, and about five million disabled persons under the age of sixty-five.² Considering the population which Medicare serves, a consumer-friendly system should be a goal for the Medicare program. However, recent changes in the Medicare program, including the increased enrollment in Medicare Health Maintenance Organizations (HMOs) and the upcoming Medicare Choice options,³ have made the Medicare program a web of confusing options, provider restrictions, and benefit changes, the extent of which has not been seen by senior citizens in the past. In fact, despite some recent consumer victories in the Medicare arena, consumer protections in the Medicare program have taken a step backwards in the past year.

I. Medicare Background

Medicare is comprised of two "parts" which together provide comprehensive health care coverage. Medicare Part A (Part A) helps cover the costs of hospital, skilled nursing facility, home health, and hospice care.⁴ Part A benefits are provided to all individuals who are eligible and are financed primarily by payroll taxes.⁵ Beneficiaries also pay certain copayments and a deductible, which was \$760 in 1997.⁶ Medicare Part B (Part B) helps to cover the costs of physician and outpatient services.⁷ Part B is financed by monthly premiums from enrollees and also by general revenue from the federal government.⁸ Participants are required to pay a deductible, which was \$100

1. See Health Care Fin. Admin., *Highlights, National Health Expenditures, 1996* (Apr. 14, 1998) <<http://www.hcfa.gov/stats/nhe-oact/hilites.htm>>.

2. See U.S. Dep't of Health & Human Servs., *1996 HCFA Statistics* (last modified Feb. 6, 1998) <<http://www.hcfa.gov/stats/stats.htm>>.

3. See *infra* text accompanying notes 127-45.

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

5. See *id.*

6. See NATIONAL ASS'N OF INS. COMM'RS & HEALTH CARE FIN. ADMIN., 1997 GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE 3 (1997) [hereinafter INSURANCE FOR PEOPLE WITH MEDICARE].

7. See S. REP. NO. 103-403, at 147.

8. See *id.*

in 1997,⁹ and a twenty percent copayment of Medicare allowable charges.¹⁰

II. Medicare HMOs

Managed care has not only exploded in the private employer-sponsored health insurance arena, but also has become a more common way to receive Medicare benefits. In 1996, approximately twelve percent of the Medicare population was enrolled in a Medicare HMO. This percentage is much higher in some states, such as California, Colorado, Arizona, and Arkansas. In some areas, Medicare HMO enrollment exceeds thirty percent.¹¹

There are two types of Medicare HMOs: risk and cost HMOs. A risk HMO is required to provide all of the benefits that traditional Medicare provides.¹² In turn, the HMO receives a fixed payment per enrollee.¹³ If the cost for providing Medicare-covered services to an enrollee exceeds this fixed payment, the HMO absorbs this cost. If the cost is less than the fixed payment, the HMO keeps the difference as profit; hence the "risk."¹⁴ Risk HMOs must also provide additional services to enrollees without additional charge.¹⁵ Such services may include, but are not limited to: preventive care, prescription drugs, dental care, and eyeglasses. Many risk HMOs also have a very small or no deductible for services. In exchange for lower costs and additional covered services, risk enrollees are "locked in" to the program, meaning that they may only receive coverage for services provided by HMO providers.¹⁶

The Health Care Finance Administration (HCFA) adopted the risk HMO option as a method for curtailing escalating Medicare expenditures.¹⁷ In theory, the Medicare program saves money because

9. See INSURANCE FOR PEOPLE WITH MEDICARE, *supra* note 6, at 6.

10. See *id.*

11. See Geraldine Dallek, *Medicare Managed Care: Securing Beneficiary Protections* (visited Apr. 19, 1998) <<http://www.epn.org/families/mmc.html>>.

12. See 42 U.S.C. § 1395mm(a)(2)(A)-(B) (1994); 42 C.F.R. § 477.440 (1997).

13. See Health Care Fin. Admin., *Managed Care in Medicare and Medicaid* (visited Apr. 19, 1998) <<http://www.hhs.gov/news/press/1997pres/9711206.html>> [hereinafter *Managed Care in Medicare and Medicaid*].

14. See *id.*

15. See *id.*

16. See *Managed Care in Medicare and Medicaid*, *supra* note 13. Although enrollees generally are limited to receiving only services provided by the HMO, there are some exceptions for emergency care. See *id.*

17. See 42 U.S.C. § 1395mm(a)(1)(A).

the fixed reimbursement rate per HMO enrollee is set at ninety-five percent of the average cost of care for Medicare beneficiaries.¹⁸

Medicare also offers cost HMOs; however, this option is less popular than the risk HMO option. Cost HMOs are reimbursed on a "reasonable cost" basis, which is often less than the actual cost of services.¹⁹ Under this method, the HMO is paid on an interim basis using a monthly payment per enrollee. At the end of the year, the payments are adjusted to equal the "reasonable cost" of providing services to the enrollees.²⁰

Cost plans do not have provider requirements. Cost plan enrollees may go to plan providers and pay only the applicable copayments, or they may go with nonplan providers, in which case Medicare will pay its share of the approved charge and the beneficiary will most likely pay the remaining amount with the exception of some emergency cases.²¹ Again, the cost HMO was designed to save HCFA and the Medicare program money through utilization restraints and reimbursement rates.

