

REPORT OF THE
**STATE CORPORATION COMMISSION ON THE
ACTIVITIES OF THE OFFICE OF THE MANAGED
CARE OMBUDSMAN**

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

COMMONWEALTH OF VIRGINIA
RICHMOND
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COMMONWEALTH OF VIRGINIA



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STATE CORPORATION COMMISSION

December 1, 2010

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, 2009, through October 31, 2010.

Respectfully Submitted,

Handwritten signature of James C. Dimitri in black ink.

Commissioner James C. Dimitri
Chairman

Handwritten signature of Mark C. Christie in black ink.

Commissioner Mark C. Christie

Handwritten signature of Judith Williams Jagdmann in black ink.

Commissioner Judith Williams Jagdmann

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 twelfth annual report of the Office and covers the period from November 1, 2009 through October 31, 2010. Previous reports may be viewed on the Bureau's website at:

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

The legislation that established the Office authorizes it to help consumers whose health insurance is provided by a Managed Care Health Insurance Plan (MCHIP). The term "MCHIP" encompasses health maintenance organizations (HMOs), preferred provider organizations (PPOs) and other forms of fully-insured managed care coverage. The coverage must be fully-insured and issued in Virginia by a company licensed by the Bureau in order for the Office to formally assist a consumer in the appeal process. The coverage may be provided by a group health insurance policy or an individual policy. Generally, if a consumer's health insurance coverage is subject to the Bureau's regulatory jurisdiction, the Office may formally assist the consumer or refer the individual to another office within the Bureau. In accordance with the Bureau's regulatory jurisdiction, the Office is unable to formally assist 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

While the Office does not have the regulatory authority to formally assist consumers whose health insurance is provided by one of the above, the staff provides general information and advice, and may be able to refer these consumers to a federal or other state regulatory agency for assistance. As part of its general consumer educational efforts, the Office may help these individuals understand how their health insurance is structured and explain why their health insurance is not subject to regulatory oversight by the Bureau.

Consumer Assistance

The Office may informally assist consumers and other individuals, such as providers, who have questions or concerns that involve some aspect of health insurance, managed care, or related areas. These inquiries cover a range of issues and problems. Two

frequent inquiries concern potential benefits available under a consumer's coverage and how to resolve problems, such as denied authorizations and unpaid claims. Inquiries range from relatively simple to very complex issues and problems. When responding to inquiries, staff provides general information and assistance which frequently enables the consumer to resolve a problem, or helps the consumer initiate an appeal. In this role, staff educates consumers by explaining how their health insurance coverage works, and potential ways to resolve a variety of problems.

In addition to responding to consumers, the Office also responds to inquiries from health care providers who request assistance on behalf of their patients. If a provider contacts the Office for assistance, staff may informally help the provider and offer general information and guidance, including helping a provider understand how he may contact an MCHIP on behalf of a patient. In some instances, this assistance will resolve a problem, and if not, the provider may then be able to initiate a formal appeal. In cases where a provider has determined that a particular patient's appeal involves an urgent problem, the Office staff explains how the provider may file an expedited appeal with the patient's MCHIP. In accordance with the legislation that established the Office, if the patient needs to file a formal appeal, staff will ask the provider to refer the patient directly to the Office for personalized assistance. In a similar manner, the Office also responds to federal and state legislators who ask for assistance on behalf of a constituent. When this occurs, staff contacts the consumer and either assists the individual in filing an appeal or refers the consumer to another source for assistance.

Consumers, providers, and other parties may submit an inquiry to the Office in several different ways: correspondence via a dedicated Ombudsman e-mail account, telephone, or facsimile. If an inquiry involves a relatively simple subject, Office staff may respond in one exchange. If the inquiry falls outside of the scope of the Office, the staff refers the matter to another section within the Bureau, such as the Consumer Services Section (CSS) or to another state agency, federal government agency, or other source. Some inquiries involve issues that are outside the regulatory purview of any state or federal regulatory agency. During this reporting period, the Office responded to 743 inquiries, which represents a decrease from the 879 inquiries the Office received during the previous reporting period.

