A SURVEY OF MEMBER GRIEVANCE PROCEDURES IN
HEALTH MAINTENANCE ORGANIZATIONS
HMO PROTOTYPES AND HMO LIKE ORGANIZATIONS

A graduate project submitted in partial satisfaction of the requirements for the degree of Master of Science in Health Science in
Health Services Administration

by

Pauline Natalie Minardi

June, 1976
The graduate project of Pauline Natalie Minardi is approved:

California State University, Northridge

April, 1976
DEDICATION

To my husband,
Fred,

My children,
Frederic, Diana, and Natalie

and

My parents,
Mr. and Mrs. J. A. Gingo
ACKNOWLEDGEMENTS

I would like to acknowledge Dr. Donald Hufhines, graduate project chairman, for his patience, encouragement, and guidance throughout this study.

I would also like to thank Dr. Goteti Krishnamurthy for his assistance in developing the original research methodology for this project.

To Dr. Sam Pollock, I would like to express my deep appreciation for his valued assistance in this research effort.

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ABSTRACT

A SURVEY OF MEMBER GRIEVANCE PROCEDURES IN HEALTH MAINTENANCE ORGANIZATIONS
HMO PROTOTYPES AND HMO-LIKE ORGANIZATIONS

by

Pauline Natalie Minardi

Master of Science in Health Science
Health Services Administration

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The purpose of this graduate project was to formulate a hypothesis for the design of a basic model grievance procedures for members of HMOs. Two main objectives needed to be achieved in order to accomplish the purpose of this study were:

(1) Identification of steps and processes necessary for a successful grievance procedure

(2) Identification of areas of common characteristics in grievance procedures as they currently exist in various types of prepaid health care organizations.
The importance of the study derives from the assumption that the federal government will be in need of criteria to determine whether an HMO has an effective grievance procedure, as required under Section 1301 (c)(7) of the Health Maintenance Organization Act of 1973.

To achieve the first objective, literature was reviewed on grievance procedures in HMOs, collective bargaining and grievance procedures, state HMO enabling legislation, patients' rights and the consumers' perspective on health. The second objective necessitated a survey of grievance procedures in HMOs, HMO prototypes, and HMO-like organizations in federal region IX. All data were secured from 22 questionnaires returned out of eligible sample of 60. The response rate was approximately 37 per cent.

Key findings resulting from the review of literature were that an effective grievance procedure should have: (1) a limited number of steps (1-6) with established time limits for each step, (2) the first step should be an oral complaint, (3) the second step requires a written complaint, (4) all successive steps involved individuals with greater responsibility, (5) every effort should be made to resolve grievances before the final step, arbitration.

Major results of the HMO member grievance survey reveal a considerable variation in the sponsorship,
administrative structure and membership of the HMOs. However, 60 to 70 per cent of the respondents do provide: (1) a standard grievance form, (b) time limits for feedback to members regarding initial action on grievances, (3) a review committee or appeals board to hear unresolved grievances, (4) an arbitration procedure.

From the results, two main conclusions were drawn. The first conclusion is that no one grievance procedure is applicable to all types of HMOs. Secondly, this research effort has provided greater insights into the components necessary for an effective grievance procedure and lays the foundation for the development of a hypothesis for the design of a basic model grievance procedure.
CHAPTER I

INTRODUCTION

Consumerism in the field of health has gained attention and significance particularly within the last decade. The term consumerism, identifies the modern consumer movement launched in the mid-1960's by the Ralph Nader auto safety investigations and by "President Kennedy's efforts to establish the rights of consumers: to safety, to be informed, to choose and to be heard." Consumerism is action oriented and may best be described as "the response of people and organizations to consumer problems and dissatisfactions."  

The apparent resurgence of consumerism in health in this country, according to Wolfe, is tied to many issues; particularly, the concept that good health care is a basic human right and not a privilege to be enjoyed by those who can afford it. Other key issues include the

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2Ibid.

3Samuel Wolfe reviews the origin, history and periodic rise of Consumerism in health in "Consumerism and Health Care," Public Administration Review (September/October 1971), p. 528.
diminishing ability of the middle-class to afford health care, greater expectations on the part of consumers concerning health care, and the increasing role of the federal government in financing health care institutions and medical care.

The repercussions of these issues in addition to the increasing awareness on the part of the American consumer that prevention is a key factor to good health, has resulted in health care emerging as a social concern. Health affairs then have moved from primarily a private concern to a matter of public policy.

On February 18, 1971, President Nixon in his Health Message to Congress proposed that the federal government promote a pluralistic approach to the delivery of health care with the endorsement of prepaid health care plans. Although these health plans date back 45 years, they have claimed national attention recently as Health Maintenance Organizations (HMOs).

The enactment of the Health Maintenance Organization Act of 1973, Public Law 93-222, represents

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4 H.R. DOC. No. 92-49, 92nd Cong., 1st Sess. 4 (1971). The prepaid health plans endorsed by President Nixon were "group practice prepayment organizations," and are not to be confused with the "prepaid health plans" offered in California solely for Medi-Cal recipients.

5 A term coined by Dr. Paul Elwood. The word "Maintenance" stresses "prevention."
a deliberate effort on the part of the federal government to provide incentives to modify the present delivery of health care which is predominantly care for acute illness provided by solo practitioners on a fee-for-service basis. This system combines both "delivery and prepayment into a personal services programme" that has as its objectives, the maintenance and restoration of good health.

In simple terms, an "HMO is an organized health care delivery system which provides a wide range of comprehensive health care services to a voluntarily enrolled population in exchange for a fixed and prepaid periodic payment." Prepaid health care under the provisions of Public Law 93-222 must be provided to HMO members either directly or indirectly by the staff of the HMO or through medical groups or individual practice associations.

In a real sense, according to the stated definition of an HMO, the voluntarily enrolled population becomes "captive" to the health organization. The


7 Frank H. Seubold, Ph.D., "HMOs - The View from the Program," Public Health Reports, XC, No. 2 (March-April, 1975), 99.

enrolled members by their own volition relinquish freedom of choice in regard to providers and location of health care facilities for the duration of their contract. The federal government, aware of the increasing demands of the health consumer that the government protect their rights, has addressed these issues in Public Law 93-222.

Section 1301 of the Health Maintenance Organization Act enumerates the requirements for HMOs to be assisted under the law. Subsection (c) (6) provides for consumer representation.

(6) to be organized in such a manner that assures that (A) at least one-third of the membership of the policymaking body of the health maintenance organization will be members of the organization, and (B) there will be equitable representation on such body of members from medically underserved populations served by the organization; 10

The right of consumers to be heard - to have a grievance procedure - is assured under subsection (c) (7).

(7) be organized in such a manner that provides meaningful procedures for hearing and resolving grievances between the health maintenance organization (including the medical group or groups and other health delivery

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9 The government has increased responsibility to protect consumers when public funds are used to provide or develop health services.

10 Public Law 93-222, 93rd Congress, S. 14, December 29, 1973, Sec. 1301 (c) (6); 3.
entities providing health services for
the organization) and the members of the
organization.\textsuperscript{11}

While both of these provisions respond to the
needs and demands of the health consumer, only the pro-
cedures for hearing and resolving grievances will be
dealt with in this study.

As the principal source of data for this project
was generated from HMOs, HMO-like organizations, and HMO
prototypes located in California, it is of interest to
note this state's current legislative activity relating
to grievance procedures in health plans.

AB 138, Knox-Keene Health Care Service Act of
1975, enacted September, 1975, was signed by Governor
Brown on September 22, 1975 and is to be operative,
July 1, 1976. AB 138 repeals the Knox-Mills Plan Act and
rests the responsibility for regulating health care ser-
vice plans in the Commissioner of Corporations. This
bill, in regard to grievance systems, requires:

\textsuperscript{11}Ibid. (c) (7)
procedure for processing and resolving grievances. Such information shall include the location and telephone number where grievances may be submitted.

(c) Every plan shall provide forms for complaints to be given to subscribers and enrollees who wish to register written complaints. The form shall be approved by the Commissioner in advance as to format.

(d) The plan shall keep in its files all copies of complaints, and the responses thereto, for a period of five years.12

Statement of Purpose

The Health Maintenance Organization Act of 1973, Section 1310 (c) (7) requires that HMOs assisted under the law must institute and maintain meaningful procedures for hearing and resolving grievances between the organization and the HMO membership. At the present time many HMOs either do not have a system or have one that is unique to their organizations. In the near future the federal government will be in need of criteria to determine whether a HMO does have an effective grievance procedure. As such it is essential that a basic model grievance procedure be designed. It is the intent of the author that the conclusions drawn from a review of pertinent literature and a survey of grievance procedures in HMOs, HMO-like organizations, and HMO prototypes will have the purpose of formulating a hypothesis for the design of such a model.

12Calif. Laws 1975, c. 941. (Department refers to Department of Corporations)
Objective of Project

There are two main objectives of this project. The first objective is to identify the steps and processes necessary for a successful grievance procedure. This may best be achieved by a review of the long and varied experience of labor and management with grievance procedures.

To determine what is legally feasible in regard to HMOs and grievance procedures, state laws and regulations must be researched for HMO enabling legislation, arbitration guidelines, and patient's rights.

The current resurgence of consumerism in health demands that any study seeking a method of addressing the problems and dissatisfactions of the public regarding health services, must also research the consumers' perspectives on health.

The second objective is to identify areas of common characteristics as they currently exist in various types of prepaid health care plans. This research will consist of a survey of grievance procedures in HMOs, HMO-like organizations, and HMO-prototypes.

Scope of Study

It is important to note that this exploratory study will not attempt to give an indepth review of the
origin and structure of prepaid group practices plans or the labor movement's interest in health issues in the United States. These subjects will be discussed only as they pertain to grievance procedures in HMOs.

Legal interpretation is not within the area of expertise of the author. Therefore, laws, regulations, and court cases will only be cited with some statements of review and comment.

Selection of prepaid health care organizations located in federal region IX as the sample locale, is not to be considered as statistically projectable to all HMOs across the country. This section of the United States however, does have a history of involvement with various types of prepaid health care organizations.

Definition of Terms

Arbitration - the process by which the parties to a dispute submit their difference to the judgment of an impartial party appointed by mutual consent or statutory provision. This is not a formal court proceeding.

Binding arbitration - the judgment rendered through arbitration must be accepted except under extremely

13 Arizona, California, Hawaii, and Nevada, constitute federal region IX.
limited conditions.\textsuperscript{14} (Usually a binding arbitration contract is signed in anticipation of future disagreements.)

Complaint - an accusation; a charge that an offense has been committed.

Fee-for-service - payment to physicians for services rendered.

