REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

STUDY OF AN OMBUDSMAN PROGRAM/ EXTERNAL APPEALS MECHANISM PURSUANT TO SJR 99

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 24

COMMONWEALTH OF VIRGINIA
RICHMOND
1999

JOINT COMMISSION ON HEALTH CARE

Chairman
The Honorable Kenneth R. Melvin

Vice Chairman
The Honorable Jane H. Woods

The Honorable William T. Bolling
The Honorable Joseph V. Gartlan, Jr.
The Honorable Benjamin J. Lambert, III
The Honorable Stephen H. Martin
The Honorable Edward L. Schrock
The Honorable Stanley C. Walker
The Honorable Thomas G. Baker, Jr.
The Honorable Robert H. Brink
The Honorable John J. Davies, III
The Honorable Jay W. DeBoer
The Honorable Alan A. Diamonstein
The Honorable Franklin P. Hall
The Honorable Phillip A. Hamilton
The Honorable Harvey B. Morgan

Secretary of Health and Human Resources
The Honorable Claude A. Allen

Director
Patrick W. Finnerty

Preface

Senate Joint Resolution (SJR) 99 of the 1998 Session of the General Assembly directed the Joint Commission on Health Care to examine both an independent external appeals mechanism and an ombudsman for health insurance issues. Specifically, the Joint Commission on Health Care was requested to examine: (i) the costs and benefits of an ombudsman program for health insurance issues; and (ii) the costs and benefits of requiring an external appeals mechanism for managed care health insurance plans.

Based on our research and analysis during this review, we concluded the following:

- The number of enrollees directly benefiting from an independent external appeals system is likely to be a small percentage of the number of persons enrolled in managed care plans; in Florida and New Jersey, the number of independent external appeals filed has averaged less than 100 per year;

- While the number of enrollees directly benefiting from an external appeals system is small, there are potential intangible benefits. These include the security of knowing that an appeal to an independent entity is possible;

- Virginia has instituted an external appeals procedures in its utilization review statute. A key question is to what extent additional external appeals provisions (such as requiring appeals to be conducted by entities selected by a state agency or to be conducted by a centralized review organization) would confer additional benefits. This is difficult to quantify as the most significant benefit that can be identified would be increased confidence in the independent nature of the appeal, as the review entity would no longer be selected by the health plan;

- A health insurance ombudsman provides a non-regulatory option for helping consumers navigate the sometimes cumbersome requirements associated with managed care plans;

- Several potential models for an ombudsman exist. These include requiring health plans to establish an internal ombudsman, contracting with a private organization to serve as a health insurance ombudsman, and having this function

conducted by a state agency (the most likely candidates are the Bureau of Insurance and the Virginia Department of Health); and

- The Arlington Area Agency on Aging has instituted a pilot ombudsman program for Medicare beneficiaries that could be used as a model for a more broadly applicable health insurance ombudsman program.

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. The policy options are shown on page 23 and pages 30-31.

Our review process on this topic included an initial staff briefing, which comprises the body of this report. This was followed by a public comment period during which time interested parties forwarded written comments to us regarding the report. The public comments received, which are provided in Appendix B, provide additional insight into the various issues covered in this report.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the staff of the Bureau of Insurance, the Virginia Department of Health, the Arlington Area Agency on Aging, and the Virginia Association of Health Plans for their assistance during this review.

Patrick W. Finnerty
Executive Director

February 19, 1999

TABLE OF CONTENTS

I.
Authority for the Study

Senate Joint Resolution (SJR) 99 of the 1998 Session of the General Assembly directed the Joint Commission on Health Care to examine the concepts of an external appeals mechanism and an ombudsman program for health insurance issues. Specifically, the Joint Commission on Health Care was requested to examine: (i) the costs and benefits of an ombudsman program for health insurance issues; and (ii) the costs and benefits of requiring an external appeals mechanism for managed care health insurance plans.

This report is composed of three sections. This section briefly discusses the authority for the study and its organization. The second section discusses external appeals mechanisms. The third section discusses the concept of an ombudsman program for health insurance issues.

A copy of SJR 99 is attached at Appendix A.

II.
External Appeals

External Appeals Proposals Are Being Considered at the State and Federal Levels

An external appeals mechanism is a system whereby a covered member of a health plan may pursue an appeal independent of the health plan's internal appeals system for denial of payment for certain services, denial of coverage, or other reasons depending on how the external appeals system is structured. Currently, there are 19 states other than Virginia that have established some type of external appeals system. Medicare currently utilizes an external appeals system for Medicare Health Maintenance Organizations. Legislation is being considered in Congress that would require such a system nationwide.

This section provides information on Virginia's current statutory provisions regarding appeals of adverse decisions from health plans. In addition, this section discusses actions in other states and at the federal level with regard to an external appeals mechanism. Finally, the costs and benefits of an external appeals approach are discussed.

Virginia Law Provides for Appeals of Adverse Utilization Review Decisions

Virginia currently has external appeals provisions in its utilization review statute. Other than Virginia's utilization review statute, there are external appeals mechanisms currently in 19 other states. In addition, the Medicare program has instituted an external appeals mechanism for Medicare beneficiaries enrolled in managed care plans. Finally, Congress is currently considering three major managed care bills that would require an external appeals system.

In 1995, the General Assembly approved House Bill 1973, which established standards for utilization review (UR) and for appeals of adverse utilization review determinations. The 1998 Session of the General Assembly incorporated these provisions, with some modifications, into Senate Bill 712, which establishes the Commissioner of Health's role in overseeing the quality of care delivered by managed care organizations. However, the utilization review provisions of SB 712 apply to all entities conducting utilization review.

The Commissioner of Health's 1997 study of overseeing the quality of care provided by the managed care industry, conducted pursuant to House Bill 2785 of 1997, concluded the following regarding an external (independent) appeals mechanism:

> Chapter 54 of Title 38.2 has provisions similar to those in states where an independent appeals mechanism has been implemented. If authority for oversight and regulations for Chapter 54 is transferred to VDH, and that statute's provisions enforced, there should be no need for an external appeals mechanism at this time. Also ERISA may pre-empt self-funded employer-sponsored plans from state requirements.

The Commissioner of Health's recommendations resulted in SB 712 (mentioned above), which gives the Commissioner a role in overseeing the quality of care provided by managed care plans. Existing utilization review requirements are now enforced by the Department of Health rather than the Bureau of Insurance. At present, utilization review is defined broadly in §32.1-137.7. of the *Code of Virginia* as:

> a system for reviewing the necessity, appropriateness and efficiency of hospital, medical or other health care services rendered or proposed to be rendered to a patient or group of patients for the purpose of determining whether such services should be covered or provided by an insurer, health services plan, managed care health insurance plan licensee, or other entity or person. For purposes of this article, "utilization review" shall include, but not be limited to, preadmission, concurrent and retrospective medical necessity determination, and review related to the appropriateness of the site at which services were or are to be delivered. "Utilization review" shall not include (i) review of issues concerning insurance contract coverage or contractual restrictions on facilities to be used for the provision of services, (ii) any review of patient information by an employee of or consultant to any licensed hospital for patients of such hospital, or (iii) any determination by an insurer as to the reasonableness and necessity of services for the treatment and care of an injury suffered by an insured for which reimbursement is claimed under a contract of insurance covering any classes of insurance defined in §§ 38.2-117

through 38.2-119, 38.2-124 through 38.2-126,38.2-130 through 38.2-132 and 38.2-134.

