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
RICHMOND
2005

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December 1, 2005

To: The House Committee on Commerce and Labor
The House Committee on Health, Welfare and Institutions
The Senate Committee on Education and Health
The Senate Committee on Commerce and 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, 2004, through October 31, 2005.

Respectfully Submitted,

Commissioner Clinton Miller
Chairman

Commissioner Mark C. Christie

Commissioner Theodore V. Morrison, Jr

Report of 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, 2004 through October 31, 2005. During this time, the Office informally and formally assisted over 800 consumers with general issues or specific problems regarding a managed care health insurance plan (an "MCHIP"). The Office continued conducting outreach and educational programs to help consumers understand the benefits available from their MCHIP and provided tools as well as direct assistance to consumers in resolving problems they encountered. When applicable, consumers were referred to another regulatory agency for assistance. We believe that the Office continues to provide a valuable service to consumers whose health insurance is provided by an MCHIP, and that the Office functions in accordance with the legislation that created the Office in 1999.

The Office of the Managed Care Ombudsman was established in the State Corporation Commission's Bureau of Insurance 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 seventh annual report of the Office and covers the period from November 1, 2004 through October 31, 2005.

As reported in previous years, the Office of the Managed Care Ombudsman is a resource for consumers whose health insurance is provided by a managed care health insurance plan (an "MCHIP"), which is defined as a managed care plan and includes all health maintenance organizations ("HMOs)," preferred provider organizations ("PPOs") and essentially any form of managed care provided by a health insurance company licensed by the Bureau to transact business in Virginia. Commensurate with the regulatory role of the Bureau, however, the Office does not have the statutory authority to assist consumers unless their coverage is fully insured and issued in Virginia. As a result, the Office is unable to assist individuals whose health insurance is provided by any of the following:

- Federal government (including Medicare);
- State government (including Medicaid recipients);
- Self-insured plans established by employers to provide coverage to their employees; and
- Managed care plans for which the contract under which health care services are provided is issued or issued for delivery outside of the Commonwealth.

When individuals insured by any of the above plans contact the Office, the staff refers the consumer to the appropriate federal or state regulatory agency for assistance.

The Office of the Managed Care Ombudsman provides informal and formal assistance to consumers that encounter a problem with their MCHIP, and also responds to general questions. The Office provides general information and assistance to consumers who submit an inquiry, which typically concerns an issue or problem related to their health insurance or managed care. Inquiries are commonly received via correspondence, telephone calls, or e-mail. When responding to inquiries, the staff utilizes the opportunity to educate consumers on

how their particular MCHIP operates and the benefits available under the terms of their health insurance. During this reporting period, the Office responded to 661 inquiries, which is slightly less than the 695 inquiries the Office received during the previous reporting period.

The staff formally assists consumers who want to appeal an adverse decision made by their MCHIP. Once the consumer provides his/her consent, which is documented on an inquiry form, the staff contacts the individual's MCHIP and ensures that the individual has full access to all of the internal appeals provided by that particular MCHIP. Designated staff at each MCHIP will in turn provide information on the circumstances surrounding the appeal, and Office of the Managed Care Ombudsman staff will coordinate with the MCHIP contact person to resolve any factual issues or questions regarding an appeal. This process frequently results in clarifying for the consumer the reason the MCHIP has issued a denial, and staff works to help the consumer formulate an effective appeal strategy. The Office also provides guidance to consumers on information to include in their appeals, and has created tip sheets on several types of denials that are commonly appealed. This specific information helps consumers focus on critical points to include in their appeals. Common types of appeals involve denials for prescription medication, hospitalization disputes, medical and surgical procedures, diagnostic tests and claims payment problems. During this reporting period, 172 consumers were assisted by Office staff in filing appeals, which is a slight decrease from the 208 consumers the Office formally assisted during the last reporting period.

When an MCHIP reverses its denial and renders a decision in the appellant's favor, the consumer's file is closed. If an MCHIP issues an adverse decision or upholds its denial, and there are further appeal opportunities, such as another level of internal appeal, the Office of the Managed Care Ombudsman will assist the consumer with the next appeal. If the appeal involves a utilization review issue (the requested service or claim payment was denied because the MCHIP determined it was not medically necessary), Office staff will assist the consumer until the internal appeal process is completed. If a final adverse decision is rendered, staff will refer the individual to the External Appeals Manager, who is also on the staff of the Bureau of Insurance. If the External Appeals Manager accepts the appeal as eligible for an external appeal, she directs an independent medical panel to review an adverse utilization review decision of an MCHIP.

In instances where a consumer's appeal is not successful, Office staff helps the individual understand why he or she lost the appeal. In those situations when a final adverse decision appears to be inconsistent with applicable insurance statutes, the Office will refer the matter to the appropriate section within the

Bureau for possible review and investigation. Finally, there are some consumers whom Office staff refers to the Virginia Department of Health, which has the statutory responsibility to regulate the quality of care provided by an MCHIP to its enrollees.

