

Patient-Reported Denials, Appeals, and Complaints: Associations With Overall Plan Ratings

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Patients' complaints about their health insurance plan and denials of care are important aspects of the patient experience. The extent to which specific care is necessary can be complex and contentious.^{1,2} Denials to cover care may reflect barriers to accessing needed care or appropriate curtailing of unnecessary care. Throughout this article, we will refer to a health plan's decision to not cover care as "denial of care" as an imperfect shorthand for the patient's report, recognizing that patients can choose to pay out-of-pocket or out-of-network for their care. Similarly, complaints about health insurance plans may indicate a misunderstanding, a lack of plan responsiveness, or appropriate voicing of patient concerns.

Managed care organizations have delivery systems that greatly influence interactions between physicians and patients.³⁻⁶ Their rules and restrictions on choice of providers, network coverage, review processes, preauthorization, and drug formularies may create conflicts with patients and providers. Through the denial and appeals process, patients, physicians, and health plans communicate and determine what care is medically necessary.

As required by CMS, all Medicare Advantage (MA) contracts (health plans) must provide beneficiaries a means to file a complaint or appeal a denial of coverage.⁷ Denied coverage for care may adversely affect MA enrollees' perceptions of plans and care. Nineteen percent of 2010 Medicare beneficiary disenrollments were prompted by denials of coverage for medical services,⁸ and over one-third of callers to the Medicare Rights Center's national helpline expressed difficulty managing coverage denials and appeals.⁹

Health plans may benefit from how they respond to grievances, complaints, and service failures, known as service recovery.¹⁰ Bitner et al¹¹ found that it is not the service failure that reduces customer ratings of their plan or care, but the service provider's actions (ie, recovery) following the failure that matter. This phenomenon is the "service recovery paradox," wherein those who complain and see their problems resolved by the offending organization may rate the organization higher than those who experience no problems.¹²⁻¹⁴

ABSTRACT

OBJECTIVES: To assess whether Medicare patients' reports of denied care, appeals/complaints, and satisfactory resolution were associated with ratings of their health plan or care.

STUDY DESIGN: Retrospective analysis of 2010 Medicare Advantage Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data.

METHODS: Multivariate linear regression of data from 154,766 respondents (61.1% response rate) tested the association of beneficiary ratings of plan and care with beneficiary reports of denied care, appeals, complaints, and complaint resolution, adjusting for beneficiary demographics.

RESULTS: Beneficiaries who reported being denied needed care rated their plans and care significantly less positively, by 17.2 points (on a 100-point scale) and 9.1 points, respectively. Filing an appeal was not statistically significantly associated with further lower ratings. Beneficiaries who filed a complaint that was satisfactorily resolved gave slightly lower ratings of plans (-3.4 points) and care (-2.5 points) than those not filing a complaint ($P < .001$ for all results).

CONCLUSIONS: Lower ratings from patients reporting complaints and denied care may notably affect the overall 0-10 CAHPS ratings of Medicare Advantage plans. Our results suggest that beneficiaries may attribute the actions that lead to complaints or denials to plans more than to the care they received. Successful complaint resolution and utilization management review might eliminate most deficits associated with complaints and denied care, consistent with the service recovery paradox. High rates of complaints and denied care might identify areas that need improved utilization management review, customer service, and quality improvement. Among those reporting being denied care, filing an appeal was not associated with lower patient ratings of plan or care.

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Service recovery in healthcare differs from other settings, like retail, banking, restaurants, or hotels, because it may not be possible to “make things right” or “undo the situation” in healthcare. A service provider’s apology also could be construed as an admission of a mistake and become the basis for litigation.¹⁵ The few articles about healthcare service recovery in the literature primarily offer managerial suggestions to healthcare administrators rather than empirical evidence.¹⁶⁻¹⁹ One study of a single health management organization (HMO) found a strong positive relationship between satisfaction with the complaint handling process and overall satisfaction with the HMO.²⁰

In general, however, relatively little is known about how denials of coverage for needed care, subsequent appeals of the denied coverage or complaints, and resolution status affect a patient’s rating of their plan or care. The question remains whether patients attribute the denial or complaint to their plan or to their providers. These attributions may also differ by beneficiaries’ health status, given that a denial of care may have greater consequences for those in poor health or with multiple chronic conditions.