The Office may help consumers who want to file an oral or written appeal of a denial issued by an MCHIP, and the staff may formally assist a consumer in filing a written appeal. The staff will ensure that consumers understand their appeal rights, and have unimpeded access to all of the internal appeals that are available with their particular MCHIP. In addition to helping consumers understand how the appeal process works, the Office will suggest what information the consumer should submit in order to ensure that his appeal is complete. Often, the first step in the appeal process involves the treating provider contacting the MCHIP and asking for a reconsideration of the adverse decision via a peer-to-peer review with an MCHIP medical director. At this time, the treating provider explains the rationale for the request and proceeds through the reconsideration process or at any time during the reconsideration process, requests that the adverse decision be reviewed by a peer of the treating provider. Such a request would vacate the

reconsideration process and initiate an immediate appeal under legislation that was effective on October 1, 2010. In the event a consumer has to file an appeal, the Office provides personalized individual assistance and formally intervenes by contacting the MCHIP to assist the consumer in filing an appeal, and resolving any problems that may occur.

Appeals generally fall into one of two classifications: medical necessity, which means an MCHIP denied authorization or payment for services or care the company determined was not medically necessary; and administrative denials, which are denials based on a contractual exclusion for the treatment or care under review. Common types of medical necessity appeals involve prescription medications, surgery, imaging tests (CT scans, PET scans, and MRIs), inpatient hospital services, and mental health services including substance abuse. Typical examples of administrative appeals include:

- a request for an MCHIP to increase the amount paid on a claim for services received from a nonparticipating provider who balance bills a patient;
- a request for a service which is specifically excluded from coverage under the terms of a consumer's health insurance policy;
- a request to extend a service, such as physical therapy, beyond the benefit cap as stated in a consumer's plan documents; or
- a request by an individual covered by an HMO to obtain treatment from a nonparticipating provider.

In some cases, an appeal may combine elements that pertain to both medical necessity and administrative issues, such as a request for surgery that an MCHIP has classified as cosmetic, as well as some claims for emergency room services.

The legislation that established the Office requires staff to obtain the written permission of a "covered person" when it assists a consumer in filing an appeal. The Office uses a form which documents the individual's written consent, and provides a copy of the form to the MCHIP. The staff provides advice on pertinent information to include in the appeal. The Office staff has developed several different consumer publications that focus on specific types of appeals and information consumers should include in a written appeal. In reviewing the particular issues and circumstances involved in an appeal, staff's expertise and insight may help a consumer submit information to support his or her appeal.

When the Office formally assists a consumer in filing an appeal, staff will contact the MCHIP in writing, provide a copy of the individual's appeal and supporting documents, and a copy of the person's written consent for the Office to intervene. The staff will also summarize key issues involved in the appeal; and if any of the facts that pertain to the appeal are not clear, staff will serve as a catalyst to ensure all of the relevant information is clear. For appeals that involve questions of medical necessity, the Office staff asks the MCHIP to focus on the applicable clinical information contained in the individual's medical record, and may also ask an MCHIP to review its own clinical guidelines. As commented on in previous annual reports, there were instances when an MCHIP

overturned a denial based on new or overlooked clinical information the Office provided to the MCHIP. Without exceptions, MCHIPs reviewed and considered any new or additional information Office staff provided at any stage during the internal appeal process; in some cases, an MCHIP reconsidered information it had or considered new information after the MCHIP's final denial had been issued.

The staff reviews decisions MCHIPs render on appeals. In the event the consumer is not successful, staff helps the individual understand the decision and why it was not favorable. The Office will ask an MCHIP to clarify any adverse decision that does not appear to be supported by facts or if the logic supporting the denial is not clear. A denial should demonstrate a logical decision based on the information the MCHIP considered; whether or not Office staff agrees with the denial is not relevant. Consequently, if a consumer loses his or her appeal, the staff would explain why the person lost and help the individual understand why the decision was not favorable. If any of the circumstances or issues involved in an appeal appear to involve a regulatory issue, staff would ask the MCHIP for additional information. If necessary, the Office will forward the case to the appropriate section in the Bureau for further review and action as appropriate, and notify the MCHIP accordingly. Although the Office is part of the Bureau, its scope of responsibilities does not include pursuing regulatory action against an MCHIP, as there are other sections within the Bureau for that purpose such as the CSS.