Internal Appeals Processes Must Meet Specific Standards

UR entities are required to establish an internal appeals process for adverse decisions. Adverse decisions are defined by §32.1-137.7 of the *Code of Virginia* as "a utilization review determination by the utilization review entity that a health service rendered or proposed to be rendered was or is not medically necessary, when such determination may result in noncoverage of the health service or health services." The internal appeals process must comply with the following provisions of §32.1-137.15 of the *Code of Virginia:*

- Any reconsideration of an adverse decision shall be requested by the provider on behalf of the covered person. A decision on reconsideration shall be made by a physician advisor, peer of the treating health care provider, or a panel of other appropriate health care providers with at least one physician advisor or peer of the treating health care provider on the panel.

- The treating provider on behalf of the covered person shall be notified of the determination of the reconsideration of the adverse decision, in accordance with §32.1-137.9, including the criteria used and the clinical reason for the adverse decision, the alternate length of treatment of the alternate treatment setting or settings, if any, that the entity deems to be appropriate, and the opportunity for an appeal pursuant to §32.1-137.15.

- Any reconsideration shall be rendered and the decision provided to the treating provider and the covered person in writing within ten working days of receipt of the request for reconsideration.

UR Entities Must Establish An Appeals Process for Final Adverse Decisions; An Expedited Appeals Process Must Also Be Established

UR entities must establish an appeals process for consideration of any final adverse decision made as a result of the entity's internal appeals process. A final adverse decision is defined by §32.1-137.7 of the *Code of Virginia* as "a utilization review determination made by a physician advisor or peer of the treating health care provider in a reconsideration of an adverse decision, and upon which a provider or patient may base an appeal." There are also statutory provisions for expedited appeals. The

statutory requirements for an appeal of a final adverse decision and expedited appeals are shown below (it is important to note that these appeal provisions do not apply to decisions to deny care or services based on those services not being a covered benefit of the health plan):

- Each entity shall establish an appeals process, including a process for expedited appeals, to consider any final adverse decision that is appealed by a covered person, his representative, or his provider. Except as provided in subsection E, notification of the results of the appeal process shall be provided to the appellant no later than sixty working days after receiving the required documentation. The decision shall be in writing and shall state the criteria used and the clinical reason for the decision.

- Any case under appeal shall be reviewed by a peer of the treating health care provider who proposes the care under review or who was primarily responsible for the care under review. With the exception of expedited appeals, a physician advisor who reviews cases under appeal shall be a peer of the treating health care provider, shall be board certified or board eligible, and shall be specialized in a discipline pertinent to the issue under review.

- A physician advisor or peer of the treating health care provider who renders a decision on appeal shall: (i) not have participated in the adverse decision or any prior reconsideration thereof; (ii) not be employed by or a director of the utilization review entity; and (iii) be licensed to practice in Virginia, or under a comparable licensing law of a state of the United States, as a peer of the treating health care provider.

- The utilization review entity shall provide an opportunity for the appellant to present additional evidence for consideration on appeal. Before rendering an adverse appeal decision, the utilization review entity shall review the pertinent medical records of the covered person's provider and the pertinent records of any facility in which health care is provided to the covered person which have been furnished to the entity.

- In the appeals process, due consideration shall be given to the availability or nonavailability of alternative health care services proposed by the entity. No provision herein shall prevent an

entity from considering any hardship imposed by the alternative health care on the patient and his immediate family.

- When an adverse decision or adverse reconsideration is made and the treating health care provider believes that the decision warrants an immediate appeal, the treating health care provider shall have the opportunity to appeal the adverse decision or adverse reconsideration by telephone on an expedited basis.

- The decision on an expedited appeal shall be made by a physician advisor, peer of the treating health care provider, or a panel of other appropriate health care providers with at least one physician advisor on the panel.

- The utilization review entity shall decide the expedited appeal no later than one business day after receipt by the entity of all necessary information.

- An expedited appeal may be requested only when the regular reconsideration and appeals process will delay the rendering of health care in a manner that would be detrimental to the health of the patient. Both providers and utilization review entities shall attempt to share the maximum information by telephone, facsimile machine, or otherwise to resolve the expedited appeal in a satisfactory manner.

- An expedited appeal decision may be further appealed through the standard appeal process established by the entity unless all material information and documentation were reasonably available to the provider and to the entity at the time of the expedited appeal, and the physician advisor reviewing the case under expedited appeal was a peer of the treating health care provider, was board certified or board eligible, and specialized in a discipline pertinent to the issue under review.

There Are Differing Points of View Regarding Virginia's UR and Appeals Process

There are two divergent viewpoints about Virginia's current utilization review statute and its appeals provisions. The first point of view, articulated by many, but not all, business groups and the insurance industry, argues that the utilization review statute contains extensive, explicit appeals provisions, including the right to an independent review

as described above. From this viewpoint, any additional appeals mechanism would be unnecessary, as it would be duplicative of existing appeals. In addition, concern is expressed that additional appeals structures would complicate the already challenging task of implementing the regulatory structure for health insurance established by Senate Bill 712, approved by the 1998 Session of the General Assembly. As regulations promulgated by the Board of Health pursuant to Senate Bill 712 are not expected to be finalized until December 1999, some argue that additional legislation in the area of managed care oversight would be premature until the current regulatory structure is established.

Another point of view is that, while the utilization review statute contains important protections for enrollees of health insurance plans, it does not establish a sufficiently independent review of final adverse decisions. From this point of view, the appeals process laid out in the *Code of Virginia* is flawed, because the health plan selects the outside reviewer. While this reviewer cannot be an employee or director of the health insurance plan, the reviewer is, in effect, a contractor of the plan. Therefore, some consumer advocates expressed skepticism as to how impartial such a reviewer actually is. This viewpoint contrasts Virginia's appeals process with that used by Medicare and some other states (such as Florida) where a centralized independent review entity reviews final adverse decisions, rather than an outside reviewer selected by the health plan. According to this viewpoint, the advantage of a centralized review entity is greater impartiality.

State Health Programs Have Implemented Appeals Processes

Both the State and Local Health Benefits Program and the Medicaid program have established appeals mechanisms for final adverse decisions made by health plan contractors. Pursuant to regulations, as of the summer of 1998, the State and Local Health Benefits Program, which serves state and local employees, expanded a process for enrollees to appeal final adverse decisions made by health plans contracted by the state to serve state and local employees. The enrollee must (i) have exhausted internal plan appeals and (ii) file the appeal within 60 business days of the final adverse decision from the health plan. The appeal is reviewed by the Director of the Department of Personnel and Training (DPT), with staff assistance from the Office of Health Benefits. At the request of the person filing the appeal, the director will schedule an informal fact finding conference to assist in reaching a decision. The director's decision must be made within 90 days, and the director's decision constitutes an agency case decision under the Administrative

Process Act (APA), and therefore is subject to the normal APA appeals process.

By regulation, any denial of an appeal by the DPT director must include:

- the specific reason or reasons for the denial,
- specific references to law, regulation, contract provisions, or relevant policies on which the denial is based,
- a description of any additional information that is required to perfect the claim and an explanation of why such material is necessary, and
- an explanation of the review process.

