

# Left hanging by health insurers

## Health plans strive for better service from the start

*By Kristen Gerencher, CBS.MarketWatch.com 7:44 PM ET April 15, 2004*

**SAN FRANCISCO (CBS.MW) -- The decision on whether your private health insurance will pick up the cost of a recommended procedure often rests on the interpretation of two little words: Medically necessary.**

But outside of emergency care, determining what your plan considers "medically necessary" can be difficult.

Take the case of Mary Ellen Kuck, a retired financial adviser in Brookfield, Conn. Kuck says she sent a letter last year to Cigna from her doctor certifying that she was prediabetic and in need of dietary counseling.

When a representative told her the letter was discarded because it didn't have the right coding information, she sent a revised letter and called the customer service line repeatedly for four months. Workers and their supervisors promised to give her an answer but never did, and the nutrition counseling her doctor called for fell by the wayside, she says.

"What upsets me is I pay for this," says Kuck, 64, noting that her Cigna premiums cost her more than \$400 a month before her employer switched her to another carrier this year.

"There's no reason I should have to make all those calls and in the end no one got back to me," she says. "They wear you down and you can't get information from them."

### Gathering information

Such allegations of unresponsiveness caught the attention of New York Attorney General Eliot Spitzer, whose investigations of Wall Street and mutual funds have rocked those parts of the financial industry.

In March, Spitzer accused some of the nation's largest health insurers of withholding medical information from some consumers who need it to determine whether they're covered for certain procedures.

Posing as consumers with five different medical conditions who were shopping for health insurance, Spitzer's staff began sending letters in March 2003 requesting information to determine if procedures for treating ailments such as Crohn's disease and diabetes were medically necessary. Half of the 22 health plans surveyed failed to provide a single "satisfactory response," Spitzer's office said.

Spitzer's office sent five letters to each health plan. The response was deemed "satisfactory" if the plan complied with New York law by sending "sufficiently specific information to constitute clinical review criteria," whether the information was in the subscriber handbook or provided as a separate document.

Because no health plan sent four or five satisfactory responses, none received an "A." One health plan, Empire HealthChoice, received a "B" by providing satisfactory clinical review criteria for three medical needs. Three health plans received a "C" by providing acceptable information for

two medical needs, while seven health plans scored a "D" by providing it for just one out of the five medical conditions surveyed.

The remaining 11 health plans failed because they didn't furnish a single satisfactory response to any of the requests, according to the survey.

The companies doing business in New York, including Aetna, Cigna, Oxford Health Plans and UnitedHealth Group, may be subject to an enforcement action as a result of the attorney general's survey.

The report comes at a time when employers and health insurers are asking consumers to take more responsibility for their own care.

"If a medical service is not deemed medically necessary, then the health plan will not pay for it, and the consumer is left with the choice of either paying for services out-of-pocket or foregoing treatment," the report says.

"Prospective members with imminent or existing medical needs must have access to clinical review criteria that apply to their condition in order to effectively shop for the best health plan for their particular medical needs."

## **Insurers take stock of the problem**

UnitedHealth rated a "D" for having only one out of five responses deemed satisfactory. The company will work to make sure requests don't fall through the cracks and see that more of their responses go into enough detail to end up on the satisfactory list, spokesman Mark Lindsay says.

"We endeavor to answer all of our questions that way," Lindsay says. "We are not happy that all our answers weren't like that and will work internally and with the attorney general" to meet that goal.

Health insurers are focusing on customer service and the technology to make it better, and consumers have more tools available to them to resolve their issues and challenge plan decisions now than they did a decade ago, says Susan Pisano, spokeswoman for America's Health Insurance Plans, a trade group representing 1,300 companies that provide medical coverage to 200 million Americans.

"All three of these things mean improvement going forward, but I think there are still some situations that don't get resolved in the most timely fashion," Pisano says. "Consumers need to understand what the procedures are with their insurance company and how to get things resolved when they need to."

But Kuck isn't convinced. As far as she's concerned, the biggest problem with the U.S. health-care system isn't the high cost of prescription drugs, she says.

"I am totally frustrated with the insurance companies running our lives because you cannot get the care you're supposed to get because you don't even know what your coverage is, and when you do have a legitimate thing you're trying to pursue, you're stonewalled," she says.

While Cigna wouldn't comment on Kuck's case, the insurer plans to make its clinical review guidelines available on its Web site by this summer, and does give authority to customer-service workers to expedite the request process, spokeswoman Patty Caballero says.

"Our front-line people are very empowered," Caballero says. "The person you reach becomes the person who works through your issue until it can be resolved for you."

Aetna received an "F" in Spitzer's survey. Still, it has perhaps one of the most expansive Web-based programs to arm consumers with the information they seek about the conditions that determine coverage.

Since 1999, the company has been posting "clinical policy bulletins" on its Web site for consumers to consult and print out to take with them to their doctors' visits, medical director Dr. Marjorie Schulman says.

Consumers, whether they're Aetna plan members or not, can go online and find out the company's standards for coverage of things such as breast reduction surgery, one of the five areas Spitzer targeted in his inquiry.

Aetna spells out its positions on 700 different ailments with charts and an outline format that's easy to follow. The clinical policy bulletins are updated regularly, which results in better business all around, Schulman says.

"It doesn't help us to win an account in 2004 and lose it in 2005," she says. "There's nothing to get an employer to change plans faster than getting a bunch of disgruntled people knocking on his door."

## **Advocates on the look-out**

Because consumers in group health insurance plans don't see the contracts their employers sign on their behalf, it's important consumers push for disclosure on guidelines whenever they can, says Wendy Mariner, a law and socio-medical sciences professor at Boston University.

Even so, economic incentives for improving the system are mostly absent, she says.

"It's a very frustrating situation, certainly for the patients and even some health plans who are trying to figure out how to do the right thing and having a tough time with it," Mariner says.

"Until we have a market that encourages competition among plans on quality and responsiveness, we can't expect the industry to take actions that would be costly to them. I don't think we're going to get that kind of market, not without some regulation that would put all the companies on an even playing field."

The best recourse consumers have if they face an unresponsive health plan is to keep track of their attempts and report the incident to their state insurance agencies, attorneys general and consumer groups, says Jamie Court, president of the Foundation for Taxpayer and Consumer Rights.

"We often can embarrass HMOs into doing better," he says. "It's only when one person comes forward that Eliot Spitzer or a group like ours can bring a case."

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