RESOLVED, That the American Bar Association supports the right of all consumers to a fair and efficient process for resolving differences with managed health care plans, health care providers, and the institutions that serve such plans and providers. That process should include three elements recommended by the Consumer Bill of Rights and Responsibilities of the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry: (1) timely written notification and explanation of a decision to deny, reduce or terminate services or deny payment for services; (2) a rigorous system of internal review; and (3) an independent system of external review.

FURTHER RESOLVED, That consumer education and ombudsman programs should provide information and assistance in resolving health care complaints; and that health care dispute resolution processes should be fully accessible.
REPORT TO THE HOUSE OF DELEGATES

I. Background: Growth of Managed Health Care

The recent wave of managed care has fundamentally changed the practice of medicine and the delivery of health care in the United States, bringing both promise and problems for American consumers. Managed care may be defined as:

"Any system of health service payment or delivery arrangements where the health plan attempts to control or coordinate use of health services by its enrolled members in order to contain health care expenditures, improve quality, or both. Arrangements often involve a defined delivery system of providers with some form of contractual arrangement with the plan."1

Managed care is marked by "a confluence of the functions of providing and paying for health care services," limits on consumer selection of providers and health care services, and assignment of the risk of excess costs to the providers -- with consequent incentives to limit care.

Managed care dates back to the development of group practice plans over 60 years ago. In the 1970s, health maintenance organizations (HMOs), funded through prepaid fees from members, offered significant preventive services and sought to provide quality care in a more cost-effective way than traditional fee-for-service medicine. In 1973, Congress passed the federal HMO Act2 to promote the development of HMOs nationwide. The move toward managed care in the 1980s and 1990s was primarily an effort by health insurance firms and employers to control rapidly escalating health care costs. With the failure of federally mandated health care reform in 1993, providers and payers have continued the trend away from indemnity coverage and have expanded the variety of managed care mechanisms beyond HMOs.

Today, managed care is exploding on the health care scene. Three quarters of all Americans with private health insurance are now enrolled in managed care,3 as are over five million Medicare and 13 million Medicaid beneficiaries.4 Medicare "risk plans" receive a


capitated rate for all beneficiaries from the Health Care Financing Administration. Since 1991, the number of Medicare beneficiaries enrolled in risk plans has more than doubled and is estimated to increase from 4.4 million in 1997 to 14.9 million in 2007. The 1997 Balanced Budget Act significantly expanded the Medicare managed care options under the new Medicare+Choice program. Additionally, state reliance on managed care to serve Medicaid beneficiaries has expanded dramatically. The Balanced Budget Act allows states to implement mandatory managed care programs without a waiver from the Department of Health and Human Services.

Managed care can offer some real advantages for consumers. "At its best, [managed care] emphasizes primary and preventive care and can improve access to care. For people without a regular source of care, or who use emergency rooms for routine care, managed care provides a stable point of entry into the medical system and to a provider they can rely on." Managed care also has the potential of coordinating care, a feature especially important for the elderly and the chronically ill. Finally, managed care presents the opportunity "to hold plans accountable for... the quality of care that they provide." However, the emphasis on cost control can result in barriers to treatment; and frail and chronically ill seniors and persons with disabilities who are more likely to need health care services may have problems enrolling and accessing the care they require.

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5 Pub. L. 105-33 (Aug. 5, 1997), at §4001 et. seq.

6 Id., §4702.


8 Id.

II. Managed Care Consumer Disputes

Consumer problems in managed care might be classified in four general areas: eligibility for services, amount of payment, coverage of services, and quality of services. While hard data on the kinds and extent of consumer disputes is meager, we do know that enrollees are experiencing a variety of difficulties in obtaining care from managed care organizations.

