Community Catalyst

Coverage & Care

Patient Complaints: Crucial Tool for Improving Health Care

Patient complaints are a crucial means of ensuring that patients get value for their insurance coverage. In particular, complaints are one way to document the insurance problems that keep patients from accessing the health care they need. But the complaints system is not being used to its fullest potential. It's time to educate patients and to leverage patient complaints to make lasting change in our health care system.

What are patient complaints?

Private insurance is regulated at the state level by the Department/Division of Insurance (DOI), which is also tasked with collecting and resolving patient complaints. Patients may file complaints about any insurance policy or plan sold by an insurance company. Complaints can be submitted about a variety of types of insurance, including auto, home, business and health. For health insurance, the DOI is responsible for "fully insured" plans and plans sold on the state marketplace. In states that operate their own state-based marketplaces, a complaint may also be filed with the state marketplace. The DOI does not have jurisdiction over Medicaid, Medicare, Tricare, or other Federal plans, or over employer plans that are "self-insured." Problems with health coverage provided by the state Medicaid program can be filed with the state's Medicaid office.

Before filing a complaint, the patient typically must file an internal appeal directly with their insurance company challenging the insurance claim that has been denied. Unfortunately, the internal appeals process is complex, and individuals may need support from an expert, such as a health advocate, who is familiar with the process. Luckily, health insurance appeals are often decided in patients' favor. If no help is available in their state and the patient feels unable to file an appeal themselves, the patient should proceed with filing a complaint. This will ensure that state regulators are made aware of the issue they are experiencing with their health coverage.

Why focus on patient complaints about health care?

Patients often experience problems with their health insurance coverage that harm their health. Many are unfairly denied the coverage they are entitled to under their insurance contract or under state or federal law, including the Essential Health Benefit standards. For example, if a patient receives a surprise medical bill from an out-of-network provider who treated her/him at an in-network hospital, the patient could file a complaint challenging the bill. In another scenario, an insurer could refuse to cover residential substance use disorders treatment, asserting that the treatment was not medically necessary. A consumer complaint about this problem could assert that the consumer is entitled to covered treatments determined by her/his provider to be medically necessary. If similar medical/surgical services are typically covered, the complaint may also question whether this denial is a parity violation. Complaints may be filed to document many types of health insurance problems. Feedback from consumers about their experiences helps identify limitations with health plans and build a case for systemic solutions.

Most patients are not aware that they have the right to file a complaint about their insurance. According to a Consumers Union survey, 83 percent of Americans have never complained to a government agency about any issue (e.g. cable bill, credit report error, bank fee, health insurance). Additionally, 87 percent of respondents do not know which state agency/department is responsible for handling complaints relating to health insurance. Some patients are part of marginalized demographic groups and may be doubly or triply disadvantaged when it comes to health equity related to race, ethnicity, sexual orientation or gender identity, disability, immigration status, primary language, behavioral health needs and/or income level. Reporting health insurance problems to state regulatory agencies is one way that vulnerable patients can stand up for themselves against discrimination, and patient health advocates can help ensure that all consumers have access to equitable health coverage.

In addition to helping individual patients solve their health insurance problems, patient complaints provide an opportunity to document experiences of patients in the aggregate, enabling data collection for future improvement. Regulatory agencies receiving a large number of complaints about a particular insurance carrier or claim denials related to a particular type of covered benefit (for example, behavioral health) may be able to use patient complaints data to change policies to ensure fair treatment for all patients.

What can health stakeholders do to help?

Health Advocates

Health advocates have long been involved in encouraging insurers and state agencies to adopt more patient-friendly health policies. Public education efforts about patient complaints processes and state-based advocacy to improve the complaints process fit neatly into the existing goals of health advocates. The patient complaints process is one method of gathering more complete data about the scope of health plan misconduct and non-compliance with state and federal health plan requirements. Advocates can help consumers understand the best method of addressing health insurance problems, especially regarding when they should appeal to their plan and when it is appropriate to file a complaint. Health advocates can also work directly with patients and assist them in filing complaints. Patients should know that filing a complaint will not impact their current coverage, and that retaliation by the insurer is prohibited.

Patients aren't the only ones who need information about patient complaints. Health advocates can serve as a bridge for sharing information about patient complaints and the complaints process with stakeholders such as provider associations, individual providers, Navigators and other enrollment assisters, and advocates working on behalf of patients of color, linguistic minorities, LGBTQ patients, or patients with specific illnesses, including mental health and substance use disorders. Advocates may want to partner with providers and enrollment assisters to provide training about the complaints process and how best to work together to support patients.

In addition, patient complaints advocacy and the sharing of information between patient advocates and the DOI can serve as a jumping off point for relationship-building between advocates and state insurance regulators.

Health Care Providers

Providers have a stake in ensuring that insurance companies are following state and federal health plan requirements. Providers are often the first to know about patients' problems with their health insurance. When plans deny patients coverage or do not pay for the services that patients have received, providers and patients both lose out.

Provider associations can play a role in disseminating educational information about patient complaints and the complaints process to relevant providers. Individual providers can help to educate their clients about the patient complaints process as well as help patients with filing an appeal.

Navigators and Enrollment Assisters

Navigators or other enrollment assisters operate in every state, serving as a primary point of contact for individuals who are newly enrolled in health coverage. Many of these individuals did not previously have health insurance and are not familiar with insurance policies and procedures, making them vulnerable to insurance misconduct. Increasingly, newly enrolled individuals are turning to Navigators and other enrollment assisters when they have issues with their insurance post-enrollment, but not all assisters are properly trained to help.

Assisters should become familiar with the patient complaints process and be prepared to help patients file complaints with state agencies when necessary. Educating patients about complaint options and helping patients file complaints are both allowable activities for Navigators and assisters. Assisters who work directly with the most vulnerable patients, such as people of color, LGBTQ patients, linguistic minorities, or those who speak English as a second language, should consider their role in supporting these patients in filing complaints to report health insurance discrimination.

Patients have several options when it comes to disputing insurer decisions about their health care:

1) **File an internal appeal with the insurance company**. Most of these appeals are decided in the consumer's favor. Help may be available in your state for patients seeking to appeal insurance decisions.
2) **Complain to a state insurance regulatory body**

- Complain to the Department of Insurance (DOI) if the issue is with a private or marketplace plan. In states that operate their own state-based marketplaces, a complaint may also be filed with the state marketplace.
- Complain to the state Medicaid office if the issue is with a Medicaid plan.

3) **Complain to the Attorney General's office (AG).** If you suspect your insurance problem is related to behavioral health parity, complaints can be filed with the AG. Responsibility for enforcing the federal parity law is shared between the federal and state governments, with the attorney general of each state tasked with primary enforcement.
4) **Directly contact the relevant federal agency**
   - If the insurance is provided through a private employee benefit plan, it may be covered by the Employee Retirement Income Security Act (ERISA). Call the ERISA toll-free line for Consumer Assistance inquiries 1-866-444-3272 or submit an inquiry online.
   - If the insurance is provided by the public sector, contact the Centers for Medicare and Medicaid Services (CMS). Call the CMS
   - A patient who believes they have been discriminated against because of race, gender, national origin, disability, age or religion may file a complaint with the federal Office of Civil Rights (OCR). Complaints can be filed by the affected patients or by someone else on their behalf, and must be submitted within 180 days of when the act or omission complained of occurred or was learned of.

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