

**MEDICARE APPEALS AND
INTERPRETATION: MEETING THE
REASONABLE EXPECTATIONS OF
MEDICARE USERS THROUGH A
COMPARISON TO PRIVATE HEALTH
INSURANCE**

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After filing a claim for reimbursement, a patient with a health insurance plan expects that the insurance company will come through and pay the medical bill. However, more claims are being denied as private insurance companies face rising health care costs while trying to maintain a profitable business. Similar problems face the federal government as it grapples with a rapidly aging population and a Medicare system struggling to meet the needs of the baby boom generation. Based upon his analysis, Mr. DeJonker proposes changes in the Medicare appeals process through the adoption of some of the positive aspects of private health insurance jurisprudence. Specifically, Mr. DeJonker promotes the use of arbitration as a way of achieving efficiency and neutrality in the resolution of claims under Medicare. In addition, he advocates the application of the reasonable expectations doctrine to Medicare appeals in order to provide a more equitable evaluation of claims.

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I. Introduction

When someone reaches a state of discontent regarding a particular situation, it is human nature to consider the situation of a neighbor, who often appears to be faring much better. In other words, the age-old axiom “the grass is greener on the other side of the fence” instantly enters the mind of the dissatisfied. Of course, this feeling causes one to angrily mutter, “I wish I were in that person’s shoes,” and cry to anyone who can hear that the better situated should be happy that his or her particular predicament is not as bad as one’s own.

In much the same way, those who suffer under the appeals process of Medicare consider the seemingly more expedient system of appeal under private health insurance and wish for the “good life” of nearly immediate court supervision. Within its current structure, Medicare requires the individual who disagrees with a decision made by a Medicare review board to seek relief through an elaborate, multi-staged appeal process.¹ In contrast, the complainant under a private health insurance policy enjoys the benefits of a single review board and may also find relief in a process similar to that of a breach of contract claim.²

A comparison of Medicare and the private health insurance industry reveals another major difference between the average Medicare appeal and the average private health insurance appeal. Federal courts exercise jurisdiction over Medicare appeals, which are primarily federal claims, whereas state courts consider the average health insurance dispute.³ Federal courts tend to defer to the decisions made by the Department of Health and Human Services (HHS) in making decisions about Medicare, while state courts tend to favor the beneficiaries of health insurance contracts.⁴

This note examines the procedures, history, and courts’ treatment of the appeals process under Medicare Part B, as well as the general appeals procedures used by most private health insurance companies and followed in state courts. Through this examination, this note suggests solutions to combine the best of both processes to create a better appeals system for Medicare. Specifically, this note fo-

1. See *infra* Part IV.
2. See *infra* Part V.
3. See *infra* Part VII.
4. See *infra* Part VII.

cuses on Medicare Part B due to the increasing number of controversies under this section arising from the differences in claimant review under Part B as compared to Part A, as well as its more insurance-like nature as a supplemental health insurance plan.⁵

Part II provides a historical overview of Medicare in general and also considers the appeals process under Medicare Part B. Part III provides general information about private health insurance and the types and forms of health insurance contracts. Part IV outlines the average appeals process under Medicare, while part V similarly describes a private health insurance appeal. Part VI explores jurisprudence under Medicare versus health insurance contracts. Finally, parts VII and VIII suggest streamlining the Medicare appeals process and the application of the reasonable expectations doctrine to the interpretation of Medicare claims. This note concludes that the grass on one side of the fence is not really greener than the other side, with each “neighbor” facing peculiar pitfalls that stymie the appeals process. Each remains capable, however, of learning valuable lessons from its counterpart.

II. The Federal Government’s Side of the Fence: An Introduction to Medicare

A. An Overview of Medicare and Medicare Part B

Created by Congress in 1965 as an instrument to help the elderly pay for adequate health care,⁶ Medicare represents the first comprehensive effort by the U.S. government to provide federally funded health care.⁷ At its inception, Congress crafted Medicare into two parts: Medicare Part A and Medicare Part B.⁸ Part A provides funding to all eligible individuals for inpatient institutional services.⁹ These services include the costs of hospital procedures and stays, skilled nursing facilities, and hospice care.¹⁰ The majority of Part A’s funding

5. See *infra* notes 15–18 and accompanying text.

6. See Health Insurance for the Aged Act, Pub. L. No. 89-97, 79 Stat. 290, 290–360 (codified as amended at 42 U.S.C. §§ 1395–1396 (1994)).

7. In reality, the federal government barely funded health care prior to the passage of the Social Security Act of 1965. See Laura A. Mellas, *Adapting the Judicial Approach to Medical Malpractice Claims Against Physicians to Reflect Medicare Cost Containment Measures*, 62 U. COLO. L. REV. 287, 287 n.2 (1991).