If a consumer's appeal is denied, staff would help the individual file another appeal, if one is available, and may be able to help a consumer develop new information for his or her MCHIP to review. If an MCHIP issues a final adverse decision on an appeal involving questions of medical necessity, the Office will help the individual file an external appeal with the Office of External Appeals, which is also located in the Bureau. Final denials for appeals that involve other types of denials, such as administrative or contractual denials, may be referred to the CSS for further review as a consumer complaint. In some instances, however, there is no further regulatory assistance that may be provided to a consumer who is unsuccessful in the appeal process with an MCHIP.

The Office assists consumers who file a standard appeal, as well as individuals who confront an urgent medical situation which is best addressed by filing an expedited appeal. When an expedited appeal is filed, an MCHIP must respond immediately. Expedited appeals are appropriate in situations such as an impending inpatient discharge, or treatment for a serious medical condition that is potentially life threatening. In these situations, a consumer may file a telephonic expedited appeal, and the staff notifies the consumer's MCHIP to expect an expedited appeal.

As in previous reporting periods, the Office continues to find that the overwhelming majority of consumers that ask for assistance have never previously appealed an adverse decision made by an MCHIP. This inexperience, combined with the inherent difficulties and frustrations that confront consumers who are seriously ill or who face potential major medical bills, are factors the Office staff recognizes and works to ameliorate as they assist consumers. The positive feedback the Office receives indicates consumers appreciate the assistance staff provides. During this reporting period, the staff assisted

154 consumers in the appeal process, which is slightly less than the 177 consumers the Office helped during the preceding reporting period.

Discussion

During this reporting period, the majority of inquiries and appeals involved the same type of common issues and problems associated with health insurance and managed care as noted in previous annual reports. The Office staff frequently encountered situations where consumers were not familiar with how their managed care plan worked, which sometimes caused avoidable problems. Since this is a recurring finding, the Office uses every opportunity to educate consumers in an effort to help people understand the major principles and concepts that pertain to health insurance and managed care. The Office's educational efforts are designed to help consumers avoid problems by understanding how their coverage works and emphasize the importance of reading and understanding plan documents. Consumer education is inherent in the staff's responses to inquiries and providing assistance to consumers in the appeal process with an MCHIP.

In responding to inquiries from providers and consumers and in assisting consumers in the appeal process, Office staff ensured that the parties understood the correct process to use in asking an MCHIP to change a decision. Such responses included providing information on a provider's right to request a reconsideration with an MCHIP medical director, and if not successful, the right for the provider and consumer to file an appeal. In some instances, having information on the proper sequence to use in disputing a denial enabled a provider or consumer to obtain a positive outcome without any further assistance from the Office. In some cases, the Office helped consumers understand the utilization review guidelines an MCHIP used in denying a service or a claim, and suggested how a consumer could use the guidelines to strengthen an appeal letter. The Office also helped providers and consumers understand how to file an expedited internal appeal in a situation that required an immediate decision.

The Office noted that the types of appeals did not vary from what has been reported previously in that typical appeals involved a wide variety of inpatient and outpatient services and claims. In addition, and consistent with previous experience, issues in these appeals ranged from relatively simple to extraordinarily complex. An example of the former were consumers whose coverage was provided by a HMO that had claims for urgent care visits denied because the individual did not follow the prescribed process for obtaining urgent care. An example of the latter were seriously ill consumers with complicated medical conditions that required extensive multi-specialty medical care and diagnostic tests, which an MCHIP denied as experimental or investigative in nature.

In some instances while helping consumers in the appeal process, the Office was able to help an individual avoid a potential expense that was not part of the appeal. For example, in one case, staff helped a consumer appeal a denial for inpatient psychiatric services. During the treatment, the consumer was admitted to an acute care hospital for two weeks in conjunction with psychiatric treatment. The acute care hospital bill was \$59K which the person's MCHIP would not pay because the individual had reached the policy's

maximum dollar limit. Office staff reviewed the hospital's charges and determined the billing codes may not have been appropriate, and advised the consumer to ask the hospital for clarification. The consumer acted on this advice, and after discussing the matter with the facility, the entire bill was canceled.

As mentioned above, the Office reviews an MCHIP's decision and depending on the situation, staff may refer the matter for further review within the Bureau. In many instances, such further review resulted in favorable resolution for the consumer and, in some instances, further corrective action taken by the MCHIP.