Previous research on patient complaints and plans’ reported denials of care has focused on whether a patient has negative or positive experiences with care coverage and identifying any contributing factors. For example, kidney transplant recipients’ interactions with their insurers²¹ suggest that patients have difficult interactions with insurers and limited skills in navigating insurance options, thereby curbing their access to needed medications and health services. More than one-third of Medicaid enrollees reported denials of care for their children in the previous year, with families of children with chronic conditions more likely to report a denial of care.²²

Among the few studies that have focused on patient complaints and plans’ reported denials of care, only 2 appear to examine the relationship between denial of care (whether it was appealed and its resolution) and the patient’s subsequent rating of their health plan or care. Denial of needed care was associated with lower ratings of health plan quality and significantly less trust in patients’ primary care physicians.²³ Similarly, many patients who are denied authorization for emergency department (ED) care are dissatisfied with their health plan but still intend to return to the ED.²⁴ These results follow Folger’s fairness theory,²⁵⁻²⁸ which states that judgments of fairness are related to people’s “would/could/should” reasoning about a decision by a powerful other. Fairness theory predicts that after being denied care, the patient, in assigning responsibility for the injustice, would choose the powerful other with the most “could” authority, here the health plan with authority over authorizations, not the care provider.

This article uses a nationally representative sample of MA enrollees to assess the relationship between patient-reported denials

TAKEAWAY POINTS

- ▶ Patients who reported denials of needed care gave low ratings to their care, and especially their plan, regardless of whether they appealed the denial. Beneficiaries satisfied with complaint resolution provided only slightly lower ratings than those with no complaints.
- ▶ Medicare beneficiaries may largely attribute the actions that lead to complaints or denials to their plans more than to the care they received.
- ▶ Medicare plans should focus on successful complaint resolution, as it can substantially mitigate the low ratings patients give their plan that result from whatever motivated them to file a complaint.

of care, appeals, complaints, and resolution and their association with overall patient ratings of plans and care. Information on plan disenrollment or health plan ratings prompted by coverage denials could be a valuable tool for consumers who need to select a plan or identify an important missed opportunity for Medicare and other health plans for service recovery with patients. Furthering understanding of complaints and reported denials of care is especially pertinent for Medicare recipients, whose average healthcare needs exceed those of the general population and who, in some cases, may have difficulty managing the complaint or appeal process due to age or infirmity.

In 2010, the MA Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey provided a unique opportunity to study these issues, as it included items that asked about complaints and denial of care. Under the Affordable Care Act, patient experience measures from this survey play a role in the determination of quality bonus payments for MA plans.²⁹

This study used additional items from the 2010 MA CAHPS survey to assess the association of MA enrollee ratings of their plan and care with whether they reported a denial of needed care, appealed the denial, or filed a complaint, along with the resolution status of the complaint. We first established the extent to which MA beneficiaries reported filing complaints with their plans or being denied coverage for needed care. Then we tested whether those with complaints/denials provided lower ratings of their health plan or care. Based on fairness theory, we hypothesized that members would assign less blame to the care they received because caregivers did not have the power (ie, “could” authority) to accept or deny the appeal. In contrast, health plan management did have the “could” authority, and so responsibility was attributed to health plans. Thus, plans received lower ratings. Next, we tested whether the patient ratings of their plan and care differed for those filing an appeal and those with successful resolution of an appeal. Based on the service recovery paradox, we hypothesized that members with successful resolution would rate their health plan nearly as high or even higher than those who experienced no problems. Finally, we tested whether those who are in poorer health rated their plans or care more negatively following denied coverage or complaints.

TABLE 1. Survey Items Analyzed

Survey Item	Response Option
Was there ever a time when you believed you needed care or services that [plan name] decided not to give you?	Yes/No
Have you ever asked anyone at [plan name] to reconsider a decision not to provide or pay for healthcare or services?	Yes/No/ Don't know
In the last 6 months, have you called or written [plan name] with a complaint or problem?	Yes/No
Was your complaint or problem settled to your satisfaction?	Yes/No/ I am still waiting for it to be settled
Using any number from 0 to 10, where 0 is the worst healthcare possible and 10 is the best healthcare possible, what number would you use to rate all your healthcare in the last 6 months?	0-10 (rescaled to 0-100)
Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your health plan?	0-10 (rescaled to 0-100)

TABLE 2. Weighted Composition of 2010 Medicare CAHPS Population, By Beneficiary Characteristics (N = 154,766)

Characteristic	%
Male	42.7
Age, years	
65-69	24.3
70-74	28.1
75-79	21.7
80-84	14.5
≥85	11.4
Race/ethnicity	
Hispanic	8.7
American Indian/Alaska Native	0.3
Black	8.0
Asian/Pacific Islander	3.5
Non-Hispanic white	70.7
Multiracial	1.6
Unknown	7.2
Census division	
New England	4.2
Middle Atlantic	16.7
East North Central	14.3
West North Central	6.3
South Atlantic	15.3
East South Central	4.4
West South Central	7.9
Mountain	8.5
Pacific	22.4

(continued)

METHODS

We used data from the 2010 MA CAHPS survey, which included items on complaints and denial of care. This survey was a mail survey of MA beneficiaries, with telephone follow-up on nonrespondents.