Both private and public managed-care organizations have been criticized for their approach to health care. Managed care generally approaches health care as a business that must control utilization and reduce expenditures.²² There are a variety of techniques that managed-care organizations utilize in order to reduce costs. Unfortunately, these techniques often emphasize cost savings to the detriment of the beneficiaries' welfare.²³

An HMO prospectively reduces costs by designing benefit packages to cover only medically necessary types of care. Medicare HMOs are required to provide all of the benefits that traditional Medicare provides; however, the medically necessary standard is applied to

18. See *id.* § 1395mm(a)(1)(D).

19. See *id.* § 1395mm(h).

20. See *id.* § 1395mm(h)(3).

21. See *Managed Care in Medicare and Medicaid*, *supra* note 13.

22. See Carolyn M. Clancy & Howard Brody, *Managed Care: Jekyll or Hyde?*, 273 JAMA 338, 338-39 (1995).

23. See HUMAN RESOURCES DIV., U.S. GEN. ACCOUNTING OFFICE, PUB. NO. GAO/HRD-94-3, *MANAGED HEALTH CARE: EFFECT ON EMPLOYERS' COSTS DIFFICULT TO MEASURE 8-10* (1993) [hereinafter *MANAGED HEALTH CARE*]; Alan L. Hillman et al., *How Do Financial Incentives Affect Physicians' Clinical Decisions and the Financial Performance of Health Maintenance Organizations?*, 321 NEW ENG. J. MED. 86, 89 (1989).

eliminate overutilization of Medicare benefits and services.²⁴ HMOs also practice cost containment by restricting provider selection, regulating access procedures, undertaking utilization and peer review, and offering financial incentives to physicians.²⁵

Medicare HMOs reduce costs by exercising special control over patients' access to doctors,²⁶ unlike the traditional fee-for-service Medicare system in which patients freely choose their doctors.²⁷ HMO enrollees are generally required to use designated HMO doctors for covered services.²⁸ Members receive basic care from a primary care physician who is also the "gatekeeper" to future services,²⁹ meaning that enrollees who desire treatment or a second opinion from a specialist must first secure permission from their primary care physician.³⁰ The frequency of approved referrals may depend not only on the gatekeeper's own professional judgment, but also the HMO's reimbursement structure. In addition to procedurally regulating access to service through the gatekeeper structure, HMOs substantively review doctors' recommendations and patients' requests for treatment.³¹

Utilization review is also used to ensure that the HMO pays only for necessary and appropriate services. An independent reviewer evaluates the physician's treatment decision to determine if the treatment is necessary and if it will be delivered in the most cost effective manner.³² Utilization review techniques typically involve pre-hospital-admission certification, concurrent hospital review to monitor the continued necessity of inpatient services, second opinions for surgeries, specialty or referral authorizations, and high-cost case management.³³ HMO utilization review is often prospective and concurrent

24. See Susan J. Stayn, Note, *Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures*, 94 COLUM. L. REV. 1674, 1679 (1994).

25. See *id.*

26. See *id.*

27. See *id.*

28. See *id.*

29. See *id.* at 1679-80.

30. See *id.* at 1680; see also Peter Franks et al., *Gatekeeping Revisited, Protecting Patients from Overtreatment*, 327 NEW ENG. J. MED. 424, 425 (1992) (explaining the primary care physician referral requirement).

31. See Stayn, *supra* note 24, at 1680.

32. See U.S. GEN. ACCOUNTING OFFICE, PUB. NO. GAO/HRD-93-22FS, UTILIZATION REVIEW: INFORMATION ON EXTERNAL REVIEW ORGANIZATIONS 8 (1992).

33. See MANAGED HEALTH CARE, *supra* note 23, at 8.

with the medical treatment,³⁴ which can pose significant problems to the health care recipient as any delay in treatment can be life threatening or at least detrimental to the beneficiary's health.

