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
2008

MARK C. CHRISTIE
COMMISSIONER

JAMES C. DIMITRI
COMMISSIONER

JUDITH WILLIAMS JAGDMANN
COMMISSIONER

COMMONWEALTH OF VIRGINIA

JOEL H. PECK
CLERK OF THE COMMISSION
P.O. BOX 1197
RICHMOND, VIRGINIA 23218-1197

STATE CORPORATION COMMISSION

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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
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, 2007, through October 31, 2008.

Respectfully Submitted,

Commissioner Judith Williams Jagdmann
Chairman

Commissioner Mark C. Christie

Commissioner James C. Dimitri

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, 2007 through October 31, 2008. During this period, the Office informally and formally assisted over 1,100 consumers and other individuals by responding to general issues or specific problems involving a Managed Care Health Insurance Plan (an MCHIP). Typically this represented issues involving managed care or health insurance. The Office staff helped consumers understand how their health insurance works and how to resolve problems. When confronted with problems outside the Office's regulatory purview, the staff referred consumers to other sections within the Bureau of Insurance for assistance, or in some cases to another regulatory agency. The Office continues to provide a valuable service oriented to consumers, and functions in accordance with the legislation that created the Office in 1999.

Background and Introduction

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 its activities 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 tenth annual report of the Office and covers the period from November 1, 2007 through October 31, 2008. Previous reports may be viewed on the Bureau of Insurance's website at:

www.scc.virginia.gov/division/boi/webpages/boiombudmanrepts.htm

The legislation that established the Office authorizes it to assist consumers whose health insurance is provided by a Managed Care Health Insurance Plan (MCHIP), which includes all health maintenance organizations (HMOs), preferred provider organizations (PPOs) and other forms of managed care coverage. In order for the Office to assist a consumer, the coverage must be fully insured and issued in Virginia, and written by a company licensed by the Bureau of Insurance. Within these parameters, the coverage can be a group health insurance policy, coverage issued in the individual market, or individual coverage. As a general rule, if a consumer's health insurance policy is subject to the regulatory jurisdiction of the Bureau, the Office can assist the consumer. The Office is unable to formally help consumers whose coverage 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 when the coverage is issued outside of Virginia

Even though the Office does not have the regulatory authority to assist consumers whose health insurance falls under one of the four categories described above, the staff provides general information and advice, and can refer these consumers to the appropriate federal or state regulatory agency for assistance. As part of its general consumer educational efforts, the Office helps these individuals understand how their health insurance is structured, and explains why their health insurance is not subject to regulatory oversight by the Bureau.

Consumer Assistance

The Office informally assists consumers and other individuals who express concerns or have questions that pertain to some aspect of health insurance, managed care, or related areas. These inquiries cover a range of subjects, and frequently involve the potential benefits that are available under a specific health insurance policy, and how an individual can access those benefits. Inquiries may include problems or issues related to proposed treatment, or result from an individual seeking assistance for a denied claim. The subject and circumstances involved in an inquiry may be relatively simple, or exceptionally complex. In responding, the staff uses each interaction to provide general and specific information and informal assistance, and can frequently suggest an effective method the consumer can use to resolve his or her problem. The Office also provides information to health care providers who ask for assistance on behalf of their patients. When this occurs, the staff will ask the provider to refer a patient directly to the Office if it appears the patient will require assistance in filing an appeal. During this reporting period, the staff noted a significant increase in the number of providers who contacted the Office for assistance, and also a notable increase in the number of consumers whose providers told them about the Office. Inquiries are received via correspondence, telephone calls, and e-mails which the staff is usually able to answer in one response or exchange. When the staff answers an inquiry, a major objective is to educate the consumer, and help him or her develop a better understanding of the matter. If necessary, the staff will refer a consumer to another state agency, federal government, or other source for additional information and help. In some instances, an inquiry relates to an issue that is outside the regulatory purview of any agency. During this reporting period, the Office responded to 951 inquiries, which represents an increase over the 890 inquiries the Office received during the previous reporting period.

The Office also assists consumers that want to formally appeal an adverse decision made by their MCHIP. If an MCHIP refuses to authorize treatment proposed by a consumer's health care provider, the individual can submit a written appeal. A consumer can also appeal a denied claim for services that the person received. Generally, appeals fall into one of two categories: those related to medical necessity and those that concern an administrative issue. Medical necessity appeals involve problems such as prescription medication, surgery, imaging tests (CAT scans, PET scans, and MRIs), inpatient hospital services, and mental health services. Examples of administrative appeals are payments for nonparticipating providers who may balance bill a patient, a request for a service which is not eligible for coverage under the terms of a consumer's health insurance policy, or a request to extend a service such as physical therapy past the benefit cap as stated in a consumer's policy.

