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STATE CORPORATION COMMISSION

December 1, 2011

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, 2010, through October 31, 2011.

Respectfully Submitted,

Commissioner Judith Williams Jagdmann
Chairman

Commissioner Mark C. Christie

Commissioner James C. Dimitri

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

2011

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 (Office) covers the period from November 1, 2010 to October 31, 2011. During this period, the Office informally and formally assisted over 700 consumers and other individuals by responding to general issues or specific problems involving a managed care health insurance plan (MCHIP). Typically, assistance involved issues of 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, 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.

Annual report

Background and Introduction

The Office of the Managed Care Ombudsman (Office) was established in the State Corporation Commission's Bureau of Insurance (Bureau) on July 1, 1999, in accordance with § 38.2-5904 of the Code of Virginia. This annual report is submitted pursuant to § 38.2-5904 B 11, which requires the Office to provide information on its activities to the State Corporation Commission for report 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 Office's thirteenth annual report and covers the period from November 1, 2010 through October 31, 2011. Previous reports may be viewed on the Bureau's website at:

http://www.scc.virginia.gov/comm/reports/finreports.aspx

The legislation that created the Office authorizes it to assist consumers whose health insurance coverage is provided by a managed care health insurance plan (MCHIP). Health maintenance organizations (HMOs), preferred provider organizations (PPOs) and other forms of fully insured managed care coverage, including plans that provide dental insurance are MCHIPs. In order for the Office to formally assist a consumer in the appeal process, the coverage must be fully-insured and issued in Virginia by a company licensed by the Bureau. The coverage may be provided by a group or an individual health insurance policy. Generally, if a consumer's health insurance coverage is provided by an entity subject to the Bureau's regulatory jurisdiction as an MCHIP, the Office may formally assist a consumer or refer the individual to another section of the Bureau. Commensurate 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.

Although the Office does not have the regulatory authority to formally assist consumers whose health insurance is provided by one of the above agencies or plans, staff provides general information and advice. As part of its general consumer educational efforts, the Office helps these individuals understand how their health insurance is structured and why the coverage is not subject to the Bureau's regulatory oversight.

Consumer Assistance

Consumers and other individuals, such as providers, who have questions or concerns that involve some aspect of health insurance, managed care, or related areas can receive general information and assistance from the Office. The inquiries received by the Office involve a variety of issues, problems and are of varying complexity. The most common inquiries concern potential benefits available under a consumer's coverage and how to resolve problems, such as denied authorizations and unpaid claims. Regardless of the nature of the inquiry the staff endeavors to provide a clear explanation of coverage and to educate consumers by helping them understand how their health insurance coverage works, and potential ways to resolve problems.

The Office also answers inquiries from health care providers who request assistance on behalf of their patients. Typically, this occurs when an MCHIP has rejected a claim and the provider is trying to appeal the denial. In some instances, the provider mistakes the Office for a patient's MCHIP, and submits an appeal to the Office. The staff can offer general information and guidance, to include helping a provider understand how to file an appeal with an MCHIP. In some situations, this information will help the provider resolve the problem. If not, the provider may refer the patient directly to the Office for formal assistance in filing an appeal. There is no mechanism in the legislation (Chapter 59 of Title 38.2 of the Virginia Insurance Code) which created the Office to allow for direct provider assistance in the appeal process. In situations where a provider has determined that a patient's medical condition requires urgent medical care, the Office can explain to the provider how to file an expedited internal appeal. The Office can also provide this information to a patient, so a consumer can coordinate a request for an expedited appeal with a physician's assistance.

The Office also responds to inquiries from federal and state legislators on behalf of their constituents. Normally, this occurs after a consumer has encountered a problem and contacted their legislator for assistance, who, in turn, contacts the Bureau. In these cases, staff contacts the consumer and either assists in filing an appeal or refers the consumer to another source for assistance. Often, the type of coverage a consumer has in this scenario is a self-insured health plan or other type of plan that is not regulated by the Bureau.

Consumers, providers, and other parties may submit inquiries to the Office via a dedicated Ombudsman e-mail account, telephone, correspondence, or facsimile. If the inquiry falls outside the purview of the Office, staff refers the matter to another section within the Bureau, such as the Consumer Services Section 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 626 inquiries, which represents a decrease from the 743 inquiries the Office received during the previous reporting period.

