

Pa. Department of Health
www.health.state.pa.us
(888) 466-2787
toll free

Pa. Insurance Department
www.insurance.state.pa.us
(877) 881-6388
toll free

What to do if you have a problem with your managed care health insurance plan

Your Rights Under State Law

State law requires managed care health insurance plans to have a process for consumer complaints and grievances. The law, known as the Quality Health Care Accountability Protection Act, was set up to protect your rights and help you get the information you need about your health-care coverage if you are enrolled in a plan with a primary care physician gatekeeper, such as a health maintenance organization (HMO) or point-of-service (POS) plan.

You also can check your subscriber contract, coverage certificate or enrollee handbook provided by your managed care plan for more information.

What if my problem is urgent?

A managed care plan must have a process for an accelerated internal grievance review within 48 hours of any grievance if a member's life, health or ability to regain maximum function is in jeopardy.

Do all managed care plans follow this process?

There may be different procedures for handling complaints and grievances if you are:

- a federal employee or dependent enrolled in a managed care plan
- a Medicare or Medicaid recipient enrolled in a managed care plan
- employed by a business that is self-funded or self-insured (ERISA)

Where to call...

Consumers are encouraged to call the Pennsylvania Department of Health's toll-free number at **(888) 466-2787**; or the Insurance Department's toll-free number at **(877) 881-6388**, or contact one of its three regional offices:

- Harrisburg (717) 787-2317
- Philadelphia (215) 560-2630
- Pittsburgh (412) 565-5020

STEPS for handling a PROBLEM

Call your managed care plan member services department

Always call your managed care plan members services department first. Give them a chance to solve the problem. Many problems are solved at this level in an informal manner.

File a formal complaint or grievance with your plan

If your phone call to the plan does not solve your problem, call the plan again and tell them that you want to file a formal complaint or a formal grievance.

You should file a *formal grievance* if the plan is denying you a covered service or treatment or has denied a claim for a covered service or treatment on the basis that the service or treatment was not medically necessary.

EXAMPLES OF GRIEVANCES:

- Your emergency claim was denied on the basis that it was not a true emergency.
- Your physician refuses to give you a referral to see a specialist on the basis that it is not medically

necessary and that the condition can be treated by him/her.

If your problem relates to any other issue with your plan, you should file a *formal complaint*.

EXAMPLES OF COMPLAINTS:

- You disagree with the treatment you received from your physician.
- You have a difficult time obtaining an appointment with your physician.
- Your plan refuses to provide treatment on the basis that the procedure is cosmetic or experimental and is not a covered benefit.
- You have a complaint about your premium increases or rates.

If you are confused about whether your problem is a complaint or a grievance, ask your plan for advice. You also may call the Department of Health or the Insurance Department on their toll-free hotlines (*see back panel*) for informal advice.

Get a hearing with your managed care plan's complaint or grievance review committee

The law creates separate, but similar, procedures for internal plan review of complaints and grievances. An initial review is made by a first-level complaint or grievance committee. If

you are dissatisfied with the decision of the first-level committee, you can appeal the decision to the second-level committee.

Both the second-level complaint committee and the second-level grievance review committee must afford you a reasonable opportunity to appear before it and explain why you believe your disputed service or claim should be paid or corrective action should be taken.

The law also gives your provider the option of filing a grievance on your behalf. However, your provider must have your written consent.

File an appeal

Separate appeals for complaints and grievances exist. Appeals must be made within 15 days of notice of the plan's second-level review decision. **GRIEVANCES:** If you are dissatisfied with the decision of the plan's internal second-level grievance review committee, you should notify the plan that you want to appeal.

The plan then will contact the Department of Health, which will assign an independent certified utilization review entity to review your case.

The plan, by law, is permitted to charge you up to \$25 for filing a grievance appeal to an independent certified utilization review entity.

If you provided written consent to a provider to file your grievance, the cost of the independent certified

utilization review entity will be paid either by the provider or the managed care plan, whichever loses the appeal. **COMPLAINTS:** If you are dissatisfied with the decision of your plan's internal second-level complaint appeal committee, you can appeal that decision to either the Department of Health or the Insurance Department. They will review it, and if the complaint involves an issue more appropriately decided by the other department, your complaint appeal automatically will transferred to them.

ADDITIONAL RIGHTS

The law also provides consumers and providers with additional rights, including the following:

- direct access to maternity and gynecological services
- right of "special needs" enrollees to select a specialist as a primary care provider or to receive an open referral to a specialist
- limited continuation of care coverage for enrollees undergoing a course of treatment from a non-participating provider when they join a plan
- a "prudent layperson" standard for emergency care
- limited continuation of care coverage for enrollees undergoing a course of treatment by a provider that is terminated by the managed care plan for other than specified reasons, such as quality, fraud, or criminal activity

Contact your plan for a complete explanation of these additional rights.