REPORT OF THE
STATE CORPORATION COMMISSION'S
BUREAU OF INSURANCE ON

The Role of the Commonwealth in Providing Public Education and Citizen Protection in Health Insurance Issues

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 7

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PRESTON C. SHANNON
CHAIRMAN

THEODORE V. MORRISON, JR.
COMMISSIONER

HULLIHEN WILLIAMS MOORE
COMMISSIONER

COMMONWEALTH OF VIRGINIA

WILLIAM J. BRIDGE
CLERK OF THE COMMISSION
P. O. BOX 1197
RICHMOND, VIRGINIA 23209-1

STATE CORPORATION COMMISSION

October 16, 1992

TO: The Honorable L. Douglas Wilder
Governor of Virginia
and
The General Assembly of Virginia

We are pleased to transmit this Report of the the State Corporation Commission's Bureau of Insurance on The Role of the Commonwealth in Providing Public Education and Citizen Protection in Health Insurance Issues.

The study was initiated and the report prepared pursuant to Senate Joint Resolution 120 of the 1992 Session of the General Assembly of Virginia.

Respectfully submitted,

Preston C. Shannon
Chairman

Theodore V. Morrison, Jr.
Commissioner

Hullihen Williams Moore
Commissioner

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EXECUTIVE SUMMARY

Legislative Request

The State Corporation Commission's Bureau of Insurance (Bureau) was requested by Senate Joint Resolution No. 120 (Appendix A), passed by the 1992 General Assembly, to study the role of the Commonwealth in providing public education and citizen protection in issues surrounding health care insurance. In its deliberations, the Bureau was asked to consider (i) the development of a single claims form for health insurance; (ii) regulatory oversight of the disclosure of criteria used in payors' case decision making, and an appeals process for the denial of claims; (iii) development of a health insurance consumer guide for small businesses; (iv) the role of the Bureau in the collection, analysis, interpretation, and evaluation of provider and consumer problems related to health insurance; and (v) development of a "health insurance hotline."

Development of a Single Health Insurance Claims Form

The Bureau surveyed the top twenty-five (25) writers of accident and sickness insurance policies in Virginia to determine whether they would be in favor of the creation of a single health insurance claims form. Out of nineteen (19) responses received, twelve (12) companies said they would be in favor of this proposal. Although the survey did not ask the respondents to comment on a particular form, several companies mentioned on the survey that they would not be opposed to the establishment of a universal claims form as long as it was the HCFA-1500 (Appendix B) for providers and the UB-82 for hospitals. These are national forms that were developed by the Uniform Claims Form Task Force and the National Uniform Billing Committee. The Health Care Financing Administration co-chaired both of these groups together with the American Medical Association and the American Hospital Association, respectively. One company stated that the development, implementation, and required use of uniform claims forms could best be achieved by using the forms already developed at the federal level. Several other companies stated that they would be opposed to any form that was unique to Virginia.

The Bureau also surveyed one hundred (100) randomly selected physicians licensed and living in Virginia to determine whether they would be in favor of the development of a single health insurance claims form. Out of thirty (30) responses received, twenty-eight (28) said they would be in favor of such a proposal. Although the survey did not ask the respondents to comment on a particular form, several physicians stated that the HCFA-1500 is currently being used as a national form.

Eighteen (18) advisory organizations representing provider groups other than physicians were also surveyed. Out of sixteen (16) responses received, fifteen (15) indicated that they would be in favor of the creation of a universal claims form for health insurance. Several organizations mentioned the HCFA-1500 and the UB-82 claims forms.

The Bureau also researched the activities of the other states to determine whether any other states had adopted a standard health insurance claims form. Twenty-six (26) states have either adopted a standard claims form or are considering it. Thirteen (13) of these states either require or plan to require insurers to accept the HCFA-1500 claims form from physicians, and eleven (11) states either require or plan to require insurers to accept the UB-82 claims form from hospitals. Nine (9) states have adopted the claims form developed by the American Dental Association (ADA) for dentists. Four (4) states have developed their own claims form for pharmacists. The National Association of Insurance Commissioners (NAIC) is also in the process of setting up a working group to study this issue. Some preliminary information obtained from the NAIC indicates that they will probably recommend adopting the HCFA-1500 for physicians, the UB-82 for hospitals, and the ADA form for dentists. They have not decided what they will recommend for pharmacists.

Based on these findings, the Bureau recommends that all accident and sickness insurers, health maintenance organizations, health services plans, and dental and optometric services plans licensed in the Commonwealth be required to accept as standard claims forms:

(i) the HCFA-1500 claims form (or its successor) for physician services and for services provided by chiropractors, audiologists, speech pathologists, clinical nurse specialists who render mental health services, physical therapists, psychologists, clinical social workers, professional counselors, podiatrists, optometrists, and opticians;

(ii) the UB-82 claims form (or its successor) for hospital services; and

(iii) the ADA claims form developed by the American Dental Association for dental services.

Payors should not be prohibited, however, from accepting any other claims form that has been determined to be acceptable by both the provider and the payor.

Because there does not appear to be a national standard form already developed for use by pharmacists, the Bureau does not recommend establishing a pharmaceutical claims form that would be unique to Virginia. The Bureau recommends that the standardized format which is being developed by the American National Standards Institute to facilitate the electronic submission of claims be used by all insuring entities as soon as the ANSI X12 837 Health Care Claim Transaction form (Appendix C) has been adopted. This form will be available for use by hospitals, physicians, dentists, pharmacists, and other health care providers.

Disclosure of Criteria Used in Payors' Case Decision Making and Establishment of an Appeals Process for Denials of Insurance Claims

The Bureau surveyed other states to determine whether they require disclosure of criteria used in payors' case decision making and appeals processes for the denials of insurance claims. None of the responding states require disclosure of criteria used in payors' case decision making and only one state requires health maintenance organizations to have an appeals process for the denial of claims. However, several states require appeals processes for prospective and concurrent utilization review denials.

The Bureau also surveyed the top writers of accident and health insurance and private passenger auto liability insurance in Virginia, Blue Cross and Blue Shield of the National Capital Area (a health services plan), all Virginia-licensed health maintenance organizations, and all Virginia-certified private review agents. The survey responses revealed that (i) most respondents use criteria for screening and not for making utilization review determinations; (ii) all allow their physician or peer reviewers to override criteria if the criteria would result in a utilization review determination that is contrary to their judgment; (iii) many respondents are prohibited from disclosing criteria by contractual terms imposed by the marketers of the criteria; and (iv) many respondents use criteria that are computerized and which consequently may be difficult to disclose. The survey responses also revealed that many respondents have appeal/reconsideration processes which are accessible to insureds.

The Bureau also performed a review of the literature. The literature offered support for both disclosure and nondisclosure of criteria and offered support for establishment of appeals processes.

Based on these findings, the Bureau does not recommend that the Commonwealth of Virginia require disclosure of criteria used in payors' case decision making to providers or consumers. The Bureau does recommend that insurers, health services plans, and health maintenance organizations that make prospective or concurrent utilization review denials should be required to have an appeals process for the appeal of these denials if the insurer, health services plan, or health maintenance organization makes the utilization review determination for its own insured, member, subscriber, or enrollee.

Development of a Consumer Guide for Small Businesses

The current publications produced for consumers by the Bureau of Insurance were developed for individual consumers. The Bureau recognizes the need for information by small businesses and considers it feasible to publish a consumer guide for that segment. A draft of the guide is found in Appendix E of this report.

Handling of Provider and Consumer Problems and Concerns

The Bureau's Life and Health Market Regulation Division has a Consumer Services Section which handles provider and consumer problems and concerns related to health insurance. This section investigates complaints, answers inquiries, and provides information to consumers who call or visit the Bureau. Complaint data is collected and analyzed on a monthly and yearly basis. The Bureau will, within the next few years, be phasing in a new computer system that will allow for more detailed tracking of complaints and analysis of complaints and other trends. This new system will also allow the Bureau to share complaint data with other states through the National Association of Insurance Commissioners.

The Bureau conducts seminars and makes presentations to groups who request information or who have special needs related to health insurance. Consumer guides are also made available to the public. Questions concerning Medicare, Medicaid, or nursing homes are referred to the Social Security Administration, the Department of Medical Assistance Services, and the Department for the Aging, respectively.

Because of its role in providing public education and citizen protection, because of the periodic reviews it conducts to analyze provider and consumer complaints, and because an upgrade of the computerized record-keeping and analysis of complaint data has already been planned, the Bureau recommends no changes at this time in the way it collects, analyzes, interprets, and evaluates provider and consumer problems and concerns related to health insurance.

Development of a Health Insurance Hotline

The State Corporation Commission makes an in-state, toll-free hotline number available to the public through which insureds can call the Bureau's Life and Health Consumer Services Section to register a complaint or to discuss a problem related to health insurance. Consumers needing assistance from other state agencies are referred to the appropriate agency. The Commission's toll-free number and the Bureau's direct number are widely distributed. Several enhancements to the phone system have already been made and several more are in the planning stages for 1993. The Bureau recommends against the development of an additional health insurance hotline since both a Commission toll-free hotline number and a Bureau direct number already exist.

INTRODUCTION

Legislative Request

The State Corporation Commission's Bureau of Insurance (Bureau) was requested by the 1992 General Assembly to study the role of the Commonwealth in providing public education and citizen protection in issues surrounding health care insurance. This study was directed by Senate Joint Resolution No. 120. The study resolution asked the Bureau to give consideration to the following:

(1) development of a single claims form for all health insurance systems in the Commonwealth;

(2) regulatory oversight of the disclosure of criteria used in payors' case decision making to providers and consumers, and an appeals process for denial of insurance claims;

(3) development of a consumer guide for small businesses to assist them in purchasing health insurance;

(4) the role of the Bureau of Insurance in the collection, analysis, interpretation, and evaluation of provider and consumer problems and concerns related to health insurance; and

(5) development of a "health insurance hotline" for Commonwealth citizens by the Bureau or another state agency.

Background

In 1991, the Virginia General Assembly requested the Board of Health Professions to study the standards and ethics for managed care systems. This request was made pursuant to House Joint Resolution No. 399 (HJR 399). In response to HJR 399, the Virginia Department of Health Professions established the Task Force on Managed Health Care which included members of the Board of Health Professions and other regulatory boards within the Department of Health Professions.

The Task Force on Managed Health Care conducted the 1991 study in consultation with over 45 advisory agencies and organizations including other state regulatory agencies, insurance industry representatives, provider organizations, consumer organizations, and business and industry associations. The purpose of the study was to determine the effects of managed health care on health care cost, access, and quality. One of the recommendations that came out of the study was the proposal to mandate a single claims form for all insurance systems. The proposal to develop a single claims form is being considered within the scope of this report as well as in another study being conducted by the Bureau in response to House Joint Resolution No. 241 (1992).

A number of recommendations were made by the Task Force on Managed Health Care including the following:

(1) The Commission on Health Care for All Virginians (now the Joint Commission on Health Care) should encourage the creation of health insurance initiatives to spread insurance risks for those in small groups;

(2) The Commission on Health Care for All Virginians, in consultation with the Bureau of Insurance, should introduce and support legislation to ensure the disclosure of criteria used in payors' case decision making to providers and consumers;

(3) The Commission on Health Care for All Virginians, in consultation with the Bureau of Insurance, should introduce and support legislation to ensure that patients and providers impacted by third-party health insurance decisions have access to an appeals process that is timely, objective, understandable, and assures quality care. Appeal processes should require the involvement of objective parties external to the dispute whose decisions should be binding;

(4) The Commission on Health Care for All Virginians should designate a single state agency and define as one of its objectives the collection, analysis, interpretation, evaluation and referral of provider and consumer problems and concerns related to health insurance; and

(5) A "health insurance hotline" with a widely publicized toll-free number should be included in the collection system mentioned above.

DEVELOPMENT OF A SINGLE HEALTH INSURANCE CLAIMS FORM

Insurance Company Survey

The first objective stated in the study resolution was to give consideration to the development of a single claims form for all health insurance systems in the Commonwealth. The Bureau began its research by sending a survey to the top writers of accident and sickness insurance policies in Virginia. These companies were selected on the basis of premiums written. Twenty-five (25) companies representing 82% of the market in Virginia were surveyed. The purpose of the insurance company survey was to determine the following:

(1) whether companies would be in favor of the creation of a universal health insurance claims form;

(2) whether companies think it would be feasible to develop a universal claims form;

(3) whether it would reduce administrative costs for companies or whether it would create additional costs;

(4) what types of problems companies would encounter if they were required to convert to a universal claims form;

(5) what types of benefits would be derived from using such a form;

(6) whether reimbursement would be handled on a more timely basis if companies were required to use the same claims form;

(7) how many companies participate in a network for the electronic transmission of health insurance claims and whether the network is restricted to their company and their participating providers; and

(8) how many companies that do not already participate in a network for the electronic transmission of health insurance claims would be willing to participate in such a network.

Out of nineteen (19) responses received, twelve (12) companies indicated that they would be in favor of the creation of a universal health insurance claims form. Eleven (11) companies said they thought it would be feasible to develop such a form. Ten (10) companies indicated that administrative costs would increase. Some of the explanations given for the expected increased expenses had to do with the following concerns:

(i) each state might have its own unique claims form with its own unique requirements;

(ii) one claims form may not develop all the information an insurer needs to know to process a claim, and additional costs might be incurred as a result of having to follow up on the initial submission;

(iii) a state-specific form would result in computer systems to accommodate modifications to the standard HCFA-1500 and UB-82 claims forms;

(iv) a new form would mean increased space for storage, additional record-keeping, and restructuring of administration kits;

(v) a new form would mean increased processing time and would increase the risk of errors.

In addition to increased costs, some of the companies noted other problems a universal claims form could create:

(i) lack of data to enforce contracts;

(ii) future processing needs or reporting requirements might not be taken into consideration when developing a new form;

(iii) creation of a new form could delay the introduction of advanced technological methods of reporting;

(iv) a universal claims form would be cumbersome and long since it would have to be designed for all health care procedures.

Thirteen (13) companies indicated on the survey that reimbursement would not be handled on a more timely basis if everyone were required to use the same claims form. However, when asked what types of benefits a universal claims form could offer, the following responses were given:

(i) increased consistency in the forms would result in less confusion on the part of providers;

(ii) administrative costs would be reduced after all systems and contracts have been changed;

(iii) processing time would be reduced;

(iv) errors would be reduced due to standard coding;

(v) expenses would be reduced;

(vi) training would be facilitated as well as interpretation of billings;

(vii) the move toward electronic data interchange would be facilitated.

Ten (10) companies that responded to the survey said they already participate in a network for the electronic transmission of health insurance claims; however, two of these companies indicated that this network was restricted to their company and/or their providers. Ten (10) companies that did not already do so said they would be willing to participate in an open network for the electronic transmission of claims.

Although the questionnaire did not ask the companies about any one particular claims form, a number of companies indicated on the survey that they already accept the national HCFA-1500 and the UB-82 claims forms and that these could be used as the standardized claims forms for Virginia. One company also mentioned that although most states do not mandate use of the HCFA-1500 and the UB-82 claims forms, many states have mandated that insurance companies accept them for payment. Several companies indicated that they would not be opposed to the establishment of a universal claims form as long as it was the HCFA-1500 for providers and the UB-82 for hospitals. Several companies also indicated that they were advocates of electronic claims submission and encouraged the development of a national electronic claims format through the American National Standards Institute.