Formal complaint - written procedures; specific steps for action; specific plan representative designated.

Grievance - a circumstance or condition thought to be unjust and grounds for complaint or resentment.

Group practice prepayment plan (GPPP) - an HMO prototype; single or multispeciality association of physicians and other health professionals who contract to provide a wide range of comprehensive services on a continuing basis for enrolled members.

Health maintenance organization (HMOs) - an organized health care delivery system which provides a wide range of comprehensive health care services to a voluntarily enrolled population in exchange for a fixed and prepaid periodic payment.

\textsuperscript{14}62 Cal. 2d606 (1965). Doyle vs. Giuliani
Individual practice association (IPA) - a type of HMO; a partnership, corporation association or other legal entity which enters into a service agreement with health professionals (usually physicians practicing in their own offices, who are usually reimbursed on a fee-for-service basis according to a fixed schedule) to provide comprehensive service to enrolled members on a continuing basis.

Informal complaint - primarily oral, encounters, some documentation.

Member - individual eligible to receive health services provided by an HMO.

Network HMO - a Metropolitan, regional, or statewide confederation of distinct and separate non-satellite medical care delivery points that relate to a central organization.\textsuperscript{15}

Non-binding arbitration - the judgment rendered through arbitration may be accepted or rejected by the parties in dispute; they may settle or sue in the courts.

Prepaid health plan (HMO-like) - a health care plan providing comprehensive health services including at a minimum, inpatient and ambulatory benefits, to a voluntarily enrolled population on a prepaid capitation basis.\textsuperscript{16}

Qualified HMO - HMOs that meet the statutory and regulatory requirements of the HMO Act of 1973 as determined by the office of HMO Qualification and Compliance in the office of the Administrator, Health Services Administration.

\textsuperscript{16} Ibid., p. 63.
CHAPTER II

METHODOLOGY

This graduate project may best be described as the research methodology referred to as a "formulative or exploratory study." The material presented does not deal with a specific hypothesis but does attempt to explore a procedure as it currently exists in a prescribed setting with the object of identifying areas of central tendencies. It is the intent of the author that the conclusions offered through this study will have the purpose of formulating a hypothesis for the design of a model internal grievance procedure for enrolled members of HMOs.

The study consists of four parts: (1) a review of pertinent literature, (2) a survey of member grievance procedures in HMOs, HMO prototypes, and HMO-like organizations in federal region IX, (3) results of the survey, (4) discussion, conclusions and recommendations.

Literature was researched initially on grievance procedures in HMOs; however due to the relatively limited span of time HMOs, as presently defined under

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federal law, have been in existence, little information was available. Other areas of literature researched included labor's role in the development of grievance procedures for union members, patients' legal rights in health care institutions and the current consumer's viewpoint on health care. The literature most relevant to this study is discussed within the main body of this text.

The second component of the text is the survey of member grievance procedures and complaints in HMOs, HMO prototypes and HMO-like organizations that are presently operational in federal region IX. Region IX was determined to be the best sample of prepaid health care organizations in the country as 65.5 per cent of all enrollees reside in the western section of the United States and California is the top state both in total prepaid enrollment and HMO-like organizations.\(^{18}\) California also has 11 HEW supported HMO projects.\(^{19}\) This section also describes in detail the development of the questionnaire and the mail survey.

The results of the survey are reported separately as the third component of the text so that


\(^{19}\) Ibid., p. 89.
the reader will be allowed to formulate opinions not biased by the author's conclusion and interpretations.

The final component is the analysis and discussion of the survey's findings as related to the review of literature.
CHAPTER III

REVIEW OF LITERATURE

The literature reviewed deals with organized labor and grievance procedures, legal aspects of HMOs, the rights of patients, and the consumer's viewpoint on health care services. Due to the overlapping relationships of the topics researched, this review is not confined to any specific time period, but ranges from the most recent to the origins of prepayment in fraternal or mutual benefit societies in the United States in the late 1700's.20 The stated objective of this review is to identify the steps and processes necessary for a successful grievance procedure in HMOs. To achieve this objective, the literature must also be reviewed for the movements that have historically pressed for redress of dissatisfactions within organizations by individuals either belonging to or purchasing services from such organizations.

Organized Labor and Prepaid Health Care

Labor's concern with the health and welfare of

employees in the United States dates back to the establishment of the mutual or fraternal benefit societies which were often union-affiliated. The majority of these societies limited care to accident and sickness insurance. Some, however, such as La Société Francaise de Bienfaisance Mutuelle, maintained their own hospital. In these societies, physician services were contracted at a dollar per year, with an additional charge ranging from 50 cents to two dollars to include families. During the early 1900's these societies were significant in the voluntary health insurance field.

Following in the path of the fraternal societies, some employee groups and industrial companies were next to offer direct medical services on a prepaid basis to their members or employees. One of the first employee groups to provide limited medical services to members was the International Typographical Union which established a Printers Home and tuberculosis sanatorium in Colorado Springs, Colorado in 1892 for sick and disabled


22Schwartz, "Early History of Prepaid Medical Care Plans," loc. cit. La Société Française was established in 1851 in San Francisco. It is still operating today.
printers. In 1913 the first union health center was established in New York City by the International Ladies Garment Workers' Union. Services, however were limited to physical examinations for new members and for members wishing to establish sick benefits.

According to Williams, other union organizations which provided medical or hospital services to members on a group basis prior to 1930 were located in: (1) Silverton, Colorado - Mine, Mill and Smelter Union, (2) New York - letter carriers, (3) Milwaukee - public utility workers, (4) Washington - engraving and printing, (5) Los Angeles - various local union members.

It would appear that the early leadership shown by unions in providing or obtaining direct medical services for members would have led to a proliferation of union-sponsored or union contracted clinics and hospitals. However, this was not the case. Unions chose to emphasize wages, job security and low union dues prior to World War II.

23 Ibid., p. 453.


in fact, unions did not support the drive for national health insurance following World War I.\textsuperscript{26}

Organized labor did work actively in the fight for Workmen's Compensation and later for industrial safety. The majority of the Workmen's Compensation laws carried provisions relating to medical care which in turn encouraged prepaid medical care plans.

The emphasis originally placed on wages, job security and low union dues was significantly altered with the impetus given to collective bargaining during and after World War II. Munts has described collective bargaining as the "'engine' of the health insurance movement, and the study of its influence as indispensable for the evaluation of what has been accomplished."\textsuperscript{27}

Garbarino enumerates what in his opinion are the three major forces that propelled collective bargaining over health insurance.

1. Wage controls during World War II and the Korean emergency which permitted fringe benefits to be increased while acting to retard direct wage increases.

\textsuperscript{26}Somers, Doctors, Patients and Health Insurance, loc. cit. Labor aims and influence in the organization and financing of medical care are related.

\textsuperscript{27}Raymond Munts, Bargaining for Health - Labor Unions Health Insurance, and Medical Care (Madison and Milwaukee: The University of Wisconsin Press, 1967), p. v.
2. The pattern-setting impact of the United Mine Workers' Welfare and Retirement Fund which, in the days when John L. Lewis was a potent factor in collective bargaining, opened up a whole new range of bargaining possibilities.

3. The court decisions requiring employers to bargain on health and welfare issues to meet Taft-Hartley Act requirements.28

These events then were instrumental in setting in motion negotiations that now provide health coverage to every union member in the country.29 While the majority of coverage was and is presently cash-indemnity insurance, a few unions, in particular the United Auto Workers under the leadership of Walter Reuther, were committed to the concept of hospital-based prepaid group practice as the best method of obtaining labor's goals of medical care.

I. S. Falk's statements regarding labor's goals are expressed as:

(1) Comprehensive modern care should be available to everybody.
(2) It should be available through well organized health services, preferably from an integrated and efficient medical care team functioning through group practice.
(3) The medical-care personnel or the organized medical team should be available to serve people wherever they should


receive care - in the doctor's office, clinic, hospital, nursing home or patients' homes.

(4) All who provide service should be expected to observe high standards of quality.
(5) And the financing should be through group payment that is as comprehensive as practical, so that the costs are neither a barrier when care is needed nor a financial burden after it has been received.30

As the number of individuals covered by voluntary health insurance increased and benefits broadened due to collective bargaining efforts, there was an even greater rise in the costs of obtaining health benefits. Consequently, an increasing number of unions followed the path set by the United Auto Workers and turned to direct service plans for medical care.

Among the better known health care organizations that contracted with unions on a prepaid basis are the HMO-prototypes which include the Ross-Loos Medical Clinic, Los Angeles, founded by two physicians in 1929 to provide services to 400 employees of the Los Angeles Water and Supply Department; the Farmers Union-Cooperative Health Association founded in 1929 by Dr. Michael Shadid in rural Elk City, Oklahoma; the Group Health Association of Washington, D.C., founded in 1937 as a co-operative

arrangement mainly for government workers; Kaiser-Permanente Health Foundation founded by Dr. Sidney Garfield in cooperation with Kaiser Industries in 1942; and the San Joaquin Medical Foundation founded by Dr. Donald Harrington in 1954 in California.\textsuperscript{31}

In 1973, organized labor, perhaps the most progressive force in health matters in the United States, strongly endorsed Public Law 93-222, the Health Maintenance Organization Act.

Establishing Grievance Procedures

As Munts has labeled collective bargaining the "engine"\textsuperscript{32} of the health insurance movement, Chamberlain identifies the grievance process as the "heart of collective bargaining."\textsuperscript{33} It is reasonable then to infer that unions, the strongest advocates and largest group of purchasers of prepaid group practice services,\textsuperscript{34} would want to establish medical grievance procedures for their members enrolled in these organizations.

\textsuperscript{31}An indepth study of HMOs and their origins - Health Science 412, California State University, Northridge, Dr. Sam Pollock, instructor.

\textsuperscript{32}Munts, Bargaining for Health, op. cit., p. v.


Specifically, Garbarino states that in 1956, partly as a result of strong union representation in the Kaiser Health Plan, Northern California, the International Longshoremen's and Warehousemen's Union and the Culinary Workers were able to establish a "fairly formal medical grievance procedure."  

This procedure in oversimplified terms consisted of four successive steps; each one of which could result in satisfactory resolution of the grievance. The first step instructed the enrolled union member to bring the problem directly to the physician's attention; the second step was an appeal to the health plan representative employed by Kaiser; the third step resulted in the involvement of a welfare officer or secretary of the local union; and the final step was the resolution of the grievance by ranking representatives of the union welfare fund and the Kaiser Health Plan at a regularly scheduled meeting.

Because a main objective of this project requires a survey of grievance procedures in prepaid health care organizations, it is necessary to research

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36 The identification of common characteristics in grievance procedures as they currently exist in various types of prepaid health care plans.
grievance procedures developed through collective bargaining in order to design an effective questionnaire.