Another way for managed-care organizations to limit and standardize the cost of health care and provide incentives for physicians to focus on the cost of care is to contract with physicians in facilities at a set service price. The price is usually set at a discount over "usual and customary rates" in exchange for a guaranteed volume of potential patients.³⁵ Another approach is to pay a capitated rate, a fixed per capita fee for delivering the services required by the members of the covered group.³⁶ In this arrangement, the providers who are paid on a capitated basis are sharing in the potential profit or loss if service utilization is less than or greater than estimated in the rates.³⁷ This acts as an incentive for the provider to look closely at all potential services and to deliver only those that are truly necessary.

Another financial mechanism, the withhold or risk/bonus arrangement, is often coupled with capitation payment rates. Under the withhold system, a percentage of the physician's monthly capitation payment is withheld and used to pay for the cost of excessive referrals to specialists or for the use of expensive or high-technology services such as laboratory tests and inpatient hospitalizations. HMOs commonly give their physicians target levels for use of high-cost health care services and will either reward or penalize physicians through the return of the withheld amount or through a financial bonus based upon their performance.³⁸

These managed-care techniques create direct and indirect incentives for physicians to restrain patients' use of health care services. Health care providers and HMO reviewers who have significant financial incentives to conserve expenditures often control when and to what extent patients receive treatment.³⁹ Such rationing may result in

34. See Stayn, *supra* note 24, at 1682.

35. See *id.*

36. See *id.*

37. See Peter R. Kongstvedt, *Compensation of Primary Care Physician Open Panels*, in *THE MANAGED HEALTH CARE HANDBOOK* 55 (Peter R. Kongstvedt ed., 2d ed. 1993). See generally Clancy & Brody, *supra* note 22 (analyzing physicians' ethical concerns in undertreating patients).

38. See Kongstvedt, *supra* note 37, at 58-59; Racquel Santiago, *Use of Physician Bonuses Gaining Popularity*, *CRAIN'S CLEVELAND BUS.*, Oct. 2, 1995, at 43.

39. See generally Erik Eckholm, *Clinton's Health Plan: Less Cost vs. Less Care*, *N.Y. TIMES*, Sept. 20, 1993, at A1, B6 (discussing the ramifications of Clinton's health care policy and whether doctors and HMOs "squeeze out" funds); Milt Freudenheim, *Changing the Fortunes of the Medical Business*, *N.Y. TIMES*, Sept. 19,

practices that are contrary to the best interests of the patients, such as a lowering of the quality of care and general undertreatment of patients.⁴⁰

III. Denial of Services and Access to Coverage

Recent case law illustrates the conflict inherent in Medicare managed care. After suffering a heart attack, a California woman was taken to a small rural facility near her home.⁴¹ Because that facility lacked intensive care and cardiac services, the woman, her family, and her HMO physician repeatedly requested that the HMO authorize her transfer (by airlift) to a more appropriate facility.⁴² Despite these repeated requests, the HMO refused the transfer, and the patient died at the rural facility.⁴³

Equally disturbing is the story of Howard Silver.⁴⁴ If he had not complained, or if the Florida state agency for health care had not intervened, his Medicare HMO would not have paid the \$350 per month for Mr. Silver to receive Lupron, a drug to treat his prostate cancer.⁴⁵ His physician had recommended castration, a less expensive treatment; however, this alternative was not necessarily more effective, and certainly not preferable from Mr. Silver's point of view.⁴⁶

The frequency of such harsh cases is unknown, but even proponents of managed care must acknowledge that the strong focus on cost containment can result in improper claim denials or overrestrictive plan practices. These issues make clear the need for prompt, fair resolution of disputes involving denials of covered services and other access to care concerns.

1993, at 6 (quoting Dr. James Todd, Executive Vice President of the AMA who believes that capitation is "an incentive to provide less care").

40. See Eckholm, *supra* note 39, at A1, B6.

41. See *Ardary v. Aetna Health Plans of Cal., Inc.*, 98 F.3d 496, 497 (9th Cir. 1996).

42. See *id.* at 497.

43. See *id.* at 498.

44. See *The HMO Maze: How Medicare Fails Seniors: Treatment Trouble*, FORT LAUDERDALE SUN SENTINEL, Nov. 7, 1993, at 25A.