The Medicaid appeals process is established in regulations promulgated by the Board of Medical Assistance Services. This appeals process is established in 12VAC30-110-10 (et. seq.) According to 12VAC30-110-30:

An individual has the right to file an appeal when:

- His application for benefits administered by the department is denied. However, if an application for State Local Hospitalization coverage is denied because of a lack of funds which is confirmed by the hearing officer, there is no right to appeal.
- The agency takes action or proposes to take action which will adversely affect, reduce, or terminate his receipt of benefits;
- His request for a particular medical service is denied, in whole or in part;
- The agency does not act with reasonable promptness on his application for benefits or request for a particular medical service; or
- Federal regulations require that a fair hearing be granted.

In order to file an appeal, the Medicaid enrollee must submit a notice of appeal in writing within 30 days of receipt of notice of an adverse action. DMAS then assigns the appeal to a hearing officer who conducts a hearing, reviews the record, decides questions of law, and renders a decision. By regulation, the final decision must include:

- A description of the procedural development of the case;

- Findings of fact which identify supporting evidence;
- Conclusions of law which identify supporting regulations and law;
- Conclusions and reasoning;
- The specific action to be taken by the agency to implement the decision; and
- The notice shall state that a final decision may be appealed directly to circuit court as provided in §9-6.14:16 B of the Code of Virginia and 12VAC30-110-40.

Nineteen Other States Have Adopted External Appeals Mechanisms

According to the National Conference of State Legislatures (NCSL), as of July 31, 1998, there were 19 states that require some type of external appeals mechanism for health insurance issues. Virginia is not counted as one of the states with an external appeals mechanism in NCSL's analysis, though the Commonwealth's existing utilization review statute contains provisions that constitute what might be considered to be an external appeals mechanism. Some states, such as Florida, have external appeals mechanisms that differ from Virginia's current approach in that the external review entity is selected independently, rather than by the health plan that made the adverse decision under dispute. In some models such as Florida's, a centralized entity has been established to process the reviews. Indeed, in 1985 Florida instituted the first external appeals mechanism to be required by a state. Eighteen other states have since adopted an external appeals mechanism, and at least five other state legislatures are currently considering external appeals legislation. Figure 1 shows the states that have currently adopted an external appeals mechanism.

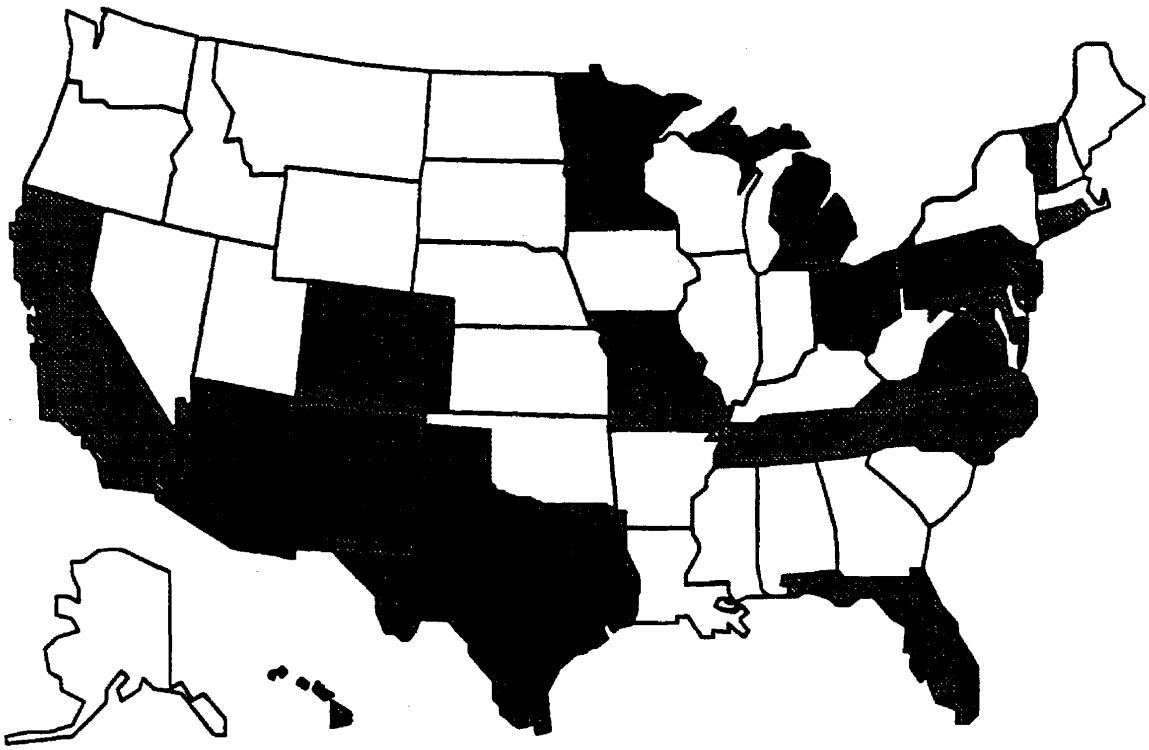
Existing Provisions for External Appeals Vary Among States

Existing provisions for external appeals mechanisms vary greatly in scope from state to state. For example, California's external appeals process is currently limited to denials of coverage for experimental treatment (legislation is currently pending to apply the external appeals process to all denials of care by a health plan). Ohio's external appeals process is currently restricted to patients with a terminal condition (that is a life expectancy of less than two years). Vermont's external appeals mechanism originally applied only to denials of care for mental health coverage, but it was expanded in 1998 to cover all denials of care.

Table 1 summarizes states that had established an external appeals mechanism by July 31, 1998. Most state laws establishing external appeals have been enacted within the past two years. It is therefore difficult to assess fully the costs and benefits of these statutes. In most cases, the direct costs to state government have been minimal, as the costs of the external appeals mechanism is funded by a consumer filing fee (charged in some states) of between $25 and $100 (generally waived for low income individuals) and the health plan. Consequently, there is an impact of the external appeals mechanism on health plan costs in terms of transaction costs and administrative expenses, as well as additional costs from services that are covered as a result of the appeal that otherwise would not have been covered. The next section will discuss more fully the estimated costs of external appeals mechanisms when applied to the United States as a whole, as part of the discussion of federal initiatives.

Figure 1

States With An External Appeals Mechanism as of 7?31/98
(Shaded State Have an External Appeals Mechanism)



Source: National Conference of State Legislatures; NCSL did not include Virginia but Virginia's UR statute is similar to some states listed by NCSL as having an external appeals mechanism

Table 1
Independent External Review Mechanisms in Other States

State	Adopted in Past Two Years?	Entity Conducting the Review?	Decision Binding on Plan?
Arizona	Yes, 1997	An independent reviewer from a list maintained by state	Yes
California	Yes, 1996 (applies only to denial of care based on the care being investigational or experimental)	panel of experts	Yes, if a majority of experts on the panel agree
Colorado	No	independent person selected by the plan	Yes
Connecticut	Yes, 1997	insurance commissioner ($25 filing fee is required)	Yes
Florida	Yes, 1998 (revised process replacing one in place since the early 1980s)	Statewide Providers and Subscribers Assistance Panel	No
Hawaii	Yes, 1998	three member panel appointed by the insurance commissioner	Yes
Maryland	Yes, 1998	Commissioner of Insurance	Yes
Michigan	No	Task force of the advisory commission	No
Minnesota	No	Alternative Dispute Resolution Process	No
Missouri	Yes, 1997	An independent review organization selected by the state health dept.	Yes