As required by the legislation that established the Office, the staff will obtain the written permission of the "covered person" when a consumer asks for help in

filing an appeal. The staff will help the individual navigate the internal appeal process that each MCHIP is required to provide, and ensure the consumer understands the process. There is no mechanism for the Office to appeal on behalf of a consumer, but upon request, the staff can help a consumer prepare an appeal. The staff provides advice on what pertinent information to provide and how to present the information, which may vary depending upon the type of appeal. The staff has developed a consumer tip sheet on how to make an effective appeal, and has also developed several specialty tip sheets oriented toward specific types of denials, such as for prescription drugs, or services an MCHIP denied as experimental in nature. The staff provides the appropriate material to consumers for their use in preparing an appeal.

When the Office assists a consumer with an appeal, the staff will contact the MCHIP in writing, and provide a copy of the appeal and supporting documents. If any of the issues or circumstances regarding an appeal is not clear, the staff will act as a catalyst to ensure the pertinent information is clearly understood by all parties, so that the relevant facts are transparent. For appeals involving questions of medical necessity, this frequently involves drawing attention to clinical information contained in the consumer's medical record. As in prior reporting periods, there were several instances in this period where an MCHIP overturned a denial based upon new information the Office received from a consumer and conveyed to the MCHIP. Without exception, every MCHIP was willing to consider any new or additional information the Office provided.

Although the Office does not have the statutory authority to adjudicate appeals, the staff reviews decisions that MCHIPs render on appeals, and helps consumers understand the MCHIP's rationale. If the review indicates a potential regulatory issue, the Office will ask the MCHIP for additional information and if necessary, refer the matter to another section within the Bureau for further review and appropriate action. When an appeal is resolved in the consumer's favor, the Office will typically not take any further action, but if the appeal is denied, the staff may refer the consumer to another internal section for further review. Such referrals include the External Appeal Program for denied appeals involving utilization review, and the Bureau's Consumer Service Section (CSS) for appeals involving an administrative or contractual issue.

In cases when a consumer is not successful in the appeal process, the Office helps the consumer understand why the MCHIP upheld the denial. If another appeal is available in the internal appeal process, the staff will help the consumer submit his or her second level appeal. The staff wants to ensure that consumers understand the reasoning behind a denial, even if the individual does not agree. If an appeal is denied for an administrative reason, such as an exclusion or limitation in the consumer's evidence of coverage, the Office will explain why the individual lost his or her appeal. In most situations when this occurs, the consumer had not read his evidence of coverage, so he was not aware the

services he requested might not be available, or that services were available but in a limited amount.

Many consumers have not previously appealed a denial issued by their MCHIP, and are intimidated by the process. The Office is an important resource and focuses its attention on the unique needs of each consumer. The staff is cognizant of the difficulties and frustrations that can confront consumers who are engaged in an appeal, especially when an individual is seriously ill or facing financial difficulties. In these situations the staff attempts to ameliorate the stress and anxiety generated when potentially costly health care services intersect with insurance coverage problems. As in previous reporting periods, the Office received positive feedback from consumers the staff assisted with an appeal. During this reporting period, the staff assisted 230 consumers in filing an appeal, which is more than the 175 consumers the Office helped during the preceding reporting period.

Discussion

The majority of the inquiries and most of the appeals involved common types of problems and issues associated with health insurance and managed care. In some instances however, the Office gathered additional information, and in some cases, forwarded the matter to the appropriate section within the Bureau for further review. One example involved an individual whose MCHIP issued a final adverse decision letter that did not comply with regulatory requirements regarding the person's right to access an expedited External Appeal with the Bureau. With input from the Office, the Bureau took action against the MCHIP and as a result, the problem was corrected. In another situation, staff noticed that an MCHIP incorrectly stated eligibility requirements for a child's access to early intervention services in the evidence of coverage. The matter was referred to the Bureau's Forms & Rates section, and the MCHIP made the necessary correction. At one point staff questioned exclusionary language in an MCHIP's evidence of coverage. This language enabled the MCHIP to omit coverage for a condition if the MCHIP wrote a rule to exclude coverage, even after the evidence of coverage had been published and distributed, placing its members at a significant disadvantage because the MCHIP could essentially unilaterally rewrite the terms of the coverage. The Office also referred this matter to the Bureau's Forms & Rates section, and as a result, the MCHIP was required to modify the evidence of coverage.