During this reporting period, there was a notable instance when the Office questioned the validity of an MCHIP's final adverse decision and referred the matter for further review. The appeal concerned a woman's request for reconstructive breast surgery following a mastectomy, which was denied by her MCHIP. Staff was concerned that the denial violated a statutory requirement regarding mandatory coverage in such cases and consequently referred the matter to another section of the Bureau for review. Bureau staff concluded that the denial of the request for reconstructive breast surgery following a mastectomy did violate the statute and addressed the matter with the MCHIP. The MCHIP then rescinded its denial and approved coverage for the case in question. Further, the MCHIP went on to review a similar denial that it had issued in another case, and proceeded to overturn its decision in that second case.

Previous reports of the Office of the Managed Care Ombudsman have mentioned difficulties frequently encountered by consumers because they did not fully understand how to utilize the benefits available under the terms of their health insurance. This trend has continued over the past year, and Office staff has continued to emphasize the importance of understanding the principles of health insurance. In conjunction with providing informal and formal assistance to consumers, staff continually works to educate consumers on the mechanics of health insurance. The goal of staff is to not only assist consumers with immediate problems, but also to help them avoid future problems through an increased level of knowledge about their health insurance coverage generally.

Over the course of this year, staff of the Office of the Managed Care Ombudsman continued to enhance the information that provided to consumers in an effort to make the information more understandable and easier to access. For example, the telephone automated voice menu was simplified to facilitate consumers contacting staff members. Further, information on the web pages for the Office of the Managed Care Ombudsman was redesigned this year. During the current reporting period, there were 5,112 visits to the Office's web page as compared to 5,284 visits during the previous reporting period. Office staff also issued updated tip sheets and brochures for consumers due to a change in our electronic contact information.

As in previous years, staff of the Office of the Managed Care Ombudsman conducted outreach programs to acquaint consumers with the Office and the assistance it offers. Consumer tip sheets and brochures were distributed at the Virginia State Fair, and staff made multiple presentations on the Office and the assistance that staff can provide to special interest groups, such as families that receive benefits from Virginia's Birth-Related Neurological Injury Compensation Fund. The Office also provided information to the Virginia Dental Association and encouraged the organization to refer its member patients to the Office for assistance in appealing denials from their MCHIPs. The Office also conducted an outreach program at the Children's Hospital of the King Daughters, located in Norfolk, in conjunction with the hospital's Cancer Survivor Day. In a cooperative effort with the United States Department of Labor, Office staff participated in a joint seminar hosted by the Bureau of Insurance and the Department of Labor, which featured information for individuals employed in the insurance industry. Virginia's Office of the Managed Care Ombudsman was also featured in an article that appeared in Kiplinger's, a financial magazine with a national circulation.

The Office of the Managed Care Ombudsman has approval authority for each MCHIP's complaint system filing, which, by statute, must be approved by the State Corporation Commission. These filings describe how MCHIPs administer their complaint, grievance, and appeal systems, and staff members use their knowledge of each MCHIP's particular procedures when assisting enrollees in the appeal process. During this reporting period, the Office reviewed a total of 52 complaint system filings. These reviews consisted of new filings, amended filings that had previously been approved, and approved filings that staff chose to re-review because in the course of assisting an enrollee, staff questioned whether or not the MCHIP was complying with its approved procedures. The number of filings reviewed by staff during this reporting period was double the number examined during the previous reporting period.

By statute, each MCHIP is required to submit an annual complaint form to the Office of the Managed Care Ombudsman. The report reflects the number of complaints the MCHIP received during the calendar year from consumers and other sources, such as the Life and Health Consumer Services Section of the Bureau of Insurance. In reviewing these reports, staff noted that generally, the number of enrollees in any particular MCHIP that filed a complaint is very small as compared to the total number of enrollees. This conclusion is consistent with findings from previous years, but does not, however, diminish the severity of serious problems that an extremely small number of enrollees have encountered with their particular MCHIP.

The Office of the Managed Care Ombudsman continued working with the Virginia Department of Health's Center for Quality Health Care Services and Consumer Protection, (the "VDH") which as noted, regulates the quality of care provided by MCHIPs. The VDH referred several consumers to the Office for assistance with an appeal, and staff reciprocated by referring some consumers that appeared to have a potential quality of care complaint against their MCHIP. This collaboration between the two staffs benefited consumers, especially those consumers whose problems involved both an appeal and a quality of care issue.

Last year's report mentioned pending federal legislation that would authorize the creation of Association Health Plans ("AHPs"), which would enable unrelated small businesses to collectively purchase health insurance for their employees, even when these businesses were not all located in the same state. As proposed, AHPs would not be licensed or regulated by state insurance departments, resulting in consumers enrolled in such plans not having access to protections afforded by state insurance laws, and denying these consumers the ability to obtain assistance from a state insurance department. While legislation was not enacted, the concept of AHPs continues to be an issue before Congress. The National Association of Insurance Commissioners, an association which consists of the 50 state insurance commissioners and their staffs, is working with other interested parties to ensure that whatever legislation regarding AHPs is enacted preserves as much state regulatory authority over AHPs as possible, including requiring the AHPs to be licensed in every state. The Office of the Managed Care Ombudsman will continue monitoring federal legislation and analyzing any proposed legislation that is introduced.