Outreach

Office staff continued outreach programs to publicize the Office in an effort to make more providers and consumers aware of the Office and the services it provides. These activities were designed to help individuals understand the purpose, role and function of the Office and specific ways the Office may assist individuals whose health insurance is provided by an MCHIP. In addition, staff also presented subjects related to health insurance and managed care in outreach programs, and provided general information on the State Corporation Commission and the Bureau. In some instances, outreach programs resulted in the staff establishing or enhancing a working relationship with a group or organization.

During this period, Office staff participated in programs for consumers and providers sponsored by the Virginia Chapter of the Leukemia & Lymphoma Society conducted in Richmond, and by the Legal Information Network for Cancer (LINC) in Richmond at the Massey Cancer Center and Johnston Willis Hospital. The Office has maintained a productive working relationship with these two organizations, and has helped their clients on multiple occasions. Staff also presented an overview of the new federal law on parity for mental health and substance abuse benefits to approximately 200 members of the Virginia Association of Community Services Boards at a meeting in Richmond.

The Office also helped staff the Bureau's booth at the State Fair of Virginia, and provided consumers with publications about the Office and information on MCHIPs and related subjects published by the Bureau. One of the publications, the Health Insurance Consumer Guide, is a general overview of health insurance, which was recently updated to reflect new changes to health insurance as a result of the enactment of the federal Patient Protection and Accountable Care Act (PPACA).

During this reporting period, the staff provided information to a reporter for Kiplinger's Personal Finance magazine for an article on explanation of benefit forms, which was written to help consumers interpret these important forms.

The Office also ensured that its information for consumers on the Bureau's Internet page was current. This includes general information on the Office, tip sheets, brochures, and the inquiry/complaint form the Office publishes. The Office also publishes a list of the mandated benefits and mandated offers that MCHIPs are required to provide as part of

their health insurance coverage, which was updated during the reporting period to reflect an important change regarding optional coverage for prosthetic devices. Consumers may also interact electronically with the Office via the Ombudsman's e-mail account located at Ombudsman@scc.virginia.gov. This dedicated e-mail account enables consumers to contact staff directly during the normal business day and also during non-business hours. During this reporting period, the web page recorded 6,919 visits, which is slightly more than the 6,840 visits that occurred during the previous reporting period.

Legislation – Federal

As required by the statute that established the Office, staff monitors changes in federal and state laws that pertain to health insurance. In the previous report, the Office commented on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which was incorporated into the federal Emergency Economic Stabilization Act (the Federal Bailout Bill). The intended result of this legislation is to assure benefits for the treatment of mental health and substance abuse is commensurate with benefits for physical illness. As an example, any coverage limitations, such as the number of days of treatment for mental health or substance abuse conditions would be prohibited unless there is a corresponding treatment restriction for other medical or surgical conditions. It is important to note the legislation only applies to health insurance coverage provided by large employer groups; the law does not affect coverage for consumers in the small group or individual health insurance market.

This federal legislation was enacted on October 3, 2008 which was during the last month of the previous reporting period. At the time, it was not clear what impact the legislation would have on the benefits MCHIPs provide so the Office has monitored the implementation of the new requirements over the past year. Neither the Office nor the CSS staff, which also assists consumers, encountered individuals who reported experiencing problems with an MCHIP in regard to new requirements under the law. This may indicate that MCHIPs implemented a modification the General Assembly made to Virginia's statutes regarding coverage for mental health and substance abuse services to bring Virginia's laws into agreement with the requirements of federal law. It is possible, however, that retrospective market conduct reviews of MCHIPs may reveal some instances of noncompliance; if that occurs, the Bureau will take appropriate action.

As reflected in the last report, the Office was monitoring and tracking potential federal health care reform legislation. The report described proposals under consideration by committees in the Senate and House of Representatives. Eventually, concepts in the various proposals from both houses of Congress were incorporated into the federal Patient Protection and Affordable Care Act (PPACA) that was passed and signed into law with an effective date of March 23, 2010. After closely following the legislation as it was developed, the Office and other Bureau staff are reviewing and analyzing the potential impact of the legislation on Virginia. This analysis includes not only the actual legislation, but also the evolving regulations issued on various sections of the law by the U.S. Department of Health and Human Services (HHS), the Department of Labor (DOL) and the Department of the Treasury. The regulations are very important because they

contain requirements which must be met in order for an entity to be in compliance with the new law.