The Office assisted a consumer with an appeal which involved serious medical conditions with a concomitant cost that resulted in a severe claim. Staff also assisted two consumers who successfully appealed adverse decisions related to cardiac surgery that resulted in claims paid that exceeded $120,000. There were some other cases where consumers successfully appealed denied surgical and hospital claims where the costs of the services were over $30,000. In these

situations, the efforts of the staff were instrumental in the favorable outcome for the consumers.

During this reporting period, the Office noted an increase in the number of appeals that resulted after an individual received authorization for a medical procedure or test from his MCHIP, but had the claim denied for lack of preauthorization or medical necessity. In cases where consumers had documentation of telephone calls of their MCHIPs' authorization, the appeals were usually overturned. These results verify the advice the staff provides to consumers about the importance of documenting telephone calls with the customer service staff at their MCHIP. In some related cases, the Office encountered situations where a consumer was admitted to a hospital but the claim was denied because a participating hospital did not take the necessary steps to obtain authorization for the admission from the individual's MCHIP. Typically, these situations were resolved in the consumer's favor once the individual appealed, because the MCHIP realized the individual was not at fault. This was also true for consumers with denied claims because their participating provider did not follow the necessary steps to obtain preauthorization. The staff also noticed a considerable increase in the number of denied imaging preauthorizations and claims for MRIs and PET scans. It is not clear if this increase is the result of an increase in the number of imaging tests requested or if it reflects a higher percent of denials, or both. Some of these requests were denied for lack of medical necessity, and other requests were denied because the MCHIP determined the use of a MRI or PET scan was experimental or investigative in nature for the patient's particular disease. In many cases however, the individual was successful in the internal appeal process, once the MCHIP was able to review the pertinent sections in the person's medical records and received additional information from the individual's physician. When an MCHIP upheld the denial, the appeal was eligible for the Bureau's External Appeal program, which provided another opportunity for the consumer to appeal.

The staff also found that in some instances, consumers completely misunderstood information in the explanations of benefits (EOB) provided by their MCHIPs. For example, some individuals concluded that claims had been denied when they had actually been applied toward the plan deductible. In these circumstances, there is nothing for the person to appeal. In cases where information on the EOB appeared incorrect or incomplete, the staff asked the MCHIP to ensure the claim was processed correctly and that the EOB contained the correct information. The staff helped consumers understand how to interpret their EOB forms, which not only helped the consumer with that particular situation, but may also help them avoid a similar problem in the future.

As noted, when consumers were not successful in the appeal process, the staff was sometimes able to refer them to another section for additional assistance, such as the office that administers the External Appeal program. In some cases the Office referred the matter to other sections within the Bureau, such as the

Consumer Services Section or the Market Conduct section, which could formally review the matter and take any appropriate regulatory action. The Office also referred consumers to other appropriate state or federal agencies for assistance, such as in cases where a consumer whose health insurance was not provided by a fully-insured policy issued in Virginia.

Outreach

The Office conducted outreach activities to inform consumers and providers that the Office is a resource for individuals whose health insurance is provided by an MCHIP. These diverse programs are designed to promote the public's awareness of the Office. During this reporting period, the staff provided consumer information on the Office to The Down Syndrome Association of Northern Virginia, the Richmond Legal Information Network For Cancer (LINC), and the Medical Society of Virginia (MSV). In addition to providing information to LINC and the MSV the staff maintained a working relationship with these organizations to facilitate referrals. The Office also provided consumer literature for individuals that visited the Bureau's display at the State Fair of Virginia. A staff member lectured a class of graduate students in health care administration at Virginia Commonwealth University on health insurance. The Office participated in a seminar sponsored by the federal government's Department of Labor designed to assist health plan administrators comply with regulatory requirements, and attended a seminar conducted by the National Association of Insurance Commissioners on health care reform. The Office was mentioned in state and national articles about health insurance and related issues, including the Fredericksburg Free Lance Star, Kiplinger's Personal Finance magazine, the Wall Street Journal and was featured in an article in the May/June edition of the Virginia Review, a professional journal for the Commonwealth's government officials.

The Bureau recently mounted an enhanced outreach program oriented to consumers and health care practitioners. The purpose of this new initiative is to enhance awareness throughout Virginia that Bureau staff is available to assist consumers and providers when they encounter problems with health insurers, including MCHIPs. The staff collaborated with the Bureau's Consumer Services Section (CSS), and designed a new joint appeal/complaint form. The Bureau also produced a new consumer brochure with tips on how to resolve a problem with an MCHIP or other type of health insurer, which also contains contact information for the Bureau. In addition, the Bureau created a new tip sheet specifically for physicians and other health care providers, which contains information on how the Bureau can provide assistance. The Office is using this new material in its educational and outreach activities, and this new material will also be placed on the Bureau's Internet web page, to ensure the information is readily available. During this reporting period, the Office coordinated an outreach effort with the MSV and as a result of the publicity generated by the MSV, staff noticed a dramatic increase in the number of consumer referrals from physician

office practices. Based upon this, the staff expects an even greater number of referrals and requests for assistance from providers as the new initiative gains momentum. During this reporting period, the Office distributed 1,330 consumer brochures and tip sheets to consumers, providers, and interested parties through outreach programs and in response to requests for information and assistance.