Our population of interest was MA enrollees 65 years or older, excluding those in US territories. The analysis was restricted to responding beneficiaries (61.1% response rate for this population), excluding the 6% not completing items about complaints or denial of care, which left 154,766 cases. We examined responses to the survey items listed in **Table 1** and estimated health contract-level standard deviations of denial, appeal, complaint, and resolution responses as the square root of contract variance components.

Second, multivariate linear regression predicted the responses to 2 ratings (health plan and care) from the denial, appeal, complaint, and resolution responses and several covariates: gender, age, race/ethnicity, education, self-reported health and mental health status, Census division, self-reported chronic conditions, Patient Health Questionnaire-2 depression symptoms,³⁰ current smoking status, functional limitations, proxy assistance, dual eligibility for Medicaid, Part D or MA only, Special Needs Plan status, and whether the respondent had a personal doctor. We ran 4 sets of regression analyses to calculate 1) population estimates, 2) within-contract estimates, 3) associations, and 4) differences in these associations. Data were weighted to account for the sample design and nonresponse.

An additional model (results not shown) assessed whether those with poorer health had a stronger negative association with plan ratings than those in better health via an interaction term between overall health status and denial of service. As the average associations were similar for those who did and did not subsequently file an appeal of the denied care, we combined these groups in this analysis.

RESULTS

Characteristics of the Sample

Characteristics of the MA beneficiaries 65 years and older appear in **Table 2**. Forty-three percent were male, 72% were non-Hispanic white, and 26% were 80 years or older. Eighteen percent had a 4-year college degree, and 14% did not have Part D coverage through their MA plan.

Prevalence of Denials, Appeals, and Complaints

Table 3 shows the prevalence of denials, appeals, and complaints. Six percent of respondents reported that their plan denied care or services they believed they needed. Among beneficiaries who

reported a denial of needed care or services, 49% filed an appeal. Overall, 8% of respondents filed a complaint, 54% of whom indicated that their complaint was resolved to their satisfaction.

The contract-level standard deviation of satisfactory complaint resolution from a linear mixed model was 9.9%, suggesting that approximately two-thirds of health plans had rates of satisfactory complaint resolution between 44% and 64% (after accounting for sampling error) and that most contracts had a rate of satisfactory complaint resolution ranging from 34% to 74%. Complaints, which had a contract-level standard deviation of 3.8%, involved a variety of issues and did not necessarily concern denials of needed care. Contract-level standard deviations were 3.7% for reports of denial of care and 5.4% for appeals.

Plan and Care Ratings

Tables 4 and 5 show multivariate linear regressions results that tested the association of denials, appeals, complaints, and resolution with overall ratings of health plan and healthcare, adjusting for beneficiary health and demographic characteristics. Compared with models that only included case-mix characteristics (Model 1), the addition of either denials and appeals (Model 2) or complaints and resolution (Model 3) resulted in a significant increase in predictive power, as shown by the increased R^2 ($P < .001$ for all partial F tests). For both plan and care ratings, denials and appeals added slightly more predictive power than complaints and resolutions.

Compared with beneficiaries who did not report denials of care, those who reported denials gave significantly lower care and plan ratings, rating their care 8.2 points and their plan 17.0 points lower than others on 100-point scales (Table 4). Similarly, those who reported filing a complaint rated their care 5.2 points and their plan 11.2 points lower than others. When denials and complaints were entered together in a model, all results remained highly significant ($P < .001$), with slightly less magnitude, but still indicating significantly lower plan and care ratings among those who filed an appeal or complaint. This suggests that each factor affected plan and care ratings independently.

Among those who reported being denied needed care, both care and plan ratings were somewhat worse for those who did not appeal their denials (a reduction of 7.0 points for those who appealed vs 9.4 for those who did not; $P < .001$) (Table 5). Complaints that were not resolved satisfactorily were associated with much worse ratings of plan and of care than those that were resolved satisfactorily. In Model 3, including only complaint/resolution (along with beneficiary characteristics), complaints with a satisfactory resolution had an average 3.8-point lower plan rating, whereas those without a satisfactory resolution had an average 20.2-point lower plan rating ($P < .001$ for each, as well as for the difference between them).