State	Adopted in Past Two Years?	Entity Conducting the Review?	Decision Binding on Plan?
New Jersey	Yes, 1997	Creates an independent health care appeals board; enrollees are required to pay a $25 filing fee	No
New Mexico	No	Independent review board	No
North Carolina	Yes, 1997	Review panel selected by the health plan	No
Ohio	Yes, 1997 Experimental or investigational therapies only	Expert selected by an independent entity retained by the health insurance plan	Yes
Pennsylvania	Yes, 1998	independent review organization selected by the health plan	Yes
Rhode Island	No	review entity selected by the insurance commissioner; cost of the appeal shared equally between the two parties	Yes
Tennessee	Yes, 1998	independent review selected by the plan	Yes
Texas	Yes, 1997	Independent review organization designated by the state insurance commissioner	Yes
Vermont	Yes, 1998 (law previously covered only mental health issues)	Independent review organization	Yes

Source: National Conference of State Legislatures Health Policy Tracking Service.

Benefits of an External Appeals Process Are Difficult to Calculate

In terms of benefits, it can be argued that external appeals mechanisms give health care consumers access to appropriate care that otherwise would have been denied to them by a health plan's existing internal appeals mechanism. The longest term data available on external appeals mechanisms would be from Florida, as this is the longest operating external appeals mechanism in any state. A principal lesson from reviewing these data is that an external appeals mechanism, even one relatively broadly crafted, is somewhat limited in its applicability.

Florida's current system for external appeals has been in place since 1993, when responsibility for the program was transferred from the Florida Department of Insurance to the Agency for Health Care Administration. During the five-year period from 1993 to 1997, 270 cases were initiated in Florida that had been resolved by the end of 1997. Of these cases, 118 were deemed ineligible, 100 were settled by mutual agreement of the parties involved, and 52 were heard by an external appeals mechanism. Of these cases, 65 percent were resolved in favor of the consumer. Similarly, New Jersey's external appeals system received only 82 appeals during its first 16 months (out of 3.5 million managed care enrollees in the state).

Costs associated with external appeals approaches are discussed later in this section.

HCFA Has An Extensive Appeals System for Medicare Managed Care Plans

The U.S. Health Care Financing Administration (HCFA) initiated an external appeals mechanism for Medicare beneficiaries as part of its ongoing efforts to encourage Medicare beneficiaries to enroll in optional Medicare managed care plans, rather than remaining in Medicare's traditional fee-for-service program. The process for Medicare managed care appeals involves the following major steps as described by HCFA's information for beneficiaries on its world wide web page.

- The member must receive a written denial (notice of initial determination) with "a clear and specific reason for the denial" in all cases of denial of services or payment. The written denial also includes a notice of the member's appeal rights.

- The member must request reconsideration of the denial decision within 60 days of receiving the notice. The reconsideration must be in writing, but this can be as simple as writing "please reconsider" on the notice of initial determination.

- The managed care organization must reconsider the denial decision within 60 days. If the managed care organization denies the appeal, it is automatically sent for review by HCFA's independent "reconsideration contractor."

- HCFA's independent reconsideration contractor, the Center for Health Dispute Resolution, "reviews the managed care organization's medical records and may consult independent experts." There is no explicit time frame for the independent reconsideration contractor to complete its review. HCFA indicates that "a simple case can be processed and resolved in 17 days on average. If additional information is required, the average processing time has been about 53 days." The Center for Health Dispute Resolution then notifies the managed care organization and the Medicare beneficiary of its decision. The decision is binding on the managed care organization, but not on the beneficiary.

- If the reconsideration contractor upholds all or part of the managed care organization's denial of care, the Medicare beneficiary may request a hearing before an administrative law judge if the disputed amount is at least $100. The Medicare beneficiary has 60 days from the date of the reconsideration contractor's notice to request a hearing before an administrative law judge. The administrative law judge has two years to make a determination.

- If the beneficiary is not satisfied with the administrative law judge's decision, and if the amount in question is at least $300 for Part B and $500 for part A, then the beneficiary may request reconsideration by the Appeals Council of the Social Security Administration's Office of Hearings and Appeals.

- Finally, if the amount in question is over $1,000 and other appeals have been exhausted, the beneficiary may file suit in federal court.

HCFA indicates that between one and two beneficiaries per 1,000 are involved in the external appeals process each year. While HCFA's appeals process provides relatively broad appeal rights to beneficiaries, on August 12, 1998 the 9th U.S. Circuit Court of Appeals in San Francisco ruled in a 3 to 0 decision that Medicare's current appeals process for managed care beneficiaries violates the due process clause of the U.S. Constitution. The court ruled that Medicare managed care plans are acting as a "governmental proxy" when they deny care and therefore are subject to due process provisions. In particular, the court ordered HCFA to set tighter deadlines for processing internal appeals, to provide additional information to beneficiaries, and to take more forceful action against Medicare managed care plans that inappropriately deny care.

In 1998 Congress Considered, But Did Not Approve, Three Bills Related to Managed Care That Would Have Required An External Appeals Process

The 1998 Session of Congress considered several managed care proposals. With respect to an external appeals mechanism for managed care plans, there were three major proposals. All three of these proposals would have implemented some type of external appeals approach nationwide. This section briefly discusses each of these proposals, as the 1999 session of Congress is likely to consider similar legislation.

One proposal was S. 2330, sponsored by the Senate Majority Leader Trent Lott; this bill was entitled the "Patient's Bill of Rights Act." Another proposal is sometimes informally referred to as the House leadership bill and was sponsored by former Speaker of the House Newt Gingrich. This bill (H.R. 4250) was approved by the full House of Representatives and failed in the Senate (the bill went from drafting immediately to the House floor and was not debated in a standing committee). H.R. 4250 was entitled the "Patient Protection Act of 1998." The third managed care bill considered by Congress in 1998 was the Patients' Bill of Rights Act of 1998 (H.R. 3605/S. 1890) sponsored by Congressman Dingell and Senator Daschle. H.R. 3605 was defeated on the House floor in the same series of votes that lead to the passage of H.R. 4250.

Senator Lott's Patients' Bill of Rights Act

This legislation would have applied to all group health plans and all health insurance issuers, except federal, state, and local government employee plans. The bill would have required plans to have an external review process for adverse determinations under certain circumstances:

- The enrollee must have exhausted the plan's internal appeals;

- The service or item must, when medically necessary and appropriate, be a covered benefit;

- Coverage must have been denied because the service was either: (a) deemed not to be medically necessary by the health plan and the amount involved exceeds $1,000; or (b) the treatment would involve experimental treatment in a case where "there is significant risk of placing the life or health of the enrollee in jeopardy." The decision of the external reviewer would be binding on the plan but not the beneficiary.

The Congressional Budget Office (CBO) did not release a formal cost estimate for this legislation. However, CBO has prepared cost estimates for the other two bills and has specifically costed out the impact of the external appeals provisions in one of the bills. These will be discussed individually below.