45. See *id.*

46. See *id.*

IV. The Appeals Process for Medicare HMOs

The Health Maintenance Organization Act of 1973⁴⁷ was adopted by Congress to encourage the development of HMOs and to ensure that HMOs “were structured to promote quality and access while restraining costs.”⁴⁸ Under the Act, HMOs are required to provide “meaningful procedures for hearing and resolving grievances between the health maintenance organization and [its] members.”⁴⁹ The grievance procedure must assure that (1) complaints are transmitted promptly to the appropriate HMO decision-making levels with the authority to take corrective action and (2) appropriate action is promptly taken which includes a full investigation, if necessary, and notification of concerned parties regarding the HMO’s results.⁵⁰

Medicare HMOs have an established appeals process for benefit denials.⁵¹ The right to a Medicare appeal is triggered by a denial or termination of benefits.⁵² An HMO must give written notice of the decision to deny or terminate benefits within sixty days of receiving a request for the services. This notice must state the reasons for the denial and inform the enrollee of his right to a reconsideration.⁵³ The request for reconsideration must be submitted in writing to either the HMO or the local Social Security office within sixty days of the date of the notice of denial or termination of benefits.⁵⁴

The request for reconsideration can contain additional evidence to support the enrollee’s request.⁵⁵ HMO personnel must then review the original determination and any additional evidence and either support or reverse the initial decision.⁵⁶ If the HMO upholds all or part of the original determination, the HMO is required to forward the appeal to the Center for Health Care Dispute Resolution (CHCDR), HCFA’s contracted entity responsible for conducting program review of the decision.⁵⁷

47. Pub. L. No. 93-222, 87 Stat. 714 (codified as amended at 42 U.S.C. §§ 300e (1994)).

48. GEORGE J. ANNAS ET AL., *AMERICAN HEALTH LAW* 780 (1990).

49. Pub. L. No. 93-222, § 2, 87 Stat. at 916.

50. See 42 C.F.R. § 417.124(g) (1997).

51. See 42 U.S.C. § 1395mm(c)(5)(B) (1994).

52. See *id.* § 405(b)(1).

53. See 20 C.F.R. § 404.904 (1998).

54. See 42 C.F.R. § 417.616 (1997).

55. See *id.* § 417.618.

56. See *id.* §§ 417.620, .622.

57. See *id.* § 417.620.

Once the appeal reaches the CHCDR, the HMO's action is reviewed and either sustained or overruled.⁵⁸ If the decision remains adverse to the enrollee, and the amount in controversy is over \$100, the enrollee can request further review from an administrative law judge (ALJ).⁵⁹ This request must be made within sixty days of CHCDR's reconsideration decision.⁶⁰ Judicial review is then available if the ALJ decision is unfavorable; however, the amount in controversy must be at least \$1,000.⁶¹

In cases of discharge from a hospital, the appeals process is triggered by the HMO's issuance of a notice of noncoverage.⁶² In this situation, the enrollee must submit a written or telephone request for an accelerated reconsideration.⁶³ The accelerated reconsideration is decided by the enrollee's local Peer Review Organization (PRO).⁶⁴ If the enrollee requests reconsideration by noon after the day following the receipt of the notice of noncoverage, the HMO must continue to provide benefits until the enrollee receives the PRO's decision.⁶⁵

If the PRO's reconsideration is adverse, the enrollee can request immediate reconsideration to the same PRO.⁶⁶ The PRO must complete the reconsideration within three working days of receipt of the request.⁶⁷ Then, the reconsideration decision may be appealed to an ALJ, provided that there is at least \$200 in controversy. Next, the decision of the ALJ is subject to judicial review if the amount in controversy is over \$2,000.⁶⁸

Despite these appeal procedures, a recent survey by the Office of the Inspector General (OIG) reported that one-third of Medicare HMO beneficiaries did not know or were not sure of their right to complain about specific problems for which filing a grievance or appeal is possible.⁶⁹ For example, thirty-five percent of disenrollees and twenty-

58. *See id.* § 417.624(a).

59. *See id.* § 417.632(d).

60. *See id.* § 417.632(b).

61. *See id.* §§ 417.60-.694.

62. *See id.* § 417.605(a).

63. *See id.* § 417.605(b).

64. *See id.* § 417.605(b)(6).

65. *See id.* §§ 417.604-.605.

66. *See id.* §§ 417.605, 473.16.

67. *See id.* § 473.32.

68. *See id.* § 473.12(b)(2)(a)(i-ii).

69. *See* OFFICE OF THE INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUMAN SERVS., OEI 06-95-00430, BENEFICIARY PERSPECTIVES OF MEDICARE RISK HMOs—1996 (1998).

seven percent of enrollees were unaware of their grievance rights.⁷⁰ Only thirty-six percent of those beneficiaries who did file a complaint thought that their complaint was handled fairly.⁷¹ Furthermore, fifty-five percent of uninformed beneficiaries said they would have filed a complaint if they had known their rights.⁷²