Although denials/appeals and complaints/resolution were strongly associated with both care and plan ratings, the differences were much greater for plan ratings (Table 5). The model predicting

TABLE 2. (Continued) Weighted Composition of 2010 Medicare CAHPS Population, By Beneficiary Characteristics (N = 154,766)

Characteristic	%
Overall health	
Excellent	9.1
Very good	28.2
Good	39.2
Fair	19.4
Poor	4.2
Mental health	
Excellent	31.2
Very good	35.7
Good	24.7
Fair	7.1
Poor	1.4
Conditions	
Angina	17.2
Cancer	17.2
Chronic obstructive pulmonary disease	15.9
Diabetes	30.0
Heart attack	13.2
Stroke	9.3
Depression	10.3
Smoke now	9.2
Limitations	
High	5.3
Some	73.7
None	21.0
Any proxy	10.7
Answer proxy	3.5
Education	
<8th grade	8.8
Some high school	11.9
High school graduate	36.6
Some college	24.8
Bachelor's degree	8.0
>4-year college	9.9
Dual-eligible	9.9
Part D (yes/no) (vs MA-only)	85.9
Special Needs Plan	
Non-Special Needs Plan	92.5
Chronic condition	1.7
Dual eligibility	5.9
Have personal doctor	95.6

CAHPS indicates Consumer Assessment of Healthcare Providers and Systems; MA, Medicare Advantage.

TABLE 3. Weighted Prevalence of Denials, Appeals, and Complaints in 2010 Medicare Beneficiary Population (N = 154,766)

Outcome	%	Contract-Level SD
Reported being denied care	6.4	3.7
Appealed denial (among those denied care)	49.4	5.4
Made a complaint	8.2	3.8
Complaint resolved satisfactorily (among those who made a complaint)	54.5	9.9

care ratings with both denials/appeals and complaints/resolution (Model 4) had an R² 36% higher than the model with case-mix adjusters alone (Model 1); for plan ratings, the increase was 179%. In those models (Model 4), appeals were associated with average differences of -5.0 points for care rating and -12.4 points for plan rating. Similarly, filing a complaint that was not resolved satisfactorily was associated with differences of -6.6 and -16.3 points, respectively.

DISCUSSION

The relationship between patients and their health plans is fundamental to high-quality care. The denial and appeals process offers patients, physicians, and health plans a means to communicate and determine what care is medically necessary. The complaint resolution process allows patients to voice their concerns about care and attempt a solution. Perceived denial of needed care and unresolved complaints can adversely affect patients' attitudes and experiences with their health plan and care.

This study of MA beneficiaries 65 years and older found that 6% reported being denied care in the past 6 months compared

with the 7% prevalence in an earlier study of a single HMO's commercially insured population²³ in the prior 12 months. We found that 48% of beneficiaries who reported being denied care filed an appeal and 9% registered a complaint; 54% of complaints were resolved satisfactorily.

Our results reinforce the earlier finding²³ that patients reporting a denial of coverage rated their care substantially lower than other patients. We extended previous research by comparing those who reported being denied needed care with those who were denied care and appealed their denial. In addition, beneficiaries who filed a complaint that was satisfactorily resolved had only slightly lower ratings of their plan and care, whereas those who had a complaint that was not satisfactorily resolved had much lower ratings, especially of their plan. We found that although denials/appeals and complaints/resolution were strongly associated with lower care and plan ratings, the association was much stronger for plan ratings. Our findings partially support the service recovery paradox, in that plan ratings improve when there is an appeal after a denial and a resolution after a complaint.

Given the significantly stronger negative associations of denied care and complaints with plan ratings in our study, it appears that beneficiaries attribute nonresolution of a complaint or denial of care to their health plan and much less so to the care they received. Patients may perceive denials and unresolved complaints as a breach of faith by their health plan, rather than their provider. These results support the prediction of fairness theory that patients associate accountability to the health plan (not the care provider) of authority over the complaint or the denied care.

Given that most MA plans satisfactorily resolved only about half of their complaints, there may be substantial opportunity to improve patients' overall health plan ratings and reduce disenrollment by

focusing efforts on increasing the rate of satisfactory complaint resolution and thoroughness during utilization review. Greater transparency with patients about coverage decisions, criteria, and utilization review may help.

Our findings also highlight the value of complaint and appeal data for identifying opportunities to improve customer service and patient education on criteria used in coverage decisions. This information could aid MA and other health plans in service recovery with patients.

