REPORT OF THE

# STATE CORPORATION COMMISSION ON THE ACTIVITIES OF THE OFFICE OF THE MANAGED CARE OMBUDSMAN

TO THE HOUSE COMMITTEE ON COMMERCE & LABOR; THE HOUSE COMMITTEE ON HEALTH, WELFARE AND INSTITUTIONS; THE SENATE COMMITTEE ON EDUCATION & HEALTH; THE SENATE COMMITTEE ON COMMERCE & LABOR AND THE VIRGINIA JOINT COMMISSION ON HEALTH CARE

COMMONWEALTH OF VIRGINIA
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COMMONWEALTH OF VIRGINIA

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To: The House Committee on Commerce & Labor
The House Committee on Health, Welfare and Institutions
The Senate Committee on Education & Health
The Senate Committee on Commerce & Labor
and
The Virginia Joint Commission on Health Care

The report contained herein has been prepared pursuant to § 38.2-5904 of the Code of Virginia.

This report documents the activities of the Office of the Managed Care Ombudsman for the reporting period covering November 1, 2003, through October 31, 2004.

Respectfully Submitted,

Commissioner Theodore V. Morrison, Jr.
Chairman

Commissioner Clinton Miller

Commissioner Mark C. Christie

Report on the activities of the Office of the Managed Care Ombudsman

Executive Summary

This annual report on the activities of the Office of the Managed Care Ombudsman (the "Office") covers the period from November 1, 2003 through October 31, 2004. During this time, the Office assisted approximately 900 consumers enrolled in Managed Care Health Insurance Plans (an "MCHIP"). The Office provided general information, responded to specific questions from consumers and other individuals, and assisted individuals that wanted to appeal an adverse decision their MCHIP issued denying a service or a claim. The Office continued its outreach and educational efforts to help consumers understand the benefits available from their MCHIPs and provided tools to assist consumers in resolving problems. When applicable, consumers were referred to other regulatory agencies for assistance. We conclude that the Office continues to provide a valuable service to consumers enrolled in Managed Care Health Insurance Plans.

The Office of the Managed Care Ombudsman (the "Office"), was established in the State Corporation Commission's Bureau of Insurance (the "Bureau"), on July 1, 1999, in accordance with § 38.2-5904 of the Code of Virginia. This report is submitted pursuant to § 38.2-5904 B 11, which requires the Office to submit an annual report of the activities of the Office to the standing committees of the Virginia General Assembly having jurisdiction over insurance and health, and also to the Joint Commission on Health Care. This is the sixth annual report and covers the period from November 1, 2003 through October 31, 2004.

As reported in previous years, the Office has emphasized two key functions that directly assist consumers: (i) providing information in response to inquiries from consumers, and (ii) formally assisting consumers in appealing adverse decisions rendered by their Managed Care Health Insurance Plans ("MCHIP"). An Inquiry is classified as a question or a general request for information or assistance that can be answered directly by the staff. Inquiries are processed informally and include telephone calls, e-mails, and correspondence. During this reporting period, the Office responded to 695 consumer inquiries, which represents a 10% decrease from the previous reporting period.

Staff can formally assist consumers that want to appeal an adverse decision, and ensure consumers have full access to all of the internal appeals offered by their MCHIPs. When the staff assists an individual with an appeal, a staff member will contact the MCHIP, obtain information regarding the circumstances or disputed facts involved in the appeal, and ensure that essential information is clarified and explained to the appellant. The staff can also advise consumers how to maximize the effectiveness of their particular appeal. Common types of appeals involve denials for prescription medication, hospitalization issues, medical and surgical procedures and tests, and claims payment. During the reporting period, the Office assisted 208 consumers in filing an appeal, approximately the same number as reported during the last reporting period, but somewhat lower than previous years. This decline is likely attributable to the relatively recent elimination by some MCHIPs of a second opportunity to appeal an adverse decision following the denial of the first appeal.