For Medicare managed care disputes, there is data concerning those disputes that have reached the external review stage. This shows that among the most "error prone" cases are problems concerning coverage of emergency care, coverage of urgent out-of-area care, and pre-service denials; and that pre-service denials have been the most rapidly growing case category, comprising about 50% of the appeals. Moreover, a 1997 survey of consumer experiences in managed care (including enrollees in Medicare, Medicaid and private commercial plans) in Sacramento, California, conducted by the Lewin Group revealed that 27% of managed care households surveyed had experienced a difficulty with their health plan in the previous 12 months. A fair number of those consumers with problems (29%) took no action to resolve them. Among those who sought resolution of their difficulties, 54% were dissatisfied with the resolution or had not yet resolved the problem. Finally, in a national 1997 survey by the Kaiser Family Foundation and Harvard University, 59% of consumers said managed care plans have made it harder for people who are sick to see medical specialists; half said managed care has decreased the quality of care for people who are sick; and 60% said it has reduced the amount of time doctors spend with patients.

All of this makes a strong case for solid, workable systems of resolving consumer-plan conflicts over care and payment. "The combination of strong financial incentives to undertreat and procedural obstacles to covered care makes clear the need for prompt, fair resolution of disputes involving HMO denials of covered services... . The existence of effective recourse procedures for HMO enrollees would... lead to prompt, covered treatment [and would] foster patient trust in HMO determinations (and in this delivery system in general) and minimize..."
disenrollment. HMOs would benefit from more satisfied memberships. Indeed, in managed care good medical treatment can be directly dependent on good dispute resolution, since prior approval for services by a gatekeeper typically is required. Conflicts often arise before the fact of treatment rather than after. Enrollee health and well-being may be at stake — and justice delayed may truly be justice denied.

III. Current Mechanisms for the Resolution of Consumer Disputes

Current mechanisms for addressing consumer disputes in managed care provide a patchwork of multiple federal and state systems uneven in procedural protections, consumer accessibility and implementation. There is not even a common language for managed care dispute resolution. Words like "complaint," "grievance," and "appeal" often are used interchangeably with little agreed-upon definition.

First, the Medicare grievance and appeal process, perhaps the strongest currently operating model, has the greatest impact for the aging and disability populations. Under Medicare, non-appealable "grievances" — such as complaints about waiting time, facilities or physician demeanor — are considered internally through plan grievance processes. Appealable issues of denial, reduction or termination of care are considered at several levels — first internally by plans, then externally by an outside reviewer (the Center for Health Dispute Resolution) under contract with the Health Care Financing Administration — and, if still unresolved, by a federal administrative law judge, and in some cases by a federal court. Medicare now has an expedited review process for urgent cases.

Second, the federal Medicaid statute requires states to provide fair hearing procedures for eligibility and coverage disputes before aid is reduced or denied. In addition, plans contracting

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18Balanced Budget Act, supra note 17, at §1851(g)(3).

with Medicaid must establish an internal complaint procedure to resolve disputes promptly.\textsuperscript{29}

Third, the federal HMO Act applies to “federally qualified plans” and allows them great discretion in setting up grievance systems with “meaningful procedures.” The process is not well defined or enforced.

Fourth, employers offering managed health care benefits to their employees must comply with requirements of the Employee Retirement Income Security Act (ERISA). ERISA sets out procedures for resolving grievances, but these procedures are geared toward disputes over payment of fees for services. The Department of Labor has solicited public input on needed improvements in the process.\textsuperscript{30}

Fifth, state laws vary considerably. All states require HMOs to have a grievance procedure. As of 1996, about 30 states set out at least some specifics concerning the procedure, and nine spelled out the process in detail— but the remaining states failed to describe the nature of the process.\textsuperscript{31} Some state laws are based on a model HMO law proposed by the National Association of Insurance Commissioners.\textsuperscript{32}

IV. Efforts to Improve Managed Care Dispute Resolution

Clearly, if the developing health care system including managed care is going to work, procedures for addressing consumer conflicts must be timely, fair, consistent, accessible—and readily understood by enrollees. What should such procedures look like?