In response to HMO horror stories and the apparent lack of adequate appeal processes, a class action lawsuit, *Grijalva v. Shalala*,⁷³ was brought against the Secretary of Health and Human Services (HHS).⁷⁴ The *Grijalva* plaintiffs complained of numerous care denials, delays in services, and the lack of a fair hearing process in the Medicare managed-care program in Arizona.⁷⁵ The court found that HMO denials of Medicare services are state action.⁷⁶ Then the court determined that the existing Medicare denials violated the plaintiffs' due process rights under the Fourteenth Amendment and Medicare laws.⁷⁷ Further, the court concluded that Medicare enrollees were "entitled to notice and hearing when an HMO denies services based on coverage determinations."⁷⁸ The court also found that the existing notices being used were vague and illegible and did not give the beneficiary adequate notice of the reason and basis for the denial and how to appeal.⁷⁹

To remedy such due process violations, the court mandated a number of requirements to be met by Medicare, the Secretary of HHS, and participating HMOs in order to comply with federal law.⁸⁰ The court ordered that written notice be given whenever a coverage determination results in denial, reduction, or termination of a requested service.⁸¹ Further, the court ordered that the written notice be prompt, requiring that such notice be given within five working days of any written or oral request, or at least one day before reduction or termination of an ongoing course of treatment.⁸² The court also permitted a

70. *See id.*

71. *See id.*

72. *See id.*

73. 946 F. Supp. 747 (D.C. Ariz. 1996).

74. *See id.* at 747.

75. *See id.* at 749-50.

76. *See id.* at 753.

77. *See id.* at 755.

78. *Id.*

79. *See id.* at 757.

80. *See Grijalva v. Shalala*, No. CIV 93-711 TUC ACM, 1997 WL 155392 (D. Ariz. Mar. 3, 1997) (court order).

81. *See id.* at *1.

82. *See id.*

delay in this time period of up to sixty days to obtain specified additional information in exceptional circumstances.⁸³

In contrast to the existing notices, the court mandated that future notices be in clear, readable form in twelve-point type.⁸⁴ These notices must also contain an explanation of the coverage rule in lay-person language, a description of the appeal process and the PRO quality review process, and information regarding the submission of evidence, including when and how to do so and the procedure for obtaining supporting evidence from attending physicians.⁸⁵ In order to ensure enforcement of these mandates, HCFA was directed to monitor the compliance of Medicare HMOs with these notice requirements.⁸⁶ Furthermore, HCFA is prohibited from renewing or entering into new contracts with HMOs who fail to substantially comply with the requirements.⁸⁷

In addition to these notice requirements, many changes to the reconsideration process were mandated. To ensure review of all benefit decisions, the court ordered that reconsideration be available for all adverse service decisions.⁸⁸ The court further mandated that first-level reconsideration must include informal, in-person communication with the decision maker.⁸⁹ Furthermore, an expedited reconsideration must be made available when denied or terminated services are urgently needed.⁹⁰ Such services would include acute care services, noncosmetic surgeries, and the like.⁹¹ Urgency may be established by the doctor or, under certain circumstances, by lay testimony.⁹² To address long delays in the appeal process, the court mandated that the expedited decision be issued within three working days.⁹³ However, this deadline may be extended up to ten working days if the HMO or the enrollee requests additional time to obtain evidence.⁹⁴

The next level of review, which is conducted by CHCDR, the independent HCFA contractor, must be completed within ten days of

83. *See id.*

84. *See id.*

85. *See id.*

86. *See id.* at *2.

87. *See id.*

88. *See id.* at *1.

89. *See id.* at *2.

90. *See id.*

91. *See id.*

92. *See id.*

93. *See id.*

94. *See id.*

the request in an expedited case.⁹⁵ The court ordered that when the expedited hearing process is triggered, services must continue pending a final reconsideration decision.⁹⁶ To assist enrollees in the preparation of an appeal, the court prohibits the use of HMO policies or procedures that impede an enrollee from obtaining evidence to support an appeal, such as letters of support from providers.⁹⁷ HCFA was also ordered to monitor the compliance of all Medicare HMOs with these appeal requirements and is prohibited from renewing or entering into new contracts with any providers who do not substantially comply with the requirements.⁹⁸

Finally, HMOs were prohibited from retaliating in any way against doctors who provide supporting evidence for enrollees in appeals.⁹⁹ HCFA was also ordered to monitor and investigate the compliance of Medicare HMOs with this rule.¹⁰⁰ Furthermore, HCFA is prohibited from renewing or entering into new contracts with providers who have not substantially complied with this mandate.¹⁰¹

In response to the *Grijalva* decision, HCFA created new appeals language and an expedited appeals procedure.¹⁰² In addition to these new regulations, the 1997 Balanced Budget Act (BBA)¹⁰³ also mandated changes in the Medicare program.¹⁰⁴ The new rules, however, do not incorporate all of the mandates from the *Grijalva* court. Furthermore, the addition of the Medicare Choice program has made the Medicare program even more confusing and complex than ever before.