Former Speaker of the House Gingrich's Patient Protection Act of 1998 (H.R. 4250)

Former Speaker Gingrich's legislation, H.R. 4250, applied its external review provisions only to self-insured plans exempted from state regulation by the Employee Retirement and Income Security Act (ERISA). This legislation would have required ERISA plans to have an external review process for adverse determinations that: (a) are based on a treatment being experimental, or (b) involve determinations on the part of the plan of medical necessity or medical appropriateness. H.R. 4250 would have allowed health plans to require that enrollees exhaust internal appeals before pursuing an external review. The plan may also have required an enrollee filing fee of between $25 and $100 for pursuing an appeal. The decision of the external reviewer would not have been binding on either party. However, according to the Congressional Budget Office "the plan would not be obligated to accept the recommendations of the independent expert, but if the patient successfully challenges the plan's final decision in federal court, the plan could be assessed civil penalties of up to $500 per day or $250,000 in total. Plans would also have been required to pay reasonable fees to plaintiff's attorneys when they represent a successful claimant in a judicial decision." H.R. 4250 also contained a provision for alternative dispute resolution if both parties agree to this approach in lieu of an external appeals process.

Congressional Budget Office Cost Estimate Examines the Total Cost of Patient Protections in H.R. 4250

The Congressional Budget Office estimated the total cost of all of the patient protection provisions in H.R. 4250. In addition to the external review process described in the previous paragraph, H.R. 4250 also included:

- more explicit timeframes and procedures for reviewing internal appeals,
- adopting a "prudent layperson" standard for determining the medical necessity of emergency room visits for purpose of payment by plans,
- allowing enrollees to select pediatricians as primary care providers for children under 18,
- prohibiting health plans from interfering in communication between patients and physicians, and
- allowing direct access to obstetrical and gynecological care for routine covered services.

H.R. 4250 also required health plans to provide certain information from time to time on a routine basis and to make other information readily available. CBO estimated the combined impact of all of these patient protections at between .2 and .4 percent on existing health insurance premiums. For a $500 per month policy, this would have meant an increase of between $1 and $2. It is emphasized that the external review provisions of H.R. 4250 represent only part of this projected increase.

Dingell/Daschle Patient's Bill of Rights Act of 1998 (H.R. 3605/S. 1890)

Congressman Dingell and Senator Daschle's legislation, the Patients' Bill of Rights Act of 1998 (H.R. 3605/S. 1890) would have applied to all employer-sponsored health plans, the individual market, and all self-insured employer plans. The bill did not apply to federal, state, or local government plans. This bill would have required all health plans to establish a two-tiered system for reviewing appeals of denials of services or payment. Enrollees would have been required to first exhaust internal appeals. Having exhausted internal appeals, enrollees would then have been permitted to appeal the plan's decision to an external

review board in certain circumstances. These included if the dollar amount exceeds certain thresholds or if the patient's life or health is jeopardized in consequence of the decision.

The Congressional Budget Office estimated that the combined impact of the internal and external review provisions of H.R. 3605/S. 1890 would raise the cost of health insurance premiums by .3 percent. This would have represented an increase of $1.50 per month on a $500 per month policy. CBO did not break out the costs of an internal and external appeals mechanism separately, because CBO deemed the two provisions to be closely interrelated.

Virginia Already Has Addressed Most Major Provisions of the Proposed Federal Legislation

The *Code of Virginia* already contains provisions that address most of the major provisions of the federal managed care legislation proposed in 1998. Table 2 compares the provisions of the federal legislation with Virginia's current statutory provisions. As Table 2 reflects, Virginia has already adopted legislation mandating a point-of-service option, prohibiting gag clauses in insurance contracts, allowing direct access to obstetrical and gynecological services, requiring health plans to arrange an outside review of final adverse decisions, and adopting a prudent layperson standard for coverage of emergency medical services.

As can be seen from Table 2, the two areas shown where the Virginia General Assembly has not adopted legislation are in the area of an ombudsman for health insurance issues and in mandating that health plans allow children under 18 to use pediatricians as primary care providers (rather than having pediatricians treated as specialists within the provider network). The issue of an ombudsman for health insurance issues is discussed in the next chapter. As for allowing access to pediatricians, staff at the Bureau of Insurance indicate that this has not proven to be a problem in the past in Virginia. Moreover, nearly all plans already allow children under 18 to use a pediatrician as a primary care provider.

Virginia's Utilization Review Statute Differs Somewhat From The Federal Proposals

Virginia's current utilization review statute requirements for external review differ somewhat from the legislation currently being considered in Congress. Virginia's requirements do not apply to employer

self-funded plans (the Employee Retirement Income Security Act prevents states from regulating such plans; this is often referred to as the ERISA preemption.) In addition, Virginia's utilization review statute gives health plans significant latitude in choosing independent reviewers, provided that the reviewer meets the conditions in the statute (not being an employee or director of the health plan, not being involved in the original decision).

In contrast, the federal legislation being considered would set parameters on the organizations or individuals who could be employed to conduct independent reviews. It is noted that former Congressman Gingrich's bill would have regulated only ERISA plans; these plans are not currently regulated by the state due to the ERISA preemption. The Gingrich bill directed the Secretary of Health and Human Services to establish parameters for external review organizations.

Senator Lott's bill would have required that one of the following entities serve as the external review entity:

- an external review entity licensed or credentialed by a state,
- a state agency established for the purpose of conducting independent external reviews,
- any entity under contract with the federal government to provide external review services,
- any entity accredited as an external review entity by an accrediting body recognized by the Secretary of Health and Human Services for such purpose,
- any fully accredited teaching hospital,
- any other entity meeting criteria established by the Secretary.

Similarly, Congressman Dingell and Senator Daschle's bills would have required that an external appeals entity be designated by the state for health insurance issuers or by the federal government for group health plans.

Table 2

Selected Provisions of Federal Managed Care Legislation

Provision	Current Virginia Law	Gingrich Bill (H.R. 4250)	Daschle/ Dingell Bill (H.R. 3605/S. 1890)	Lott Bill S. 2330
Mandatory Point of Service Provision?	Yes §38.2-3407.12	Yes	Yes	Yes
Ombudsman for health insurance?	No	No	Yes	No
Anti-Gag Clause Provision?	Yes § 38.2-3407.10	Yes	Yes	Yes
Direct access to OB/GYN services?	Yes § 38.2-4300	Yes	Yes	Yes
Mandate use of pediatricians as primary care providers?	No*	Yes	Yes	Yes
External Review of Appeals?	Yes** §32.1-137.15	Yes	Yes	Yes
Adoption of Prudent Layperson Standard for Emergency Room Care?	Yes § 38.2-4300	Yes	Yes	Yes

* Nearly all plans allow children under 18 to use a pediatrician as a primary care provider.
**Does not apply to self-insured plans; reviewer selected by health plan.

Source: JCHC Staff analysis.

Costs of Additional External Appeals Measures are Uncertain, But Direct Benefits Would Be Limited to a Small Number of Consumers

The direct benefits of an external appeals system, even if it is very broadly structured on the Medicare model, will likely be limited to a small percentage of health plan enrollees in the Commonwealth (those who successfully appeal an adverse decision). For example, while Florida has among the broadest external appeals systems crafted in any state, in any given year only about 100 external appeals are filed, representing a very small portion of the total enrollees in the state. Of those appeals deemed eligible for consideration, slightly over half are decided in favor of the enrollee. Even under the Medicare managed care appeals system, which includes mandatory external reviews of final adverse decisions rendered by Medicare managed care organizations, only one to two per 1,000 enrollees use the external appeals system annually.