Physician Survey

The Bureau also sent a survey to one hundred (100) randomly selected physicians across the state. This list was provided by the Department of Health Professions and included all physicians licensed and living in Virginia. The same survey was sent to the Virginia Medical Group Managers Association which is a state organization that represents administrators and office managers of medical groups. The purpose of the physician survey was to determine the following:

(1) whether physicians or their office managers would be in favor of the creation of a universal health insurance claims form;

(2) whether physicians or their office managers think it would be feasible to develop a universal claims form;

(3) whether it would reduce administrative costs, and if so how, or whether it would create additional costs;

(4) what types of problems physicians would encounter if they were required to convert to a universal claims form;

(5) whether reimbursement would be handled on a more timely basis if companies were required to use the same claims form;

(6) how many physicians participate in a network for the electronic transmission of health insurance claims; and

(7) how many physicians who do not already participate in a network for the electronic transmission of health insurance claims would be willing to participate in such a network.

Out of thirty (30) responses received, twenty-eight (28) physicians indicated that they would be in favor of the creation of a universal health insurance claims form. Twenty-nine (29) said they thought it would be feasible to develop such a form. Twenty-one (21) physicians said they thought it would reduce administrative costs. Estimates of cost savings varied, but the majority of respondents indicated that the cost savings would be the result of a reduction in staff time and a reduction of supplies needed for processing claims. Five (5) physicians indicated that the creation of a universal health insurance claims form would pose special problems for them such as having to redesign computer software and having to change current forms. Nineteen (19) indicated that they thought reimbursement would be handled on a more timely basis if everyone used the same claims form. Ten (10) said they already participate in a network for the electronic transmission of health insurance claims and twelve (12) said they would be willing to participate in such a network.

Although the questionnaire did not ask the physicians about any one particular claims form, two respondents said the HCFA-1500 should be used as a universal form. Two other respondents said the HCFA-1500 is essentially used by everyone now. Another respondent said the HCFA-1500 form was too complicated and time consuming to be used.

Advisory Organization Survey

The Bureau also sent a survey to eighteen (18) organizations that served in an advisory capacity on the Task Force for Managed Health Care. Most of the organizations selected for the survey represented providers other than physicians. The following organizations were surveyed:

Mental Health Association of Virginia
Psychiatric Society of Virginia
Virginia Academy of Clinical Psychologists
Virginia Association of Allied Health Professions
Virginia Association of Clinical Counselors
Virginia Chiropractic Association
Virginia Counselor's Association
Virginia Dental Association
Virginia Health Care Association
Virginia Health Care Coalition
Virginia Health Council
Virginia Hospital Association
Virginia Nurses' Association
Virginia Pharmaceutical Association
Virginia Psychological Association
National Association of Managed Care Physicians
Health Insurance Association of America
Medical Society of Virginia

The format of the advisory organization survey was very similar to that of the physician and company surveys. The purpose of the advisory organization survey was two-fold: (i) to determine the impact that a single claims form would have from the perspective of a variety of provider groups and (ii) to allow associations that had participated on the Task Force on Managed Health Care an opportunity to provide input for this study.

Out of sixteen (16) responses received, fifteen (15) organizations indicated that they would be in favor of the creation of a universal health insurance claims form. Fourteen (14) said they thought it would be feasible to develop such a form. Fourteen (14) said they thought it would reduce administrative costs. Eleven (11) said they thought claims reimbursement would be handled on a more timely basis if everyone used the same claims form. Four (4) favored the idea of requiring all providers and insurance carriers to participate in a network for the electronic transmission of health insurance claims.

Two of these organizations said they favored the HCFA-1500 claims form and indicated that they would not be opposed to the requirement of a standardized claims form as long as the form was not unique to the Commonwealth of Virginia. One organization mentioned that the UB-92 was in the process of being developed and that this was an update of the current form most often used by hospitals (UB-82). Two organizations said that while they supported the movement toward electronic data interchange, they did not support mandates for participation in such a network.

State Survey

The Bureau contacted the Texas Department of Insurance to obtain the results of a state survey the Texas Department had conducted in May, 1992. This survey was sent to all state insurance departments to determine (i) how many states have a centralized claim processing center for insurance claims and (ii) how many states have adopted a standardized health insurance claims form. By the end of June, twenty-five (25) states had responded to the survey and some preliminary information had been gathered. According to the results of the survey, only one state indicated that they had a centralized claim processing center for insurance claims and eleven (11) states indicated that they had either adopted a standardized claims form or had legislation pending. In addition to the eleven (11) states that had indicated on the Texas survey that their state had adopted a standardized claims form or had legislation pending, the Bureau learned that fifteen (15) other states were either considering adopting a standardized claims form or had already adopted one. The following shows a summary of the twenty-six states' activities:

Claims Form Adopted	Legislation/Adoption Pending	Study in Progress
Alabama	California	Colorado
Arkansas	Maryland	Maine
Florida	Michigan	Montana
Indiana	Pennsylvania	Texas
Kansas	Vermont	
Kentucky	Wyoming	
Mississippi		
Nevada		
New York		
North Dakota		
Oklahoma		
Oregon		
South Carolina		
Tennessee		
West Virginia		
Wisconsin		

Among the states that have adopted a standardized health insurance claims form or have legislation pending, thirteen (13) states either require or plan to require insurers to accept the HCFA-1500 claims form from physicians. Eleven (11) states require or plan to require insurers to accept the UB-82 claims form from hospitals. The HCFA-1500 was developed by the Uniform Claims Form Task Force which was co-chaired by the American Medical Association and the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services. The UB-82 was developed by the National Uniform Billing Committee which was co-chaired by the American Hospital Association and the Health Care Financing Administration. Nine (9) states indicated that a separate claims form is used for dentists and pharmacists. Each of these states indicated that the claims form developed by the American Dental Association is used for dentists. There does not appear to be a widely used form for pharmacists and only four (4) states indicated that a standard pharmaceutical claims form had been developed in their state.

NAIC Proposal

The National Association of Insurance Commissioners (NAIC) was also contacted to determine whether any consideration had been given to developing a model claims form on a national level. The NAIC is an organization of the chief regulatory officials of all of the state insurance departments. Among other functions, the NAIC provides a forum for the exchange of ideas and the formulation of uniform policy through model insurance laws and regulations. The NAIC is considering the idea of developing a model health insurance claims form. According to information obtained from NAIC staff, they are in the process of setting up a working group, and will probably propose that the HCFA-1500 be adopted as the model claims form for physicians and that the UB-82 be adopted as the model claims form for hospitals. At this time they are not sure which form they will suggest for pharmacists, but they will probably suggest that the ADA form

currently used by most dentists be adopted as the standard dental claims form.

Survey of Other Agencies

The Virginia Department of Medical Assistance Services was contacted, as well as the United States Department of Health and Human Services, to determine whether a universal claims form was required to be used for services provided under Medicaid and Medicare in Virginia. According to information obtained from the Virginia Department of Medical Assistance Services, the HCFA-1500 (12/90 Edition) is required to be used by physicians filing claims under both Medicaid and Medicare. Other providers such as mental health providers, podiatrists, and optometrists also use the HCFA-1500 claims form. Hospitals are required to use the UB-82 claims form. Dentists and pharmacists have their own separate forms and do not use the HCFA-1500. According to information obtained from the Social Security Administration Office of the United States Department of Health and Human Services, the HCFA-1490 SC (2/87 Edition) is used by beneficiaries to file their own Medicare claims. The Travelers Companies (the Part B Medicare carrier for part of Virginia) confirmed that the HCFA-1500 (12/90) Form was the correct form to be used by physicians for all services rendered to Medicare patients. The original effective date for this form was 1/1/92, but that date was revised to become effective on 7/1/92. Copies of these forms are shown in Appendix B.

The American National Standards Institute (ANSI) has also been working on developing a standard health insurance claims form. ANSI is the coordinator of national standards in the United States and serves as the central body responsible for the identification of a single consistent set of voluntary standards. ANSI provides an open forum for identifying, planning, and agreeing on standards. Within the ANSI organization, the Accredited Standards Committee (ASC) X12 has been established to develop standards to facilitate electronic data interchange. An insurance subcommittee, which is called the X12N subcommittee, is working on a proposal to combine into one form the HCFA-1500 and the UB-82 (this will include changes incorporated into the UB-92 when that form is adopted). The new form is being referred to within the ANSI organization as the ANSI X12 837 Health Care Claim Transaction (see Appendix C). The X12N subcommittee expects the ANSI X12 837 to be approved as a standard claims form in October. This will be approved through the ANSI Consensus Ballot process in which HCFA and approximately 800 other providers and insurers participate. According to information from the X12N subcommittee, the new form will be suitable for use by dentists and pharmacists as well as physicians and hospitals.

Electronic Claims Processing

One means of standardizing claims administration is through the use of electronic claims processing. Electronic claims processing eliminates paper files and enables transactions to

occur instantaneously. Electronic claims processing offers the following advantages:

1. **Standardization.** Claim and billing standards are uniform.

2. **Accuracy.** Clearinghouses ensure that data is accurate.

3. **Reduced Costs.** Providers can reduce administrative staff and payors can reduce clerical staff.

4. **Faster Payment.** Providers can be paid daily. Bank accounts can be credited through electronic funds transfer, thus eliminating paper bills and mailings.

5. **Fraud Control.** Fraudulent claim activity can be identified more quickly and questionable practices flagged.[1]

Companies are already entering the marketplace to provide electronic claims processing services. According to information submitted to the Bureau by the Mid-Atlantic Medical Counsel, over fifty-six (56) public and private insurance payors participate in electronic claims processing. The Mid-Atlantic Medical Counsel is an organization that, in association with GTE Health Systems Incorporated and the National Electronic Information Corporation (NEIC), offers electronic claims processing services to physicians and health care providers in the Commonwealth and throughout the Mid-Atlantic region. Their goals are to reduce paper work and administrative costs, file claims within twenty-four (24) hours of the date of service, report rejected claims and refile amended claims forms within ninety-six (96) hours of service, and have payment rendered within twenty-one (21) days of service. The president of Mid-Atlantic Medical Counsel indicates that both of these electronic claims clearinghouses (GTE and NEIC) subscribe to the ANSI X12 standards set by the American National Standards Institute. A list of NEIC participating payors is shown in Appendix D of this report.

Blue Cross and Blue Shield of Virginia (BCBSVA) has also developed a system for the electronic transmission of claims data and payment using the ANSI 820 standardized remittance format. The company plans to convert to the ANSI 835 format. Healthcare Communication Services (HCS), which is a wholly owned subsidiary of BCBSVA, serves as a health claims clearinghouse for Blue Cross and Blue Shield plans. By establishing a paperless claims submission process, the company is able to operate more efficiently through a reduction in postage expenses, a reduction in check and envelope costs, a reduction in processing errors, improved processing time, and streamlined operations.[2]

The concept of mandating the use of electronic claims processing was also considered at the federal level. One of the proposals in a bill recently introduced in Congress, the "Health Insurance Purchasing Cooperatives Act" (S.2675), would have required participating insurers to use electronic administration of claims and billing. Under this proposal, a national health

insurance data system would have been established and would have consisted of (i) a centralized national data base for health insurance and health outcomes information; (ii) a network of no more than five regional health insurance data collection centers; and (iii) a standardized, universal mechanism for electronically processing health insurance and health outcomes data. A national health board would have established uniform billing and claims forms and mandatory reporting requirements including information on member eligibility, benefits, use, outcomes, and efficacy. No action was taken on this bill.

In a separate proposal put together by the Bush Administration, a computerized health billing system would have been implemented which would have given Secretary of Health and Human Services Louis W. Sullivan the power to require insurers to use standardized computer software and uniform claims formats. The President's proposal anticipated a savings of $4 billion the first year and $20 billion annually by the year 2000. [3] No action was taken on this bill.

The House Ways and Means Committee has also studied the issue of computerization in health care administration. In testimony given before the House Ways and Means Subcommittee on Health, Joseph T. Brophy, the co-chair of the Work Group on Electronic Data Interchange (WEDI), cited the benefits of electronic data interchange, but he warned Congress to "resist the impulse to legislate prematurely." In his statement, the co-chair advised the subcommittee that the government should ensure the proper environment in which electronic data interchange can flourish but should "refrain from micro-managing the process." He also stated that rather than instituting penalties and mandates, the government should provide incentives to encourage the development of electronic data processing.[4]

In a recent report issued by the United States General Accounting Office (GAO), a recommendation was made to create a national commission to study health care fraud and abuse. As envisioned by the GAO, one of the directives of the commission would be to develop recommendations to promote greater standardization in claims administration. In doing so, some of the obstacles which currently stand in the way of detecting and preventing fraud would be removed. The GAO report pointed out that, with 1,000 insurers processing four billion health care claims a year and with providers and insurers using different payment methods and billing standards, the health care system is especially vulnerable to fraud and abuse. The commission would be responsible for establishing ways to ease the exchange of information without undermining legitimate patient and provider privacy concerns. Also mentioned in the GAO report was the Forum on Administrative Costs which convened in November, 1991, and which proposed certain administrative reforms that included (i) electronic billing using standardized formats and (ii) computerized medical record systems for providers. Working groups have been in the process of implementing these reforms.[5]

Despite the fact that over 450 claims forms are currently in existence, most of the differences in data requirements are small and many data fields are identical; they are simply labeled with different words.[6] If payors and providers are willing to subscribe to a universal set of data requirements, standardization through the use of an electronic claims processing system can cut processing costs by as much as 25-40 percent. This will substantially reduce the claims processing costs for insurers, hospitals, and physicians who, in 1991, spent $79.8 billion for claims processing.[7] Three major health care payors have already announced their support for standardization in electronic data interchange through the use of the ANSI X12 format. These payors are the Blue Cross and Blue Shield Association, Travelers, and HCFA (payors under Medicare). If ANSI standards are adopted universally, the costs of health care claims administration can be reduced and quality improved.[8]

DISCLOSURE OF PAYORS' CRITERIA TO PROVIDERS AND CONSUMERS AND ESTABLISHMENT OF AN APPEALS PROCESS FOR THE DENIAL OF CLAIMS

State Survey

One of the objectives cited in this study resolution was to consider regulatory oversight of the disclosure of criteria used in payors' case decision making to providers and consumers, and an appeals process for denial of insurance claims. The Bureau conducted a survey of all state insurance departments to determine (i) whether any states require disclosure of criteria used in claims or utilization review decision making to providers or to consumers and (ii) whether any states require appeals/reconsideration processes for the denial of insurance claims or for utilization review non-certification denials.

A total of eighteen (18) states responded to the survey. Some of the respondents did not respond to the specific questions asked in the survey, but instead submitted statutes and regulations with a letter stating that the enclosed statutes and regulations addressed the questions asked in the survey. In these instances, and to obtain additional information, Bureau staff abstracted the needed information by reviewing the submitted information and through telephone conversations with the responding state. The Bureau also contacted several Health Departments in states that did not respond to the survey since utilization review is sometimes regulated by Health Departments instead of Insurance Departments. Two (2) of these states submitted statutes and regulations on utilization review in response to our request. Consequently, the information presented here is based on information from twenty (20) states.