V. A Step Backwards

As stated above, the language in the BBA does not incorporate all of the recent changes and protections for Medicare beneficiaries. Under the *Grijalva* order, appealable issues include the denial, termi-

95. *See id.*

96. *See id.*

97. *See id.*

98. *See id.* at *1.

99. *See id.* at *2.

100. *See id.*

101. *See id.*

102. *See* 42 C.F.R. §§ 417.600-.694, 466.1, 473.10-.48 (1997); *see also* 42 U.S.C. §§ 405, 1395mm, 1395xx (1994).

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

104. *See id.* § 4000, 111 Stat. at 270.

nation, or reduction of a service.¹⁰⁵ Furthermore, the expedited-appeals regulations state that a termination of service, not just the denial of a requested service, is an appealable decision.¹⁰⁶ However, the new BBA language does not specifically clarify whether or not an appeal may be taken from a termination or reduction of service. This leaves open the possibility that plans will narrowly interpret the BBA language to mean that the appeal procedures apply only when requested services are denied. This matter may be remedied, if HCFA issues new regulations to implement the BBA appeals sections in the future.

As discussed above, the *Grijalva* court also ordered that all coverage determinations include: an explanation in lay language of the medical basis for the decision that is sufficiently detailed to allow the enrollees to understand the decision and argue their cases, a description of the additional evidence needed to support an appeal, and an explanation of how to obtain a second opinion.¹⁰⁷ However, the BBA only requires that a “decision” must be in writing and include a statement in understandable language of the reasons for the denial and a description of the reconsideration and appeals processes.¹⁰⁸

Regarding timeliness, the *Grijalva* court ordered that all HMO decisions be made within five days of an enrollee’s request.¹⁰⁹ However, current HCFA regulations allow sixty days.¹¹⁰ In contrast, the BBA merely requires that decisions regarding nonemergency care be made on a timely basis without specifying any time frame;¹¹¹ however, the Secretary of HHS is required to establish a time frame for reconsiderations of nonexpedited decisions that does not exceed sixty days from the date of the request.¹¹²

A. Expedited Appeals

Pursuant to the BBA, the expedited-appeals process is warranted only when a longer time frame could seriously jeopardize the life or health of the enrollee, or jeopardize the ability of the enrollee to regain

105. See *Grijalva v. Shalala*, No. CIV 93-711 TUC ACM, 1997 WL 155392, at *1 (D. Ariz. Mar. 3, 1997) (court order).

106. See 62 Fed. Reg. 23,368 (1997).

107. See *Grijalva*, 1997 WL 155392, at *1.

108. See Balanced Budget Act of 1977, Pub. L. No. 105-33, § 1852(g)(1)(B), 111 Stat. 251, 293.

109. See *Grijalva*, 1997 WL 155392, at *1.

110. See 42 C.F.R. § 417.608(a)(1) (1997).

111. See Balanced Budget Act of 1977, § 1852(g)(1)(A), 111 Stat. at 293.

112. See *id.* § 1852(g)(2)(A), 111 Stat. at 293.

maximum functioning.¹¹³ Fortunately, the BBA also states that a request by a doctor to expedite a determination or reconsideration will be automatically granted.¹¹⁴ However, if the request for an expedited appeal is made only by the beneficiary, the Medicare Choice plan itself makes the determination because the plan is merely required to "maintain procedures" for processing enrollee requests.¹¹⁵ Furthermore, the BBA does not address the possibility of enrollee redress of a plan's decision to deny an expedited appeal which seriously hampers the effectiveness of the expedited appeal rule.

The *Grijalva* court's requirements for expedited appeals have not all been incorporated into the new rules and regulations.¹¹⁶ The BBA requires that an expedited decision be made no later than seventy-two hours after the receipt of the request for reconsideration; however, the time period may begin to run from the receipt of the information necessary to make the determination.¹¹⁷ Furthermore, the Secretary of HHS is also given discretion to permit longer time periods in "specified cases."¹¹⁸ No limit is placed on the amount of time the plan may wait to receive additional information, and the beneficiary does not have any input as to the delay.¹¹⁹ However, the expedited appeals regulations offer more protection than the BBA as they allow an extension of up to ten working days for additional information, if the delay is in the interest of the enrollee.¹²⁰

B. Hearings

The *Grijalva* court requirements that are outlined above are not addressed under the BBA. However, the expedited-appeals regulations give all parties a "reasonable" opportunity to present evidence in person or in writing.¹²¹ In comparison, the protections in the *Grijalva* decision are comprehensive and, as such, are not likely to be incorporated into any forthcoming regulations issued by HCFA. This failure to incorporate comprehensive regulations could likely result in future legal action, again based upon due process principles.