The legislation that established the Office requires it to have a consumer's written authorization in order for the Office to provide assistance. Consequently, the Office has developed and refined an inquiry form which is provided to each consumer that directly or indirectly requests assistance in filing an appeal. The form documents the individual's consent for the Office to assist him or her in the appeal process, and also contains an authorization for access to the individual's medical records. When the staff initiates contact with the individual's MCHIP, the MCHIP receives a copy of the individual's inquiry form. Obtaining documentation of the person's consent, especially as it pertains to the release of medical records, has taken on increased importance due to federal legislation enacted under the Health Insurance Portability and Accountability Act (the "HIPPA").

When an MCHIP renders a favorable decision on an appeal, the Office closes the file. If an appeal is denied, the Office provides assistance in submitting another appeal, if that

option is available. The staff ensures that the individual understands the reason the appeal was not favorably considered. When an MCHIP renders a final adverse decision, resulting in the individual completing the internal appeal process, the staff provides information on any applicable alternative means to resolve the issue. This includes possible referrals to the External Appeal program conducted by the Bureau, a referral to another section in the Bureau, or to another regulatory agency. Due to the nature of some appeals, once some consumers complete the internal appeal process, there are no further regulatory alternatives or options available.

As mentioned in last year's annual report, the inquiry form was redesigned in an attempt to make it more consumer-oriented. While the return rate of the new form has not increased from that of the previous form, staff nevertheless believes that the new form is a significant improvement over the form previously used.

Having recognized that many consumers encounter difficulties understanding and properly utilizing the available benefits available from their MCHIP, the Office has continued to aggressively educate consumers in an attempt to ensure each person fully understands his or her benefits and how to access those benefits effectively. Regrettably, numerous consumer appeals are not successful because of an individual's failure to follow the procedures established by his or her MCHIP prior to obtaining medical treatment. The Office continually stresses the importance of following the procedures outlined in an individual's Evidence of Coverage (EOC) in order to obtain the coverage and benefits available under the terms of the health benefit plan. In a similar manner, the Office assists consumers in understanding information contained in the EOC and other documents provided by an MCHIP, relating to coverage limitations or exclusions for certain services. The primary objective in the Office's educational efforts is the prevention of problems resulting from a lack of understanding of the plans, benefits, procedures and limitations of health care plans. To assist the staff in this role, the Office maintains sample file copies of EOCs issued by MCHIPs to Virginia consumers, and consults these documents when assisting consumers with inquiries and appeals.

As part of the extensive outreach program conducted by the Bureau, the Office had several opportunities to present educational programs and provide printed material to consumers this year. Consumer tip sheets and brochures were distributed at the booth staffed by the Bureau at the Virginia State Fair, and staff made presentations to a civic organization, specialty hospital, and to the Virginia Pharmacists Association at its annual meeting. Staff also made a presentation at a meeting for families enrolled in the Virginia Birth-Related Neurological Injury Compensation Program (BIF), and will make additional presentations at future meetings. The Office also assisted consumers affiliated with support groups for individuals suffering from lyme disease and obesity. Information the Office provided to these two support groups was circulated to other members. Staff also addressed the Joint Commission on Health Care during its meeting in September, and provided an update on the activities of the Office. The Richmond Times-Dispatch mentioned the Office in an article about common problems consumers encounter with their health insurer.

As noted in previous reports, the Office analyzes the types of problems consumers encounter that commonly evolve into appeals. During this reporting period, the staff noted an increase in appeals in which it was contended that MCHIPs did not have sufficient provider networks in place to deliver adequately the medically necessary care these appellants required. Consequently, the staff developed and published a new consumer tip sheet designed to assist individuals appealing their MCHIP's decision not to authorize care from a nonparticipating provider. The staff also published a consumer tip sheet designed to assist consumers filing an appeal for denied services or claims deemed experimental or investigative in nature by their MCHIP. As with the other tip sheets, these new tip sheets provide specific information to assist an individual in constructing an effective appeal. The Office also published some elementary *Frequently Asked Questions* on the Office's Internet page, in an effort to facilitate consumer access to basic information.