The question is a compelling one that raises a host of knotty issues: How can the consumer really have an opportunity to be heard? What kinds of processes would engender careful and fair review of enrollee health care needs? What are reasonable timeframes for the resolution of consumer disputes? Urgent care disputes? What kinds of help should consumers have in navigating managed care systems and cutting through bureaucratic delays and impediments? Should plan decisions be reviewable by external independent entities—as now occurs in Medicare? Should services slated to be reduced or terminated be continued pending appeal? How can dispute resolution processes be most accessible to older persons and persons with disabilities? How much do dispute resolution processes cost and who should pay for them?

\textsuperscript{29} 42 C.F.R. §434.32 (c) (1994).
\textsuperscript{31} Families USA Foundation, HMO Consumers At Risk: States to the Rescue (July 1996).
\textsuperscript{32} National Association of Insurance Commissioners, Health Carriers Grievance Procedure Model Act (October 1996).
These issues have been in the forefront recently in several arenas. The new Medicare+Choice language in the Balanced Budget Act addresses appeals and grievance procedures and requires the Health Care Financing Administration to publish regulations establishing standards. HCFA has solicited public input on beneficiary protections and ways to strengthen the grievance and appeals process, and expects to publish regulations in June 1998.

In March 1997, President Clinton appointed an Advisory Commission on Consumer Protection and Quality in the Health Care Industry, composed of representatives of all major stakeholders in today's health care arena. The President recognized the importance of dispute resolution by mandating that the Commission develop a consumer bill of rights assuring that consumers have access to simple and fair procedures for resolving health care coverage disputes with plans. In heralding the Commission's Consumer Bill of Rights and Responsibilities, President Clinton has ordered federal agencies to adopt its protections to the extent of their authority, challenged private health plans to adopt them voluntarily, and is seeking Congressional action where necessary. In addition, a broad range of federal and state legislative initiatives have recently targeted consumer dispute resolution in managed care, seeking to strengthen and clarify the grievance and appeals process.

The industry too has recognized the importance of effective grievance and appeals mechanisms. The American Association of Health Plans (AAHP) in 1997 adopted a policy statement concerning appeals. AAHP acknowledges that "dispute resolution is a core priority for health plans" since "a patient's complaint may lead to improvements in providing services, thus contributing to improvements in the overall quality of care. Moreover, a health plan's ability to resolve disputes has a bearing on overall patient satisfaction."

Finally, two American Bar Association entities have highlighted the need for changes in managed care consumer dispute resolution. First, the ABA Commission on Legal Problems of the Elderly held a two-day interdisciplinary roundtable in April, 1997 that focused specifically on

30Ignagni, K. & Wilber, K., "Encouraging Innovation in Resolving Disputes Between Health Plans and their Members," 34 NIDR Forum 1, National Institute for Dispute Resolution (December 1997). Karen Ignagni is the AAHP President and Chief Executive Officer and Kathryn Wilber is Assistant General Counsel.
resolution of managed care disputes involving older persons and persons with disabilities. The session explored the full scope of dispute resolution processes, including grievances and appeals as well as possible alternative techniques. Three working groups produced "exploratory recommendations" for improving dispute resolution structure and processes.26

Second, the Association has joined with the American Arbitration Association and the American Medical Association in a Commission on Health Care Dispute Resolution. Its mission is to "evaluate and make recommendations as to how alternative dispute resolution should be used to provide a just, prompt, and economical means of resolving disputes over access to health care treatment, and coverage, in the private health plan/managed care environment." This Commission expects to complete its work by the summer of 1998, and issue a final report on the applicability of alternative dispute resolution mechanisms such as mediation and arbitration to address disputes in the private managed care arena. The broader recommendation proposed here, with its overall emphasis on specific procedural due process provisions in dispute resolution, should set the stage for this kind of innovative ADR solution.

V. Elements of the Proposed Recommendation

Recognizing that different approaches are being taken by a broad array of federal, state, industry and professional entities and that there has been little systematic collection of data on resolution of health care disputes, nonetheless certain basic principles have emerged. The three due process requirements are set forth in the first resolved and the two supporting requirements in the second resolved.

