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A COMPARISON OF KANSAS AND MISSOURI HEALTH CARE GRIEVANCE PROCEDURES, AND THE NEED FOR A UNIFIED PROCESS AT THE FEDERAL LEVEL

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I. INTRODUCTION

People purchase health insurance for the purpose of managing unexpected economic loss resulted from medical sufferings. In today's medical field, many patients and physicians feel frustrated and powerless when a Managed Care Organization ("MCO")[1] refuses to pay for treatment, often because the insurer is playing a game of denial, delay and deceit to help the company avoid issuing big outgoing paychecks.[2] Allegedly, private insurers are making payment decisions rather than medical decisions.[3] This creates an issue because the denial of insurance coverage is often equivalent to a denial of medical care to the patient.[4] The beneficiaries, of course, can always visit a different doctor not covered by the insurance policy if the insurer denies their claims, but this would be at the beneficiaries' own cost, and most people cannot afford the huge expense.

The problem with physicians ("health care providers")[5] is that they are often required to complete the pre-certification process[6] before they get paid for

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[1] In the United States, the term "managed care" or "managed health care" is used in the to describe a variety of techniques intended to reduce the cost of providing health benefits and improve the quality of care. *Managed Care, Market Reports and the States*, NATIONAL CONFERENCE OF STATE LEGISLATURES (June 2013) http://www.ncsl.org/research/health/managed-care-and-the-states.aspx. The service is usually provided through HMO (health maintenance organizations) or private health care insurers. *Id.* For purposes of this Note, the MCO refers to private healthcare insurance carriers who get paid insurance premiums and agree to pay or indemnify the beneficiary (the insured's) treatment cost in accordance with the insurance policy.

[2] Bernadine Healy, *How Crafty Health Insurers Are Denying Care,* U.S. NEWS: HEALTH, Aug. 25, 2008, http://health.usnews.com/health-news/articles/2008/08/25/how-crafty-health-insurers-are-denying-care.

[3] Joyce Krutick Craig, *Managed Care Grievance Procedures: The Dilemma and the Cure*, 21 J. NAT'L ASS'N ADMIN. L. JUDGE 336, 336 (2001).

[4] *Id.* at 336-37.

[5] Hereinafter, "provider."

[6] Pre-certification, a.k.a. prior authorization, is the process of obtaining eligibility, certification or authorization and collecting information from the health plan prior to providing health care

treating the insured beneficiary under the insurance policy. Providers face the dilemma of patients experiencing long waits for care or perhaps denial of pre-certification altogether, or on the other hand, receiving no payments at all after providing care to patients.[7]

The current management system calls for a quick and efficient dispute resolution process. States have generally provided a provision of minimum grievance procedure requirement in the Insurance Codes that must be maintained by private health insurance carriers when an adverse decision is rendered against the beneficiary.[8] Each state requirement applies to the insurance policies issued in the each respective state. Without a uniform procedural requirement, two residents living in different states but who suffer from the same condition and carry the same insurance plan may receive different results. One resident may be denied health care while the other is granted care because of the varying grievance procedures between their respective states.[9]

Insurers and beneficiaries often have conflicting interests because the insurer wants to pay only what is "medically necessary" under the beneficiary's healthcare policy, yet the beneficiary needs as much coverage as possible to recover from an illness. Thus, the managed healthcare system must have an efficient and fair "grievance procedure" in order to resolve these conflict. This article will compare the statutory grievance procedure requirements applied to the denial of health coverage claim between Missouri and Kansas, and will argue for the need of establishing a uniform federal grievance procedure among all states, proposed by Joyce Krutick Craig[10] years ago.[11]

II. GRIEVANCE PROCEDURES

A. Kansas

In Kansas, "[a] health maintenance organization (HMO)[12] shall provide in its certificate of coverage the procedures for resolving enrollee grievances."[13] It must include (a) the definition of a grievance, and (b) how, where, and to whom the enrollee should file such enrollee's grievance.[14] If it is a "clean

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treatment to the patient under a health plan. *Pre-Certification (Health Care) Law & Legal Definition*, USLEGAL, http://definitions.uslegal.com/p/pre-certification-health-care/ (last visited Apr. 6, 2015). Failure to obtain such authorization may result the health insurer's nonpayment and the cost would be shifted onto the beneficiary or the health care provider. *Id.*

[7] *Standardization of Prior Authorization Process for Medical Services White Paper*, AMERICAN MEDICAL ASSOCIATION (June 2011), *available at* http://massneuro.org/Resources/Transfer%20from%20old%20sit/AMA%20White%20Paper%20on%20Standardizing%20Prior%20Authorization.pdf.

[8] *See generally*, *Claims-Grievance Procedures*, 50 STATE STATUTORY SURVEYS: INSURANCE: GENERAL (2014), *available at* Westlaw 0110 SURVEYS 15.

[9] Craig, *supra* note 3, at 339.