Limitations

This study had several limitations. It was not designed to link Medicare CAHPS survey responses to actual Medicare health plan coverage decisions, so it was not possible to determine whether each patient's report of a

TABLE 4. Associations of Reported Denial of Care and Complaints With Overall Ratings of Care and Plan: Multivariate Linear Regression Model, Main Effects Only, Weighted^{a,b}

	Model 1: CMAs Only Estimate	Model 2: Denial Estimate (SE)	Model 3: Complaint Estimate (SE)	Model 4: Denial and Complaint Estimate (SE)
Care Ratings (n = 119,991)				
R ²	.0644	.0817	.0751	.0857
Denial		-8.20 (0.30)		-7.29 (0.31)
Complaint			-5.24 (0.24)	-3.94 (0.25)
Plan Ratings (n = 147,667)				
R ²	.0435	.0954	.0731	.1106
Denial		-17.01 (0.34)		-15.11 (0.35)
Complaint			-11.22 (0.29)	-8.55 (0.28)

CMA indicates case-mix adjustment; SE, standard error.

^aP < .0001 for all coefficients.

^bAll models include the case-mix adjusters presented in Table 2: gender, age, race/ethnicity, Census division, general and mental health, indicators for 6 chronic conditions, depression, current smoking, limitations, proxy status, education, dual eligibility, Medicare Part D participation, Special Needs Plan type, and having a personal doctor.

TABLE 5. Associations of Reported Denial of Care, Appeals, Complaints, and Satisfactory Resolution With Overall Ratings of Care and Plan: Multivariate Linear Regression Model, Main Effects Only, Weighted^{a,b}

	Model 1: CMAs Only Estimate	Model 2: Denial/Appeal Estimate (SE)	Model 3: Complaint/Resolution Estimate (SE)	Model 4: Denial/Appeal and Complaint/Resolution Estimate (SE)
Care Ratings (n = 119,991)				
R ²	.0644	.0820	.0775	.0877
Denial/appeal				
Denial and appeal		-7.04 (0.40)		-4.98 (0.41)
Denial, no appeal		-9.42 (0.45)		-8.87 (0.45)
No denial (ref)				
Complaint/resolution				
Complaint and resolution			-2.68 (0.29)	-2.31 (0.29)
Complaint, no resolution			-8.33 (0.38)	-6.57 (0.39)
No complaint (ref)				
Plan Ratings (n = 147,667)				
R ²	.0435	.0954	.0889	.1212
Denial/appeal				
Denial and appeal		-17.16 (0.48)		-12.38 (0.47)
Denial, no appeal		-16.86 (0.50)		-15.55 (0.49)
No denial (ref)				
Complaint/resolution				
Complaint and resolution			-3.77 (0.30)	-2.84 (0.30)
Complaint, no resolution			-20.16 (0.47)	-16.25 (0.47)
No complaint (ref)				

CMA indicates case-mix adjustment; ref, reference; SE, standard error.

^aP < .0001 for all coefficients.

^bAll models include the case-mix adjustors presented in Table 2: gender, age, race/ethnicity, Census division, general and mental health, indicators for 6 chronic conditions, depression, current smoking, limitations, proxy status, education, dual eligibility, Medicare Part D participation, Special Needs Plan type, and having a personal doctor.

denial of coverage reflected a health plan decision. Patients reporting a health plan denial may have misinterpreted statements by their physicians or actions by their physicians' group practice. We knew only that the patients believed they had experienced a denial of coverage. Our study provided no data on subsequent healthcare utilization or outcomes, and it was not intended to evaluate the legitimacy of the grounds on which the MA plan based its denials of coverage.

Although just under half of patients who reported being denied care filed an appeal, filing an appeal does not seem to reflect a beneficiary perception that the denial was particularly egregious, but may instead reflect the beneficiaries' self-efficacy with respect to filing an appeal. Patients who file a complaint that is not resolved satisfactorily may continue to view their plan experiences negatively, more so than their care experiences, which may increase their risk of disenrollment.³¹ The most common reason for disenrollment in 2010, applying to one-fourth of MA disenrollments, was concerns

or issues related to out-of-network providers and prompted by an acute episode of illness or diagnosis (most often cancer).⁸

Although there may be unobserved differences associated with beneficiaries whose complaints are satisfactorily resolved and those whose complaints are not, our results suggest that improved complaint resolution might substantially improve the perceptions of patients whose initial experiences were sufficiently negative to motivate a complaint. Given that many beneficiaries may have equally negative experiences but do not file complaints, active outreach to patients to elicit concerns might identify additional opportunities to improve care and patient experiences. ■

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