The due process requirements are notice, internal plan grievance and appeal processes and external review. They are described more fully below.

1. Notice of Decisions to Deny, Reduce or Terminate Services. A keystone of consumer rights in managed care is adequate notice to enrollees if a service is to be denied, reduced or terminated. Consumers cannot take action if they are unaware of an adverse decision, unaware of appeal rights, or unaware of how to use the appeal system -- that is, if notice is lacking, inadequate or untimely.

At the state level, some jurisdictions specifically provide that consumers must have a written notice of service denial, but others fail to address the issue.27 Those that do not should, those that do need to police compliance with the requirement.


Notice for Medicare beneficiaries has been problematic. HMOs are required to provide notice if a service is denied or terminated, including the reasons for the denial, and information on how to appeal. But plans do not always meet this requirement. Also, they may treat a consumer concern as a grievance necessitating only internal plan level determination rather than as an appeal requiring notice of an adverse determination and elevation to a higher level for re-evaluation. Moreover, a notice may fail to give clear reasons for the denial. A recent U.S. District Court decision, Grijalva v. Shalala, found that notices to Medicare beneficiaries were insufficient, often giving only "vague, ambiguous, non-specific reasons for denial."

The Consumer Bill of Rights and Responsibilities of the President’s Advisory Commission provides for “timely written notification of a decision to deny, reduce or terminate services or deny payment for services. Such notification should include an explanation of the reasons for the decisions and the procedures available for appealing them.” At the Roundtable conducted by the ABA Commission on Legal Problems of the Elderly, the working group on grievances and appeals recommended improvements in consumer notice and “access to information relevant to the consumer’s situation.” The industry also seeks to strengthen notice. The AAHP states in its appeals policy that —

“Health plans should explain, in a timely notice to the patient, the basis for a coverage or treatment determination with which the patient disagrees, accompanied by an easily understood description of the patient’s appeal rights and the time frames for an appeal.”

2. Internal Plan Grievance and Appeal Processes. There is little information about internal plan processes for addressing consumer conflicts. It appears that most or all plans have some type of internal complaint procedure. But we don’t know, for instance, how plans define an adverse decision, how they explain appeal rights to enrollees, how they reconcile competing mandates under varying state and federal laws — or how long the review process takes, how

31 42 C.F.R. §417.608(a). The Balanced Budget Act, supra note 17, addresses notice at §1851(g)(1)(B).
33 Id.
36 Karp & Wood, supra note 29 at 4.
37 Ignagni & Wilber, supra note 28, at 1.
urgent cases are handled, and to what extent enrollees can participate. The Grijalva decision found that grievance and appeal procedures followed by HMOs fail to secure minimum due process for Medicare beneficiaries. Moreover, a series of 1996 reports from the Office of the Inspector General for the Department of Health and Human Services detailed problems in the way in which plans handle Medicare appeals, including failure to distinguish properly between grievances and appeals. 30

The Consumer Bill of Rights and Responsibilities of the President’s Commission provides that all consumers have the right to "a rigorous system of internal review" including: timely written notification of a decision to deny, reduce or terminate services or deny payment; timely resolution of appeals; a review conducted by credentialed professionals not involved in the initial decision; and written notification of the determination; as well as reasonable processes for resolving complaints about issues such as waiting lists, hours, staff and provider demeanor, and facilities. 31

At the ABA Commission on Legal Problems of the Elderly Roundtable, the working group on grievances and appeals recommended models for the internal plan level of review that "strengthen the consumer’s voice, including use of in-person resolution, effective representation, and timely review." 32 The industry also seeks improvement in internal processes. AAHP is "committed to finding ways to improve further the internal processes used by health plans for resolving disputes in order to make them more responsive to consumers needs and expectations." 33 The AAHP appeals policy states that "an expedited appeals process should be made available for situations in which the normal time frame could jeopardize a patient’s life or health. Appeals should be resolved as rapidly as warranted by the patient’s situation." 34

3. External Review. If a dispute remains unresolved after internal plan review, should there be review by an expert decision-maker outside the plan? A well developed external review appears a critical safeguard for consumers — and also could benefit plans by affording a check on their decision-making process and important feedback on how the system is working.