[10] Ms. Craig is a former U.S. Administrative Law Judge for the Social Security Administration, with a focus on hearing disability and health insurance claims. *See* LawGuru, http://www.lawguru.com/answers/atty_profile/view_attorney_profile/ldyjdg#more_info (last visited May 25, 2015).

[11] *See generally*, Craig, *supra* note 3.

[12] KAN. STAT. ANN. § 40-3202 (2014).

[13] § 40-3228.

[14] *Id.*

claim,"[15] the investigation, or the review of the original adverse decision made against the enrollee beneficiary, shall be completed within twenty working days after receipt of the grievance.[16] If it is not a clean claim, the insurer shall notify the beneficiary within thirty working days to submit additional information to complete a clean claim (and state the reasons for why such additional information requested is needed) before the insurer starts the investigation process.[17] Within five business days after the investigation is complete, the beneficiary will be notified of the grievance decision affirming or reversing the original denial decision.[18] The grievance decision should also explain the reasons or basis of the grievance resolution and inform the beneficiary that he or she has the right for a further appeal (second level).[19] However, the statute also states that the insurer may establish a grievance advisory panel as the second level appeal reviewer, but such panel is not obligated to conduct the review.[20]

B. Missouri

Unlike in Kansas, a Missouri beneficiary facing an adverse decision has the option of the medical provider filing a "reconsideration" of the original adverse decision with the insurer.[21] Though it is not a prerequisite to the standard grievance procedure, the insurer must take a second look at the original adverse decision within one business day of receiving a reconsideration request..[22] As a result, some beneficiaries may receive a prompt relief without going through the long formal appeal procedure if the adverse decision was based on some obvious errors by the insurer. In addition, Missouri requires at least two levels of grievance review by the insurer.[23] The insurance carrier shall complete investigation of the grievance and make a decision within twenty working days after receipt of the grievance for a clean claim, or it should request additional information from the claimant beneficiary and state reasons for why such information is needed in order to make it a clean claim.[24] The beneficiary will be notified of the grievance resolution within five working days after the investigation is completed.[25] If the resolution affirmed the original denial decision, then the beneficiary claimant has a statutory right to request a second-level appeal review by the insurer. The appeal panel usually consists of agents or medical consultants who are not involved in any of the previous decision-

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[15] A claim for insurance coverage, submitted by the medical provider, that complete information required by the insurer in processing the claim received and make a decision of either grant or denial of the coverage for the medical service provided on the enrollee beneficiary. *Clean Claims and Other Information for Health Providers*, DEP'T OF INS. & FIN. SERV., http://www.michigan.gov/difs/0,5269,7-303-12902_35510-263283--,00.html (last visited Apr. 6, 2015).
[16] § 40-3228.
[17] *Id.*
[18] *Id*.
[19] *Id.*
[20] *Id.*
[21] MO. REV. STAT. § 376.1365 (2015).
[22] *Id.*
[23] § 376.1382.
[24] *Id.*
[25] *Id.*

makings.[26] If the adverse decision is again affirmed at the second level, the beneficiary will have the right to file an appeal with the Director of the Department of Insurance for an "external review."[27] The Director then makes a decision based on the Independent Review Organization's recommendation, which is the final agency decision binding both the beneficiary claimant and the health insurance carrier.[28] The decision is subject to judicial review, but the court can vacate the Director's administrative decision only if it finds the decision is "unconstitutional, unlawful, unreasonable, arbitrary, capricious or involves an abuse of discretion or is in excess of the statutory authority or jurisdiction of the director."[29] However, court will typically defer to the administrative decision unless some serious mistakes are discovered.

C. Differences Between Kansas and Missouri

The first major difference between Kansas and Missouri grievance procedures is that beneficiaries in KS cannot receive an informal review immediately after an adverse determination, while Missouri beneficiaries may.. Also, for non-clean claims in Kansas, the insurer is allowed to request additional information from the claimant beneficiary or the health provider within thirty days from the receipt of the grievance appeal, while Missouri allows only twenty days for an insurance policy. Second, although both states mandate internal administrative review of the grievance within the insurer, Missouri mandates two levels of internal appeal system to be established by the insurer while Kansas technically only mandates one level of internal appeal. Kansas law requires the insurer to notify the insured beneficiary of a right to second appeal by a grievance advisory panel, but the panel is not obligated to conduct the review.[30] Health insurance carriers in Kansas have the option to provide two levels of internal review to resolve the claimant's grievance by establishing a grievance advisory panel, but the insured beneficiary may also voluntarily waive the second appeal right[31] and move straight to the external review stage. In other words, a Kansas health insurance carrier may choose to establish only one level of internal appeal process by not establishing the advisory panel. However, in Missouri, the insurer is obligated to establish a grievance panel to conduct the second appeal review upon request and the beneficiary must exhaust both levels of internal appeal before moving forward. [32]

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[26] § 376.1385.