The Office assists consumers in filing an oral or formal written appeal of an adverse decision issued by an MCHIP. Staff provides an overview of the process; helps consumers understand their appeal rights; explains how the appeal process works; and ensures consumers have full access to the appeal process. If an appeal involves an issue of medical necessity, the Office encourages the consumer to ask the treating provider to contact the MCHIP for a peer-to-peer review, which is an opportunity for the treating provider to discuss the medical issues involved in the appeal with one of the MCHIP's medical directors. In some cases, this provider-to-MCHIP contact will resolve the problem. The treating provider may decide to request the MCHIP to consult a peer in the same or similar specialty as typically manages the requested service at any time during the reconsideration process. This request may result in the reconsideration being vacated and initiation of an immediate appeal under legislation that was effective on October 1, 2010.

Appeals generally fall into one of two types, depending on the reason an MCHIP issued a denial. One type is a denial based on medical necessity, which is a denied authorization or payment for services or care the insurance company determined was not medically necessary, and includes denials based on an MCHIP's determination the treatment is experimental or investigational in nature. Typical appeals of this type involve prescription medications; surgery; imaging tests (CT scans, PET scans, and MRIs); inpatient hospital services; and mental health services, including substance abuse. The other type of denial is administrative or contractual where the insurance company determines the requested service is not eligible for coverage under the terms of a consumer's health insurance policy, so the insurance company will not pay the claim or approve the service. Common administrative or contractual appeals include a request: (i) for an MCHIP to increase the amount paid on a claim for services received from a nonparticipating provider who balance bills a patient; (ii) a request for a service which is specifically excluded from coverage under the terms of a consumer's health insurance policy; (iii) a request to extend a service, such as physical therapy, beyond the benefit cap as stated in the policy; and (iv) a request by an individual covered by an HMO to obtain treatment from a nonparticipating provider.

In some cases, an MCHIP may issue a denial that is based on components of both types of denials; medical necessity and contractual, such as cosmetic surgery denials. In this situation, an MCHIP determines the surgery is not medically necessary, and the purpose of the surgery is purely for cosmetic reasons, which is a denial based on a contractual exclusion. In the event a consumer files a written appeal with an MCHIP, the staff can formally assist with the appeal. Although there is no mechanism for the Office to file an appeal on a consumer's behalf, staff can explain the essential

information to the consumer, and, if necessary, how to obtain letters from providers and other supporting documentation. 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 helps consumers file standard appeals, which involve services that have been requested but not received, or services the consumer received, but the MCHIP refused to pay. These are services classified as pre-service, post-service, or, in some cases, concurrent care appeals, which involve continuing care a consumer is receiving. MCHIPs typically respond to pre-service appeals within 30 days and post-service appeals within 60 days. Staff also assists consumers with a serious medical condition that requires an immediate response. In this situation, a consumer can file an expedited appeal, and the MCHIP must issue a decision within 72 hours. Expedited appeals are applicable for situations, such as an impending inpatient discharge, or treatment for a serious medical condition that is potentially life threatening.

When formally assisting a consumer in filing an appeal, staff writes to the MCHIP and provides a copy of the consent form, a copy of the individual's appeal and all supporting documents. Staff summarizes the key issues involved in the appeal; and if any of the relevant facts are not clear or disputed, acts as a catalyst to clarify the MCHIP's position and understanding of the issues involved. For appeals that involve questions of medical necessity, the Office may ask the MCHIP to focus on the applicable clinical information documented in the consumer's medical record, and to review any applicable utilization review criteria. Without exception, the MCHIPs, without objection and at any stage of the internal appeal process, agreed to review and reconsider exiting information or overlooked clinical information as suggested by the Office. As a result, in several cases, the MCHIP revised or reversed a denial on the basis of the new information or as the result of reviewing existing information provided by Office staff.

Once an MCHIP issues a decision on an appeal, staff reviews the decision. If the denial is upheld, staff helps the individual understand the reasons the appeal was not successful. Office staff may ask an MCHIP to clarify the rationale for an adverse decision that does not appear to be supported by the facts that pertain to the appeal. A denial should reflect a logical reasoning process and a decision based on the information the MCHIP considered. If it appears that circumstances or issues surrounding an appeal may require further regulatory review, the staff will ask the MCHIP for additional information. If necessary, staff will forward the case to the appropriate section within the Bureau for further review and any necessary action; the MCHIP is notified that another section in the Bureau may contact the MCHIP regarding the case. Other sections within the Bureau are responsible for pursuing regulatory actions involving an MCHIP.

If the decision on an appeal is favorable to the consumer, Office staff can help the individual access authorization for medical care, help ensure a claim is paid, or provide additional help if required. If a consumer's appeal is denied, staff can help the individual file another appeal, if another opportunity remains available. Some MCHIPs provide one level of appeal, and some insurers provide two levels of appeal to persons enrolled in group health benefit plans. If an MCHIP issues an adverse determination that (i) may be eligible for an independent external review involving questions of medical necessity, appropriateness, health care setting, level of care, or effectiveness; or (ii) if the services are determined by the MCHIP to be experimental/investigational, the Office will help the individual file a request for an external review with the Office of Independent External Review, which is also located in the Bureau. In the case final denials are based on administrative or contractual denials, the Office may refer the matter to the Consumer Services Section 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.