The reader however must bear in mind that a grievance procedure applicable to a labor-management relationship must be altered in its adaptation to a health consumer (enrolled member) - health administration setting.

What Is A Grievance

It is essential to consider the nature of a grievance prior to a review of the grievance process.

According to Maby, there are two approaches to the concept of a grievance. The narrower concept views a grievance as a complaint or dissatisfaction arising solely from the application or interpretation of a clause in the negotiated agreement. The second approach is broad in concept in that any complaint is considered a grievance regardless of the source of the dissatisfaction.37

In the context of this project, the broad approach will be used in defining a grievance as a circumstance or condition thought to be unjust and grounds for complaint or resentment.

Structure of a Grievance Procedure

The most important of the many different functions served by the grievance process is that it channels conflict into an institutional mechanism for peaceful resolution, thereby preventing minor misunderstandings from being inflated to major problems. Of equal importance to the aggrieved individual is the opportunity to complain with dignity and the knowledge that a prescribed system of appeals is available for a thorough review of the substance of one's grievance.

Development of the present form of grievance procedures emerged during World War II, in 1942, when the National War Labor Board was charged with the responsibility of handling any labor disputes that threatened to disrupt the war effort. Although the War Labor Board did not impose a model grievance procedure on all labor-management disputes, it did promote specific guidelines for grievance machinery.

The basic policy of the board included: (1) keeping the number of steps at a minimum; (2) having different people at the different levels in the procedure; (3) making arbitration, a cardinal tenet of the

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board, the last step in the process. Other precedent-setting guidelines were that individual employees could present their grievances without union assistance at the first step; time limits should be established for each step; all grievances should be in written form if not resolved at the first step.

To illustrate the prevalence of the War Labor Board's policy on grievance procedures, it is relevant to relate the comments of the following authors.

Kuhn, in reporting on the structure of grievance procedures has stated that usually four steps are involved although some agreements list six steps. In the interest of promptness, the number of steps should be regarded as less important than having different individuals carefully review the grievance at each successive level. As the steps progress, individuals with greater responsibility (higher authority) should be involved. Finally, in the step before arbitration, a committee of

39 J. Bela Salvatore, "Grievance Disputes," Labor Law Journal, VII, No. 6 (June, 1957), 427. In reference to the word "different," the Board's position was, "There is no use in multiplying steps if you have the same people sitting around the same table each time." In the context of this project, "different" people would refer to persons having a higher level of authority at each successive step.

40 Ibid., pp. 428-430. Although the board favored the presentation of all grievances in writing, it did allow for a reduction in the number submitted at the first level, by permitting oral presentation.
union representatives and designated staff officers of management should attempt to settle the grievance. Arbitration is to be considered the final and last resort.41

Kuhn also urges that a distinction be made between the use of written grievance as a method of keeping records and a source of information. In his opinion, the written grievance is a good indication of the number of complaints and the steps used for resolution; however, a written grievance, particularly, in the early steps can be unreliable and misleading due to the brevity or obscurity of the statement.

Gardner reports that an effective method in handling grievances is to welcome complaints, get all the facts initially, respond quickly, provide steps for unresolved grievances, involve different people at different levels, and make every effort to settle problems at the lowest possible step.42

The findings of a survey conducted by the Bureau of Labor Statistics in 1964 on "Grievance Procedures:


42Glenn Gardiner, How To Handle Grievances (n.p.: Elliott Service Co., 1943), pp. 7-33.
Major Collective Bargaining Agreement" are presented by
A. W. J. Thomson.

(1) 47% of 416 agreements surveyed defined a
grievance as any complaint or dispute on
any subject. 53% of all agreements re­
strict grievances to disputes arising out
of contracts.
(2) Number of steps in the grievance procedure
range from 1-6 before arbitration, with
3-4 steps being in general use.
(3) Time limits were set forth on some or all
steps in 343 out of the 416 agreements.
Approximately 1 out of 6 fix the limit
set from the time the act occurred up to
the end point of the grievance process
(before arbitration). Extensions are
permitted if justified.
(4) Most procedures require written grievances
at the second step rather than the first
step even though a form is provided.
(5) Many agreements have a clause which makes
a settlement final and binding, regardless
of particular step number.43

In the January, 1975 issue of Hospital Progress,
Randyl D. Elkin discusses labor-management contract nego­
tiations as they are likely to occur in non-profit hos­
pitals as a result of Public Law 93-360.44 Included in
this analysis of collective bargaining is the method of
handling and adjusting grievances.

Dr. Elkin cites the four principles suggested
by Arbitrator Harold W. Davey. The first being that

43 A. W. J. Thompson, The Grievance Procedure in
the Private Sector, op. cit., pp. 9-11.

44 Effective August 25, 1974 nonprofit hospitals
were no longer exempt from the National Labor Relations
Act.
grievance should be settled promptly and preferably, at the first step. The second principle requires that procedure and grievance forms be easy to use and clearly understood. Third, all grievance procedures should provide "a timely avenue of appeal" that progresses through a higher level of authority at each successive step. Finally, the grievance procedure should end in final and binding arbitration.45

Grievance Procedures in HMOs

The author, initiated a search of literature specifically relating to grievance procedures in HMOs by requesting a Medline search through the Reference Division, Biomedical Library, University of California, Los Angeles and the Library Reference Service, Medical Group Management Association.

The Medline files were searched for 34 months, covering 2300 journals. Of the 46 citations retrieved, little pertains to grievance systems in HMOs. A bibliography entitled "Patient Grievance Systems," obtained from the Library Reference Service of Medical Group Management Association lists 17 references. The majority of these citations deal with complaint procedures in England's National Health Service.

45Randyl D. Elkin, "Negotiating and Administering a Union Contract," Hospital Progress, LVI, No. 1 (January, 1975), 42.
One of the few sources available is an extensive report prepared for the Secretary's Commission on Medical Malpractice. Although this report was to inventory patient grievance systems in all types of health care institutions in the United States the response was predominately from hospitals. A complete summary of this research effort will not be attempted within this literature review, but it is relevant to note the following findings.

1. None of the systems now in existence have the authority to analyze, document, and offer equitable settlement (either financial or medical) in malpractice situations;
2. many of these systems dealt with petty problems only and were perceived by other staff as being public relations functions;
3. no one staffing pattern was preferred;
4. few administrators had utilized the system as a conduit of information that would indicate needed changes in operations;
5. little systematic analysis as to the origin and reasons for complaints has been undertaken;
6. most physicians would accept only marginal interference from the patient grievance representative on the physician patient relationships.


47 Ibid., p. 758.
HMO Legislation and Regulation

The signing of the Health Maintenance Organization Act on December 29, 1973 has resulted in the continuous growth of HMOs throughout the nation.\(^48\) Parallel to this development activity has been the increase in the number of states enacting HMO enabling legislation. As of June 30, 1975, twenty five states had enacted HMO legislation as compared to four states at the end of 1972.\(^49\) It is significant to note however, that "enactment of HMO legislation does not necessarily assure the development of HMOs or their accountability to consumer for the cost and quality of their services. Nonetheless, the standards embodied in HMO enabling legislation may have a pronounced effect on the pattern of HMO development in a state. . . ."\(^50\)

In the context of this research, the review of literature is concerned with


\(^{49}\) Ibid., p. 2.

\(^{50}\) Andreas G. Schneider, "Model Consumer Health Maintenance Organization Act and Commentary," Rutgers-Camden Law Journal, VI, No. 2 (Fall, 1974), pp. 269-270. The three objectives of this model act are to eliminate existing barriers to HMO development, promote the formation, development and operation of consumer-accountable HMOs, and assure that HMO performance will be responsive to consumer need.
standards as set forth in grievance system sections in HMO legislation of the states of Arizona, California, Hawaii, and Nevada.

A grievance system section in HMO bills, according to Interstudy, is the mandatory inclusion of a system required for providing reasonable procedures for resolution of complaints initiated by enrollees concerning health care services.\(^51\) As previously noted in chapter one of this text, the federal HMO act, Public Law 93-222, and current California legislation, AB 138, have included grievance system sections.\(^52\)

Arizona and Nevada enacted HMO legislation in 1973, but the statutes did not include sections on grievance system. Hawaii does not have HMO enabling legislation.\(^53\)

**HMOs and Medicaid**

On May 9, 1975 the Social and Rehabilitation Service (SRS) in the Department of Health, Education, and Welfare (DHEW) published final regulations in the


\(^{52}\)California Laws, 1975, c-941.

Arbitration has been established as a vital and final step in collective bargaining and grievance procedures. The issues to be considered in regard to the use of arbitration in this research project are whether mandatory grievance system provisions in state HMO legislation should require arbitration as the final step in otherwise unresolved enrollee grievances and whether medical malpractice claims can be classified as grievances.

As noted earlier in this text, a search of the literature relating to grievance procedures in HMOs was non-productive. The potential of medical malpractice arbitration, however, has commanded the attention of many authors. Nonetheless, it is beyond the scope of this project to attempt an in-depth study of such a complex and controversial legal issue.

Of the sources which discuss the problems of arbitration and medical malpractice, two reports, prepared for the Secretary's Commission on Medical Malpractice, are relevant to the use of arbitration in grievance procedures in prepaid health care organizations. One

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54 Salvatore, "Grievance Disputes," loc. cit.
56 See above, p. 28.
extensive report discusses the law of arbitration in 51 jurisdictions and its applicability in resolving medical malpractice claims. The findings for the states of California, Arizona, Nevada, and Hawaii indicate that the law of arbitration as written in these four jurisdictions could encompass the settlement of medical malpractice disputes. Of the four jurisdictions only Hawaii has no reported appellate case law where arbitration has been used to resolve personal injury claims. In California, a state that has long favored arbitration, the Supreme Court in Doyle v. Guiliucci (1965) confirmed an arbitration award involving a medical malpractice claim and held "that a contract for family health care between an infant's father and a medical group which provided for arbitration of claims arising thereunder was binding on the minor."  

A significant study when contemplating the use of arbitration as a means of resolving medical malpractice claims is "The Experience of Binding Arbitration in the


58 Ibid., pp. 346-390.

59 Ibid., pp. 357-359.
Ross-Loos Medical Group." Of four major health plans that use arbitration as a "medical malpractice resolution mechanism," Ross-Loos has the broadest experience. In this report prepared by Dr. Davis S. Rubsamen for the Secretary's Commission on Medical Malpractice, 177 active and closed cases are reviewed. An analysis of the 35 closed cases reveals that indemnities were paid in 33 cases but only three cases necessitated complete arbitration. One conclusion drawn from this report is that Ross-Loos medical group is willing to settle cases almost to the time of arbitration. Because the majority of patients enter this health plan through union contracts, it is logical to assume that the union's experience with arbitration (as a final and binding step in grievance procedures) coupled with the "patient-oriented" philosophy of the medical group conceivably accounts for Ross-Loos' method of handling medical malpractice claims.