113. See *id.* § 1852(g)(3)(B)(i), 111 Stat. at 294.

114. See *id.* § 1852(g)(3)(A)(ii), (B)(ii), 111 Stat. 293-94.

115. See 42 C.F.R. § 417.617(b) (1997).

116. See *Grijalva v. Shalala*, No. CIV 93-711 TUC ACM, 1997 WL 155392, at *2 (D. Ariz. Mar. 3, 1997) (court order).

117. See Balanced Budget Act of 1977, § 1852(g)(3)(B)(iii), 111 Stat. at 294.

118. See *id.* § 1852(g)(3)(A)(iii), 111 Stat. at 293.

119. See 62 Fed. Reg. 23,368 (1997).

120. See *id.* at 23,370.

121. See *id.*

C. Review of Decisions

In contrast to the order by the *Grijalva* court, the BBA only requires independent review of medical necessity decisions.¹²² At the plan level, a medical necessity decision must be made by a physician who was not involved in the initial determination.¹²³ Furthermore, the reviewing doctor also must have “appropriate expertise” in the field of medicine relating to the determination.¹²⁴ As discussed previously, the *Grijalva* court stated that due process requires continuation of services pending a final ruling on a termination decision.¹²⁵ However, the BBA and the current HCFA regulations are silent as to this issue. Although, in a recent press release HCFA announced that they are reviewing this topic.¹²⁶

VI. Medicare Choice Program

The Balanced Budget Act of 1997 creates a new “part” of Medicare: Medicare Part C.¹²⁷ Medicare Part C is called the Medicare Choice program. The Medicare Choice program offers beneficiaries a variety of health delivery models including HMOs, Preferred Physician Organizations (PPOs), Physician Services Organizations (PSOs), medical savings accounts (MSAs), and private fee-for-service Medicare.¹²⁸ Medicare PSO plans are operated by a health care provider, such as a hospital or another group of health care providers (e.g., a geriatric unit of a hospital), and provide a substantial portion of the required health care through that group.¹²⁹ The Medicare Choice fee-for-service plan reimburses doctors, hospitals, and other providers per service used, at a rate determined by the plan.¹³⁰

Under the MSA option, the beneficiary chooses a catastrophic health plan which provides for deductibles, limits out-of-pocket expenses to \$6,000, and establishes a medical spending account.¹³¹ If the

122. See Balanced Budget Act of 1997, § 1852(g)(3)(A)(i), 111 Stat. at 293.

123. See *id.* § 1852(g)(2)(B), 111 Stat. at 293.

124. See *id.*

125. See *supra* text accompanying notes 77-98.

126. See Health Care Fin. Admin., *Clinton Administration Generates Rapid Response to Medicare Beneficiaries' Appeals of Treatment Denials* (Apr. 29, 1997) <<http://www.hcfa.gov/news/n970429.htm>>.

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

128. See *id.* §§ 1851-1859, 111 Stat. at 276-327.

129. See *id.* § 1855(d)(1), 111 Stat. at 316.

130. See *id.* § 1859(b)(2), 111 Stat. 325.

131. See § 1859(b)(3), 111 Stat. at 327.

premium for the catastrophic plan is less than half of the Medicare Choice capitation rate, the difference between the premium and the capitation rate is deposited by HCFA into the person's MSA.¹³² That money can then be used at a later date for medical expenses.¹³³

The Medicare Choice plans (with the exception of the MSAs) must provide the same service and benefits as traditional Medicare. MSA plans must provide reimbursement for items and services covered under Parts A and B of traditional Medicare after the beneficiary reaches the deductible.¹³⁴

Medicare Choice plans will still be required to pass on to beneficiaries a percentage of any "savings" they achieve if their costs are less than the Medicare payment by offering additional benefits not normally covered under traditional Medicare.¹³⁵ These services may include prescriptions, glasses, and the like. Plans may also offer supplemental benefits for which they charge a separate premium.¹³⁶ Beneficiaries may not have the option to decline the supplemental benefits unless HCFA determines that required participation would "substantially discourage" enrollment in the plan.¹³⁷

Medicare Choice plans are required to provide beneficiaries with information about benefits, premiums, and any potential beneficiary liability; however, the current state "balance billing provisions"¹³⁸ do not apply to all Medicare Choice plans. One problem with the Medicare Choice fee-for-service plan is that physicians are permitted to bill 115% of the Medicare rate; as a result, beneficiaries may be responsible for increased out-of-pocket costs.¹³⁹ Another potentially troublesome aspect of the plan is section 4507, the private contract provision.¹⁴⁰ This provision allows doctors to refuse the standard Medicare reimbursement amounts and to enter into private contracts with Medicare enrollees at their own set rates on a 100% private pay basis for services that would ordinarily be covered by Medicare.¹⁴¹

132. *See id.*

133. *See id.*

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

135. *See id.* § 1852(a)(1)(B), 111 Stat. at 286.