8. See 42 U.S.C. §§ 1395–1396 (1994).

9. See *id.* § 1395c.

10. See *id.*

is provided by payroll taxes.¹¹ Part B addresses those health services not covered by Part A, helping to offset the costs associated with physician visits and various outpatient services through monthly premiums from enrollees and general government revenues.¹² Coverage provided under Part B includes payments for doctors, outpatient hospital care, and additional medical services that Part A fails to cover.¹³ Services include more than just those offered by doctors, as Medicare Part B, for example, also covers the costs of physical and occupational therapists.¹⁴ The primary stipulation, however, remains that all services covered under Part B must be “medically necessary,” a term which continues to trouble many experts.¹⁵ Medicare allows for services to be completed anywhere, including “a doctor’s office, clinic, nursing home, hospital, or at home.”¹⁶

Of course, because Medicare was created to cover the medical costs of a growing segment of the population, funding remains an issue.¹⁷ Principally, Part A continues to be funded by Social Security taxes, while Part B remains primarily a federally subsidized voluntary health insurance supplement.¹⁸ Part B places some of its financial

11. See 1 SPECIAL COMM. ON AGING, DEVELOPMENTS IN AGING: 1993, S. REP. NO. 103-403, at 146 (1994).

12. See 42 U.S.C. §§ 1395k, 1395x(s); 42 C.F.R. §§ 410.3, .10 (1998); 1 S. REP. NO. 103-403, at 146.

13. See *Medicare and You*, 2000 (visited Feb. 2, 2000) <<http://www.medicare.gov/publications/Mandy.pdf>> [hereinafter *Medicare and You*].

14. See *id.*

15. See *id.*

16. *Id.*

17. For example, all national health expenditures in 1967 totaled \$51 billion, which accounted for 6.3% of the gross national product. By 1995, Medicare expenditures totaled \$248.9 billion or 16.4% of the federal budget. In fiscal year 1996, HCFA (the Health Care Financing Administration) projects that nearly 62 million people will receive services paid for by Medicare or Medicaid. Nearly 20% of Medicare users, more than 11.7 million people, will require inpatient hospital services covered by Medicare or Medicaid during the same year. See *1996 HCFA Statistics*, (visited Oct. 17, 1998) <<http://www.hcfa.gov/stats/hstats96/blustcov.html>>.

18. See 42 U.S.C. §§ 1395j–1395w (1994). Part B remains a voluntary government service, where an individual is required to sign up either during the general enrollment period (January 1st through March 31st) or during a special enrollment period (if the individual failed to sign up for other reasons, like previous health care coverage). An individual is eligible under Part B if he/she is eligible under Part A (eligibility for Part A implies eligibility for Part B) or if he/she is a U.S. citizen or permanent resident age 65 or older. Under Part B, Medicare deducts a monthly premium (\$45.50 for 1999) from a person’s government retirement payments (e.g., Social Security, Railroad Retirement, or Civil Service Retirement payments), or bills the applicant directly every three months. See *Medicare and You*, *supra* note 13.

burden upon its beneficiaries, as it is supported by periodic premiums and supplemented by contributions from the federal government, with the combined capital held in the Federal Supplementary Insurance Trust Fund.¹⁹

As a result, Medicare Part A provides hospital service to all Americans,²⁰ while Part B is premised on prepayment by the user, serving as a kind of supplemental insurance designed to meet the nonhospital needs of elderly Americans. The individual prepays into the aforementioned trust fund and then receives a full range of services.²¹ Unlike private health insurance companies, the federal government, by its nature, does not seek to turn a profit. Minimizing costs, however, still remains an issue.

Medicare continues to be the largest source of funding for public health care services²² and historically suffers from funding difficulties.²³ Since its inception, Congress met these funding needs through a series of early amendments and statutes to provide for increased tax revenue²⁴ or to curtail costs.²⁵ However, congressional efforts proved rather unsuccessful in curtailing costs or creating a financially strong Medicare program, which resulted in further legislation.²⁶ In 1982,

19. See 42 U.S.C. §§ 1395l, 1395r, 1395t, 1395w.

20. See generally 42 U.S.C. § 1395c.

21. See generally *supra* notes 13 and 19 and accompanying text.

22. See *Nat'l Health Expenditures and Average Annual Percent Change, by Source of Funds: Selected Calendar Years 1970–2008* (visited Oct. 20, 1998) <<http://www.hcfa.gov/stat/NHE-proj1998/tables/table3a.htm>>.

23. See Eleanor D. Kinney, *Making Hard Choices Under the Medicare Prospective Payment System: One Administrative Model for Allocating Medical Resources Under a Government Health Insurance Program*, 19 IND. L. REV. 1151, 1163 (1986).

24. In Medicare's early stages, Congress passed two amendments to adjust the amount of money entering the fund via payroll taxes, the primary source of revenue for Medicare Part A. See Social Security Amendments of 1967, Pub L. No. 90-248, 81 Stat. 821, 835–37 (increasing payroll taxes for the first time to offset increased Medicare costs); Social Security Amendments of 1972, Pub L. No. 92-603, 86 Stat. 1329, 1362–64 (increasing payroll taxes for the second time to offset increased Medicare costs).

25. See Social Security Amendments of 1972, Pub L. No. 92-603, § 223, 86 Stat. at 1330. Congress attempted to constrain the rising costs of health care by authorizing the Secretary of Health, Education and Welfare to establish limits on hospital costs reimbursed by Medicare, as well as establishing organizations to determine whether hospital services were reasonable, medically necessary, and cost efficient. See *id.* § 249F(b). For a general analysis of the Social Security Amendments of 1972, see B.D. REAMS, *THE PROFESSIONAL STANDARDS REVIEW ACT: A LEGISLATIVE HISTORY OF TITLE XI OF THE SOCIAL SECURITY AMENDMENTS OF 1972* (1990).

26. See Timothy P. Blanchard, "Medical Necessity" Denials as Medicare Part B Cost-Containment Strategy: *Two Wrongs Don't Make It Right or Rational*, 34 ST. LOUIS U. L.J. 939, 974 (1990).