Patients' Rights

There is no "legal right to health care" in the

60 Secretary's Commission, op. cit., pp. 424-425. Other major arbitration plans are the Southern California-Kaiser Health Plan, a pilot study involving eight hospitals sponsored by the Southern California Medical Association and the California Hospital Association, and the arbitration plan initiated by Casualty Indemnity Exchange (CIE) Insurance Company, Denver, Colorado, with its insured physicians.
United States. Neither the U. S. Constitution nor the Declaration of Independence acknowledge a right to health care. The resurgence of consumerism in health however, has been attributed in part to the political or philosophical conception of health care as a "basic human right." 

The patient's bill of rights is one of the few demands articulated by the health consumer that has generated favorable yet cautious responses from health care providers. One response has been the publication of several documents outlining the rights of patients particularly in hospitals. The best known statement and one of great impact was first issued by the American Hospital Association in 1973. Others include the Catholic Hospital Association Guidelines for Patients' Bill of Rights, the American Medical Association's statement on the principles which should underline an appropriate bill of

61 George J. Annas has written a guidebook that provides information for both health consumers and health care providers in The Rights of Hospital Patients, ed. by Norman Dorsen and Aryeh Neier (New York: Avon Books, 1975), p. 6. A human right is defined by Annas as a statement "of what the law ought to be, based on a political or philosophical conception of the nature and needs of man."


63 Several forms of this statement have been issued, a recent reprinting in 1975.
rights for hospital patients, Minnesota's legislated patients' bill of rights for hospitals and nursing homes (effective, 1973), and Pennsylvania's Citizens Bill of Hospital Rights: What the Patient and Public Can and Should Expect from Our Hospitals (1973). 64

The Pennsylvania patients' bill of rights is particularly significant in that the action was directed at consumers in general and not specifically to hospital patients. This statement was published in 1973 by then Insurance Commissioner Herbert S. Denenberg with a pledge to use the full regulatory power of his agency for implementation. Included among Mr. Denenberg's 12 points was the right to:

(7) Action on Complaints and Problems.
The patient has a right to redress of grievances in a reasonably efficient and timely fashion. This means the hospital should establish formal grievance procedures and appoint an ombudsmen or patient advocates to be certain that problems are identified and remedied.

Complaints should be handled promptly and action taken as soon as possible. New techniques should be considered in handling grievances such as arbitration for certain types of patient disputes.

Patients should know how to assert complaints and forms for doing so should be readily available. 65

It is therefore reasonable to expect that any member of a prepaid health care organization who pays or has paid on his behalf a premium for membership in an HMO should have the right to "action on complaints and problems." This is a right that an HMO should designate for its health consumer (enrolled members) to improve both the quality and delivery of health care services within the HMO. The implementation of this right should not rest upon the HMO's intention of applying for certification by the federal government as a qualified HMO. 66

Consumers' View

This review of the literature is confined to views expressed by patients or consumers in regard to health care services associated primarily with prepaid group practice plans. The importance of the consumers' satisfaction or dissatisfaction with services obtained through these HMO prototypes cannot be overlooked; for ultimately the growth of the HMO concept depends on wider


66 See above, page 5.
acceptance of this method of health care delivery by consumers.

It is essential to first note that the consumers' attitudes on health care delivery may be influenced by many factors; one being their perception of "high quality medical care." Whereas physicians judge quality by the professional expertise demonstrated by their colleagues, the patient is usually only moderately aware of differences in physician skills. Krizay and Wilson report that patients' judgment of quality is based on:

1. The accessibility of the physician,
2. The physician's attitude - whether friendly, firm, confident,
3. The physician's willingness to continue searching for the right solution to what the patient perceives as a difficult problem.67

Studies on the levels of satisfaction of group health members are surprisingly similar in their findings. Results show relatively high degrees of overall satisfaction toward health services. There are however complaints about the "impersonality of the doctor-patient relationship."

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relationship in a 'clinic setting'."\textsuperscript{68}

As this project is concerned with grievance procedures in HMO settings, it is relevant to report on the types of complaints that presumably may be channeled into this system.

Krizay and Wilson describe some of the complaints subscribers have of prepaid group practice. These include:

1. Doctors are interested in patients only if they are seriously ill
2. Waiting times are too long
3. Intimate personal problems must be discussed with different doctors on each visit as the patient's 'personal' physician is often not available.\textsuperscript{69}

Garbarino also reports on patient complaints of closed panel groups. Subscribers voiced their dissatisfaction with "'assembly-line' medicine, waiting for service, hasty and perfunctory treatment, inaccessibility of preferred physicians and inadequate concern for patient welfare."\textsuperscript{70}


\textsuperscript{69} Krizay, The Patient as Consumer, op. cit., p. 147.

\textsuperscript{70} Garbarino, Health Plans and Collective Bargaining, op. cit., p. 83.
Dr. Richard Weinerman's 1964 analysis of studies on the attitudes and experiences of patients in prepaid group practice plans concluded:

In general, the various investigations of attitudes of group health members suggest much appreciation for the technical standards of group health care, but less satisfaction with the doctor-patient relationship itself. In one way or another, patients report disappointment with the degree of personal interest shown by the doctor and with the availability of his services when requested. Much more rarely is their criticism of the quality or the economics of group health care. 71

The findings of Roemer et al. in a study designed to compare three major types of health insurance plans show that "although consumers in the large group practice plan are for the most part satisfied with their financial and medical care, dissatisfaction with the medical clinics operations is substantial." 72

The results of a study of consumer satisfaction with prepaid group practice by Tessler and Mechanic are consistent with those of prior studies. "A significant minority of patients feel prepaid practice is


unresponsive, that physicians are less interested in them and that the personal dimension is lacking. Prepaid subscribers also indicate that the medical care setting has a clinic atmosphere that makes them feel like charity cases and that their medical care setting is not well organized."

CHAPTER IV

COLLECTION OF DATA

Survey of HMOs/HMO Prototypes
HMO-Like Organizations

Sample selection. The prepaid health care organizations selected for this survey were obtained from a list provided by the office of the HMO regional program consultant, DHEW region IX, located in San Francisco. Although this sample is not to be considered as statistically projectable to all prepaid health care organizations in the country, research as presented here will support the choice of federal region IX as the sample area.74

In May, 1975 a publication, Health Maintenance Organization, Program Status Report75 issued by DHEW reported that 173 prepaid health care organizations serving approximately 5.7 million enrolled members were operating in the country. This included three qualified HMOs under PL 93-222 and 73 prepaid health care organizations located in federal region IX. A review of the

74 See footnote 13, p. 8.
73 organizations located in region IX resulted in the identification of 10 HMO prototypes, 11 HEW supported HMO projects, 47 prepaid health care organizations with Title XIX Contracts, and nine organizations providing services under the federal employees benefit plan. In the top ten states of total prepaid enrollment, California was first and Hawaii, sixth.

The selection of this sample is also substantiated by California's experience with prepaid health plans. In 1971, Governor Ronald Reagan encouraged the development of prepaid health plans to provide health care services to Medi-Cal beneficiaries as a cost saving mechanism. This resulted in a proliferation of prepaid health plans which were loosely regulated. Some of the plans taking advantage of the situation, reaped benefits for themselves and provided inadequate services to the enrolled members. To correct the situation, California legislators have added quality control measures through legislation; the most recent being AB 138, the Knox-Keene Health Care Service Plan Act of 1975. The federal government also, as a reaction to the health plan scandals and patient dissatisfaction in California, built stiff quality controls into the Health Maintenance Organization Act of 1973.
Questionnaire. The questionnaire was designed to obtain factual information in order to produce a profile of grievance procedures for enrolled members in prepaid health care organizations. The objective of the survey was to identify common characteristics in existing internal grievance procedures in HMOs, HMO prototypes, and HMO-like organizations. All questions were designed to be answered retrospectively with general knowledge and a minimum of effort.

Two major topics were to be examined through the use of the questionnaire. The first dealt with facts regarding the age and sponsorship of the organization, contractual arrangements, and the membership. The second consideration was to inspect the components of the grievance system such as member access to the system, steps within the grievance procedure, and type of complaints reported.

Formulation of questions regarding pertinent elements of grievance procedures were identified through: (1) a review of relevant literature on collective bargaining and grievance procedure, (2) personal interviews with the administrative staff in several HMOs, (3) research material obtained in two courses, Alternative in
Health Delivery (HMOs) and Consumers and Health Delivery.76

The initial questionnaire was submitted to the author's faculty committee on September 28, 1975 for review and comment on format and relevance of questions. At that time suggestions were made resulting in the elimination of questions that might encounter resistance. Technical aspects of the questionnaire were corrected.

On October 9, 1975 the revised questionnaire was mailed to four selected staff members77 of HMOs for pre-testing. Approximately three weeks were allowed for reviewing the questionnaire prior to personal interviews being conducted by the author. This pretest led to a shorter format as a result of restating and change of sequence of some questions. The questionnaire and cover letter are presented in Appendix A.

Mail survey. As previously indicated a list of prepaid health care organizations was obtained from DHEW's regional office in San Francisco. This list

76 Classes offered at California State University, Northridge, Department of Health Service under the instruction of Dr. Sam Pollock.

77 The four staff members included a manager of member relations in a health plan, a clinic administrator, an assistant administrator of a health plan, and a subscribers' services representative.
contained the names and addresses of 74 HMOs, HMO prototypes, and HMO-like organizations. Prior to the mailing of the questionnaire, five newly identified, qualified HMOs\textsuperscript{78} were added to the survey.\textsuperscript{79} Included with the questionnaire and stamped self-addressed return envelope was a cover letter from Dr. Donald Hufhines, Coordinator, Health Administration Program, explaining the purpose of the survey and urging the completion and return of the questionnaire by November 20, 1975.

Questionnaires were coded as they were returned to maintain confidentiality. An attempt was made to trace all returned mail. Some of the returns could be readdressed and mailed again, but other HMO-like organizations were no longer operating as prepaid health care organizations.

Two weeks after the initial mailing, a postcard, dated November 15, 1975 was used as a follow-up to again encourage completion and return of the questionnaire. (Post card is presented in Appendix B.)


\textsuperscript{79}The addition of the qualified HMOs was to review their grievance procedure and hopefully make a comparison with the prepaid health care organizations in region IX which does not have a qualified HMO.
Table 1 depicts the mail survey response.