There were 5,284 visits to the Office's page on the Bureau's Internet web site during this reporting period, as compared to 8,379 visits during the previous reporting period. The reason for the decrease in visits to the web site is unknown, but continued feedback from consumers indicates that the information posted on the web site is very helpful. The volume of e-mail received from consumers during non-business hours substantiates that consumers benefit from from the accessibility of the dedicated Office e-mail account as well as the information readily available on line.

During this reporting period, the Office reviewed the complaint system filings for 24 MCHIPs. These filings describe the method used by the MCHIP to administer its complaint, grievance, and appeal systems, and are required by statute to be approved by the Commission. Since the filings must also be approved by the Virginia Department of Health's Center for Quality Health Care Services and Consumer Protection (the "Center"), the Office worked closely with the Center to identify and resolve any problems of mutual concern regarding a filing. Some of the filings were generated by MCHIPs wanting to initiate business in Virginia, and, in some instances, staff initiated a review in the course of assisting a consumer when it appeared that the MCHIP was not processing an appeal in accordance with its approved filing. Specific sections of some MCHIPs' complaint systems were reviewed, when staff determined that correspondence from the MCHIP to enrollees in the appeal process did not conform to sample correspondence in an approved filing. The staff is familiar with the appeal process used by each MCHIP that conducts business in Virginia and applies this knowledge to assist consumers through the appeal process.

The Office also collaborated with the Center in reviewing the annual complaint report that each MCHIP is required by statute to provide to each office. The report reflects the number of complaints the MCHIP received during the calendar year from consumers and other sources, such as the Bureau's Life and Health Consumer Services Section. As in previous years, the collective reports indicate that the ratio of persons covered by MCHIPs who file complaints is very low compared to the total number of persons covered by MCHIPs. While this outcome is consistent with previous years, it does not

reduce the severity of serious problems that a very limited number of enrollees have experienced with their specific MCHIP.

The Center regulates the quality of care provided by an MCHIP, and the Office referred consumers to the Center for assistance in the course of responding to inquiries and formally helping consumers with appeals when it appeared that quality of care issues were involved. Conversely, the Center referred Consumers to the Office for assistance in filing appeals for denied claims and services. The Office maintains an excellent working relationship with the Center, and periodic meetings ensure that the respective staffs collectively work together to assist consumers.

As the Office assisted consumers with appeals, the staff ensured that each consumer had full access to the internal appeals offered by their particular MCHIP. On occasions, this resulted in the staff reviewing consumer material provided by the MCHIP, such as the EOC and other plan documents. In instances where conflicting information appeared in these documents, staff referred the matter to the Bureau's Life and Health Forms and Rates Section.

In last year's annual report, the Office noted concerns regarding some MCHIPs decisions to offer only one internal appeal instead of two levels of appeal, in order to comply with requirements imposed by the U.S. Department of Labor (the "DOL"). In an effort to ensure that managed care plans did not delay processing consumers' appeals, the DOL issued regulations which affected the appeal procedures used by some MCHIPs in Virginia. By offering only one level of appeal instead of two levels, an MCHIP could ensure that it complied with the regulation. In many instances, however, eliminating the opportunity for a second appeal adversely affected a covered person because of his or her lack of familiarity with the process and the mechanics of making an effective appeal. For this reason, the Office seeks to assist consumers actively in the early process of their appeal.

As was noted in last year's report, Congress considered legislation that would establish Association Health Plans (the "AHPs"), which would enable unrelated small businesses to collectively purchase health insurance for their employees. As envisioned, an AHP could include businesses in multiple states. Because AHPs would not be licensed or regulated by state insurance departments, consumers enrolled in these plans would not be able to seek assistance from state insurance departments in the event a problem arose. This legislation was not enacted, however interest remains high, and the Office will monitor events this year to see if AHPs are reintroduced.