While the number of enrollees directly benefiting from an external appeals system is small, there are potential intangible benefits. These include the security of knowing that an appeal to an independent entity is possible. However, given that Virginia has instituted external appeals procedures in its utilization review statute, the question is to what extent additional external appeals provisions (such as requiring appeals to be conducted by entities selected by a state agency or to be conducted by a centralized review organization) would confer additional benefits. This is difficult to quantify, as the most significant benefit that can be identified is increased confidence in the independent nature of the appeal, as the review entity would no longer be selected by the health plan.

In terms of costs, there are several potential ways in which an external appeals system (beyond Virginia's existing system) can potentially add to the cost of health insurance. First, health plans would incur certain administrative costs of complying with a mandate to participate in a more centralized external appeals system. Second, health plans' internal appeals processes may become more likely to reverse initial adverse determinations, feeling that such determinations may be reversed by the external appeals entity in any event (depending on one's perspective, this could also be viewed as a potential benefit). Third, the external appeals entity would, in some cases, presumably require a health plan to pay for care or services that the plan would not have paid for under the present system (again, depending on perspective, this can be viewed as either a cost or a benefit).

State-level actuarial work would be required to identify a precise figure of the impact of an external appeals system on health care costs. However, CBO analysis of federal proposals suggest that the cost impact of an external appeals system on a state without such a system would be less than .3 percent of health premium costs. As Virginia's system has many if not most of the attributes of the appeals systems described in the federal proposals, it is possible that Virginia's costs could be somewhat less than the figures cited in the CBO analysis. However, it is reemphasized that Virginia-specific actuarial analysis would be required to fully determine this.

Policy Options for Independent External Appeals

Option I: Take No Action

Option II: Introduce legislation requiring that any independent reviewer or review organization selected by a health plan must be approved by the Commissioner of Health (the Commissioner would maintain a list of approved reviewers).

Option III: Introduce legislation directing the Commissioner of Health to contract with an independent review organization to perform independent external reviews.

Note: For options II and III a funding source would need to be considered and a delayed effective date should be considered to allow for the implementation of SB 712.

III.
An Ombudsman Approach for Health Insurance

There Are Several Models of How an Ombudsman Might Function

The common language definition of ombudsman is "one that investigates reported complaints (as from consumers), reports findings, and helps achieve equitable settlements." This definition is a fairly accurate description of the role of the ombudsman envisioned by various proposals at the federal, state, and local level for an ombudsman program for health insurance. Private industry in some cases establishes an ombudsman function within an organization to ensure that its practices comply with the organization's values and its practitioners' professional ethics. A notable example is the newspaper industry, where ombudsmen are often employed, reporting to the publisher, to investigate reader concerns about the newspaper's journalism practices and ethical conduct. Another example that is more closely related to health care is the hospital industry, where in-house patient representatives are available to respond to and investigate patient complaints.

In the public sector, perhaps the closest nationwide model of an ombudsman program is the Long-Term Care ombudsman program established by the Older Americans Act. In terms of an ombudsman for health insurance issues, Florida is the largest Southern state that has attempted implementation of an ombudsman approach for health insurance issues. In addition, in Virginia the Arlington County Area Agency on Aging has implemented a pilot ombudsman program for health insurance issues to primarily serve the needs of seniors.

The Long-Term Care Ombudsman Program Is One Potential Model

The long-term care ombudsman program began with five demonstration projects in 1972 and was expanded nationally through amendments to the Older Americans Act in 1975 and 1978. The 1981 amendments to the Older Americans Act extended the program to include board and care facilities in addition to nursing homes. The long-term care ombudsman program is a non-regulatory approach that does not even rise to the level of binding arbitration. Rather, an ombudsman acts as an honest broker between the consumer and the provider. Neither the provider nor the consumer is required to utilize an ombudsman program's services, which are aimed at resolving disputes amicably (Diz, 1995).

Virginia is the only state at present where the long-term care ombudsman program is housed outside of state government. In Virginia, the Office of the State Ombudsman is located organizationally within the Virginia Association of Area Agencies on Aging (V4A). Ombudsman services are delivered by the state office for localities that do not have a local ombudsman. Local ombudsmen currently cover about 60 percent of the state's localities and are part of the staff of Area Agencies on Aging (AAAs).

While the long-term care ombudsman program is a potential model for a health insurance ombudsman program, it is important to acknowledge the distinction between the positions of long-term care consumers and consumers of health insurance. In long-term care, the government is the majority payor, the person receiving services is often either physically or mentally incapacitated (or both), and the threat of litigation is a powerful inducement to the provider to resolve disputes informally. All of these conditions are somewhat different with respect to health insurance issues.

The Florida Health Insurance Ombudsman Program Is Another Potential Model, But This Program Is Just Being Implemented

In 1996, the Florida legislature enacted legislation that requires the Florida Agency for Health Care Administration to establish District Managed Care Ombudsman Committees statewide. According to the Florida Agency for Health Care Administration, the purpose of these committees will be to "advocate for consumers enrolled in [HMO's], Medicaid prepaid health plans and Medicaid primary care case management programs [and to] encourage public input in the development of managed care policy." District committees will each consist of between nine to 16 members, including physicians, other health care providers, consumers, and attorneys. The precise function of these district committees, as well as lessons learned from their operation, are uncertain as they are only now being established.

The Arlington Area Agency on Aging Has Received a Grant to Offer Ombudsman Services to Medicare Recipients

In 1997, Arlington County received a grant of $76,800 from the Arlington Health Foundation to initiate a managed care education and ombudsman program. The program builds on the aging network's existing insurance counseling program (the VICAP program). The program is staffed by one full-time ombudsman, and it provides a variety

of educational and dispute resolution services to all Northern Virginia Medicare beneficiaries. The program will also provide certain specialized educational services for Arlington County residents. These include:

- teaching about the advantages and disadvantages of managed care plans,
- instruction about the rights and responsibilities of enrollees in a managed care plan, and
- individual counseling sessions.

The Arlington project commenced operation in March 1998. During its first nine months, the program's activities included:

- conducting 24 workshops with an attendance of approximately 320 persons;
- responding to approximately 200 individual requests for information about managed care;
- addressing 32 grievance cases (which raised a total of 76 issues);
- working with managed care organizations serving Medicare beneficiaries in the Northern Virginia Area.

In evaluating the results of this pilot project, two caveats are necessary. First, the program is in its first year of operation, therefore it is likely that due to the need to publicize the program and administrative obstacles associated with startup, the program's number of clients served in its first year will be lower than in future years. Second, the Northern Virginia insurance market for Medicare beneficiaries has been unusually fluid during the past year. Three of the area's four Medicare managed care organization contracts were not renewed (at the request of the health plans), and one new managed care organization entered the Northern Virginia Medicare managed care market. This market flux has two potential effects. First, it complicates the ability of the Arlington program to build relationships with managed care organizations (though these efforts are ongoing and appear successful to date). Second, the flux in the Northern Virginia Medicare managed care market creates additional demand for consumer information, which has increased the number of requests for information from the program in recent months (Figure 2).

Figure 3 shows the types of complaints addressed by the Arlington program. As can be seen from Figure 3, the most common complaints were: inappropriate/inadequate care or treatment, inadequate discharge planning, balance billing by providers, delays in obtaining appointments, communication issues, and patient education.