Medicare currently provides for such a system of external review. If an internal plan decision is not "wholly favorable to the beneficiary" it is forwarded to the reviewer for the Health Care Financing Administration — the Center for Health Dispute Resolution, which has been

30 Office of Inspector General, supra note 32.
33 Ignagni & Wilber, supra note 28 at 1.
34 Id.
conducting external review for HCFA since 1989. Following the lead of Medicare, a number of
states have recently mandated external/independent review requirements.

The President’s Commission Bill of Rights calls for “an independent system of external
review” available after internal processes have been exhausted (except in urgent cases, in which
exhaustion would not be necessary). The external review would apply to decisions to deny,
reduce or terminate coverage or deny payment “based on a determination that the treatment is
either experimental or investigational in nature, . . . or that such services are not medically
necessary and the amount exceeds a significant threshold or the patient’s life or health is
jeopardized.” The Bill of Rights specifies that external review should be conducted by
appropriately credentialed professionals not involved in the initial decision; should “follow a
standard of review that promotes evidence-based decision-making and relies on objective
evidence” and is timely.

The working group on grievances and appeals of the Commission on Legal Problems of
the Elderly Roundtable stated that “automatic review of ‘adverse’ decisions at the plan level is
generally seen as beneficial, but needs assessment to determine if it is the most effective and
efficient way to monitor plan grievances and appeals.”

AAHP also is exploring the implications of external review and recognizes that it may in
certain circumstances “hold promise as a means of resolving disputes and providing an additional
assurance to patients.” Finally, it is notable that three major HMOs — Kaiser Permanente, HIP
Insurance Plans and the Group Health Cooperative of Puget Sound — with the American
Association of Retired Persons and Families USA, have endorsed an “external, independent
review process to examine denials of coverage for certain experimental treatments.”

Principles of due process do not serve their purpose unless they are understood by, and
implementation is available to, those whom they are designed to protect. For that reason the
second resolve urges education programs and special efforts to afford accessibility for consumers
of health care services.

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4Id. At 6-7.
4Ignagni & Wilber, supra note 28, at 3.
4AARP, Group Health Cooperative, Kaiser Permanente, HIP, Families USA,
Consumer Education and Ombudsman Programs. Consumers today must grapple with a proliferation of health insurance products, rapidly changing rules and regulations, industry acquisitions and mergers, staff turnover -- and differing grievance and appeal systems for different payers. Conflicts may arise out of internal plan decisions riddled by tension between the health needs of consumers and the cost constraints of the managed care organization. Consumers may sometimes be in the dark about who made the decision, on what grounds and with what evidence -- and where to turn next.

Even well educated consumers require help in navigating the managed care system. Recent studies have shown that some people do not understand what "managed care" is and how it differs from traditional health insurance; and studies have shown that Medicare enrollees have little awareness of appeal rights -- a 1996 report by the HHS Office of the Inspector General found that 89% of respondents were knowledgeable about their general right to make a complaint, but were much "less aware of specific instances on which they might exercise their appeal and grievance rights." Moreover, consumers may experience difficulties when they are least able to be their own advocate -- when they are sick, traumatized by health concerns, under stress and lacking in stamina.

Health plans and physicians should be the first source of education and assistance, and often are of great help. A number of health plans provide consumers with one-on-one help through customer and member service departments. But there is considerable variation in how plans respond; and some consumers may not turn to their health plans, seeking instead independent resources.

A public-private patchwork of consumer assistance services currently exists -- including programs by large group purchasers and labor unions; a network of HCFA-funded information, counseling and assistance programs; legal services and other resources. Fourteen state or locally

Kaiser-Harvard Project, supra note 11. Also see Findlay, S., "Survey on HMOs Finds Widespread Ignorance," USA Today (November 11, 1996).