136. *See id.* § 1852(a)(3)(A), 111 Stat. at 287.

137. *See id.*

138. Some states have "balanced billing regulations" which prohibit doctors from charging Medicare beneficiaries any amount over Medicare's allowable rates.

139. *See* Balanced Budget Act of 1977, § 1852(k)(2)(A)(i), 111 Stat. at 298.

140. *See id.* § 4507(e)(3)(B), 111 Stat. at 439 (known as the Kyle Amendment which amends 42 U.S.C. § 1395(a)).

141. *See id.*

Because this option is dramatically different from the traditional manner in which seniors receive benefits, many seniors may not realize that they are giving up their right to have a particular service covered by Medicare and therefore must pay 100% of the cost. Hopefully, providers will be scrupulous in explaining the consequences of their choice to senior citizens who choose to enter into these arrangements.

Beginning in November of 1999, HCFA will conduct an annual coordinated election period during which time all Medicare beneficiaries will have to choose between traditional Medicare and the Medicare Choice program.¹⁴² Fifteen days before the start of the election period, HCFA will mail all beneficiaries information about the Medicare Choice plans available in their area, plus information to help them choose among the plans.¹⁴³ Accordingly, enrollees may not have an adequate period of time to become informed of the various plans and potential advantages or disadvantages of a particular plan. Beneficiaries who fail to make an election will remain in original Medicare; those already in an HMO or other Medicare Choice plan will remain in that HMO.¹⁴⁴ Elections become effective January 1 of the year following the election with a few minor exceptions.¹⁴⁵ HCFA is attempting to devise a plan for educating the public regarding the Medicare Choice plans, but considering the radical changes to the system, the confusing language and policies, and the population that Medicare serves, it may be extremely difficult to ensure adequate knowledge of the new system.

In contrast to the current system which allows beneficiaries to disenroll from their HMO if they are not satisfied, pursuant to the BBA, beneficiaries will retain the ability to enroll or disenroll continuously from a Medicare Choice plan only through the end of the year 2001.¹⁴⁶ In the year 2002, they will be entitled to one change in option during the first six months of the year.¹⁴⁷ After that time, beneficiaries may change their option once during the first three months of the year,¹⁴⁸ or at other times if they move from a plan's service area, the plan discontinues serving Medicare enrollees, or they can prove to HCFA that the plan is not complying with its contract and they are

142. *See id.* § 1851(e)(3)(B), 111 Stat. at 282.

143. *See id.* § 1851(d)(2), 111 Stat. at 278.

144. *See id.* § 1851(c)(3), 111 Stat. at 278.

145. *See id.* § 1851(f), 111 Stat. at 283-84.

146. *See id.* § 1851(G)(2)(A), 111 Stat. at 281.

147. *See id.* § 1851(G)(2)(B)(i), 111 Stat. at 281.

148. *See id.* § 1851(G)(4)(A)-(D), 111 Stat. at 282-83.

injured by the noncompliance.¹⁴⁹ Starting in 2002, new Medicare enrollees will be able to return to original fee-for-service Medicare once during their first year of eligibility.¹⁵⁰ Individuals who enroll in MSA plans, however, must remain in that plan for a year, although those choosing MSA plans for the first time will have until the fifteenth of December after their election to disenroll.¹⁵¹

VII. Conclusion

Many senior citizen advocates looked at the *Grijalva* decision as a huge step forward for Medicare HMO enrollees. However, recently promulgated rules and regulations and the Balanced Budget Act have not incorporated all of the consumer protections ordered by the *Grijalva* court to protect enrollees' due process rights. Accordingly, it is unclear whether consumers will find increased satisfaction with Medicare HMOs in the future, and senior advocates may encounter the exact same problems with appeals that they did before the *Grijalva* decision was rendered. In addition to the appeals problems, the major changes to the Medicare program create a very different Medicare program, one which may be too complex for seniors to navigate without significant assistance from consumer advocates and attorneys. Even more disturbing is that the new program destroys or alters some important consumer protections such as balanced billing protections and disenrollment rights. Consequently, seniors may take imprudent actions without realizing the significance of their actions until it is too late. To prevent this tragedy, the new changes in Medicare rules and regulations must be examined and understood by senior advocates so that Medicare enrollees will be afforded the full extent of benefits to which they are entitled.

149. See *id.* § 1851(G)(2)(C)(i), 111 Stat. at 281.

150. See *id.* § 1851(G)(4), 111 Stat. at 283.

151. See *id.* § 1851(G)(5), 111 Stat. at 283.