### TABLE 1
MAIL SURVEY RESPONSES

<table>
<thead>
<tr>
<th></th>
<th>Initial Mailing</th>
<th>Eligible Sample</th>
<th>Respondents</th>
<th>Per Cent of 22 Respondents</th>
<th>Response* Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>5</td>
<td>25%</td>
</tr>
<tr>
<td>Calif.</td>
<td>65</td>
<td>48</td>
<td>17</td>
<td>77</td>
<td>35%</td>
</tr>
<tr>
<td>Hawaii</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>9</td>
<td>67%</td>
</tr>
<tr>
<td>Nevada</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td><strong>74</strong></td>
<td><strong>55</strong></td>
<td><strong>20</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Qualified HMOs</td>
<td>5</td>
<td>5</td>
<td>2</td>
<td>9</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>79</strong></td>
<td><strong>60</strong></td>
<td><strong>22</strong></td>
<td></td>
<td>37%</td>
</tr>
</tbody>
</table>

* No. of Respondents
No. of Eligible Sample

**Method of Data Analysis.** With the assistance of Launis Look, consultant, Computer Center, California State University, Northridge, raw data was prepared for computer analysis. The preliminary steps included coding the data, transposing the data onto Fortran sheets, and then keypunching the information on computer cards. Computer cards were then checked for accuracy by the "card
lister and a random sample check of 25 per cent of the computer cards against the original data sheets.

A pre-written program, Statistical Package for Social Sciences (SPSS) was run through the computer for measures of central tendencies, frequencies, cross-tabulations and chi square tests.
CHAPTER V

RESULTS OF THE SURVEY

This chapter presents the responses of HMOs, HMO prototypes, and HMO-like organizations to a questionnaire on grievance procedures for enrolled members. The questionnaire was designed to gather factual information on the age and sponsorship of the organization, contractual arrangements, membership, and components of the grievance system. The purpose of the questionnaire was to provide profiles of grievance procedures in prepaid health care organizations of varying organizational structure. The objective of the survey was to identify common characteristics in existing internal grievance procedures in HMOs, HMO prototypes, and HMO-like organizations.

A pre-written computer program for statistics, SPSS, was used to analyze the data for measures of central tendencies, frequencies, crosstabulations and chi square tests.

The large number of variables (40) combined with the limited number of HMOs responding to the survey (22)

In reporting survey results, HMOs, HMO prototype, and HMO-like organizations will be referred to as HMOs.
make the results of the crosstabulations and chi squares tests suspect. The responses to the survey will therefore be tabulated and reported in frequency tables.

The chapter is divided into two sections, characteristics of HMOs and grievance components.

Section 1

Characteristics of HMOs, HMO Prototypes, and HMO-Like Organizations

Nine types of institutions were identified as either "single" or "multiple" sponsors of HMOs, HMO prototype, and HMO-like organizations. Of the sponsors cited (insurance company, business corporation, prepaid group practice, medical clinic, fee-for-service, hospital, fraternal organization, community and medical society), prepaid group practices sponsored the largest number of HMOs (22.2% - Table 2). Seventy three per cent of the respondents labelled themselves as a GPPP type of HMO (Table 3); 73 per cent of the organizations have been operational for less than four years (Table 4).
**TABLE 2**

**DISTRIBUTION OF SPONSORS OF HMOs, HMO PROTOTYPES, HMO-LIKE ORGANIZATIONS**

<table>
<thead>
<tr>
<th>SPONSORS</th>
<th>CODE</th>
<th>ABSOLUTE FREQ</th>
<th>RELATIVE FREQ (PCT)</th>
<th>CUM FREQ (PCT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Co.</td>
<td>1.</td>
<td>2</td>
<td>9.1</td>
<td>9.1</td>
</tr>
<tr>
<td>Busi Corp</td>
<td>2.</td>
<td>4</td>
<td>18.2</td>
<td>27.3</td>
</tr>
<tr>
<td>P G P</td>
<td>3.</td>
<td>3</td>
<td>13.5</td>
<td>40.9</td>
</tr>
<tr>
<td>Fee for service</td>
<td>8.</td>
<td>1</td>
<td>4.5</td>
<td>45.5</td>
</tr>
<tr>
<td>Hospitals</td>
<td>10.</td>
<td>1</td>
<td>4.5</td>
<td>50.0</td>
</tr>
<tr>
<td>Community</td>
<td>11.</td>
<td>3</td>
<td>13.6</td>
<td>63.6</td>
</tr>
<tr>
<td>*Other</td>
<td>12.</td>
<td>3</td>
<td>13.6</td>
<td>77.3</td>
</tr>
<tr>
<td><strong>PGP Clin FFS</strong></td>
<td>13.</td>
<td>1</td>
<td>4.5</td>
<td>81.8</td>
</tr>
<tr>
<td>PGP FFS Comm</td>
<td>14.</td>
<td>1</td>
<td>4.5</td>
<td>86.4</td>
</tr>
<tr>
<td>FFS Med Soc</td>
<td>15.</td>
<td>1</td>
<td>4.5</td>
<td>90.9</td>
</tr>
<tr>
<td>Med Clin Hosp</td>
<td>16.</td>
<td>1</td>
<td>4.5</td>
<td>95.5</td>
</tr>
<tr>
<td><strong>19.</strong>*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>22</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Indicates write in answer of fraternal organization.

** Multiple sponsors are:
(1) prepaid group practice, fee-for-service, and community
(2) prepaid group practice, fee-for-service, and medical clinic
(3) fee-for-service and medical society
(4) medical clinic and hospital

*** No answer.
<table>
<thead>
<tr>
<th>CATEGORY LABEL</th>
<th>CODE</th>
<th>ABSOLUTE FREQ</th>
<th>RELATIVE FREQ (PCT)</th>
<th>CUM FREQ (PCT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GPPP</td>
<td>1</td>
<td>14</td>
<td>63.6</td>
<td>63.6</td>
</tr>
<tr>
<td>IPA</td>
<td>2</td>
<td>1</td>
<td>4.5</td>
<td>68.2</td>
</tr>
<tr>
<td>Network</td>
<td>3</td>
<td>3</td>
<td>13.6</td>
<td>81.8</td>
</tr>
<tr>
<td>GPPP &amp; Network</td>
<td>4</td>
<td>2</td>
<td>9.1</td>
<td>90.9</td>
</tr>
<tr>
<td>Network of Group Practices</td>
<td>5</td>
<td>1</td>
<td>4.5</td>
<td>95.5</td>
</tr>
<tr>
<td>*Other</td>
<td>6</td>
<td>1</td>
<td>4.5</td>
<td>100.0</td>
</tr>
</tbody>
</table>

**TOTAL**  
22 100.0

* Community based health plan.
### TABLE 4
DISTRIBUTION OF HMOs BY YEARS OF OPERATION

<table>
<thead>
<tr>
<th>CATEGORY LEVEL</th>
<th>ABSOLUTE FREQ</th>
<th>RELATIVE FREQ (PCT)</th>
<th>CUM FREQ (PCT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Yr.</td>
<td>3</td>
<td>13.6</td>
<td>13.6</td>
</tr>
<tr>
<td>2 Yrs.</td>
<td>4</td>
<td>18.2</td>
<td>31.8</td>
</tr>
<tr>
<td>3 Yrs.</td>
<td>7</td>
<td>31.8</td>
<td>63.6</td>
</tr>
<tr>
<td>4 Yrs.</td>
<td>2</td>
<td>9.1</td>
<td>72.7</td>
</tr>
<tr>
<td>10 Yrs.</td>
<td>2</td>
<td>9.1</td>
<td>81.8</td>
</tr>
<tr>
<td>17 Yrs.</td>
<td>1</td>
<td>4.5</td>
<td>86.3</td>
</tr>
<tr>
<td>40 Yrs.</td>
<td>1</td>
<td>4.5</td>
<td>90.8</td>
</tr>
<tr>
<td>125 Yrs.</td>
<td>1</td>
<td>4.5</td>
<td>95.3</td>
</tr>
<tr>
<td>*NA</td>
<td>1</td>
<td>4.5</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>22</strong></td>
<td><strong>100.0</strong></td>
<td></td>
</tr>
</tbody>
</table>

* No answer.

Median = 2.375
Medical Care Facilities and Staff. All respondents indicate a capability for providing a wide range of health services. These services can be obtained at facilities such as hospitals, health centers, pharmacies, and dental and optical clinics that are owned directly by the HMO or are under contract to the HMO. With the exception of hospital and dental facilities, the majority of HMOs own their pharmacies, health centers, and optical clinics. Thirty six point four per cent of the HMOs directly employ physicians and approximately 60 per cent contract with medical groups (Table 5).
TABLE 5
DISTRIBUTION OF HMOs BY OWNERSHIP OF FACILITIES
AND EMPLOYMENT OF PHYSICIANS

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question &amp; Category</th>
<th>Yes</th>
<th>No</th>
<th>Contracted</th>
<th>NA*</th>
<th>CUM%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>HMO has its own</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a)</td>
<td>Hospital(s)</td>
<td>4</td>
<td>2</td>
<td>15</td>
<td>1</td>
<td>22</td>
</tr>
<tr>
<td>b)</td>
<td>Health Center (Clinic)***</td>
<td>16</td>
<td>8</td>
<td>5</td>
<td>-</td>
<td>22</td>
</tr>
<tr>
<td>c)</td>
<td>Dental Clinic</td>
<td>6</td>
<td>7</td>
<td>8</td>
<td>-</td>
<td>22</td>
</tr>
<tr>
<td>d)</td>
<td>Pharmacy</td>
<td>12</td>
<td>7</td>
<td>8</td>
<td>-</td>
<td>22</td>
</tr>
<tr>
<td>e)</td>
<td>Optical Unit</td>
<td>10</td>
<td>2</td>
<td>8</td>
<td>2</td>
<td>22</td>
</tr>
<tr>
<td>2</td>
<td>Physicians are employed directly by HMO</td>
<td>8</td>
<td>12</td>
<td>2</td>
<td>9.1</td>
<td>22</td>
</tr>
<tr>
<td>3</td>
<td>Medical Groups contract with HMOs</td>
<td>13</td>
<td>9</td>
<td>22</td>
<td>100.0</td>
<td>50</td>
</tr>
</tbody>
</table>