Disclosure of Payors' Criteria to Providers and Consumers

The survey revealed that none of the states reviewed require broad disclosure of criteria used in claims or utilization review decision making to providers or consumers. However, Maine has just begun to ask medical utilization review entities to file all utilization review criteria with the Maine Bureau of Insurance. In a telephone conversation the Maine Bureau explained that they have only recently begun requesting the criteria and that they are having difficulty obtaining them because criteria disclosure is not specifically addressed in the statute or the rule. The Maine Bureau of Insurance further explained that if it received a request for access to the criteria, and the medical utilization review entity did not wish the criteria disclosed on the basis of confidentiality, the Attorney General would determine whether the criteria are confidential and should be held in confidence.

Similarly, Texas's statute regarding health care utilization review agents requires utilization review agents, insurers, health maintenance organizations, and health services plans to make available written screening criteria for review and inspection by the Insurance Commissioner and copying as necessary for the Commissioner to carry out his lawful duties under the code. In a telephone conversation, the Texas Department of Insurance explained that although the utilization review statute protects the confidentiality of the criteria, if the Department were to receive a request to view the criteria, the letter would be forwarded to the Attorney General's office for a determination as to whether this statutory protection is in conflict with any other laws.

Other states, while not requiring broad disclosure to providers and consumers of criteria used in claims decision-making, have instituted statutes and regulations concerning (i) the input of appropriate providers in the establishment of criteria; (ii) the use of criteria in performing utilization review; and (iii) the disclosure, on a case-by-case basis, of the clinical reasons for claims denials on the basis of utilization review. For example:

A. Oklahoma's Hospital and Medical Services Utilization Review Act requires that private review agents, insurance companies, not-for-profit hospital services, and medical indemnity plans shall submit to the Insurance Department "assurances that the standards and criteria to be applied in review determinations are established with input from health care providers representing major areas of specialty and certified by the boards of the various American medical specialties."

B. Nebraska's Utilization Review Certification Act requires that for an appeal of a decision not to approve or certify for clinical reasons, the utilization review agents shall provide an enrollee or attending physician on behalf of an enrollee, upon request, timely access to the clinical bases for the decision, including any criteria, standards, or clinical indicators used as a basis for such recommendation or decision.

C. Minnesota's utilization review legislation (which will become effective January 1, 1993) requires that (for prior authorization of services only):

> [a] utilization review organization's decisions must be supported by written clinical criteria and review procedures. Clinical criteria and review procedures must be established with appropriate involvement from physicians. A utilization review organization must use written clinical criteria, as required, for determining the appropriateness of the certification request. The utilization review organization must have a procedure for ensuring the periodic evaluation and updating of the written criteria.

D. Missouri's utilization review regulation requires that the utilization review agent submit "a summary of the process whereby utilization standards and procedures are established, modified and updated." The Missouri Department of Insurance further explained in a telephone conversation that this information is considered confidential.

E. Connecticut's act concerning utilization review requires each utilization review company to "utilize written clinical criteria and review procedures which are established and periodically evaluated and updated with appropriate involvement from practitioners."

F. Arkansas's rules & regulations for utilization review requires private review agents to assure that a consulting physician shall be reasonably available by telephone to discuss the medical basis (e.g., criteria, protocols, medical literature) with the attending physician for a determination not to certify a continued length of stay due to questions of medical necessity or appropriateness.

G. Montana's health utilization review statute requires that those who perform utilization review must maintain with the Commissioner:

> [a] description of review criteria, standards, and procedures to be used in evaluating proposed or delivered health care services that, to the extent possible, must:
> (a) be based on nationally recognized criteria, standards, and procedures;
> (b) reflect community standards of care...;
> (c) ensure quality of care; and
> (d) ensure access to needed health care services.

H. Kentucky requires private review agents, as part of the application process, to submit to the Cabinet for Human Resources descriptions and names of review criteria upon which utilization review decisions are based. In addition, Kentucky's utilization review statute requires that the Cabinet for Human Resources report annually to the General Assembly on the types of criteria used to perform utilization review.

I. Texas's health care utilization review agents statute requires utilization review agents to include in a notification of adverse determination "a description of the source of the screening criteria that were utilized as guidelines in making the determination." In addition, in an appeal, the utilization review agent is required to state the clinical basis for an appeals denial and the specialty of the physician making the denial. Texas also requires that each utilization review agent, insurer, and health maintenance organization "shall utilize written medically acceptable screening criteria and review procedures which are established and periodically evaluated and updated with appropriate involvement from physicians, including practicing physicians, and other health care providers."

Appeals Process for the Denial of Claims

Several states require entities that make utilization review determinations to have either an appeals process or a complaint process. Appeal requirements differ greatly from state to state depending on the type of utilization review (for example, prospective, concurrent, or retrospective), who the utilization review is performed by (private review agents, insurers, health maintenance organizations, or auto medical expense insurers), and the setting of the care being reviewed (for example, hospital care or non-hospital care).

Of the twenty (20) states reviewed, five (5) do not require an appeals process. Of the remaining fifteen (15), two (2) require an appeal process of private review agents only and one (1) requires HMOs to provide an appeals process for the denial of claims only (this state is the only one identified that has any requirement for an appeals process for the denial of claims). That leaves twelve (12) states that require appeals processes under differing circumstances for utilization review conducted by entities other than private review agents.

Eight (8) of these twelve (12) require an appeals process for prospective and concurrent utilization review, three (3) of these twelve (12) require an appeals process only for prospective and concurrent utilization review of hospital care, and one (1) of these twelve (12) requires an appeals process for prospective and concurrent utilization review of inpatient admissions to facilities and outpatient admissions to surgical facilities. Of the eight (8) that require an appeals process for prospective and concurrent review, eight (8) make this demand of insurers, seven (7) make this demand of HMOs, and six (6) make this demand of auto medical expense insurers. In addition, one (1) requires HMOs to have a complaint system that allows providers to file complaints.

In the Commonwealth of Virginia, Insurance Regulation No. 37, Rules Governing Private Review Agents, requires private review agents to have an appeals process when an adverse utilization review decision is made. In addition, Chapter 43 (§38.2-4300 et seq.) Title 38.2 of the Code of Virginia and Insurance Regulation No. 28, Rules Governing Health Maintenance Organizations, require that health maintenance organizations establish and maintain a complaint system to provide reasonable procedures for the resolution of written complaints.

Accident and Health Insurer Survey

The Bureau sent a survey to the top writers of accident and health insurance policies in Virginia (representing 78 percent of total accident and health premiums written in Virginia) and to Blue Cross and Blue Shield of the National Capital Area (the largest health services plan in Virginia). These companies were selected on the basis of premiums written. Twenty-six (26) companies were surveyed. Sixteen (16) survey responses were received. The purpose of the survey was to determine:

(i) whether accident and health insurers perform utilization review, the role of criteria in the performance of utilization review, and whether companies are prohibited from disclosing criteria by contractual terms imposed by the marketers of the criteria; and

(ii) whether accident and health insurers provide a formal appeals/reconsideration process for the denial of claims and who has access to the appeal/reconsideration.

Disclosure of Payors' Criteria to Providers and Consumers

1. Of the sixteen (16) respondents, nine (9) stated that they perform utilization review.

2. When the nine (9) companies performing utilization review were asked if the company uses criteria to perform utilization review,
   - eight (8) companies responded "yes"
   - one (1) company responded "no."

3. When the eight (8) companies that use criteria to perform utilization review were asked whether the criteria are documented in writing or are in a computer program,
   - eight (8) answered that the criteria are documented in writing
   - three (3) answered that criteria are in a computer program.

[Note that some companies had both written and computerized criteria.]

4. When the eight (8) companies that use criteria to perform utilization review were asked if the utilization review criteria are used for screening (e.g., if care does not comply with criteria, case is then referred to a peer reviewer who makes a utilization review determination) or are used for making utilization review determinations (e.g., by virtue of not satisfying predetermined criteria, care is determined to be not medically necessary or appropriate),
   - eight (8) responded that the criteria are used for screening
   - one (1) company responded that criteria are used for

making utilization review determinations.

[Note that one company uses criteria for both screening and for making utilization review determinations.]

5. When the eight (8) companies that use criteria to perform utilization review were asked if the companies' physician reviewers or peer reviewers could override the criteria in any given case if the criteria would result in a utilization review determination that is contrary to their judgment,
   - eight (8) of the companies responded "yes"
   - none (0) of the companies responded "no."

6. When the eight (8) companies that use criteria to perform utilization review were asked if they are prohibited from disclosing the criteria by contractual terms imposed by the marketers of the criteria,
   - three (3) responded "yes"
   - five (5) responded "no."

In summary, of the respondents that use criteria to perform utilization review, all but one (1) use criteria to screen cases for referral to a peer reviewer and not to make utilization review determinations, and all allow their physician or peer reviewers to override the criteria in any given case if the criteria would result in a utilization review determination that is contrary to their judgment. Three (3) are prohibited from disclosing criteria by contractual terms imposed by the marketers of the criteria. In addition, three (3) use computerized criteria. Disclosure of computerized criteria may be difficult because of their computerized form.

Appeals Process for the Denial of Claims

1. When the sixteen (16) companies were asked if the company provides a formal appeals/reconsideration process for the denial of claims,
   - fifteen (15) answered "yes"
   - one (1) answered "no."

2. When the fifteen (15) companies that provide a formal appeals/reconsideration process were asked which of the following (insureds, health care providers, others) have access to the appeals/reconsideration process for the denial of insurance claims,
   - fifteen (15) answered "insureds"
   - thirteen (13) answered "health care providers"
   - six (6) answered "others". The "others" identified include attorneys representing the insured, the insured's representative, the group policyholder, agents representing the policyholder, claims administration personnel, and employers of insureds.

[Note that some companies have indicated that several classes of individuals have access to the appeals/reconsideration process.]

In summary, of the sixteen (16) respondents, fifteen (15) provide a formal appeals/reconsideration process which is accessible by insureds.

Medical Expense Insurer Survey

The Bureau sent a survey concerning medical expense coverage to the top writers of private passenger auto liability insurance in Virginia. These companies were selected on the basis of premiums written. Twenty-five (25) companies (representing 82 percent of total private passenger auto liability insurance premiums written in Virginia) were surveyed. Nineteen (19) survey responses were received. The purpose of the survey was to determine:

(i) whether medical expense insurers perform utilization review, the role of criteria in the performance of utilization review, and whether companies are prohibited from disclosing criteria by contractual terms imposed by the marketers of the criteria; and

(ii) whether medical expense insurers provide a formal appeal/reconsideration process for the denial of claims and who has access to the appeal/reconsideration.

Disclosure of Payors' Criteria to Providers and Consumers

1. Of the nineteen (19) respondents, seven (7) stated that they perform utilization review.

2. When the seven (7) companies performing utilization review were asked if the company uses criteria to perform utilization review,
   - seven (7) responded "no."
   - none (0) responded "yes."

In summary, of the respondents that perform utilization review, none use criteria to perform utilization review.

Appeals Process for the Denial of Claims

1. When the nineteen (19) companies were asked if the company provides a formal appeals/reconsideration process for the denial of medical expense claims,
   - seven (7) answered "yes"
   - twelve (12) answered "no." Two (2) of those answering "no" stated that while no formal appeals process is established, any provider requesting a review of a determination will be granted a review.

2. When the seven (7) companies that provide a formal appeal/reconsideration process were asked which of the following (insureds, health care providers, others) have access to the appeals/reconsideration process for the denial of insurance claims,

- seven (7) answered "insureds"
- six (6) answered "health care providers"
- seven (7) answered "others." The "others" identified include insured's/claimant's attorney, attorneys, any person involved, and personal representatives.

[Note that some companies have indicated that several classes of individuals have access to the appeals/reconsideration process.]

In summary, of the nineteen (19) respondents, seven (7) provide a formal appeals/reconsideration process which is accessible by insureds.

Health Maintenance Organization Survey

The Bureau sent a survey to all Virginia-licensed health maintenance organizations (HMOs). Twenty (20) health maintenance organizations were surveyed. Thirteen (13) survey responses were received. The purpose of the survey was to determine:

(i) whether HMOs perform utilization review, the role of criteria in the performance of utilization review, and whether HMOs are prohibited from disclosing criteria by contractual terms imposed by the marketers of the criteria; and

(ii) whether HMOs provide a formal appeals/reconsideration process for the denial of claims, who has access to the appeals/reconsideration, and whether the appeals/reconsideration process results in additional health services being recommended.

Disclosure of Payors' Criteria to Providers and Consumers

1. Of the thirteen (13) respondents, all thirteen (13) stated that they perform utilization review.

2. When the thirteen (13) HMOs performing utilization review were asked if the HMO uses criteria to perform utilization review,

- thirteen (13) responded "yes"
- none (0) responded "no."

3. When the thirteen (13) HMOs that use criteria to perform utilization review were asked whether the criteria are documented in writing or are in a computer program,

- twelve (12) answered that the criteria are documented in writing
- two (2) answered that the criteria are in a computer program.

[Note that one HMO has both written and computerized criteria.]

4. When the thirteen (13) HMOs that use criteria to perform utilization review were asked if the utilization review criteria are used for screening (e.g., if care does not comply with criteria, case is then referred to a peer reviewer who makes a utilization review determination) or are used for making utilization review determinations (e.g., by virtue of not satisfying predetermined criteria, care is determined to be not medically necessary or appropriate),

- thirteen (13) responded that criteria are used for screening
- three (3) responded that criteria are used for making utilization review determinations.

[Note that three HMOs use criteria for both screening and for making utilization review determinations.]

5. When the thirteen (13) HMOs that use criteria to perform utilization review were asked if the HMOs physician reviewers or peer reviewers could override the criteria in any given case if the criteria would result in a utilization review determination that is contrary to their judgment,

- thirteen (13) responded "yes"
- none (0) responded "no."

6. When the thirteen (13) HMOs that use criteria to perform utilization review were asked if they are prohibited from disclosing the criteria by contractual terms imposed by the marketers of the criteria,

- eight (8) responded "yes"
- five (5) responded "no."

In summary, all of the respondents perform utilization review and all use criteria to perform utilization review. All but three (3) use criteria for screening only and three (3) use criteria both for screening and for making utilization review determinations. All allow their physician or peer reviewers to override criteria in any given case if the criteria would result in a utilization review determination that is contrary to their judgment. Eight (8) are prohibited from disclosing criteria by contractual terms imposed by the marketers of the criteria. In addition, two (2) use computerized criteria. Disclosure of computerized criteria may be difficult because of its computerized form.

Appeals Process for the Denial of Claims

1. When the thirteen (13) HMOs were asked if the HMO provides a formal appeals/reconsideration process for the denial of claims,
   - thirteen (13) answered "yes"
   - none (0) answered "no."

2. When the thirteen (13) HMOs that provide a formal appeals/reconsideration process were asked which of the following (members, health care providers, others) have access to the appeals/reconsideration process for the denial of health services,
   - thirteen (13) answered "members"
   - twelve (12) answered "health care providers"
   - two (2) answered "others." The "others" identified include members' advocates and employer groups.