Figure 2
Calls to Medicare Managed Care Ombudsman Program
June-November, 1998

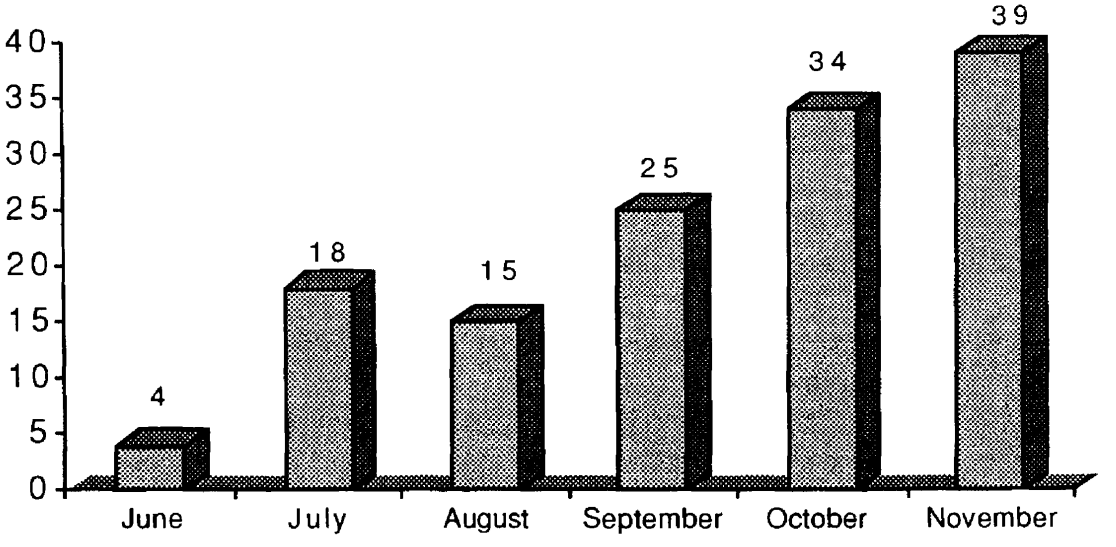
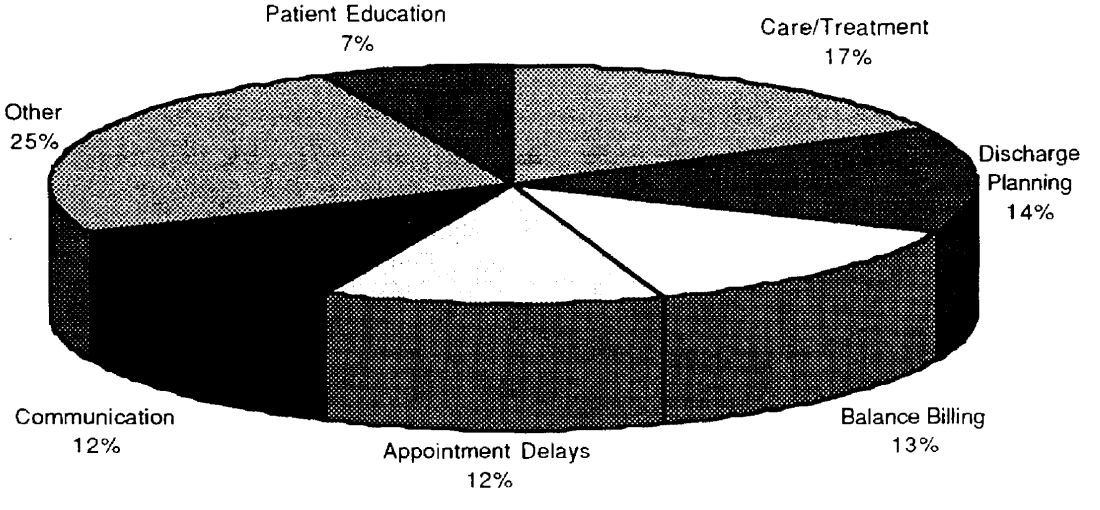


Figure 3
Types of Complaints Received by the Arlington Project



Source: Arlington Area Agency on Aging Medicare Managed Care Ombudsman Program

To date, the Arlington program has been successful in resolving virtually all of the cases that it has pursued. So far, nineteen of twenty cases have been resolved to the satisfaction of the consumer involved (95 percent). The director of the Arlington program indicates that her experience suggests that over time, the percentage of problems resolved will be somewhat lower than the current 95 percent.

Costs and Benefits of an Ombudsman Program Would Depend on How Such a Program Was Structured

In structured interviews with representatives of the health insurance industry, some representatives expressed concern that an ombudsman program is not necessary, as such a program would replicate services already provided by the Bureau of Insurance and the Department of Health. Representatives of the health insurance industry also expressed concern that an ombudsman for health insurance issues may go too far in the direction of acting as a consumer advocate, and that this would limit the utility of such a program in informally resolving disputes (by acting as a neutral broker).

Conceptually, the benefits of a health insurance ombudsman program are enhanced consumer education, improved consumer confidence in the health care system, and more speedy resolution of consumer concerns, ideally at the lowest possible level of review. The dollar value of these benefits, if realized is difficult to quantify. The costs of an ombudsman program, on the other hand, depend on how such a program is structured.

Proposed Federal Legislation Would Have Established Ombudsman Programs

The federal legislation introduced by Senator Daschle and Congressman Dingell (H.R. 3605/S. 1890) would have provided an estimated (by CBO) $60 million to fund grants from the U.S. Department of Health and Human Services to states to establish a health insurance ombudsman. According to CBO, "the ombudsman would be directed to assist consumers in choosing health insurance coverage and to help dissatisfied enrollees with appeals and grievances." If a particular state chose not to provide an ombudsman program, the federal government (through the Secretary of Health and Human Services) would provide an ombudsman program for citizens of that state.

Potential Approaches for an Ombudsman for Health Insurance

H.R. 3605/S. 1890 is the only one of the three major managed care proposals considered by Congress in 1998 that would have provided funding for an ombudsman program. Absent federal funding, if the state chose to pursue its own ombudsman program, the costs of the program would depend on the approach selected for the program. One approach would be to replicate the existing Arlington Area Agency on Aging program in other parts of the state. The costs of this approach would be approximately $75,000 per year per site (each site would be responsible for a region of the state), or $300,000 for four sites. These costs would be for serving Medicare recipients; the cost would be much higher to serve all health insurance enrollees.

A second approach for structuring an ombudsman program would be to require health plans to designate an internal ombudsman within the health plan, reporting to the chief executive officer of the health plan. This "internal ombudsman" would be responsible for acting as a focal point for resolving consumer concerns, providing consumer information, and informal dispute resolutions. The costs of this approach would vary according to plans in terms of the extent to which the plan already provides such services in a centralized way and the salary structure of the health plan.

A third approach for implementing an ombudsman program would be to introduce legislation requiring the Commissioner of Health to establish a managed care ombudsman for health insurance issues within the Center for Quality Health Services and Consumer Protection. This approach would require a companion budget amendment (estimated cost would be developed in conjunction with the Department of Health if this approach is selected). The cost per position would likely be in the $40,000 to $45,000 range.

Policy Options for a Health Insurance Ombudsman

Option I: Take No Action

Option II: Introduce legislation requiring health plans to designate an internal ombudsman.