* No answer.
** Number of respondents = N
*** One HMO owns a health center and also contracts with a health center.
Enrolled Members. Respondents were requested to identify the per cent of their total enrollment that could be categorized as medicaid, medicare, individual or group members. In addition to these designated classifications, information was requested as to the per cent of non-member patients that utilized the HMO. Findings indicate: (1) 32 per cent of the reporting HMOs have medicaid populations greater than 71 per cent of their total enrollments, (2) none of the respondents indicated a medicare population greater than 50 per cent of their membership; the majority of HMOs reported a medicare population of less than 10 per cent, (3) 9.1 per cent of the HMOs report that individual subscribers comprise 91-100 per cent of their enrollment; the majority of HMOs indicate less than 10 per cent individual subscriber enrollment, (4) 59 per cent of all respondents have a group membership that ranges from 61-100 per cent of their total enrollment (Table 6).
<table>
<thead>
<tr>
<th>Intervals</th>
<th>Medicaid N</th>
<th>Medicaid %</th>
<th>Medicare N</th>
<th>Medicare %</th>
<th>Individual Subscribers N</th>
<th>Individual Subscribers %</th>
<th>Group Subscribers N</th>
<th>Group Subscribers %</th>
<th>Fee-for-Service Patients N</th>
<th>Fee-for-Service Patients %</th>
</tr>
</thead>
<tbody>
<tr>
<td>91 - 100</td>
<td>3</td>
<td>14.0</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>9.1</td>
<td>5</td>
<td>22.7</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>81 - 90</td>
<td>2</td>
<td>9.1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>9.1</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>71 - 80</td>
<td>2</td>
<td>9.1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>13.6</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>61 - 70</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>13.6</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>51 - 60</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>41 - 50</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>4.5</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>4.5</td>
<td>1</td>
<td>4.5</td>
</tr>
<tr>
<td>31 - 40</td>
<td>1</td>
<td>4.5</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>21 - 30</td>
<td>2</td>
<td>9.1</td>
<td>1</td>
<td>4.5</td>
<td>1</td>
<td>4.5</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>9.1</td>
</tr>
<tr>
<td>11 - 20</td>
<td>2</td>
<td>9.1</td>
<td>3</td>
<td>13.6</td>
<td>2</td>
<td>9.1</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>18.2</td>
</tr>
<tr>
<td>1 - 10</td>
<td>1</td>
<td>4.5</td>
<td>8</td>
<td>36.4</td>
<td>9</td>
<td>41.0</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>13.6</td>
</tr>
<tr>
<td>0</td>
<td>9</td>
<td>41.0</td>
<td>9</td>
<td>41.0</td>
<td>8</td>
<td>36.4</td>
<td>8</td>
<td>36.4</td>
<td>8</td>
<td>36.4</td>
</tr>
</tbody>
</table>

* N = 22 respondents

** 13.6% of the HMOs did not answer this question.
Section II

Grievance Components

All HMO respondents reported having either a "formal" or "informal" grievance procedure to review member grievances. Eighty-six point four per cent of the HMOs indicated a formal procedure or a combination formal-informal procedure (Table 7). The responding HMOs (82%) consider the formal grievance procedure an administrative policy of the HMO; none indicated any relationship between a formal procedure and a union-HMO subscriber agreement (Table 8). Approximately 60 to 77 per cent of the HMOs specify a standard grievance form, a time limit for feedback to members denoting actions taken on grievances, a review committee and/or appeal board to hear unresolved grievances, and an arbitration procedure (Table 9). Over 50 per cent of the HMOs have binding arbitration clauses in their contracts; 15.4 per cent have resorted to arbitration to resolve grievances (Table 10).

81A formal procedure is written documentation of a method to resolve a grievance; whereas, an informal procedure is primarily an oral complaint, with little or no documentation.
TABLE 7
DISTRIBUTION OF HMOs BY TYPE OF GRIEVANCE PROCEDURES

<table>
<thead>
<tr>
<th>CATEGORY LEVEL</th>
<th>CODE</th>
<th>ABSOLUTE FREQ</th>
<th>RELATIVE FREQ (PCT)</th>
<th>CUM FREQ (PCT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formal</td>
<td>1.</td>
<td>9</td>
<td>40.9</td>
<td>40.9</td>
</tr>
<tr>
<td>Informal</td>
<td>2.</td>
<td>3</td>
<td>13.6</td>
<td>54.5</td>
</tr>
<tr>
<td>Formal/Informal</td>
<td>3.</td>
<td>10</td>
<td>45.5</td>
<td>100.0</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>22</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

TABLE 8
DISTRIBUTION OF HMOs HAVING FORMAL GRIEVANCE PROCEDURE AS A RESULT OF PERSONAL POLICY OR UNION AGREEMENT

<table>
<thead>
<tr>
<th>CATEGORY LEVEL</th>
<th>CODE</th>
<th>ABSOLUTE FREQ</th>
<th>RELATIVE FREQ (PCT)</th>
<th>CUM FREQ (PCT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Policy</td>
<td>1.</td>
<td>18</td>
<td>81.8</td>
<td>81.8</td>
</tr>
<tr>
<td>Union Agreement</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>81.8</td>
</tr>
<tr>
<td>*NA</td>
<td>4</td>
<td>18.2</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>22</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

* No answer
### TABLE 9
DISTRIBUTION OF HMOs BY FORMAL GRIEVANCE PROCEDURE CHARACTERISTICS

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question and Category</th>
<th>Yes</th>
<th>%</th>
<th>No</th>
<th>%</th>
<th>NA*</th>
<th>%</th>
<th>CUM</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 2</td>
<td>There is a standard grievance form.</td>
<td>17</td>
<td>77.3</td>
<td>2</td>
<td>9.1</td>
<td>3</td>
<td>13.6</td>
<td>22</td>
<td>100.0</td>
</tr>
<tr>
<td>F 3</td>
<td>There is a time limit for feedback to members regarding initial action on grievance.</td>
<td>16</td>
<td>72.7</td>
<td>3</td>
<td>13.6</td>
<td>3</td>
<td>13.6</td>
<td>22</td>
<td>100.0</td>
</tr>
<tr>
<td>F 4</td>
<td>Is there a review committee and/or appeals board in HMO grievance procedure to hear unresolved grievances?</td>
<td>15</td>
<td>68.2</td>
<td>3</td>
<td>13.6</td>
<td>4</td>
<td>18.2</td>
<td>22</td>
<td>100.0</td>
</tr>
<tr>
<td>F 5</td>
<td>Is there an arbitration procedure?</td>
<td>13</td>
<td>59.1</td>
<td>6</td>
<td>27.3</td>
<td>3</td>
<td>13.6</td>
<td>22</td>
<td>100.0</td>
</tr>
<tr>
<td>F 6</td>
<td>Has arbitration ever been resorted to?</td>
<td>2</td>
<td>15.4</td>
<td>11</td>
<td>84.6</td>
<td></td>
<td></td>
<td></td>
<td>13** 100.0</td>
</tr>
</tbody>
</table>

* No answer.

** Percentage calculated against the number of respondents to the questions as a denominator, not the entire sample.
TABLE 10

DISTRIBUTION OF HMOs ACCORDING TO THE USE OF ARBITRATION TO RESOLVE GRIEVANCES

<table>
<thead>
<tr>
<th>CATEGORY LABEL</th>
<th>CODE</th>
<th>ABSOLUTE FREQ</th>
<th>RELATIVE FREQ (PCT)</th>
<th>CUM FREQ (PCT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Arbitration</td>
<td>2</td>
<td>6</td>
<td>27.3</td>
<td>27.3</td>
</tr>
<tr>
<td>Binding Arb</td>
<td>3</td>
<td>12</td>
<td>54.5</td>
<td>81.8</td>
</tr>
<tr>
<td>Non Binding Arb.</td>
<td>4</td>
<td>1</td>
<td>4.5</td>
<td>86.4</td>
</tr>
<tr>
<td>NA*</td>
<td></td>
<td>3</td>
<td>13.6</td>
<td>100.0</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>22</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

* No answer.

Accessibility of Grievance Procedure to Members

Each respondent was asked to select from a number of given variables, their method of informing members about handling of grievances and access to the grievance system.

The majority of HMOs (73%) publicize their grievance procedures through a combination of grievance literature such as brochures, newsletters, and posted information at the health facility (Table 11). Seventy seven point three per cent of the HMOs have designated a specific department to handle grievances and 36 per cent
report a special telephone number to receive complaints (Table 12).

**TABLE 11**

**DISTRIBUTION OF HMOs BY METHOD OF COMMUNICATION DESCRIBING GRIEVANCE PROCEDURE**

<table>
<thead>
<tr>
<th>CATEGORY LABEL</th>
<th>CODE</th>
<th>ABSOLUTE FREQ</th>
<th>RELATIVE FREQ (PCT)</th>
<th>CUM FREQ (PCT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brochure</td>
<td>1.</td>
<td>1</td>
<td>4.5</td>
<td>4.5</td>
</tr>
<tr>
<td>Posted Information</td>
<td>3.</td>
<td>2</td>
<td>9.1</td>
<td>13.6</td>
</tr>
<tr>
<td>*Other Means of Communication</td>
<td>4.</td>
<td>2</td>
<td>9.1</td>
<td>22.7</td>
</tr>
<tr>
<td>More than one Method of Communication</td>
<td>5.</td>
<td>16</td>
<td>72.7</td>
<td>95.5</td>
</tr>
<tr>
<td><strong>NA</strong></td>
<td>1</td>
<td>4.5</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td>22</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

* Means of communication other than those listed in questionnaire (brochure, newsletter, news bulletin, posted information in center).

** No answer.
<table>
<thead>
<tr>
<th>Question Number</th>
<th>Question and Category</th>
<th>YES</th>
<th>NO</th>
<th>CUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>G 1</td>
<td>Does HMO have a specific department to handle member grievances?</td>
<td>17</td>
<td>5</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td></td>
<td>77.3</td>
<td>22.7</td>
<td>100.0</td>
</tr>
<tr>
<td>G 3</td>
<td>Does HMO have a special telephone number to handle member grievances?</td>
<td>8</td>
<td>14</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td></td>
<td>36.4</td>
<td>63.6</td>
<td>100.0</td>
</tr>
<tr>
<td>G 4</td>
<td>Is there a suggestion box available to members?</td>
<td>10</td>
<td>12</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td></td>
<td>45.5</td>
<td>54.5</td>
<td>100.0</td>
</tr>
</tbody>
</table>

* N = Number of respondents

** % = No. of respondents / No. of Eligible sample
Complaints

Each HMO surveyed was asked to report the number of complaints received per quarter and to list the three most common complaints. Although 73 per cent of the respondents did report on the number of complaints received, the relevance of the data for analysis is questionable. A number of variables could possibly influence both the kind of complaint and number of complaints reported. Variables might include age of the plan, organizational structure, population represented in the membership, effectiveness of the grievance system, and the attitudes reflected by the HMO staff as well as the members in accepting a grievance system. These are all areas for future studies. Therefore, data pertaining to the number of complaints will not be presented.