[Note that some HMOs have indicated that several classes of individuals have access to the appeals/reconsideration process.]

3. When the thirteen (13) HMOs that provide a formal appeals/reconsideration process were asked if the appeals/reconsideration process results in additional health services being recommended to their members frequently, sometimes, rarely, or never,
   - none (0) answered "frequently"
   - eight (8) answered "sometimes"
   - three (3) answered "rarely"
   - two (2) answered "never."

In summary, all respondents provide a formal appeals/reconsideration process that is accessible to members. In addition, eleven (11) HMOs stated that the appeals/reconsideration process has resulted in additional health services being recommended to their members.

Private Review Agent Survey

The Bureau sent a survey to all Virginia-certified private review agents (PRAs). Thirty (30) private review agents have been certified and all were surveyed. Twenty-two (22) survey responses were received. The purpose of the survey was to determine the role of criteria in the performance of utilization review and whether PRAs are prohibited from disclosing criteria by contractual terms imposed by the marketers of the criteria.

Disclosure of Payors' Criteria to Providers and Consumers

1. When the twenty-two (22) PRAs were asked if they use criteria to perform utilization review,
   - twenty-one (21) responded "yes"
   - one (1) responded "no."

2. When the twenty-one (21) PRAs that use criteria to perform utilization review were asked whether the criteria are documented in writing or are in a computer program,
   - eighteen (18) answered that the criteria are documented in writing
   - ten (10) answered that criteria are in a computer program.

[Note that some PRAs have both written and computerized criteria.]

3. When the twenty-one (21) PRAs that use criteria to perform utilization review were asked if the utilization review criteria are used for screening (e.g., if care does not comply with criteria, case is then referred to a peer reviewer who makes a utilization review determination) or are used for making utilization review determinations (e.g., by virtue of not satisfying predetermined criteria, care is determined to be not medically necessary or appropriate),
   - twenty (20) responded that the criteria are used for screening
   - two (2) responded that the criteria are used for making utilization review determinations.

[Note that one (1) PRA uses criteria for both screening and for making utilization review determinations.]

4. When the twenty-one (21) PRAs that use criteria to perform utilization review were asked if the PRA's physician reviewers or peer reviewers could override the criteria in any given case if the criteria would result in a utilization review determination that is contrary to their judgment,
   - twenty-one (21) responded "yes"
   - none (0) responded "no."

5. When the twenty-one (21) PRAs that use criteria to perform utilization review were asked if they are prohibited from disclosing the criteria by contractual terms imposed by the marketers of the criteria,
   - eleven (11) responded "yes"
   - twelve (12) responded "no."

[Two (2) PRAs responded "yes' for some criteria and "no" for other criteria. One (1) of the PRAs responding "yes" qualified its response by stating that it can only disclose criteria on a specific case by case basis. One (1) of the PRAs responding "no" stated that the respondent is the marketer of the criteria and that internal policy requires that the criteria not be disclosed.]

In summary, all but one (1) of the PRAs use criteria for performing utilization review and only two (2) use criteria for making utilization review determinations. All allow their physician or peer reviewers to override the criteria in any given case if the criteria would result in a utilization review determination that is contrary to their judgment. Eleven (11) are prohibited from disclosing the criteria by contractual terms imposed by the marketers of the criteria. In addition, ten (10) use computerized criteria. Disclosure of computerized criteria may be difficult because of its computerized form.

Literature Review

The Bureau reviewed (i) the November 1991 Board of Health Professions Task Force on Managed Health Care Report to the Commission on Health Care for All Virginians, (ii) the June 1991 Utilization Review Accreditation Commission National Utilization Review Standards, (iii) The Guidelines for Concurrent Review, (iv) The Guidelines for Claims Submission, Review, and Appeals Procedures, and (v) "Should We Regulate 'Utilization Management'?", published in Health Affairs in Winter 1989 to identify what positions are espoused in these documents with respect to (a) disclosure of criteria to providers and consumers and (b) an appeals process for the denial of claims.

Disclosure of Payors' Criteria to Providers and Consumers

1. The Task Force's report provides support for nondisclosure of review criteria and support for disclosure of review criteria. Specifically, the report (on pages 48-49) provides the following factors supporting nondisclosure of criteria:

- criteria are considered to be proprietary materials of the insurer,
- criteria are expensive to develop, and their disclosure would provide an unfair advantage to competing health benefit product companies,
- disclosure would facilitate "gaming" of the system by providers, and
- insurers are prohibited from disclosing the third party proprietary review criteria they use by contractual terms imposed by the marketers of the criteria.

The report (on page 50) provides the following support for disclosure of criteria:

- disclosure would improve provider and patient acceptance of and confidence in the standards with which they are asked to comply, and
- collaboration between payers and providers can improve the validity of the criteria as community-level measures of acceptable practice.

2. The Utilization Review Accreditation Commission (URAC) was established by the utilization review industry to encourage efficient and effective utilization review processes and to provide a method of evaluation and accreditation for utilization programs on a national basis. URAC's Board includes representatives of the provider, insurer, and utilization review industries. URAC has developed minimum industry standards which serve as the basis for its voluntary accrediting process. These standards apply to prospective and concurrent utilization review for inpatient admissions to hospitals and other inpatient facilities and to outpatient admissions to surgical facilities. The June 1991 standards state:

> Each UR Organization shall have utilization review staff who are...supported by written clinical criteria... Clinical criteria and review procedures shall be established with appropriate involvement from physicians.[page 9]
>
> UR Organizations shall utilize: 1. Written clinical criteria, as needed, for the purpose of determining the appropriateness of the certification; such criteria shall be periodically evaluated and updated.[page 10]

3. The Guidelines for Concurrent Review, which were developed jointly by representatives of the American Hospital Association, the American Managed Care and Review Association, the American Medical Association, the Blue Cross and Blue Shield Association, and the Health Insurance Association of America, and which focus on inpatient utilization review programs, state:

> Professionally accepted pre-established review criteria should be used for concurrent review. Review criteria should be periodically evaluated and updated.[page 3]
>
> The claim administrator or the utilization review organization should inform, upon request, designated hospital personnel and/or the attending physician of the utilization review requirements and the general type of criteria used by the plan (eg., AEP or ISD-A criteria, PAS norms).[page 3]
>
> A review should be conducted by a physician advisor on a determination not to certify a continued length of stay due to questions of medical necessity or appropriateness. A physician advisor should be reasonably available by telephone to discuss the medical basis for that determination (e.g., criteria, protocols, medical literature) with the attending physician.[page 4]

4. "Should We Regulate 'Utilization Management'?", published in Health Affairs in Winter 1989, states (on page 110) that the Institute of Medicine's Committee on Utilization Management by Third Parties reached the conclusion that "review criteria should be publicly accessible rather than secret or proprietary." However, it should be noted that the committee did not endorse regulation but instead suggested criteria disclosure as a nonregulatory direction for utilization management. Reasons for disclosure include (i) providers and patients should know the basis for utilization review decisions, (ii) disclosing review criteria will expose them to additional scrutiny and may result in increased educational impact, and (iii) utilization review organizations should not compete on the basis of criteria but should compete on the basis of data systems, efficiency, and performance. Arguments against disclosure include (i) disclosure is unfair to firms that have invested in criteria development, (ii) disclosure will discourage criteria development because firms will not be able to fully reap the benefits of their investment but will have to share them with competitors and, (iii) disclosure of criteria may facilitate "gaming" and may reduce the cost effectiveness of utilization management. [pages 110-111]

Appeals Process for the Denial of Claims

1. The Task Force's report states (on page 51) that its recommendation for an appeals process "is based upon general principles of public protection."

2. The Utilization Review Accreditation Commission (URAC) was established to encourage efficient and effective utilization review processes and to provide a method of evaluation and accreditation for utilization programs. URAC has developed minimum industry standards which serve as the basis for its voluntary accrediting process. These standards apply to prospective and concurrent utilization review for inpatient admissions to hospitals and other inpatient facilities and to outpatient admissions to surgical facilities. These standards state (on page 7) that:

> [e]ach UR Organization shall have in place procedures for appeals of determinations not to certify an admission, service or extension of stay. The right to appeal shall be available to the patient or enrollee, and to the attending physician.

3. The Guidelines for Claims Submission, Review and Appeals Procedures, which were jointly developed by representatives of the American Medical Association's Council on Medical Service, the Blue Cross and Blue Shield Association's Provider Affairs Committee, and the Health Insurance Association of America's Medical Relations Committee, and which focus on inpatient utilization review programs state that:

> [e]very claim administrator should establish and maintain a procedure by which a claimant has a reasonable opportunity to appeal a claim that is denied for lack of medical necessity.[page 9]

4. The Guidelines for Concurrent Review, which were developed jointly by representatives of the American Hospital Association, the American Managed Care and Review Association, the American Medical Association, the Blue Cross and Blue Shield Association, and the Health Insurance Association of America, and which focus on inpatient utilization review programs, state:

> [i]n cases where a determination not to certify continued length of stay is made, and the attending physician believes the decision warrants immediate reconsideration, the attending physician should have an opportunity to request a reconsideration or an appeal of the decision over the phone on an expedited basis. Such reconsiderations which cannot be resolved may be reconsidered in the standard appeals process.[page 5]

5. "Should We Regulate 'Utilization Management'?", published in Health Affairs in Winter 1989, states (on page 111) that:

> [s]ince overly burdensome or obscure appeal processes could discourage physicians from challenging questionable decisions by review organizations, there is much to commend more standard appeals mechanisms and better materials to explain them.

However, it should be noted that the regulation of appeals processes was not endorsed in this article.

DEVELOPMENT OF A CONSUMER GUIDE FOR SMALL BUSINESSES

The Bureau of Insurance was also directed to determine the feasibility of developing a consumer guide for small businesses to assist them in purchasing health insurance. The Bureau recognizes that its current publications are geared to individual consumers, and that recent changes in the health insurance market, including legislative requirements, have created a distinct difference in health insurance considerations for small employers.

The Bureau, therefore, concludes that it would be advisable to develop a guide to assist small businesses. A draft of a potential guide is included as Appendix E of this report. The final content of this document will be subject to further review. Additionally, changes instituted pursuant to other health insurance studies conducted in 1992, as well as resulting 1993 legislative changes, should be included in the guide that is distributed to small businesses.

The publication would be available to the public through the current distribution network for consumer publications. The guide would also be provided to the Virginia Employment Commission, the Virginia Chamber of Commerce, the Department of Economic Development, the Joint Commission on Health Care, and other organizations in contact with small businesses.

ROLE OF THE BUREAU IN HANDLING PROVIDER AND CONSUMER PROBLEMS AND CONCERNS

One of the objectives cited in this study resolution was to consider the role of the Bureau of Insurance in the collection, analysis, interpretation, and evaluation of provider and consumer problems and concerns related to health insurance. An overview of the Bureau's organizational structure should provide a framework for understanding the Bureau's role in handling these types of problems and concerns.

The Bureau is divided into four organizational divisions: (i) the Life and Health Market Regulation Division; (ii) the Property and Casualty Market Regulation Division; (iii) the Financial Regulation Division; and (iv) the Administration Division. The Life and Health Market Regulation Division is organized into seven sections, one being the Consumer Services Section. This section handles telephone inquiries, written complaints and inquiries, and walk-ins from the public. The professional staff of the Consumer Services Section consists of one supervisor and five consumer service representatives. Any type of consumer inquiry related to health insurance is referred to this section.

The primary function of the Consumer Services Section is to investigate complaints, answer inquiries, and provide information to consumers who call in with questions and concerns. The Consumer Services Section is currently handling between 4,000 and 5,000 complaints and inquiries per year. The Consumer Services Section assists in the resolution of complaints and recommends the initiation of disciplinary actions when violations of statutes or regulations are discovered during the complaint evaluation process.

Generally, it is preferred that complaints be received in writing so that written authorization can be obtained to allow the Commission to intervene in the dispute between the insured and the company or agent. When written authorization has not been obtained, independent judgment is used to determine whether the Commission can intervene. When a complaint is received, the Consumer Services Section sends a copy of the complaint letter to the company or agent against whom the complaint has been filed and requests the information necessary to evaluate the complaint. When the requested information has been received, it is evaluated and the appropriate response is made to the complainant. Where violations of the law have occurred, the Bureau takes appropriate disciplinary measures.

Inquiries can be handled by telephone or in writing. Normally, a response to an inquiry does not necessitate contact with the company or agent for resolution. An inquiry can be a simple request for information, such as the address or telephone number of a company or whether a company or agent is licensed in Virginia. The Consumer Services Section also receives inquiries

from providers. These generally involve unpaid or delayed claims. The Consumer Services Section views these as inquiries rather than as complaints because, as providers are not usually parties to the insurance contracts, the Bureau lacks the jurisdiction to intervene in the collection process between providers and patients and providers and insurers. In every instance, however, the Bureau responds to these types of inquiries with an appropriate explanation.

Other sections within the Life and Health Market Regulation Division also play a role in the collection, analysis, interpretation, and evaluation of problems and concerns related to health insurance. The duties of the Forms and Rates Section, the Agents Investigation Section, and the Market Conduct Section are closely related to those of the Consumer Services Section in that the Consumer Services Section may refer special problems to these other sections for further investigation, especially if it finds that certain companies or agents are generating a large number of complaints. The Market Conduct Section also reviews the number and types of complaints received by the Consumer Services Section prior to conducting a market conduct examination of an insurance company. In addition, the Consumer Services Section provides complaint information to the Financial Regulation Division in conjunction with that division's financial examinations of insurance companies.

Complaint data is compiled by the Consumer Services Section in a Monthly Complaint Analysis. This analysis includes a General Complaint Report for each month and a final report for the end of the fiscal year. These reports summarize the number of complaints received, the number of complaints concluded, the number re-opened, and the number re-closed. A breakdown of all general complaints against insurance companies concluded during the month is also summarized. This breakdown is provided by type of coverage and indicates the number of complaints that were justified or unjustified, the number of complaints where the Bureau had no jurisdiction to intervene, the number of complaints where no determination was made as to whether the complaint was justified or unjustified, the number of inquiries where information was furnished, and a general category for miscellaneous complaints. The monthly analysis also provides a listing of the five companies with the largest volume of justified complaints. Justified complaints are further broken down by the type of complaint. These are categorized according to whether the complaint was claims related, service related, underwriting related, trade practices related, or other. Monthly and year-to-date totals are provided. The Bureau also generates a report showing the names of all companies and agents that were subject to disciplinary action during the month. This information is totaled for the year and provides the date the action was taken, the type of action taken, the code section(s) or rule violated, and the subject of the violation.

The Bureau actively carries out its role of providing public education in the area of health insurance. The Bureau publishes a "Virginia Health Insurance Consumer's Guide" as well as a "Consumer's Guide to Insurance for Senior Citizens." The Bureau also makes available other guides such as "A Shopper's Guide to Long-Term Care Insurance" and "A Guide to Health Insurance for People with Medicare." Consumers who have specific questions or concerns with regard to Medicare, Medicaid, or nursing homes are referred to the Social Security Administration, the Department of Medical Assistance Services, or the Department for the Aging. In addition, presentations are made on a regular basis to senior citizen and other consumer groups. The Bureau serves as a liaison with Area Agencies on Aging in cooperation with the Virginia Department for the Aging. Information on Medicare coverage, Medicare supplement policies, and long-term care insurance is provided. Presentations are also given in conjunction with pre-retirement seminars sponsored by the Virginia Retirement System. Other organizations, such as the Virginia Cooperative Extension Services and various church and civic organizations, also request the Bureau to conduct seminars for senior citizens and others. Bureau staff is also available to speak to any other groups which request information on health insurance.