[27] External review is an additional level of review or appeal that the beneficiary can utilize to resolve disputes with the insurance company, which is conducted by an "Independent Review Organization" or "External Review Organization" authorized by the Department of Insurance, a third party independent of the health insurance carrier at dispute. *See* MO. REV. STAT. § 376.1387 (2015); *see also* KAN. STAT. ANN. § 40-22a13(c) (2014).

[28] *See generally*, *External Review Process*, MO. DEP'T OF INS., http://insurance.mo.gov/consumers/health/externalreviewprocess.php (last visited Apr. 6, 2015).

[29] § 376.1387.

[30] *See* KAN. STAT. ANN. § 40-3228 (2014).

[31] § 40-22a09(a).

[32] This conclusion is based upon the fact that most health plans are covered under federal ERISA employee benefit health coverage. ERISA provides federal preemption to state insurance law that the claimant beneficiary who received an adverse health care decision by the insurer must first exhaust all internal level of appeals within the insurer before being able to file a suit with the court. 29 CFR § 2560.503-1(l) (2015). This is important because as of 2010, 55.3% of U.S. health

Thus, Kansas and Missouri differ in the minimum procedural remedies provided to the insured. Some grievance procedure requirements in Missouri and Kansas are quite similar. For instance, both states allow beneficiaries to request external review through the state's Department of Insurance, which contracts with Independent Review Organizations ("IROs") to review the adverse decision. However, Kansas and Missouri also differ in the minimum procedural requirements provided to the insured. These slightly different requirements may nevertheless lead to drastically different outcomes for two beneficiaries living in different states, needing the same care, but carrying two different health plans. A Kansas beneficiary may request an external review immediately after one level of review is completed and a Missouri beneficiary may have to deal with the insurer back and forth for two levels before he may request an external review.[33] In addition, judicial review in Missouri is limited to the records before the Director of the Department of Insurance (DOI) used in making the external review decision and the court generally has to defer to the Administrative decision unless it is arbitrary or capricious, whereas in Kansas, the judicial review of the external review decision can consider all evidence and materials used in reaching the decision and nowhere in the statute requires the court to give any deference to the Administrative decision.[34] As a result, two beneficiaries from two different states may receive the quite opposite outcome for their health coverage claims for the same health care service received. Within the United States, it could have fifty different grievance procedure practices, as a result of which a huge imbalance of insurance coverage delivery would not be a surprise.

III. CONCLUSION

A uniform requirement at the federal level would help solve the problem these differences present. As of now, the federal Health Maintenance Organization Act of 1973[35] only includes a general provision requiring the insurers to provide "meaningful procedures" for hearing and resolving beneficiary grievances.[36] A uniform standard and application of the standard shall be established in all fifty states to achieve the goal of providing fast and easy remedial procedure, applying to both patient and the health insurance carriers with due process afforded to both sides. [37]

Here is one proposal: Congress should pass a statute mandating a federal appeals process for all grievances made under an adverse health care decision, where the alleging claimant will be offered a due process hearing before a U.S. Administrative Law Judge serving in the Social Security Administration.[38] The statute shall also mandate that all health insurance carriers maintain only one level of internal grievance procedure and the internal grievance must be resolved

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insurance plans are employment-based benefit plans covered under ERISA. *See* Brian Mauersberger, *Tracking Employment-Based Health Benefits in Changing Times* (Jan. 27, 2012), http://www.bls.gov/opub/mlr/cwc/tracking-employment-based-health-benefits-in-changing-times.pdf.

[33] § 40-22a16.

[34] *Id.*

[35] Health Maintenance Organization Act of 1973, Pub. L. No. 93-222, § 14, 87 Stat. 914 (1973).

[36] 42 U.S.C. § 300e(c)(5) (2015).

[37] Craig, *supra* note 3, at 398.

[38] *Id.* at 399.

with a decision rendered within five days of the receipt of a clean claim for non-emergency[39] situations, or within twenty-four hours in case of emergencies.[40] After the exhausting the single level internal appeal review, the grieved beneficiary may then file appeal with the Administrative Law Judge, whose decision shall be final and binding on both parties.[41]

After all, for a patient needing access to affordable healthcare, nothing is more important than time. Fast access to proper treatment must not be sacrificed by the long and complicated grievance procedures enacted by individual states.[42]

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[39] *See* MO. REV. STAT. § 376.1350(12) (2015). Emergency medical condition means a sudden and unexpected health condition that "manifests itself by symptoms of sufficient severity that would lead a prudent lay person, possessing an average knowledge of medicine and health, to believe that immediate medical care is required." *Id.* (whereas a non-emergency condition would be a health condition other than emergency condition).

[40] Craig, *supra* note 3, at 401.

[41] This is a reiteration of the proposal. For more details of how this proposed statute should work and its justification of why such scheme would achieve better result than the current grievance procedural process, please see Joyce Krutick Craig, *Managed Care Grievance Procedures: The Dilemma and the Cure*, 21 J. NAT'L ASS'N ADMIN. L. JUDGES 336 (2001).

[42] Craig, *supra* note 3, at 398.