Table 13, however, lists the aggregated complaint categories for the three most commonly reported complaints.\(^{82}\) The most frequently mentioned category of complaints is the "availability" of HMO services to enrolled members.

\(^{82}\)See Appendix "C" for a complete listing of the various responses under each complaint category.
TABLE 13
DISTRIBUTION OF HMOs BY CATEGORY OF COMPLAINTS RECEIVED FROM MEMBERS*

<table>
<thead>
<tr>
<th>Category Label**</th>
<th>Relative Freq (Pct) Most Frequent</th>
<th>Relative Freq (Pct) Second Most Frequent</th>
<th>Relative Freq (Pct) Third Most Frequent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Availability</td>
<td>18.2</td>
<td>18.2</td>
<td>9.1</td>
</tr>
<tr>
<td>Communication</td>
<td>18.2</td>
<td>13.5</td>
<td>9.1</td>
</tr>
<tr>
<td>Acceptability</td>
<td>4.5</td>
<td>9.1</td>
<td>18.2</td>
</tr>
<tr>
<td>Accessibility</td>
<td>9.1</td>
<td>13.6</td>
<td>4.5</td>
</tr>
<tr>
<td>Administrative</td>
<td>18.2</td>
<td>4.5</td>
<td>4.5</td>
</tr>
<tr>
<td>***NA</td>
<td>31.8</td>
<td>40.9</td>
<td>54.5</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

* HMOs were requested to list three most common member complaints.

** Categories defined from the perspective of consumer (Member).

*** No answer.

Availability: Services of the HMO must be at hand and ready when needed (manpower, time, place).

Accessibility: Services of the HMO must be easy to reach (geographically and by telephone).

Acceptability: Services of the HMO are viewed as relevant and reasonable.
Communication: Ability of HMO personnel and medical staff to communicate with membership.

Administrative: Service associated with the non-medical administration of the HMO.

Time Period Needed to Resolve Grievance

Each respondent was also asked to report the percent of grievances resolved within specified time periods. The replies presented in Table 14 indicate 88 percent of the responding HMOs resolved between 95-100 percent of their grievances within 30 days.

---

83 Per cent based on the number of respondents.
### TABLE 14
PERCENTAGE OF GRIEVANCES RESOLVED BY HMOs WITH SPECIFIC TIME PERIODS

<table>
<thead>
<tr>
<th>Code</th>
<th>7 Days</th>
<th>14 Days</th>
<th>30 Days</th>
<th>90 Days</th>
<th>6 Months+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>25%</td>
<td>15%</td>
<td>30%</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>2.</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>99%</td>
<td></td>
<td></td>
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<td>9.</td>
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<td>30%</td>
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<tr>
<td>20.</td>
<td>50%</td>
<td>50%</td>
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</table>

**Member Satisfaction**

Approximately 65 per cent of the respondents surveyed for member satisfaction on a yearly basis (Table
15). Less than 50 per cent of the reporting HMOs survey former members for reasons of disenrollment (Table 16).

**TABLE 15**

DISTRIBUTION OF HMOs SURVEYING FOR MEMBERS SATISFACTION

<table>
<thead>
<tr>
<th>CATEGORY LABEL</th>
<th>CODE</th>
<th>ABSOLUTE FREQ</th>
<th>RELATIVE FREQ (PCT)</th>
<th>CUM FREQ (PCT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No*</td>
<td>1</td>
<td>4</td>
<td>20.0</td>
<td>20.0</td>
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<tr>
<td>1 Yr.</td>
<td>2</td>
<td>13</td>
<td>65.0</td>
<td>85.0</td>
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<td>2 Yrs.</td>
<td>3</td>
<td>2</td>
<td>10.0</td>
<td>95.0</td>
</tr>
<tr>
<td>3 Yrs. or more</td>
<td>4</td>
<td>1</td>
<td>5.0</td>
<td>100.0</td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>20**</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

* Do not survey for member satisfaction.

** Number of responding HMOs.

**TABLE 16**

DISTRIBUTION OF HMOs SURVEYING FORMER MEMBERS FOR REASONS OF DISENROLLMENT

<table>
<thead>
<tr>
<th>CATEGORY LABEL</th>
<th>CODE</th>
<th>ABSOLUTE FREQ</th>
<th>RELATIVE FREQ (PCT)</th>
<th>CUM FREQ (PCT)</th>
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<tr>
<td>Yes</td>
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<tr>
<td>NA*</td>
<td></td>
<td>1</td>
<td>4.5</td>
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<tr>
<td>TOTAL</td>
<td></td>
<td>22</td>
<td>100.0</td>
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</table>

* No answer.
Further Information On Grievance Procedures

Respondents were given the opportunity in an open-ended question to describe or comment on their grievance procedure. Approximately fifty per cent of the HMOs participating in the survey responded.

Although the comments provided valuable insight into the different grievance procedures of the responding HMOs, the many variations do not allow for categorization. Nonetheless, several general observations can be made. These include:

(1) The grievance procedure usually has more than two steps.

(2) Step one is an attempt to resolve an oral complaint by any employee or provider at the initial contact with member.

(3) If the complaint is unresolved, a written complaint may be filed with an individual or committee designated to handle grievances.

(4) If arbitration is the final step in the grievance procedure the complaint will be resolved in this manner. In HMOs where arbitration is not used, the member may request disenrollment.

Some of the grievance procedures described were well-documented, detailed statements; others briefly outlined a few simple steps. The following selected
descriptions are included in this study as an example of some of the grievance procedures currently being used in some HMOs:

(1) Oral complaint may be addressed to any employee or provider. This person then attempts to resolve complaint or have it resolved. If member is dissatisfied with solution he/she may file a written complaint that goes to membership services office.

Membership Service Representative (MSR) is responsible for determining what action, if any, is necessary to resolve complaints. MSR responds in writing to member within 15 days from receipt of written complaint. If more days are needed by the representative, member must be notified, orally or in writing within this period.

Written response contains: (1) resolution of complaint, (2) basis for resolution, (3) notification that member may seek a review of resolution of the complaint. Request for review must be filed within 30 days of the receipt of resolution of complaint with member service representative.

Medical Review Committee reviews complaints, initial resolution, and any additional information submitted by member. Member is notified of decision within 30 days. [Additional time may be requested, orally or in writing within the 30 day period.]

(2) Member Relations Counselor is advised of complaint and investigates. The Counselor then advises member of findings in writing. If the complaint is still unresolved it is taken before a grievance committee. Committee consists of one representative of the Board of Directors, one physician from the plan, one non-professional employee and two consumers (members). Aggrieved member is notified in writing of the findings. If complaint is still unresolved it will go to arbitration.
(3) Oral complaints may be made to staff/employee preferably to Membership Service Office where a log is kept of all oral complaints. If unresolved written complaint is filed at Membership Service Office (in person or by mail). Response is made within 30 days after receipt of written complaint (Request may be made for extension).

Response acknowledges receipt of complaint and action taken. If unresolved, the member may request a second review with more information (if desired) to Health Plan Manager. Member allowed 60 days to file.

Membership Service Committee - reviews complaint and Health Plan Manager notifies member of action within 60 days (extension possible).

(4) Grievances including request for disenrollment are submitted to Grievance Committee Chairperson. The plan public relations person attempts to resolve problem. If unresolved, the Grievance Committee meets within seven days and asks member to attend.

Grievance Committee makes recommendations.

Unresolved grievances go to the Community Advisory Council.

Final step - Grievance goes to Board of Directors.

(5) Office staff of each clinic will attempt to resolve complaint either informally or by a signed complaint. If unresolved, the member may request an appointment to appear before the Grievance Committee (three patients, three administrative personnel, one neutral - chairperson).

Recommendation of Committee will be presented to member at hearing. If member is not in attendance letter is forwarded within five days (working). Plan representatives must be given seven days to respond to member regarding policy of services. If unresolved member may disenroll/or reappear before Committee.
CHAPTER VI

MAJOR FINDINGS AND CONCLUSIONS

The purpose of this graduate project was to formulate a hypothesis for the design of a basic model grievance procedure for HMOs. The development of the hypothesis was to be based on the conclusions resulting from:

(1) Identification of steps and processes necessary for a successful grievance procedure

(2) Identification of areas of common characteristics in grievance procedures as they currently exist in various types of prepaid health care organizations.

Major Findings

The key findings that resulted from this research effort were:

Review of Literature

(1) Unions, the strongest advocates and largest group of purchasers of prepaid group practice services have used their influence to establish fairly formal medical grievance procedures in prepaid group practice plans.
(2) The most important function of the grievance process is that it channels conflict into an institutional mechanism for peaceful resolution, thus preventing minor misunderstandings from becoming major problems.

(3) To be effective, the grievance process should have a minimum number of steps (1-6) with established time limits for each step. The first step should be an oral complaint. Secondly, the complaint should be reduced to a written form. All successive steps should involve individuals with greater responsibilities. Every effort should be made to resolve the grievance before the final step, arbitration.

(4) Laws of arbitration in Arizona, California, Nevada, and Hawaii could encompass the settlement of medical malpractice disputes.

(5) The consumers' perception of "high quality medical care" is based more on the "doctor-patient relationship" than on the technical skills of the physician.

Survey of HMO's Member Grievance Procedures

(1) Seventy three per cent of the 22 responding HMOs

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84 Survey of HMOs, HMO Prototypes, and HMO-Like Organizations.
identified themselves as GPPP.

(2) The median age of the responding HMOs was 2.34 years.

(3) Sixty eight per cent of the HMOs contract with hospitals for their services, but the majority of HMOs own their clinics (77.2%), pharmacies (54.5%), and optical units (45.5%).

(4) Approximately 37 per cent of the HMOs directly employed physicians; fifty nine per cent contract with medical groups.

(5) Group subscribers represent the largest category of enrolled members.

(6) Eighty six per cent of the HMOs have either a formal or combination formal-informal grievance procedure.

(7) Sixty to seventy seven per cent of the HMOs provide a standard grievance form, time limits for feedback to members regarding initial action on grievances, a review committee or appeals board to hear unresolved grievances and an arbitration procedure.

(8) Approximately 50 per cent of the HMOs have binding arbitration clauses in their member contracts.

(9) Approximately 73 per cent of the HMOs describe the grievance procedure in their literature and
77 per cent designate a specific department for handling grievances.

(10) Enrolled members' major complaint was cited as the lack of "availability" of HMO services.

(11) Eighty eight per cent of the HMOs resolve between 95-100 per cent of their members' complaints within 30 days.

(12) Approximately sixty five per cent of the HMOs survey for member satisfaction on a yearly basis.

(13) Fifty per cent of the HMOs survey former members for reasons of disenrollment.