DEVELOPMENT OF A HEALTH INSURANCE HOTLINE

The final objective stated in the study resolution was to consider the development of a "health insurance hotline" for Commonwealth citizens by the Bureau or another state agency. The State Corporation Commission has, since 1978, provided an in-state toll-free consumer hotline number (800-552-7945) which is available to assist citizens who either need information or who wish to file a complaint with regard to any business regulated by the State Corporation Commisssion, including health insurance. The Bureau of Insurance also has several direct numbers, including one for the Life and Health Consumer Services Section (804-786-7691). These numbers are distributed throughout the Commonwealth in a number of different ways:

(1) Every health insurance policy delivered or issued for delivery in the Commonwealth must contain the Commission's toll-free hotline number for in-state calls as well as the Bureau's direct number for out-of-state and local calls. The policy must state that if the insured is unable to obtain satisfaction from the company or agent, the insured may contact the Bureau of Insurance. This information is required pursuant to Section 38.2-305 of the Code of Virginia.

(2) The Bureau publishes five consumer guides. These cover automobile insurance, homeowners insurance, health insurance, and life insurance, and one guide is designed for the specific needs of senior citizens. Each of these consumer guides contains the Commission's toll-free hotline number as well as a direct number for the Bureau of Insurance for local or out-of-state calls. Consumer guides pertaining to life and health insurance issues list the direct number for the Life and Health Consumer Services Section (804-786-7691). These consumer guides are distributed to libraries across the state and are also given to individual consumers or consumer groups who call or write to the Bureau of Insurance requesting basic insurance information or educational material.

(3) The Commission's toll-free number is also shown in the "Blue Pages of Government Listings" in the C&P Telephone Directory. This is listed under Corporation Commission in the state government pages. The Bureau's direct number for the Life and Health Consumer Services Section is also listed. This number is shown under the heading "Complaints" under Life and Health Insurance.

(4) The State Corporation Commission has recently begun to distribute a plastic, wallet-sized reference card listing consumer assistance phone numbers at the Commission. The toll-free hotline number is featured prominently on one side of the card. These reference cards are being given to divisions within the State Corporation Commission and to consumer-oriented state agencies and citizen groups.

The Commission instituted the toll-free hot-line number in 1978. In 1988, the Telecommunications Device for the Deaf (TDD) was installed. The TDD system allows deaf, hard-of-hearing, or speech impaired people to "talk" by telephone to hearing people. The Commission's TDD number is (804) 225-3806.

In June, 1991, the State Corporation Commission automated the toll-free hotline number to accommodate more in-coming calls. The caller now hears a message which tells him he has reached the State Corporation Commission and instructs him to press a certain number depending upon the nature of his call. For example, if his inquiry or complaint is related to life, health, accident, or medical insurance, he is instructed to press 2. If he presses that number, his call automatically transfers to the Life and Health Market Regulation Division. If personal assistance is needed or if the caller has a rotary dial, he is advised to remain on the line and an operator will assist him.

Several enhancements to the current automated system are being planned for 1993. One enhancement will be made possible through the utilization of Automatic Call Distributing (ACD). One of the advantages of ACD is that the operator will not have to depress a switch to answer a call. The operator will wear a headset and will be able to hear a certain tone at which time the caller will automatically come on the line. This will enable the operator to answer more calls.

Other enhancements to the current phone system will include the use of "speed dial" which allows certain numbers to be programmed for easier and faster transfer by the operator. Also, if the operator transfers a call to a number that rings busy, the call will be "stacked" and the caller will be able to stay on the line instead of having to call back. This is referred to as "queuing."

In addition, improved technology through the use of computerization will allow the State Corporation Commission to monitor and evaluate the number of incoming calls so as to better meet the needs of the citizens of Virginia.

RECOMMENDATIONS

Development of a Single Health Insurance Claims Form

Based on the findings contained in this report, the Bureau of Insurance recommends that accident and sickness insurers, health maintenance organizations, health services plans, and dental and optometric services plans be required to accept certain standardized claims forms but that they be allowed to accept other claims forms as well.

Under this proposal, accident and sickness insurers, health maintenance organizations, health services plans, and optometric services plans would be required to accept the HCFA-1500 claims form (or its successor) as a standard claims form for physician services and for services provided by chiropractors, audiologists, speech pathologists, clinical nurse specialists who render mental health services, physical therapists, psychologists, clinical social workers, professional counselors, podiatrists, optometrists, and opticians. Payors would not be prohibited, however, from accepting other claims forms if the provider and the payor agreed upon a different claims form.

For hospital services rendered, accident and sickness insurers, health maintenance organizations, and health services plans would be required to accept the UB-82 claims form (or its successor), but they would not be prohibited from accepting other agreed-upon claims forms.

For dental services rendered, accident and sickness insurers, health maintenance organizations, health services plans, and dental services plans would be required to accept the ADA form prepared by the American Dental Association, but another claims form considered acceptable by both parties could also be used.

Because there does not appear to be a national standard form already developed for use by pharmacists, the Bureau does not recommend establishing a pharmaceutical claims form that would be unique to Virginia. The Bureau recommends that the standardized format which is being developed by the American National Standards Institute to facilitate the electronic submission of claims be used by all insuring entities as soon as the ANSI X12 837 Health Care Claim Transaction form has been adopted. This form will be available for use by hospitals, physicians, dentists, pharmacists, and other health care providers.

Proposed Language

The Bureau recommends that the following language be incorporated as a new section under Chapter 3 of Title 38.2 of the Code of Virginia to become effective on and after January 1, 1994:

§38.2-322. Standardized Claims Forms. A. No accident and sickness insurer, health maintenance organization, health services plan, or optometric services plan licensed in the Commonwealth shall refuse to accept, as a standard claims form for physician services or for services provided by chiropractors, optometrists, opticians, professional counselors, psychologists, clinical social workers, podiatrists, physical therapists, clinical nurse specialists who render mental health services, audiologists, and speech pathologists, the standardized HCFA-1500 health insurance claims form, or its successor as it may be amended from time to time. However, nothing in this section shall prohibit an insurer, health maintenance organization, health services plan, or optometric services plan from accepting any other claims form.

B. No accident and sickness insurer, health maintenance organization, or health services plan licensed in the Commonwealth shall refuse to accept as a standard claims form for hospital services the standardized UB-82 claims form, or its successor as it may be amended from time to time. However, nothing in this section shall prohibit an accident and sickness insurer, health maintenance organization, or health services plan from accepting any other claims form.

C. No accident and sickness insurer, health maintenance organization, health services plan, or dental services plan

licensed in the Commonwealth shall refuse to accept as a standard claims form for dental services the standardized ADA form prepared by the American Dental Association, or its successor as it may be amended from time to time. However, nothing in this section shall prohibit an accident and sickness insurer, health maintenance organization, health services plan, or dental services plan from accepting any other claims form.

D. The forms specified in this section may be modified as necessary to accommodate the transmission and administration of claims by electronic means.

Disclosure of Payors' Criteria to Providers and Consumers and Establishment of an Appeals Process for the Denial of Claims

Disclosure of Payors' Criteria to Providers and Consumers

In performing this study, the Bureau strove to determine whether criteria used in payors' case decision making should be disclosed to providers and consumers. It should be emphasized that the type of disclosure this study and recommendation contemplate is the disclosure of all criteria, and not disclosure just for denials of claims on a case-by-case basis.

The Bureau of Insurance is unable to recommend that the Commonwealth of Virginia require disclosure of criteria used in payors' case decision making to providers or consumers. The bases for this recommendation are as follows: (i) such criteria are considered to be proprietary; (ii) most private review agents, insurers, health services plans, and health maintenance organizations that responded to our surveys use criteria for "screening" and not for making utilization review determinations; (iii) many of the insurers, health services plans, health maintenance organizations, and private review agents that responded to our surveys are prohibited from disclosing criteria by contractual terms imposed by the marketers of the criteria; (iv) many respondents use criteria that are computerized and which, consequently, may be difficult to disclose; (v) neither URAC, The Guidelines for Concurrent Review, nor The Guidelines for Conduct of Prior Authorization Programs recommend that such criteria be disclosed; (vi) a requirement by the Commonwealth for the disclosure of criteria would not apply to self-insured single employer plans subject to ERISA laws; and (vii) none of the states reviewed require disclosure to providers or consumers of the criteria used in payors' case decision making.

With respect to the Institute of Medicine's Committee on Utilization Management by Third Parties' recommendation that criteria should voluntarily be disclosed because providers and patients should know the basis for utilization review decisions, the Bureau would point out that most insurers, health services plans, health maintenance organizations, and private review agents responding to our surveys do not use criteria for making utilization review determinations but instead use criteria for screening.

Appeals Process for the Denial of Claims

The Bureau recommends that insurers, health services plans, and health maintenance organizations that make prospective or concurrent utilization review denials should be required to have an appeals process for the appeal of these denials if the insurer, health services plan, or health maintenance organization makes the utilization review determination for its own insured, member, subscriber, or enrollee. If an entity external to the insurer, health services plan, or health maintenance organization makes the utilization review determination, then Insurance Regulation Number 37, Rules Governing Private Review Agents, requires that the private review agent provide an appeals process. A number of the states reviewed have a requirement similar to that recommended here. The Bureau believes that given the differences of opinion regarding what constitutes medically necessary or appropriate care, an appeals process would be beneficial. The Bureau does not recommend requiring an appeals process for retrospective review at this time. Since retrospective review would not result in withheld or delayed care, other mechanisms, such as the court system, already exist to handle disagreements of this nature.

The Bureau, therefore, recommends that the General Assembly consider amending the Code of Virginia to require that insurers, health services plans, and health maintenance organizations that make prospective or concurrent utilization review decisions must make available on appeals process for the appeal of these adverse decisions. "Adverse decision" means a utilization review determination that a health service given or proposed to be given was or is not necessary, appropriate, or efficient when such determination may result in non-coverage of the health service.

Development of a Consumer Guide for Small Businesses

The Bureau concludes that it would be advisable to develop a guide to assist small businesses. A draft of a potential guide is included as Appendix E of this report. The final content of this document will be subject to further review. Additionally, changes instituted pursuant to other health insurance studies conducted in 1992, as well as resulting 1993 legislative changes, should be included in the guide that is distributed to small businesses.

Handling of Provider and Consumer Problems and Concerns

The Bureau's Life and Health Consumer Services Section handles provider and consumer problems and concerns related to health insurance. Complaint data is collected and analyzed on a monthly and yearly basis. Within the next few years, a new computer system will be phased in. This will allow for more detailed tracking and analysis of complaint data and other trends. The Bureau conducts seminars and makes presentations to groups who request information or who have special needs related to health insurance. Consumer guides are also made available to the public. Because of its role in providing public education and citizen protection and because of the periodic reviews it conducts to analyze the complaints it receives, the Bureau recommends no changes at this time in the way it collects, analyzes, interprets, and evaluates provider and consumer problems and concerns related to health insurance.

Development of a Health Insurance Hotline

The State Corporation Commission makes an in-state, toll-free hotline number available to the public through which insureds can call the Bureau's Life and Health Consumer Services Section to register a complaint or to discuss a problem related to health insurance. This toll-free number and the Bureau's direct number are widely distributed. Several enhancements to the phone system have already been made and several more are in the planning stages for 1993. The Bureau recommends against the development of an additional health insurance hotline since both a Commission toll-free hotline number and a Bureau direct number already exist.

ENDNOTES

(1)"The New Electronic Revolution," At Issue, National Association of Health Underwriters, Washington, June 7, 1992, pp. 2-3.

(2) John M. Miller V, CCM, "Innovations in Paperless Insurance Claims Processing and Payment," Journal of Cash Management, May/June 1992, pp. 53-54.

(3) Rick Pullen, "Bush Proposes Streamlined Health Billing System," Best's Insurance Management Reports, June 29, 1992, p.1.

(4) At Issue, pp.2-3.

(5) Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May, 1992).

(6) At Issue, p.2.

(7) Howard J. Anderson, "Insurers See EDI as Key Ingredient of Cost Cutting", Hospitals, April 20, 1992, p.51.

(8) "Key Health Payors Back Common Data Format," National Underwriter, Life & Health/Financial Services, June 29, 1992, p. 16.

APPENDIX A

SENATE JOINT RESOLUTION NO. 120

Requesting the Bureau of Insurance to consider the Commonwealth's role in providing public education and citizen protection in issues surrounding health care insurance.

Agreed to by the Senate, February 11, 1992
Agreed to by the House of Delegates, February 21, 1992

WHEREAS, citizens and consumer groups have voiced concerns to the Commission on Health Care for All Virginians regarding health care insurance; and

WHEREAS, the 1991 study of the Board of Health Professions of managed health care systems raised consumer protection issues; and

WHEREAS, the number of uninsured and underinsured Virginians who lack basic health insurance to their medical needs continues to grow; and

WHEREAS, small businesses in the Commonwealth are more likely to not provide insurance, and in many cases lack the knowledge and skills to choose the appropriate health insurance plan for their employees; now, therefore, be it

RESOLVED, by the Senate, the House of Delegates concurring, That the Bureau of Insurance be requested to consider the role of the Commonwealth in providing public education and citizen protection in issues surrounding health care insurance.

In its deliberations the Bureau should include, but not be limited to, a consideration of:

1. Development of a single claims form for all health insurance systems in the Commonwealth;

2. Regulatory oversight of the disclosure of criteria used in payors' case decision making to providers and consumers, and an appeals process for denial of insurance claims;

3. Development of a consumer guide for small businesses to assist them in purchasing health insurance;

4. The role of the Bureau of Insurance in the collection, analysis, interpretation, and evaluation of provider and consumer problems and concerns related to health insurance; and

5. Development of a "health insurance hotline" for Commonwealth citizens by the Bureau or another state agency.

All agencies of the Commonwealth shall provide assistance to the Bureau for this work as appropriate.