Office of Inspector General, supra note 32.

Advisory Commission on Consumer Protection. , supra note 25, at 22.

based Medicaid programs have established ombudsman programs to aid beneficiaries; and the Center for Health Care Rights is operating a pilot managed care ombudsman program for consumers in Sacramento, California. Nonetheless, consumer assistance is not widespread, well-funded or coordinated.

The Bill of Rights of the President's Commission states that "Consumers have the right to receive accurate, easily understood information and some require assistance in making informed health care decisions about their health plans, professionals and facilities." Education and ombudsman programs can help consumers in choosing plans and understanding their rights and responsibilities. They can help consumers to be their own advocates and can intervene when necessary, clarifying communications or pursuing formal grievances and appeal processes. Finally, they can collect and analyze data that can be used to improve the health care delivery system.

The usage of medical ombudsman and other dispute resolution tools... may aid both the consumer and the plan in the development of a healthy relationship and settle many disputes." Indeed, AAHP and member plans currently "are taking steps to develop and test... ombuds-based models." Accessibility of Dispute Resolution Programs. Consumers who are older, frail, have significant health problems or chronic illnesses, or have disabilities face added challenges in managed care. They may have reduced energy and more difficulty reading, hearing and attending face-to-face meetings. They may be less able to question and contest plan decisions. Some older persons may have diminished capacity to make health care decisions and may have trouble weighing the costs and benefits of plan options, understanding plan rules and pursuing grievances and appeals. Yet these same consumers may be more in need of health services than the general population.

According to Lee & Scott, "ombudsman," originally a Swedish word, classically refers to an official who is independent, deals with specific complaints by individuals, and has the power to investigate and raise questions but not to reverse administrative decisions. In the United States, ombudsman programs serve in many arenas to educate consumers, investigate — and sometimes provide individual advocacy.

Lee, supra note 52.


Fried, supra note 28, at 5.
The working group on the Elderly and Persons with Disabilities of the Commission on Legal Problems of the Elderly Roundtable recognized that dispute resolution systems in managed care must meet the unique needs of this vulnerable population. The working group stated that "dispute resolution systems in managed care should be designed to accommodate the needs of enrollees who are elderly and/or have disabilities. . . . Appropriate accommodations include those required by the Americans with Disabilities Act." The working group cited several examples of accommodations: holding hearings or other dispute resolution sessions at convenient, accessible locations including an individual's home, providing appropriate transportation, providing simple notices in large type, and encouraging the use of support persons to help in the resolution of disputes.

VI. Existing Association Policy

The Association has recognized the importance of procedural due process for consumers in the health care delivery system. ABA policy supports efforts to "improve the administrative and judicial process utilized by the Department of Health and Human Services" in Medicare (8/88), and to "establish more comprehensive rules of procedure for each of the various classes of Health Care Financing Administration administrative proceedings" (2/89). Moreover, a 1990 resolution sponsored by the Commission on Legal Problems of the Elderly, revised in 1994 by the Sections of Taxation, Real Property, Probate and Trust Law, and Business Law calls for legislation to provide "quality health care [with] procedural due process for consumers, providers and other interested parties" (2/94).

These broadly phrased policies provide a strong base of support for the proposed recommendation, but were drafted before the widespread changes in the health care system including the emergence of managed care. The proposed recommendation focuses on specific procedural protections in a managed care environment, thus lending specificity and timeliness to the Association's current policy. It would allow the Association to play a critical role in ensuring procedural due process rights for consumers as the health care delivery system continues to change.

F. Wm. McCalpin
Chair
Commission on Legal Problems of the Elderly
August, 1998

Submitting Entity: Commission on Legal Problems of the Elderly

Submitted By: F. Wm. McCalpin, Chair

1. Summary of Recommendation(s): The recommendation supports the right of consumers to a fair and efficient process for resolving problems with managed health care plans, including timely written notice of decisions to deny, reduce or terminate services, rigorous internal plan review and independent external review. The recommendation also supports consumer assistance through education and ombudsman programs and accessibility of managed care dispute resolution processes for enrollees who are older, frail, chronically ill or have disabilities.