Conclusions

The results of the survey of HMOs, HMO prototype, and HMO-like organizations indicate a considerable variation in the size, sponsorship, and administrative structure of HMOs. A specific number of steps or exact description of "Model" procedures for a member grievance system would not be uniformly applicable to all HMOs. The conclusions drawn from this study are intended to serve as a foundation for the development of a hypothesis for the design of a basic model grievance procedure in HMOs.

The following conclusions are derived from the results presented in the preceding chapters of this
(1) An effective grievance procedure is able to channel conflict between members and HMO staff (professional and non-professional) into an institutional mechanism for peaceful resolution.

(2) The grievance procedure is of greatest value only if the members and the HMO staff know of its existence and purpose.

(3) HMO members must be able to identify and have access to the designated individual or department handling grievances.

(4) The member service office in a health facility should be placed where it would attract the members' attention.

(5) A 24-hour answering service will encourage members to phone in complaints; this service is particularly important when an HMO must contract for services.

(6) Complaints should be welcomed and acted upon promptly.

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85 Chapter III describes the literature review; Chapter V, the results of the survey of member grievance procedures in HMOs, HMO prototypes, and HMO-like organizations.

86 The individual will be identified as the Member Service Representative or the department, as the Member Service Department.
(7) The grievance procedure should deal constructively with complaints.

(8) The health consumer (member) desires personal services in what is perceived as a non-personal bureaucratic organization.

(9) An effective grievance procedure can include malpractice claims.

(10) The grievance procedure is most effective if the member service representative is allowed to cross lines of authority to resolve disputes.

(11) Member service representative, to truly represent the member, should be responsible to the Board of Directors or Trustees rather than the administrator. 87

(12) Member service representative's qualifications are important and ideally should include a basic knowledge of medicine, law, insurance, and communicative skills.

(13) The grievance procedure should have both an informal and formal stage (See Appendix D).

(14) The HMO should survey for member satisfaction once a year.

(15) Former members should be surveyed for reasons of disenrollment.

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APPENDIX A

CALIFORNIA STATE UNIVERSITY, NORTHRIDGE
Northridge, California 91324

"IN THE SAN FERNANDO VALLEY"

DEPARTMENT OF HEALTH SCIENCE
885-3101

Dear Administrator:

This is to introduce Mrs. Pauline Minardi, a candidate for the Master's Degree, Health Administration, at California State University, Northridge. With the approval of her advisory committee members, Dr. Sam Pollock, Dr. Coteti Krishnamurti and the undersigned she is fulfilling the graduate school requirements for thesis by conducting a survey of Health Maintenance Organizations, HMO Prototypes and HMO-like Organizations in regard to internal member grievance systems. These systems should be directed to hearing and resolving grievances between the enrolled member and the organization.

The purpose of the survey is to determine the various methods used by HMO's/Prototypes/HMO-like Organizations for handling complaints of enrollees. It is assumed that some handling procedures will be common to all organizations.

The data supplied will be held in the strictest confidence and will be used for statistical purposes only. A copy of the survey's results will be forwarded to you if you indicate interest in receiving it.

I would appreciate your directing this letter and questionnaire to an appropriate member of your staff. Please call Mrs. Minardi at (213) 885-7819 if you need any clarifications. A self-addressed stamped envelope is enclosed for your convenience in returning the survey. It would be most helpful if this data were returned by November 20, 1975.

Your participation and contribution to this survey are most gratefully appreciated.

Respectfully,

Donald M. Hufstines, Dr. PH
Coordinator
Health Administration Program
APPENDIX A

1975 Survey of Health Maintenance Organizations, HMO Prototypes and HMO-Like Organizations - Member Grievance Procedures

Note: Data supplied will be held in confidence and used for statistical purposes only.

I would like to have a copy of the survey's result. (Please check) 

Definition: A Health Maintenance Organization is an organized health care delivery system which provides a wide range of comprehensive health care services to a voluntarily enrolled population in exchange for a fixed and prepaid periodic payment.

A grievance is a circumstance or condition thought to be unjust and grounds for complaint or resentment.

Name and Address of Organization (Optional)

________________________________________________________________________________________

Length of time plan has been operational ________ (Years)

Title of person preparing this report __________________________

Date __________________________

A. Total Number of Enrolled Members __________________________

1. What Percent of Total are Medicaid __________________________

2. What Percent of Total are Medicare __________________________

3. What Percent of Total are Individual Subscribers __________________________

4. What Percent of Total are Group Subscribers __________________________

5. Percent of Fee-For-Service Patients Using HMO __________________________

B. Sponsors of HMO/HMO-Like Organizations (Please check appropriate answers)

1. Insurance Company __________________________

2. Business Corporation __________________________
3. Prepaid Group Practice
4. Medical Foundation
5. Medical Clinics
6. Teaching Hospital and Medical School
7. National Societies and Professional Associations
8. Fee-For-Service Groups
9. Medical Societies
10. Hospitals
11. Community
12. Other (If none of the above applies, please enclose a brochure describing your organization)

C. Type of HMO (Please check one)
1. Group Practice Prepayment Plan (GPPP)
2. Individual Practice Association (IPA)
3. Network

D. Medical Care Facilities and Staff (Please check appropriate answers)
1. HMO has its own:
   (a) Hospital(s)  Yes  No  Contracted
   (b) Clinic or Health Center
   (c) Dental Clinic
   (d) Pharmacy
   (e) Optical Unit
2. Physicians employed directly by HMO  Yes  No
3. Medical Groups Contract with HMO  Yes  No

E. Procedures to Review Member Grievances (Please check one or both)
1. Formal - Written procedures/specific steps for action/specific plan representative designated.
2. Informal - Primarily oral, encounters, some documentation.
F. If HMO has a Formal Grievance Procedure, Please Review the Following Before Continuing to Section G. (Please check if applicable)

1. The Formal Procedure is a result of:
   Personal Policy _____ Union Agreement _____

2. There is a standard grievance form.
   Yes _____ No _____

3. There is a time limit for feedback to members regarding initial action on grievances.
   Yes _____ No _____

4. Is there a review committee and/or appeals board in HMO grievance procedures to hear unresolved grievances?
   Yes _____ No _____

5. Is there an Arbitration procedure?
   Yes _____ No _____
   (a) If answer is yes, please indicate if Arbitration is:
       Binding _____ Non-Binding _____
   (b) Has Arbitration ever been resorted to?
       Yes _____ No _____

G. Grievances (Please check appropriate answer)

1. Does HMO have a specific department to handle member grievances?
   Yes _____ No _____

2. How are members informed about handling of grievances? (Please check appropriate answer)
   Brochure ______
   News Bulletin, Newsletter ______
   Posted Information in Center ______
   Other Communication ______

3. Does HMO have a special phone number to handle member grievances?
   Yes _____ No _____

4. Is there a suggestion box available to members?
   Yes _____ No _____
5. Average number of grievances received quarterly

6. Most common grievances
   Most frequent ____________________________
   Next in frequency ____________________________
   Third in frequency ____________________________

7. Please indicate percent of grievances resolved:
   _____% within 7 days     _____% within 30 days
   _____% within 14 days    _____% within 90 days
   _____% 6 months or more

8. Do you survey for member satisfaction?
   Yes ____    No ____
   (a) If answer is yes, please indicate intervals between survey:
   No more than one year interval ______.
   No more than 2 year intervals ______.
   No regular intervals but approximately every ________ (fill in period).
   (b) Do you particularly survey former members for reasons of disenrollment?
   Yes ____    No ____

H. Further Information on Grievance Procedures

"To correctly interpret the data you have provided please identify the steps in your Grievance procedure with corresponding time periods for each step or attach a brochure which explains the procedure to your members."

Thank you for your cooperation
APPENDIX B

POSTCARD

RE: 1975 Survey of Health Maintenance Organizations, HMO Prototypes, and HMO-Like Organizations - Member Grievance Procedures

November 15, 1975

Dear Administrator:

I am approaching the final stages of compiling the data of the above survey. I would appreciate your participation in the survey if you have not already done so.

Respectfully,

Pauline Minardi (213) 885-7810
Candidate for the Master's Degree
California State University, Northridge
APPENDIX C

COMPLAINTS ABOUT HMOs, HMO PROTOTYPES, HMO-LIKE ORGANIZATIONS - CODING CATEGORIES

Availability

Doctor's limited time with patients.
Physician turnover.
Long wait in clinics.
Generally, waiting is too long.
Moved out of service area.
Under a specific course of treatment by other than a plan-physician.
Time lapse between request for appointments and scheduling.

Accessibility

Clinic too far.
Difficult to get appointments.
Poor telephone access, long wait on telephone when calling facility.
Transportation is not provided.
Transportation, facility too far from public transportation.

Acceptability

Impersonal care by physicians.
Diagnosis and treatment.
Attitude of staff.
Insufficient training of personnel.
Patient education into system.
Doctor not prescribing quantity prescriptions.
Comfort of facility.
Receptionist's attitude.
Dental and medical care.

Communication

Patient-physician communication.
Lack of understanding of benefits and plan limitations.
Misunderstanding of necessary procedures.
Personality conflicts.
Members seek reimbursement for unauthorized services.

Administrative
Billing errors.
Member name not on eligibility list.
Receipt of ID's (Identification cards).
Misrepresentation by former sales personnel.
Enrollment cards are late.
APPENDIX D

ESSENTIAL STEPS IN A GRIEVANCE PROCEDURE

(1) At the first step (informal stage) a member may voice a complaint to any provider or employee of the HMO. If the complaint cannot be resolved the member is directed to the member service representative. If the complaint is resolved, a memo is sent to the member service representative indicating the nature of the complaint and resolution. All oral complaints should be recorded for periodic review.

(2) The second step is the beginning of the formal complaint procedure. Here the member service representative provides the member with a standard grievance form to file a complaint. If the member is reluctant to file a written complaint, the member service representative will consider the issue an oral complaint for tabulation purposes. The member service representative will then attempt to resolve the complaint. This may entail consulting with the heads of departments, the medical director or supervisory personnel. The member service representative should inform the aggrieved member of the resolution of the complaint or its progress within five working days.
(3) If the complaint is still unresolved, the member service representative submits the dispute to a review committee. This committee should meet bimonthly for an ongoing review of all complaints in an attempt to improve the delivery and quality of services. The committee composition may vary in structure depending on the sponsorship and administrative organization of the HMO. However, members should include the member service representative, the medical director or a physician representative and a representative of the administrator. The aggrieved member should be notified in writing of a resolution or the status of the complaint within ten working days following the committee meeting.

(4) If the complaint is still unresolved, the dispute is subject to arbitration or the member may seek disenrollment.