The Bureau of Insurance shall report its findings and recommendations by September 1, 1992, to the Commission on Health Care for All Virginians, the Governor and the 1993 General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

APPROVED OMB-0938-0008

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1 MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. PATIENT STATUS Single Married Other	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code)	Employed Full-Time Student Part-Time Student	ZIP CODE / TELEPHONE (INCLUDE AREA CODE)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? PLACE (State) YES NO	b. EMPLOYER'S NAME OR SCHOOL NAME
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. ____ 2. ____ 3. ____ 4. ____		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO
28. TOTAL CHARGE $	29. AMOUNT PAID $	30. BALANCE DUE $
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

APPROVED OMB NO. 0938-0279

	2		3 PATIENT CONTROL NUMBER	4 TYPE OF BILL
5 BC/BS PROV NO.	6 FEDERAL TAX NO.	7 MEDICARE NO.	8 MEDICAID NO.	9

10 PATIENT'S LAST NAME	FIRST NAME	INITIAL	11 PATIENT'S ADDRESS	CITY	STATE	ZIP

12 BIRTH DATE	13 SEX	14 MS	ADMISSION 15 DATE	16 HR.	17 TYPE	18 SRC	19 A.H	20 D.H.	21 STAT	22 STATEMENT COVERS PERIOD FROM	THROUGH	23 COV D.	24 N-C D.	25 C-I D.	26 L-R D.	27

28 OCCURRENCE CD	DATE	29 OCCURRENCE CD	DATE	30 OCCURRENCE CD	DATE	31 OCCURRENCE CD	DATE	32 OCCURRENCE CD	DATE	33 OCCURRENCE SPAN CD	FROM	THROUGH

34	CONDITION CODES 35	36	37	38	39	BLOOD RECORD (PINTS) 40 FURN	41 REPL.	42 NOT RP	43 DED.	44 SP PROG.	45

	46 VALUE CD	AMT	47 VALUE CD	AMT	48 VALUE CD	AMT	49 VALUE CD	AMT
a								
b								

50 DESCRIPTION	51 R. CODE	52 S UNITS	53 TOTAL CHARGES	54	55	56

57 PAYER	58 REL INFO	59 ASG BEN	60 DEDUCTIBLE	61 CO-INSURANCE	62 EST. RESPONSIBILITY	63 PRIOR PAYMENTS	64 EST. AMOUNT DUE
A							
B							
C							

DUE FROM PATIENT ▶

65 INSURED'S NAME	66 SEX	67 P.REL.	68 CERT.-SSN-HIC.-ID. NO.	69 GROUP NAME	70 INSURANCE GROUP NO.
A					
B					
C					

71 EID	72 ESC	73 EMPLOYER NAME	74 EMPLOYEE ID	75 EMPLOYER LOCATION

76 PRINCIPAL AND OTHER DIAGNOSES DESCRIPTIONS	77 PRIN. CODE	OTHER DIAGNOSES CODES 78	79	80	81

82 P.C.	83 PRINCIPAL AND OTHER PROCEDURES DESCRIPTIONS	84 PRINCIPAL PROCEDURE CD	DATE	85 OTHER PROCEDURE CD	DATE	86 OTHER PROCEDURE CD	DATE

PSRO UR DATA 87 CD	88 APP FROM	89 APP THROUGH	90 GRC	91 TREATMENT AUTH	92 ATTENDING PHYSICIAN ID	93 OTHER PHYSICIAN ID.

94 REMARKS

FOR INTERMEDIARY USE ONLY VERIFIED N-C. STAY DATES FROM	THROUGH	PR. PSC. D.		

AMT. REIMBURSED	N-PYM. CD			APPROV BY	DATE APPROV

95 I CERTIFY THAT THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

PROVIDER REPRESENTATIVE X

96 DATE

UB-82 HCFA-1450

PAYER COPY

[redacted]

FORM APPROVED
OMB NO 0938-0008

PATIENT'S REQUEST FOR MEDICAL PAYMENT

IMPORTANT—SEE OTHER SIDE FOR INSTRUCTIONS

PLEASE TYPE OR PRINT INFORMATION — MEDICAL INSURANCE BENEFITS SOCIAL SECURITY ACT

NOTICE: Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law. No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).

SEND COMPLETED FORM TO:

1 Name of Beneficiary from Health Insurance Card (Last) (First) (Middle)

2 Claim Number from Health Insurance Card

Patient's Sex
☐ Male
☐ Female

3 Patient's Mailing Address (City, State, Zip Code)
Check here if this is a new address ☐
(Street or P.O. Box — Include Apartment Number)
(City) (State) (Zip)

3b Telephone Number (Include Area Code)
(___ ___ ___)
___ ___ ___ – ___ ___ ___ ___

4 Describe the Illness or Injury for which Patient Received Treatment

4b Was condition related to:
A. Patient's employment ☐ Yes ☐ No
B. Accident ☐ Auto ☐ Other

4c Was patient being treated with chronic dialysis or kidney transplant?
☐ Yes ☐ No

5 a. Are you employed and covered under an employee health plan? ☐ Yes ☐ No

b. Is your spouse employed and are you covered under your spouse's employee health plan? ☐ Yes ☐ No

c. If you have any medical coverage other than Medicare, such as private insurance, employment related insurance, State Agency (Medicaid), or the VA, complete:
Name and Address of other insurance, State Agency (Medicaid), or VA office

Policy or Medical Assistance No.

Policyholders Name:

NOTE: If you DO NOT want payment information on this claim released, put an (X) here ☐

I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL, AND REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS TO ME.

6 Signature of Patient (If patient is unable to sign, see Block 6 on reverse)

6b Date signed

IMPORTANT
ATTACH ITEMIZED BILLS FROM YOUR DOCTOR(S) OR SUPPLIER(S) TO THE BACK OF THIS FORM

Dental Claim Form

Check one:

☐ **Dentist's pre-treatment estimate**

☐ **Dentist's statement of actual services**

Carrier name and address

PATIENT COVERAGE INFORMATION

1. Patient name — first / m.i. / last
2. Relationship to employee — ☐ self ☐ child ☐ spouse ☐ other
3. Sex — m f
4. Patient birthdate — MM DD YYYY
5. If full time student — school / city
6. Employee/subscriber name and mailing address
7. Employee/subscriber soc. sec. or I.D. number
8. Employee/subscriber birthdate — MM DD YYYY
9. Employer (company) name and address
10. Group number
11. Is patient covered by another dental plan? ... yes ... no If yes, complete 12-a. Is patient covered by a medical plan? ... yes ... no
12-a. Name and address of carrier(s)
12-b. Group no.(s)
13. Name and address of other employer(s)
14-a. Employee/subscriber name (if different than patient's)
14-b. Employee/subscriber soc. sec. or I.D. number
14-c. Employee/subscriber birthdate — MM DD YYYY
15. Relationship to patient — ☐ self ☐ parent ☐ spouse ☐ other

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

▶ Signed (Patient, or parent if minor) Date

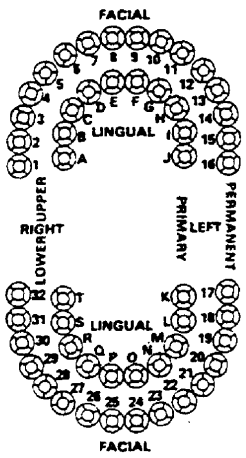
I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

▶ Signed (Insured person) Date

BILLING DENTIST

16. Name of Billing Dentist or Dental Entity
17. Address where payment should be remitted
City, State, Zip
18. Dentist Soc. Sec. or T.I.N.
19. Dentist license no.
20. Dentist phone no.
21. First visit date current series
22. Place of treatment — Office Hosp. ECF Other
23. Radiographs or models enclosed? — No Yes How many?
24. Is treatment result of occupational illness or injury? — No Yes — If yes, enter brief description and dates.
25. Is treatment result of auto accident?
26. Other accident?
27. If prosthesis, is this initial placement? — (If no, reason for replacement)
28. Date of prior placement
29. Is treatment for orthodontics? — If services already commenced enter: Date appliances placed / Mos. treatment remaining

Identify missing teeth with "x"



30. Examination and treatment plan — List in order from tooth no. 1 through tooth no. 32 — Use charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo. Day Year	Procedure number	Fee

For administrative use only

31. Remarks for unusual services

I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.

▶ Signed (Treating Dentist) License Number Date

Total Fee Charged	
Max. Allowable	
Deductible	
Carrier %	
Carrier pays	
Patient pays	

J510

APPENDIX C

ASC X12-ELECTRONIC DATA INTERCHANGE (EDI)

Accredited Standards Committee
operating under the procedures of the
American National Standards Institute

X12N Insurance Subcommittee
Lee Barrett - Chairman
The Travelers
One Tower Square - 5 FP
Hartford, CT 06183
TEL: 203 277-7647 FAX: 203 277-2107

Document No.:

July 3, 1992

Ms. Joanne Scott
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23209

Dear Ms. Scott:

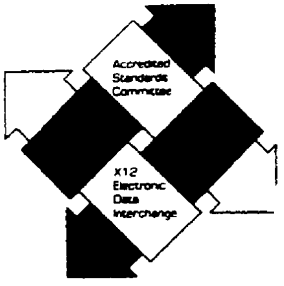
In accordance with your request to Lee Barrett, enclosed please find a copy of Health Care Claim Transaction 837.

Please let me know if you need further information.

Sincerely,

Mike Braddon

Mike Braddon
203 277-9389



837 Health Care Claim

FUNCTIONAL GROUP=HE

This Draft Standard for Trial Use contains the format and establishes the data contents of the Health Care Claim Transaction Set (837) for use within the context of an Electronic Data Interchange (EDI) environment. This standard can be used to submit health care claim billing information from providers of health care services to payers, either directly or via intermediary billers and claims clearinghouses. It can also be used to transmit health care claims and billing payment information between payers with different payment responsibilities where coordination of benefits is required.

For purposes of this standard, providers of health care products or services may include entities such as physicians, hospitals and other medical facilities or suppliers, dentists, and pharmacies. The payer refers to a third party entity that pays claims or administers the insurance product or benefit or both. For example, a payer may be an insurance company, health maintenance organization (HMO), preferred provider organization (PPO), government agency (Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), etc.) or an entity such as a third party administrator (TPA) or third party organization (TPO) that may be contracted by one of those groups.

DMSe:
264192

Table 1

POS. NO.	SEG. ID	NAME	REQ. DES.	MAX. USE	LOOP REPEAT	NOTES & COMMENTS
005	ST	Transaction Set Heacer	M	1		
010	BGN	Beginning Segment	O	1		
015	REF	Reference Numbers	O	3		
020	NM1	Individual or Organizational Name	O	1	1000/10	NTE
025	N2	Additional Name Information	O	2		
030	N3	Address Information	O	2		
035	N4	Geographic Location	O	1		
040	REF	Reference Numbers	O	2		
045	PER	Administrative Communications Contact	O	2		

Table 2

POS. NO.	SEG. ID	NAME	REQ. DES.	MAX. USE	LOOP REPEAT	NOTES & COMMENTS
005	PRV	Provider Information	M	1	2000/100	NTE
010	CUR	Currency	O	1		
015	NM1	Individual or Organizational Name	O	1	2010/2	NTE
020	N2	Additional Name Information	O	2		
025	N3	Address Information	O	2		
030	N4	Geographic Location	O	1		
035	REF	Reference Numbers	O	20		
040	PER	Administrative Communications Contact	O	2		

045	SBR	Subscriber Information	M	1	2100/99999	NTE
050	DTP	Date or Time or Period	O	5		
055	NM1	Individual or Organizational Name	O	1	2110/10	NTE
060	N2	Additional Name Information	O	2		
065	N3	Address Information	O	2		
070	N4	Geographic Location	O	1		
075	DMG	Demographic Information	O	1		
080	PER	Administrative Communications Contact	O	2		
085	REF	Reference Numbers	O	5		
090	PAT	Patient Information	M	1	2200/99	
095	NM1	Individual or Organizational Name	O	1	2210/10	NTE
100	N2	Additional Name Information	O	2		
105	N3	Address Information	O	2		
110	N4	Geographic Location	O	1		
115	DMG	Demographic Information	O	1		
120	PER	Administrative Communications Contact	O	2		
125	REF	Reference Numbers	O	5		
130	CLM	Health Claim	M	1	2300/100	
135	DTP	Date or Time or Period	O	40		
140	CL1	Claim Codes	O	1		
145	DN1	Orthodontic Information	O	1		
150	DN2	Tooth Summary	O	35		
155	PWK	Paperwork	O	10		
160	CN1	Contract Information	O	1		
165	DSB	Disability Information	O	1		
170	UR	Peer Review Organization or Utilization Review	O	1		
175	AMT	Monetary Amount	O	40		
180	REF	Reference Numbers	O	10		
185	K3	File Information	O	10		NTE
190	NTE	Note/Special Instruction	O	4		NTE
195	CR1	Ambulance Certification	O	1		NTE
200	CR2	Chiropractic Certification	O	1		
205	CR3	Durable Medical Equipment Certification	O	1		
210	CR4	Enteral or Parenteral Therapy Certification	O	3		
215	CR5	Oxygen Therapy Certification	O	1		
220	CRC	Certification Conditions	O	3		
225	PC	Procedure Codes	O	25		

230	AM1	Informational Values	O	25		
235	CD2	Multi-Valued Characteristics	O	30		
240	QTY	Quantity	O	10		
245	LS	Loop Header	O	1		
250	NM1	Individual or Organizational Name	O	1	2310/9	NTE
255	PRV	Provider Information	O	1		
260	N2	Additional Name Information	O	2		
265	N3	Address Information	O	2		
270	N4	Geographic Location	O	1		
275	PER	Administrative Communications Contact	O	2		
280	LE	Loop Trailer	O	1		
285	LX	Assigned Number	O	1	2400/10000	NTE
290	SV1	Professional Service	O	1		
295	SV2	Institutional Service	O	1		
300	SV3	Dental Service	O	1		
305	SV4	Drug Service	O	1		
310	LIN	Item Identification	O	1	2410/10	NTE
315	CTP	Pricing Information	O	1		
320	SV5	Durable Medical Equipment Service	O	1		
325	SV6	Anesthesia Service	O	1		
330	SV7	Drug Adjudication	O	1		
335	CD2	Multi-Valued Characteristics	O	5		
340	PWK	Paperwork	O	10		
345	CR1	Ambulance Certification	O	1		NTE
350	CR2	Chiropractic Certification	O	5		
355	CR3	Durable Medical Equipment Certification	O	1		
360	CR4	Enteral or Parenteral Therapy Certification	O	3		
365	CR5	Oxygen Therapy Certification	O	1		
370	CRC	Certification Conditions	O	3		
375	DTP	Date or Time or Period	O	15		
380	QTY	Quantity	O	5		
385	CN1	Contract Information	O	1		
390	REF	Reference Numbers	O	10		
395	AMT	Monetary Amount	O	15		
400	K3	File Information	O	10		NTE
405	NTE	Note/Special Instruction	O	10		NTE
410	PS1	Purchase Service	O	1		
415	LS	Loop Header	O	1		

420	NM1	Individual or Organizational Name	O	1	2420/10			NTE
425	PRV	Provider Information	O	1				
430	N2	Additional Name Information	O	2				
435	N3	Address Information	O	2				
440	N4	Geographic Location	O	1				
445	PER	Administrative Communications Contact	O	2				
450	LE	Loop Trailer	O	1				
455	LS	Loop Header	O	1				
460	NM1	Individual or Organizational Name	O	1	2500/10			NTE
465	N2	Additional Name Information	O	2				
470	N3	Address Information	O	2				
475	N4	Geographic Location	O	1				
480	PER	Administrative Communications Contact	O	1				
485	SBR	Subscriber Information	O	1				
490	CA1	Claim Adjudication	O	1				NTE
495	AMT	Monetary Amount	O	15				
500	DMG	Demographic Information	O	1				
505	DTP	Date or Time or Period	O	2				
510	REF	Reference Numbers	O	3				
515	LE	Loop Trailer	O	1				
520	SE	Transaction Set Trailer	M	1				

Notes & Comments — Table 1

POS. NO.	TYPE	TEXT
020	NTE	Loop 1000 contains submitter and receiver information. If any intermediary receivers change or add data in any way, then they add an occurence to the loop as a form of identification. The added loop occurence must be the last occurence of the loop.