2. Approval by Submitting Entity: The recommendation was approved unanimously by the Commission on Legal Problems of the Elderly at its April 18 meeting.

3. Has this or a similar recommendation been submitted to the House or Board previously? This or a similar recommendation has not been submitted previously. See #4 below for relevant recommendations that have been approved as existing Association policy.

4. What existing Association policies are relevant to this recommendation and how would they be affected by its adoption? The Association has recognized the importance of procedural due process for consumers in the health care delivery system. ABA policy supports efforts to "improve the administrative and judicial process utilized by the Department of Health and Human Services" in Medicare (8/88), and to "establish more comprehensive rules of procedure for each of the various classes of Health Care Financing Administration administrative proceedings" (2/89). Moreover, a 1990 resolution sponsored by the Commission on Legal Problems of the Elderly, revised in 1994 by the Sections of Taxation, Real Property, Probate and Trust Law, and Business Law calls for legislation to provide "quality health care [with] procedural due process for consumers, providers and other interested parties" (2/94).

These broadly phrased policies provide a strong base of support for the proposed recommendation, but were drafted before the widespread changes in the health care system including the emergence of managed care. The proposed recommendation focuses on specific procedural protections in a managed care environment, thus lending specificity and timeliness to the Association's current policy, without reference to a particular dispute resolution procedure. It would allow the Association to play a critical role in ensuring procedural due process rights for consumers as the health care delivery system continues to change.
5. **What urgency exists which requires action at this meeting of the House?**

Resolution of disputes in managed care currently is under consideration in a number of forums at the federal and state level. Several bills concerning managed care are pending before the Congress, and each includes some form of grievance and appeals procedures. In November, 1997 the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry released a Consumer Bill of Rights and Responsibilities in health care that includes grievance and appeal processes; and the President has ordered federal agencies to adopt its protections to the extent of their authority, challenged private health plans to adopt it voluntarily, and is seeking Congressional action where necessary. The 1997 Balanced Budget Act included provisions on the Medicare grievance and appeal system, and the Health Care Financing Administration currently is drafting regulations. The National Association of Insurance Commissioners is considering revisions in its Health Carrier Grievance Procedure Model Act. Many states have managed care grievance and appeal studies underway or legislation pending. The Association should be active in ensuring procedural due process protections for consumers in these forums.

6. **Status of Legislation.** (If applicable.) While relevant legislation is pending before Congress, this recommendation emphasizes broad principles and does not relate to a particular bill.

7. **Cost to the Association.** (Both direct and indirect costs.) There are no costs to the Association.

8. **Disclosure of Interest.** (If applicable.) N/A. Commission members have no conflict of interest in supporting this recommendation. They seek to advocate for procedural protections for elderly and other enrollees in the managed care environment.

9. **Referrals.** Referred to the Section of Administrative Law & Regulatory Practice, Section on Dispute Resolution, Section of Health Law, Section of Individual Rights and Responsibilities, and Section on Tort and Insurance Practices, Section of Taxation, Section of Real Property, Probate and Trust Law, Business Law Section, Senior Lawyers Section, Young Lawyers Division, and Commission on Mental and Physical Disability Law in June 1998. Also referred to the AAA/ABA/AMA Commission on Health Care Dispute Resolution. Responses not yet known.

10. **Contact Person.** (Prior to the meeting.) F. Wm. McCalpin, Chair, Commission on Legal Problems of the Elderly, c/o Lewis, Rice & Fingerh, 500 N. Broadway, Suite 2000, St. Louis MO 63102, telephone 314-444-7600. At the Commission staff, contact Nancy Coleman, Erica Wood or Naomi Karp, 740 15th Street NW, Washington DC 20005, telephone 202-662-8690.

11. **Contact Person.** (Who will present the report to the House.) F. Wm. McCalpin, Commission Chair.