The law is extraordinarily complex, and a complete analysis of its requirements and effects are outside the scope of this report. The law changes the way that MCHIPs and other health insurance companies conduct business, and seeks to increase access to affordable health insurance options. Some elements of the law became effective six months after it was enacted, such as a prohibition on lifetime dollar limits, coverage of preventive health services without cost sharing, increased patient protections, coverage for children to age 26 by a parent's health insurance policy, and a prohibition against exclusions or restrictions of coverage for preexisting conditions for children up to age 19. Another immediate provision creates Ombudsman and consumer assistance programs to help consumers. Other sections of the law will be effective in later years, including the establishment of Health Insurance Exchanges to facilitate the purchase of health insurance in the individual and small group markets. Office staff has worked closely with other state regulators to develop standardized plan documents to be provided to consumers in accordance with the PPACA, including a standard summary of benefits and definitions of common insurance and medical terms.

The PPACA also establishes new rating requirements for individual and group health insurers. Beginning in 2011, insurers will be required to rebate premiums to policyholders when and if specific medical loss ratios (MLR) are not achieved. The MLR will be computed using a complex formula which has not been finalized as of the writing of this report. Essentially, though, rebates will be required when and if an MLR of at least 80% and 85% has not been achieved for individual and small group products, and for large group products, respectively.

The Bureau has undertaken an extensive review of Virginia's current insurance statutes to identify areas of conflict or inconsistency between state insurance laws and those within the PPACA. At the time of the writing of this report, the Bureau is finalizing this review and will bring these inconsistencies and conflicts to the attention of the House and Senate Committees on Commerce and Labor. The implementation of various sections of PPACA will be influenced by what occurs in the political arena and the judicial system. Consequently, at this point, it is difficult to predict what the final outcome will be for every part of the legislation.

Legislation – Virginia

As reported last year, legislation was enacted that created an option for health insurers or health services plans to market limited benefit policies to small employers in Virginia. A small employer is one who employs at least two individuals but not more than 50 eligible individuals. Specifically, the coverage would only have to provide coverage for the following mandates:

- Coverage for mammograms
- Coverage for pap smears

- Coverage for PSA testing
- Coverage for colorectal cancer screening

The objective of the legislation was to make health insurance coverage less expensive and hence more affordable for small groups by allowing them to purchase “basic health insurance policies,” which would be available at a lower cost since the coverage excluded most of the mandated benefits. The Bureau reviewed the market impact of these plans, which are known as “mandate-lite plans,” and in a report issued on August 2, 2010, noted that as of May 1, 2010, no mandate-lite plans had been sold in Virginia, and only one insurer had a plan available for sale at that time. While a majority of insurers in the small group market stated they did not intend to offer the plans, some of the largest insurers in Virginia indicated they would offer this type of coverage, so it is possible mandate-lite plans will become more readily available in the future. It is important to note that since PPACA requires coverage for essential benefits in 2014, and mandate-lite plans do not provide these benefits, it is not clear if such plans will be viable.

New legislation was enacted that affects the course of internal appeals. Title 32.1 which is under the regulatory purview of the Virginia Department of Health, was amended to allow a treating provider an opportunity to initiate an immediate appeal with an MCHIP at any time during the reconsideration process. This change may allow a treating provider quicker access to a review by an impartial peer. Since the legislation was effective on October 1, 2010, the full impact of this new law has not been determined, and the Office will monitor how MCHIPs implement this new requirement and what effect it has on the internal appeal process.

Conclusion

During this reporting period, the Office staff assisted consumers and accomplished its responsibilities in accordance with the legislation that established the Office. Staff provided informal and formal assistance to consumers and other parties, and used every opportunity to educate people who contacted the Office staff for assistance. On many occasions, the staff’s expertise resulted in consumers successfully resolving issues and minor problems, and frequently helped consumers prevail in the internal appeal process with their MCHIPs. Consumers and other parties expressed appreciation for the efforts of the Office staff. Staff participated in numerous outreach efforts to increase its exposure within Virginia and ensured consumers who asked for assistance received a timely response. During the past year, the Office staff tracked legislation at both the federal and state level, and will continue reviewing and analyzing federal health care reform legislation that was enacted.