Notes & Comments — Table 2

POS. NO.	TYPE	TEXT
005	NTE	A sample of the overall structure of Table 2 of the 837 Transaction Set is: 2000 PROVIDER (Billing Provider) 2100 SUBSCRIBER 2200 PATIENT 2300 CLAIM 2400 SERVICE LINE(S) 2500 INSURANCE 2300 CLAIM 2400 SERVICE LINE(S) 2200 PATIENT 2300 CLAIM 2400 SERVICE LINE(S) 2500 INSURANCE 2100 SUBSCRIBER 2200 PATIENT 2300 CLAIM 2300 CLAIM 2000 PROVIDER (Billing Provider) 2100 SUBSCRIBER 2200 PATIENT 2300 CLAIM 2400 SERVICE LINE(S) 2500 INSURANCE 2100 SUBSCRIBER 2200 PATIENT 2300 CLAIM
015	NTE	Loop 2010 contains provider information: • Billing Provider Information • Pay-To Provider
045	NTE	Loop 2100 contains information about the subscriber of the current insurance carrier.
055	NTE	Loop 2110 contains name and address information for: • Subscriber • Subscriber's Current Insurance Carrier • Subscriber's School or Employer
095	NTE	Loop 2210 contains name and address information for: • Patient • Patient's Legal Representative • Party Responsible for the Patient
185	NTE	The K3 segment contains information specific to any Federal, State or Plan changes.
190	NTE	The NTE segment contains diagnosis description information and certification narrative information.
195	NTE	The CR1 through CR5 and CRC certification segments appear on both the claim level and the service line level because certifications can be submitted for all services on a claim or for individual services. Cerfication information at the claim level applies to all service lines of the claim, unless overridden by certification information at the service line level.
250	NTE	Loop 2310 contains information about the provider rendering the service(s). This provider name and address information will apply to all service lines of the claim, unless overridden by provider information at the service line level. This information can also be facility identification information or oxygen therapy facility information.

Notes & Comments — Table 2

POS. NO.	TYPE	TEXT
285	NTE	Loop 2400 contains Service Line information.
310	NTE	Loop 2410 contains compound drug components, quantities and prices.
345	NTE	The CR1 through CR5 and CRC certification segments appear on both the claim level and the service line level because certifications can be submitted for all services on a claim or for individual services. Certification information at the claim level applies to all service lines of the claim, unless overridden by certification information at the service line level.
400	NTE	The K3 segment contains information specific to any Federal, State, or Plan changes.
405	NTE	The NTE segment contains certification narrative information.
420	NTE	Loop 2420 contains information about the provider rendering the service detailed on the service line. These segments override the information in the claim-level segments (within loop 2310), if the entity identifier codes in each segment are the same. This information can also be purchased service information or oxygen therapy facility information.
460	NTE	Loop 2500 contains insurance information about: • Paying and Other Insurance Carriers for that Subscriber • Subscriber of the Other Insurance Carriers • School or Employer information for that Subscriber • Segments NM1 - N4 contain name and address information of the insurance carriers referenced in the above note.
490	NTE	The CA1 segment contains crossover data.

APPENDIX D

MID-ATLANTIC MEDICAL COUNSEL

NEIC PARTICIPATING PAYORS

14-Feb-92

Acordia Benefits of Florida
Aetna Health Plans - PPO
Aetna Life & Casualty Company
American General Group
American Healthnet - Texas
American Postal Workers Union (APWU)
Enthem-Florida Health Network
Anthem Group Services
Anthem Health Plan
Anthem Life Insurance
Benefit Trust Life Insurance Company
CIGNA (Connecticut General Life)
CIGNA Health Plan - HMO
CNA Insurance Companies
CNA Mailhandlers
Confederation Life Insurance company
Confed Admin Services Inc
Connecticut General Life Insurance
EBA - Employee Benefit America
EQUICOR (CIGNA)
Florida Health Network
General American Life Insurance Company
Georga Power Co.
Great Southern Life (Modern American Life Insurance Company)
Great- Western Life Assurance Company of America
The Guardial Life Insurance Company of America
Gulf Group Services
HCN - Health Care Network - Milwaukee
Health Economics Corporation
Health Net - California
Health Net - Kansas City, Mo
Healthpoint Corporation
Healthy Choice
ICH Corporation
John Hancock Mutual Life Insurance Company
John Hancock Health Security Program
John Hancock Preferred Health PLan
Liberty Life Insurance Compnay
Life Insurance of Georgia

NEIC PARTICIPATING PAYORS – CONT.

Med Connect – Chicago
Metropolitan Life Insurance Company
Modern American Life Insurance Company
Mutual of Omaha Insurance Company
Mutually Preferred
The New England
New York Life Insurance Company
Pacific Mutual Life Insurance Company
Pacific Health Systems
Philadelphia American Life Insurance Company
The Phoenix
Phoenix Mutual Life
PMG
Peferred One – Minneapolis
Principal Financial Group (formerly Bankers Life of Iowa)
Principal Mutual Life Insurance Company
Provident Life and Accident Insurance Company
Provident Life and Accident Insurance Company of America
Provident Life and Casualty Insurance Company
Prudential Life Insurance
Sagamore – South Bend Indiana
Sanus – St. Louis, Missouri
Sanus PPO
State Mutual Life Insurance Company of America
The Travelers
United Benefit Life Insurance
United of Omaha

APPENDIX E

DRAFT

A Guide to Health Insurance For Small Employers

I. INTRODUCTION

There are different ways to insure your employees for sickness or injury. Many types of health insurance are available at differing prices. Some policies pay most of the cost of health care bills for any serious injury or illness. Others pay only some of the bills or only for certain injuries or illnesses. Some policies pay an amount directly related to the actual health care costs. Others pay a set amount for each day of hospitalization without regard to the actual bill. Health insurance should be carefully selected to make sure that it adequately protects the needs of the insureds.

This guide has been developed to assist the small employer in making decisions about health insurance for his business. A small employer is defined in the Virginia Insurance Code as one with at least two unrelated employees but less than 50 employees. The majority of the employees must be living in Virginia.

Group health insurance covers a number of people under one policy. The group policy is issued to the group policyholder to cover the members of the group. A group policyholder is usually an employer, a labor union, an association, or other organization.

There are a number of advantages to obtaining group insurance for your employees. Usually the premium payments for group insurance are lower than for an individual policy because insurance companies can administer group plans more economically. An insured person's dependents are often eligible for coverage under the group policy.

II. TYPES OF POLICIES AND BENEFITS

A. Basic Medical Expense Insurance (Hospital/Medical/Surgical Insurance)

Hospital insurance usually pays for some portion of the hospital room and board. It may also pay some expenses for other hospital services such as operating room use, laboratory tests and x-rays.

Medical/surgical insurance pays a benefit for surgical operations (either in the hospital or doctor's office) and may also pay benefits for fees for the assistant surgeon and anesthesiologist. It also pays benefits for the doctor's fee for in-hospital medical visits when someone is hospitalized for medical care other than surgery.

Most basic policies have time and dollar limits on benefits. For example, a policy may pay $150 per day for hospital room and board for 31 days. Or, a policy may pay a fixed percentage (say 80%) of all covered hospital costs for a stated number of days.

Payments for surgical expenses are usually based on a surgical fee schedule so that a stated amount is paid for a specified operation.

Some polices may provide for the payment of "usual, customary, and reasonable" charges. This means that the company can determine what it will pay for a service.

B. Major Medical Insurance

Since all basic policies stop paying benefits when certain time limits or dollar limits are reached, major medical policies provide additional protection against the high costs of serious or continuing illnesses and injuries.

These policies usually provide broader coverage than basic policies. They may cover the costs of blood, drugs, and out of hospital costs, such as doctors' visits. Benefits are paid longer, and dollar limits are higher in comparison to basic policies.

Major medical policies usually have a yearly deductible (an amount that the insured individual must pay before the insurance company begins paying benefits). Then they usually pay 80% of covered expenses above the deductible. The insured individual pays the remaining 20% under a participation clause (sometimes called a co-insurance or co-payment clause).

After the insured individual has paid a stated amount under the participation clause, some policies pay 100% of any remaining covered expenses.

Many companies offer polices that combine basic and major medical plans into one policy. These policies are often called comprehensive policies.

C. Limited Mandated Benefit Policies

Recently the Virginia General Assembly passed legislation that allows a policy to be sold to individuals and groups with less than 50 employees, that does not include all of the statutorily required benefits that other medical, surgical and major medical contracts must include. Those contracts are sometimes referred to as "limited mandated benefit contracts." The cost of this type of contract is generally lower than for other contracts.

Your group would have to have been without coverage for twelve months or the entire time your group has been in operation if you have not been in business 12 months to be eligible for this coverage.

The policy must include basic levels of primary, preventive and hospital care. The policy must include at least the following:

- 30 days of inpatient hospitalization coverage each year
- Prenatal care
- Obstetrical care
- Well-baby and well-child care
- At least two physician office visits per calendar year for primary and preventive care.

The policy <u>is not</u> required to directly reimburse each of the provider categories included under other medical surgical contracts. It <u>is not</u> required to include coverage for mental, emotional or nervous disorders or alcohol and drug dependence.

There are a few companies offering this contract in Virginia at the present time. You can obtain more information about each company's contract from the company or agent.

It is important to remember that the coverage is limited. However, depending on your employees and your company's financial situation it may be a viable option for you.

D. Dental Insurance

You might consider providing dental coverage to your employees in addition to basic medical expenses and major medical coverage.

Dental insurance provides coverage to help pay for routine dental care and dental injuries. It is usually offered as group insurance.

Benefits include the payment of reasonable costs for preventive services such as routine examinations and cleaning of teeth. For fillings, x-rays and other general services, plans usually pay 80% of the reasonable cost for the service; the insured pays the rest. For other restorative services (such as crowns and dentures) plans usually pay half of the reasonable costs and the insured pays the rest. Some plans also pay orthodontic benefits.

E. Alternate Types of Coverage

Small employers should shop carefully when looking for health insurance. You can obtain coverage from any of a number of companies operating in Virginia. You may be able to obtain similar coverage at a lower price if you shop around.

You can consider attempting to obtain coverage under a traditional indemnity contract. Under these contracts the insured individual is reimbursed a set percentage based on the usual, customary and reasonable payment for the services that are received. The individual insured can obtain medical services from any doctor or other health care provider that insurers are required to reimburse.

Sometimes coverage may be available to your group through another type of coverage. Preferred Provider Organizations (PPOs) and Health Maintenance Organizations (HMOs) are different from traditional indemnity insurance. Coverage may be available to you through a PPO or HMO at a lower price.

Preferred Provider Organizations (PPOs)

Preferred provider organizations (PPOs) are a relatively new concept in health care. To form a PPO, an employer or insurance company directly contracts with hospitals or doctors (the preferred providers) to furnish services at rates that are lower than usual. With a PPO, the individual insured is usually able to choose any doctor or hospital, but if he does not go to a preferred provider, he will have to pay more in the form of a deductible and a copayment.

Health Maintenance Organizations (HMOs)

Health maintenance organizations (HMOs) are not insurance, but are another way to provide for meeting health care costs.

HMOs are organized systems for health care that provide services directly to members. (In comparison, insurance companies provide reimbursement for health care services; and other types of prepaid plans, such as Blue Cross and Blue Shield, contract with hospitals and doctors to provide services.) **Usually, HMO members must receive health care services at the HMO facility or from the HMO physicians.**

An HMO provides or arranges for health care services such as routine office visits, diagnostic tests (laboratory tests and x-rays), hospital care, surgical care, emergency care, and preventive services (such as check-ups) for enrolled members and their families who have paid a predetermined fee.

Some HMOs employ physicians who treat patients at an HMO center. Other HMOs contract with groups of physicians or individual physicians who maintain their own health center or individual offices where they treat HMO patients.

Before joining an HMO you should consider:

- What kinds of services are available from the HMO compared to the services covered by your present insurance policy or by a policy you are considering buying?
- How much will you have to pay for the HMO as compared to what you have to pay for the insurance plan, including deductibles?
- Is the location of the HMO facility or physicians' offices convenient?
- Are your group members willing to use doctors chosen by an HMO instead of doctors of their own choice?
- If members need emergency medical care when they are out of town, will the HMO pay for the services?

You should also visit the HMO and ask any questions you have on how it works.

F. Multiple Employer Welfare Arrangements (MEWAs)

A Multiple Employer Welfare Arrangement (MEWA) is defined in Virginia to mean any plan or arrangement which is established or maintained for the purpose of offering or providing coverage for health care services to the employees of two or more employers, or to their beneficiaries. MEWAs, or Multiple Employer Trusts (METs) as they are sometimes called, have been used for many years as a way for small employers to provide health and welfare benefits to their employees. Basically, a MEWA combines two or more employers into a large group for the purpose of obtaining health care coverage on terms similar to those available to large corporations. Generally, large groups

can purchase health care coverage at a lower price than small groups. As a result, the premiums you pay to purchase health care coverage may be affected by the size of the group involved.

In previous years there has been some confusion over the extent to which state insurance regulation could be applied to the operation of a MEWA. The confusion stemmed from a "preemption" provision included in the federal Employee Retirement Income Security Act of 1974 (ERISA). The "preemption" provision appeared to limit the ability of the states to regulate the operation of a MEWA. However, amendments to ERISA in 1983, clarified the ability of the states to regulate the operation of MEWAs. Accordingly, since 1983, MEWAs, regardless of their status under ERISA, are subject to some level of state regulation.

The Bureau revised its regulation of MEWAs in 1992. MEWAs are subject to all of the provisions of the Insurance Code. MEWAs are now required to be fully insured before they can operate in Virginia unless the MEWA is licensed as an insurance company, health maintenance organization, health services plan, or dental or optometric services plan.

Even a fully insured MEWA must provide detailed information to the Bureau before it can operate in Virginia. The information must include proof that there is direct coverage of all covered benefits by an insurance company licensed and in good standing in Virginia or that there is an arrangement or provision of services on a direct basis for an HMO, health services plan, or dental or optometric plan licensed in this Commonwealth.

Many of the problems associated with MEWAs in the past are addressed by Virginia's regulation. Prior to the clarification of federal regulation, some MEWAs claimed exemption from state regulation and operated with insufficient funding and inadequate reserves. At some point in their operations across the country a number of MEWAs have been unable to pay claims because of a lack of funds.

Virginia's requirements that a MEWA be fully insured by a company in good standing in Virginia or meet the requirements imposed to be licensed as an insurer in Virginia were instituted to provide protection to employers and their employees.

It is important to know if a MEWA is licensed to operate in Virginia if you are considering joining one. Contact the Bureau of Insurance before you make your final decision.

All states do not have requirements as stringent as Virginia's. The MEWA could be operating in a state that requires less protection for policyholders. Or, the MEWA could be operating without meeting the requirements of any state.