Option III: Introduce a budget amendment to fund replication of the Arlington AAA project at three additional sites throughout

the state (cost would be $75,000 per site for Medicare recipients; considerably higher if targeted at all consumers)

Option IV: Introduce a budget amendment directing VDH to establish an in-house ombudsman program (cost would be $40,000-$45,000 per position funded).

APPENDIX A

SENATE JOINT RESOLUTION NO. 99

Directing the Joint Commission on Health Care to study the need for an ombudsman program and an external appeals mechanism for insurance issues.

Agreed to by the Senate, February 13, 1998
Agreed to by the House of Delegates, March 12, 1998

WHEREAS, the Virginia Department of Health (VDH) conducted a 1997 study, pursuant to House Bill No. 2785, of the Role of the Commonwealth in Monitoring and Improving the Quality of Care in Managed Care Plans; and

WHEREAS, the VDH study made a number of recommendations for improving oversight of managed care plans; and

WHEREAS, the VDH study did not recommend pursuing either an ombudsman program or an external appeals mechanism; and

WHEREAS, the long-term care ombudsman program has been a successful model for mediating disputes; and

WHEREAS, certain other states have implemented an external appeals mechanism; and

WHEREAS, a consensus does not yet exist regarding the appropriateness of an external appeals mechanism or an ombudsman program for insurance issues; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That the Joint Commission on Health Care be directed to study (i) the costs and benefits of an ombudsman program for health insurance issues and (ii) the costs and benefits of requiring an external appeals mechanism for managed care health insurance plans.

All agencies of the Commonwealth shall provide assistance to the Joint Commission for this study, upon request. The Joint Commission shall complete its work in time to submit its findings and recommendations to the Governor and the 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS: STUDY ON EXTERNAL APPEALS AND OMBUDSMAN FOR HEALTH INSURANCE (SJR 99)

Individuals/Organizations Submitting Comments

A total of seven individuals and organizations submitted comments on the draft issue brief regarding options for external appeals and an ombudsman for health insurance issues:

- American Association of Retired Persons (AARP)
- Culpepper Garden Retirement Community (Culpepper Garden)
- Northern Virginia Aging Network (NVAN)
- Trigon
- Virginia Association of Area Agencies on Aging (V4A)
- Virginia Association of Health Plans (VAHP)
- Virginia Hospital and Health Care Association (VHHA)

Policy Options Included in the Issue Brief

Options for External Appeals

Option I: Take No Action

Option II: Introduce legislation requiring that any independent reviewer or review organization selected by a health plan must be approved by the Commissioner of Health.

Option III: Introduce legislation directing the Commissioner of Health to contract with an independent review organization to perform external reviews.

Note: Staff recommended considering a delayed effective date if Option II or III was selected to allow for the full implementation of SB 712.

Options for Ombudsman for Health Insurance

Option I: Take no action.

Option II: Introduce legislation requiring health plans to designate an internal ombudsman.

Option III: Introduce a budget amendment to fund replication of the Arlington AAA project at three additional sites throughout the state.

Option IV: Introduce a budget amendment directing VDH to establish an in-house ombudsman program.

Overall Summary of Comments

Only one commenter expressed interest in any option other than Option I with regard to external appeals (AARP supported Option III). Regarding an ombudsman approach, VHHA and Trigon supported Option I, AARP supported Option IV, and three commenters (NVAN, V4A, and Culpepper Garden) supported Option III.

Summary of Individual Comments

American Association of Retired Persons (AARP)

Norma L. McDonough, William L. Lukhard, Jack R. Hundley, and Mary H. Madge wrote on behalf of AARP. Their comments supported Option III with regard to external appeals and argued against a delayed effective date, stating that "AARP understands that complaints by beneficiaries to the Department of Health under SB

712 will not be resolved on an individual basis." With regard to an ombudsman approach for health insurance issues, AARP stated "with the complexity of managed care systems, consumers need the assistance of an ombudsman service to help them understand their rights and responsibilities, and when necessary guide them through the grievance and complaints procedure. This service is particularly important for severely ill or disabled citizens. Therefore, AARP supports Option IV to provide statewide service."

Culpepper Garden Retirement Community (Culpepper Garden)

William P. Harris, executive director of Culpepper Garden, commented that "The Arlington/Northern Virginia Medicare Ombudsman program has been a big help to our staff as well as our residents . . . The counsel provided under this program has been invaluable." Mr. Harris added that "I therefore wholeheartedly support Policy Option III."

Northern Virginia Aging Network (NVAN)

Barbara A. Cleaveland commented on behalf of NVAN in support of Option III with regard to an ombudsman for health insurance. Ms. Cleaveland stated that "The Arlington/Northern Virginia program has proven valuable in the six months it has been operational." She added that, in addition to supporting Option III, NVAN supported state funding of the Arlington program to replace grant funds once they expired in March 2000.

Trigon

Leonard L. Hopkins, Jr., Vice President, Public Policy Officer for Trigon commented in support of Option I for both external appeals and an ombudsman approach. Mr. Hopkins stated that Trigon agreed with the Commissioner of Health's 1997 conclusion that "there is no need for an external appeals mechanism at this time." Mr. Hopkins added that "we agree with those who believe that any `additional legislation in the area of managed care would be premature until the current regulatory structure is established.'"

Virginia Association of Area Agencies on Aging (V4A)

Debbie Palmer, President of V4A, commented in support of Option III regarding an ombudsman approach for health insurance issues. Ms. Palmer also commented in support of continuing funding for the Arlington project. Ms. Palmer stated that "older Virginians and their caretakers need an impartial party to represent their interest in resolving problems and/or issues with their managed care coverage."

Virginia Association of Health Plans (VAHP)

Mark C. Pratt, Executive Director of VAHP, stated that "VAHP has not yet adopted formal positions on the policy options contained in the Draft Issue Brief 4." However, Mr. Pratt commented on the existing internal and external review provisions in Virginia law and stated "SB 712 provides VDH with a significant new role in overseeing the quality of managed care plans in the Commonwealth." Mr. Pratt added that "it is worth noting that in its comprehensive study conducted just last year . . . VDH recommended against establishing a new "independent external appeals mechanism" or an "ombudsman."

Virginia Hospital and Health Care Association (VHHA)

Catherine C. Hammond, Vice President of VHHA, commented in support of Option I—Take No Action, stating "initiatives to improve quality protections for consumers must be evaluated in the midst of a rapidly changing health delivery environment. Currently this environment includes two major changes that suggest a cautious approach."

JOINT COMMISSION ON HEALTH CARE

Director

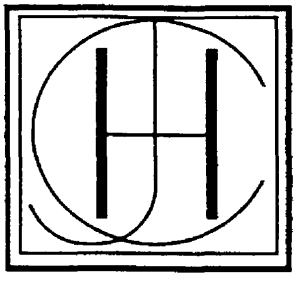
Patrick W. Finnerty

Senior Health Policy Analysts

Joseph J. Hilbert
William L. Murray, Ph.D.

Office Manager

Mamie V. White



Joint Commission on Health Care
Old City Hall, Suite 115
1001 East Broad Street
Richmond, Virginia 23219
(804) 786-5445
(804) 786-5538 (FAX)

E-Mail: jchc@leg.state.va.us

Internet Address:
http://legis.state.va.us/jchc/jchchome.htm