When the Office assists an individual, one of the goals is to help the person develop a better understanding of health insurance generally. In order to achieve this goal, staff incorporates the approach of Outreach staff, and seeks opportunities to provide consumer education not only through presentations and copies of educational brochures, but to provide for personal interaction with consumers. Educational efforts are also designed to help a consumer resolve a problem, and in many instances a consumer may be able to avert future problems from what he has learned. The staff believes this is a key function of the Office and will continue its educational efforts. As part of its outreach and educational functions, the Office maintains an Internet web page containing information about the Office and consumer material. All of the publications the Office disseminates are available on the web page, and the page also contains a list of the mandated benefits and mandated offers that MCHIPs are required to provide as part of their health insurance coverage. The web page also provides a direct e-mail link to the Office via a dedicated account that goes directly to the staff. This special e-mail account also enables consumers to easily scan and submit important documents, such as those related to an appeal. During this reporting period, the web page recorded 5,971 visits, which is slightly less than the 6,014 visits that occurred during the previous reporting period.

Legislation

As required by statute, the Office monitors changes in federal and state laws relating to health insurance. Last year, the Office reported on pending federal legislation designed to establish mental health parity: S. 558: Mental Health Parity Act of 2007 and H.R. 1424: Paul Wellstone Mental Health and Addiction Equity Act of 2007. These bills were introduced in the Senate and House of Representatives respectively, and represented an effort to enhance federal legislation addressing coverage for mental health conditions and substance abuse services. Although these bills were introduced, no definitive action was taken until the federal government's recent response to the problems in the financial services industry. As part of the federal Emergency Economic Stabilization Act (the Federal Bailout Bill), these bills were incorporated into the final legislation that established the government's response entitled the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. The legislation prohibits large employer health plans from imposing more stringent coverage for mental health or substance abuse services than they provide for medical and surgical benefits. Coverage limitations, including the number of days of treatment, for example, may not be imposed for these

conditions, unless there is a corresponding treatment restriction for other medical or surgical conditions.

This new federal requirement expands the concept of parity beyond that which is currently required under the existing Virginia mandate. Consequently, this new federal legislation may have a significant impact on the benefits that health plans, insurers and MCHIPs provide when coverage is issued to a large employer in Virginia. The Bureau is reviewing the new legislation in conjunction with current Virginia insurance statutes and regulations to determine what, if any, changes need to be considered by the Virginia General Assembly. At this point, the review is not complete because the federal legislation was enacted on October 3, 2008, and its potential impact has not been completely assessed to date.

In the previous report, the Office noted a legislative initiative in Massachusetts which resulted from a law enacted in 2006. This legislation required nearly every resident to obtain health insurance coverage and contained financial incentives to encourage individuals to purchase coverage. The incentives include subsidies for low income individuals provided by the Commonwealth, and more favorable tax treatment for individuals who obtain coverage. It appears this program has increased the number of individuals that have health insurance, but the costs have escalated from initial projections due to several reasons, including the continuing acceleration of the cost of medical care.

The Massachusetts program and a similar one in Tennessee were models for legislation that was proposed in Virginia. During the last General Assembly session, legislation was introduced to establish the Virginia Share (VaShare) program. This program would have provided incentives for small business owners to provide health insurance coverage for their employees. The coverage would contain a dollar cap on the benefits with a limited premium, which would have been funded by the employee, the business, and the Commonwealth. While the legislation was generally favorably received, the proposal expired in the legislative process when uncertainty arose over how the Commonwealth's portion of the premiums would be funded.

Conclusion

The Office has continued to assist consumers and accomplish its responsibilities in accordance with the legislation by which it was created. In responding to both informal and formal requests for assistance, staff attempts to educate and assist consumers and other parties. In every interaction, staff seeks both to provide assistance and educate which reflects both the educational and functional assistance the Office is able to provide. The Office's consumer education efforts were in keeping with the Bureau's motto, "Knowledge is your best policy." As a result of the staff's assistance, consumers were frequently successful in the MCHIP appeal process and, in many cases, the successful outcome was the result of staff assistance. Office staff continued efforts to help publicize the

Office, which resulted in more consumers learning what assistance the Office provides. Staff continues to monitor legislative issues at both the federal and state level, and provides input to other sections within the Bureau as required.