Joining a MEWA may be attractive to you because of a lower cost, but remember to ask questions about how long the MEWA has been in operation and how many members they have and who those members are. Try to get information from other members about how their claims have been handled.

G. Limited Contracts

There are other types of policies that companies may offer to you and your employees. These policies should not be expected to pay for the majority of the costs for illnesses or injuries. You may wish to allow your employees to decide for themselves if they want any of the following types of coverage, in addition to their major medical and basic medical expense coverages.

Hospital Confinement Indemnity Insurance

Hospital confinement indemnity insurance pays a fixed amount (an indemnity) per day, per week or per month when you must stay in a hospital. The benefits paid are not based on your actual expenses. **You should use this type of policy to supplement rather than substitute for basic medical expense insurance policies.** Four types of limited benefit insurance are:

- Cancer and other specified disease insurance
- Skilled nursing home insurance
- Accident only insurance
- Intensive care insurance.

Cancer and Other Specified Disease Insurance

Specified disease insurance policies only pay benefits for certain diseases, usually for cancer or health disease. Some of these policies pay benefits based upon actual medical expenses for treatment of the specified disease. Others pay a certain indemnity for hospital confinement and outpatient treatment for the specified disease(s), or pay a one-timed fixed lump sum indemnity benefit payment. Some policies provide a combination of benefits.

Cancer policies pay benefits for the actual treatment of cancer, and some policies may pay benefits for any other conditions or disease caused or aggravated by cancer or the treatment of cancer.

Accident Only Insurance

Accident only policies cover death, loss of limb or sight, disability, or hospital and medical care due to an **accident. They will not pay benefits when you are sick.** For example, an accident only policy would pay benefits for a broken leg but would not pay benefits if you had appendicitis.

Intensive Care Insurance

Intensive care insurance policies provide coverage only while you are in an intensive care unit (ICU) of a hospital.

Disability Income Insurance

Disability income insurance pays a weekly or monthly income benefit if you are disabled due to a covered injury or sickness. This type of insurance can provide an income to partially replace wages lost when a person is unable to work for an extended time. Policies are available to cover disability due to an accident only, or due to either accident or sickness.

Disability income policies have elimination periods before benefits become payable. The elimination period starts after you have become disabled for a covered disability. The longer the elimination period, the lower the premium will be.

The period of time for which benefits are payable can also vary considerably. Benefit periods may depend on whether the disability was caused by accident or sickness. A short term policy may provide benefits for 13, 26 or 52 weeks. A long term policy may provide for lifetime accident benefits and sickness benefits to age 65. The longer the benefit period, the higher the premium will be.

A disability income policy generally requires that you be totally disabled before benefits become payable. **The definitions of total disability vary from policy to policy.** Some definitions require only that you be unable to perform your normal job, while others require that you be unable to perform any work you are suited for by education or experience.

A partial disability benefit may provide or may be available on an optional basis. Some partial disability coverages pay benefits for a partial disability immediately following a period of total disability.

The amount of monthly benefit provided by a disability income policy may be stated as a percentage of income or as a set dollar amount. The amount of benefit for which you can qualify is usually based on a percentage of your gross earnings, normally around 60%.

Some policies may reduce your benefit by any amount that you receive from Social Security so that your disability benefit and Social Security benefit together will provide a specified income. Some companies will consider possible Social Security benefits when they decide the amount of benefits for which you qualify.

Limited occupational therapy and vocational rehabilitation benefits may also be provided by a disability income policy.

III. Waiting Periods, Pre-existing Conditions, and Other Exclusions

These provisions limit the insurance company's obligation to pay benefits. All health insurance policies have a list of certain things (exclusions) they will not pay for. The longer the list, the less coverage the policy provides. Policies with fewer exclusions may be more expensive than policies with more exclusions. Make sure you understand what will and will not be covered.

A. Waiting Periods

If a policy has a waiting period (sometimes called a "probationary period") benefits will not be paid for expenses arising during a certain number of days after the policy is in effect. Accidents are usually covered from the first day the policy is in effect. Some policies have a waiting period of 15 to 30 days before any illness will be covered. Waiting periods of not more than six months may be required for certain diseases or medical conditions such as hernia, adenoids, and varicose veins unless emergency treatment is required.

Policies covering pregnancy usually have a waiting period before benefits will be paid for costs incurred in a birth. If one of your employees anticipates needing maternity coverage, check the policy language very carefully. Ask your agent for details on pregnancy benefits.

B. Pre-existing Conditions

Many policies usually will not pay benefits until a certain time period has passed for a health condition you had when you bought the policy. This type of health condition is known as a "pre-existing"condition. Pre-existing conditions exclusions are intended to prevent a person with an illness or injury from buying a policy and then obtaining treatment to be paid for under the policy.

You should know the meaning of any provisions excluding benefits for pre-existing conditions. Also, you should know how long the provision will exclude benefits for pre-existing conditions. These provisions are the reason that many claims are denied.

Do not think that because the application asks no questions about health or medical history or the policy requires no physical examination, the policy will cover conditions that your group already has. It will not!

Policies may define pre-existing conditions differently. A pre-existing condition can be defined as the existence of symptoms that would cause an ordinarily careful person to seek treatment, a condition for which medical treatment was received or recommended, or one that shows itself within a certain time period.

Under some definitions a condition would be considered "pre-existing" even if you did not know that you had the condition before you bought your policy. Also, you need to know how many years the policy will go back in looking for pre-existing conditions. Some policies may go back as far as birth, others go back two years. For a small employer group contract issued or renewed after July 1, 1992, any preexisting-conditions provision may not limit, deny or exclude coverage for a period beyond twelve months following the insured's effective date of coverage and may only relate to conditions manifesting themselves in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment was recommended or received during the twelve months immediately preceding the effective date of coverage or as to pregnancy existing on the effective date of coverage.

Policies vary as to how long they exclude benefits for pre-existing conditions. Usually, policies will not pay for pre-existing conditions for one or two years after the effective date of the policy, but some policies may have longer or shorter periods. If a small employer group policy is issued or renewed after July 1, 1992, it will not be able to extend the period beyond 12 months (unless the new insurer provides open enrollment).

A policy may exclude a certain medical condition from coverage.

Shop for a policy with the shortest possible exclusion for pre-existing conditions.

C. Other Exclusions

In addition to excluding pre-existing conditions, health insurance policies usually exclude illness or injury resulting from:

- War or military service
- Attempted suicide or intentionally self-inflicted injuries (regardless of mental problems)
- Aviation (under certain circumstance)
- Injury or illness covered under worker's compensation
- Treatment provided in government hospitals.

Understanding the Policy Language

Certain general provisions are required by law, but policy language can be very different. You should read and understand any policy that you are considering buying. You should also read your own policy after it is issued. Simplified language and large type must be used in individual and certain small group accident and sickness policies. It should be easier for you to read your policy than it used to be.

(1) Other Insurance Provisions and Coordination of Benefits Provisions

These provisions prevent multiple or excessive payments for a given medical expense or loss of income.

Individual policies may have "other insurance" provisions that limit the amount of insurance that a person can have with the same insurance company. These provisions allow a person either to have a set maximum amount of insurance or to collect benefits only on one policy. The person has the right to choose which policy will pay benefits, and the insurance company will cancel all other policies and refund all premiums paid for them.

Some individual policies have an "insurance with other insurers" provision. A policy with this provision will pay only a portion of the benefits if a person has other valid policies providing coverage and if the insurer had no notice of the other policies.

Coordination of benefits provisions in group policies limit the total benefits payable under two or more group policies so that benefits do not exceed the actual amount of medical expenses incurred or wages lost. Coordination of benefits is particularly important when both the husband and wife each have obtained family coverage under group policies offered by employers. Group policy benefits may not be reduced because benefits are payable under an individually underwritten health insurance policy. Individual policies may reduce the amount of benefits payable if benefits are payable under other insurance.

Your employees should check their policies and group certificates to see if they have these provisions and if they have duplicate coverage. Your employees may be paying several premiums for coverage of limited value.

(2) Renewal Provisions and Changing of Premium Rates

You should also know if your policy may or may not be renewed on the renewal date. The renewal provision is usually on first page of the policy. Since a policy is written for a limited time, usually a year, it must be renewed at the end of

each term. The type of renewal provision affects the cost of a policy. For example, when a company issues a noncancellable policy, it assumes a greater risk and has to charge more. The following chart summarizes the basic types of renewal provisions.

TYPE OF PROVISION	MEANING
Term or Nonrenewable	Policy cannot be renewed.
Optionally Renewable	Policy can be renewed. Insurance company can decide not to renew but may only cancel at certain times, such as when premiums are due. Premium rates can be changed.
Conditionally Renewable	Insured can renew until a specified age subject to the insurance company's right to decline renewal under conditions specified in the contract. Usually renewal would not be denied if the insured's health had deteriorated. Premium rates can be changed.
Guaranteed Renewable	Insured has the right to renew until a specified age. Premium rates can be changed for a class of insureds, but not just for an individual.
Noncancellable	Insurance company cannot change, cancel or refuse to renew the policy if premiums are paid on time. Premium rates cannot be changed. The policy can provide for scheduled rate increases as the insured gets older.

If your small employer contract is issued or renewed after July 1, 1992 it must be guaranteed renewable.

IV. Recent Changes in Small Employer Health Insurance

Legislation went into effect in July of 1992 to provide additional requirements for health insurance policies issued to small employer groups.

The new requirements provide that:

- An insurer may not limit, deny or exclude coverage for a pre-existing condition for more than 12 months following the insured's effective date of coverage;

- If a person was covered under an individual or group coverage of at least equal value, prior to obtaining new coverage under a small employer group contract, the new contract must provide a credit for the amount of time the person was covered under the previous contract

  (Example: You change your coverage from one insurance company to another, you have an employee that had a back injury that was not covered for nine months under the old policy. The new policy can exclude the pre-existing back condition for three months, not for 12 months.);

- The policies must be renewed if you want them renewed, unless you do not pay premiums, go out of business, abuse or misuse providers, or you or your employees commit fraud or misrepresentation;

- Contracts may not include coverage for only some eligible employees or dependents. No eligible employees or dependents can be excluded because of their health status.

V. Things to Remember

- Make sure your employees sign up properly if they want coverage for their spouse and children. The insurer should be notified if there are changes in the family such as an expected child, an adoption, a child reaching 18 or marrying, a marital separation or divorce. Many contracts require that the insurer be notified within 30 days when children are added to the family or other changes occur. Help your employees remember the requirements in your contract.

- Remember to make premium payments on time

- You can reduce the cost of your group policy by using deductibles, co-payments, and waiting periods. Many contracts pay 80% of the cost of services and the insured pays the other 20%. You can reduce to cost of your premium by increasing the percentage of the claims that you and your employees pay.

Health insurance policies are available from many insurance companies and Blue Cross and Blue Shield associations. Shop carefully because policies and plans differ in cost, coverage, and claims service.

Coverage under a group policy usually begins after a waiting period specified in the policy. Many policies require a person to have been employed full time and actively working for a month before coverage begins. The date that coverage ends is also dependent on the group contract. Coverage may end on the date employment or membership in the group ends or 30 days after the employment or membership ends.

As an employer and a group policyholder, you have the option of selecting to continue coverage to your employees for 90 days after eligibility would normally end. The employee would have to apply to you to extend the coverage and pay the premium for the 90 days prior to termination. The other option you can choose is to allow your employees to convert to an individual policy without having to provide evidence of insurability (unless §38.2-3416 exempts the insurer). The application for the policy must be made and the first premium must be paid to the insurers within 31 days after the termination.

The premiums that your former employee would have to pay for a converted policy will be higher than the cost for the employee under your group policy.

You should look for a company that will pay your claims promptly, fairly, efficiently, and courteously. When you are shopping for insurance ask your relatives, friends, and business associates what kind of service their companies have given them.

Most companies use agents or sales representatives to sell their policies to groups. Ask other employers you know and respect if they would recommend their agent. An agent should be:

- Reliable, helpful, and able to answer any questions you may have about a policy
- Available in the future to answer additional questions
- Able to help you file your claims.

Most agents are honest, but remember:

- An agent cannot change the contents of a policy; only the insurance company can.
- If the agent fills out the application for you, read it carefully and completely before signing.

The Bureau of Insurance recommends that you buy a policy from a company licensed in Virginia. The Bureau can be of greater help if you have a problem with a company licensed in Virginia. If you have questions about companies or agents, contact the Bureau. The Bureau cannot recommend a specific company or agent, but the Bureau can tell you if a company or agent is licensed in Virginia.

If you choose to join a group that is based in another state remember, it is that state's laws that will apply and not Virginia's.

VI. INSURANCE COMPLAINTS

A. Know Your Rights

The General Assembly has enacted laws to protect consumers by regulating insurance company practices.

- Insurance companies are not allowed to discriminate unfairly as to the rates of kinds of coverage available to consumers.
- Claims must be paid promptly and fairly.
- Consumers have a right of access to certain information collected by insurance companies, including information on adverse underwriting decisions.

An adverse underwriting decision is an action taken by a company or agent to:

- Refuse you coverage,
- Terminate your coverage,
- Offer you coverage that differs from what you applied for,
- Or offer the coverage you applied for at a different premium rate than was quoted to you when you applied.

For example, if you apply for insurance and are refused coverage, the insurance company must tell you why or tell you that upon written request you may receive an explanation.

There are exceptions to consumer information rights, such as when fraud might be involved.

B. When a Problem Occurs

(1) Contact Your Agent or Company First

If you believe your insurance company has improperly refused to issue or renew your policy, or refused to pay all or part of a valid claim, you have a right to question and complain. Your first step should be to contact your agent or company representative. Many times a mistake has been made, and it will be corrected upon inquiry.

When contacting your agent or company, give:

- Your name
- Your address
- Your telephone number

- Your policy and/or certificate number
- The type of policy

- The nature of your complaint

A complaint by letter is best. Always keep a photocopy of your letter.

If you, or one of your employees, decide to complain by telephone, keep a written record of:

- The date and time of the call
- The name of the person talked to at the company
- What was said during the call.

(2) Help From the Bureau of Insurance

If you do not receive a prompt, courteous and satisfactory response from your agent or company, you may need to get help to resolve your problem.

The State Corporation Commission's Bureau of Insurance provides professional information and complaint services to all residents of Virginia.

Here are ways to take advantage of these services:

To Call	If you live in Richmond:	786-7691
	If you live in Virginia but outside of Richmond, you may call the toll-free State Corporation Commission (SCC) "Hot Line" number:	1-800-552-7945
To Get Help In Person	Visit the SCC's Bureau of Insurance in downtown Richmond at:	The Jefferson Building Corner of Bank and Governor Streets (1220 Bank Street) Richmond, Virginia 23209

The Bureau of Insurance Will:

- Thoroughly investigate the complaint
- See that you get a clear response to your questions
- Cut through red tape
- Correct misunderstandings.

But the Bureau Cannot:

- Force a favorable action on the complaint if it is not supported by facts and law
- Provide legal services that are sometimes required to settle complicated problems.

If the Bureau is unable to resolve the problem, we will tell you why. If the law and facts are on your side, we will try to see that your rights are protected and that your complaint is resolved in a satisfactory manner.