As noted in previous annual reports, the overwhelming majority of consumers who ask for assistance in appealing an adverse determination had never appealed a denial. The Office is responsive to this inexperience, especially in conjunction with consumers who are seriously ill or confront significant medical bills. The Office attempts to ameliorate these factors, along with consumers' general frustrations, by offering assistance in the appeal process. During this reporting period, the Office received very positive feedback and comments from consumers and the staff assisted 111 consumers in the appeal process, which is less than the 154 consumers the Office helped during the preceding reporting period.

Discussion

During this reporting period, most of the inquiries and appeals involved the same types of issues and problems associated with health insurance and managed care as commented upon in prior annual reports. Frequently, consumers encountered problems because they were not familiar with how their managed care plan worked. These consumers were seldom able to recall having reviewed the applicable plan documents that applied to their specific problem. Unfortunately, in many cases, consumers could have avoided problems if they had read and understood their plan documents, such as the evidence of coverage or certificate of coverage. The Bureau and its staff emphasize the importance of reviewing and understanding coverage documents. When assisting consumers and other interested parties, the Office's objective is to educate individuals on the basics and the intricate issues in the intersection of managed care and health insurance. The Office has placed great importance on serving as an education resource in helping consumers and other individuals.

The Office assisted numerous consumers whose health insurance was provided by a source outside the Bureau's regulatory jurisdiction, such as coverage through a self-insured employer. With few exceptions, consumers whose coverage was self-insured did not understand how the coverage worked until they contacted the Office for assistance. Even though Office staff was unable to formally assist these consumers in filing an appeal, staff was usually able to make suggestions and provide general information and assistance.

The Office attempts to help health care practitioners understand how to contact a patient's MCHIP to initiate a request for a reconsideration, and in certain cases, how to request an expedited appeal. For example, after the Office advised a physician to request reconsideration in one case, the MCHIP decided to approve coverage and paid a subsequent claim for $40,000. Additionally, after the Office advised a provider to request reconsideration in another case, the MCHIP approved coverage of a drug that costs $6,000 per month. Staff finds that many physicians are not aware of the possibility of an expedited appeal in emergent situations. The Office also helped consumers understand the dynamics of filing an appeal, especially in situations where an MCHIP issued a denial based on a lack of medical necessity. Staff was able to help consumers whose appeals involved a question of medical necessity access and understand an MCHIP's clinical guidelines. In many instances, consumers were able to use such information to support their appeal, which often resulted in an MCHIP overturning a denial.

There were successful outcomes for many consumers, especially those who were overwhelmed by the severity of their medical condition and did not know how to file an appeal. During this reporting period, there were several significant positive outcomes for consumers who were seriously ill with life-threatening medical problems and confronted significant medical bills. In one case, staff helped a consumer prevail in an appeal for services at two highly regarded medical facilities located out-of-state where the total claim was approximately $200,000. The Office also assisted another consumer in a similar situation, and the MCHIP approved coverage and paid $190,000 for the resulting claims. Finally, during this reporting period, the Office helped a consumer win an appeal for medical services the member received in Europe.

Outreach

Office staff participated in an outreach event sponsored by the Legal Information Network for Cancer (LINC) in Richmond at the Medical College of Virginia. The event was designed to provide assistance to individuals who have cancer, and their families. For many years, the Office has participated in programs sponsored by LINC, and staff has also maintained a working relationship with LINC and has on numerous occasions helped consumers LINC referred to the Office. Office staff also participated in the

Richmond Blood Cancer Conference, sponsored by the Virginia Chapter of the Leukemia & Lymphoma Society, and an outreach program oriented toward the Spanish speaking population in central Virginia, sponsored by the Hispanic Chamber of Commerce. This Spanish outreach event was held in Richmond, and included consumer information translated into Spanish. Consumer publications that contained information on managed care and related subjects were available at the Bureau's booth at the State Fair of Virginia.

Office staff revised the insert discussing federal health care reform in the Health Insurance Consumer Guide, which is one of the most popular publications the Bureau publishes. The staff also wrote a consumer guide, explaining the immediate provisions of federal health care reform. In addition, the staff helped revise the consumer assistance and outreach forms and brochures, and translate these materials and the consumer inquiry/complaint form into Spanish.

In addition to updating information about the Office on the Bureau's website, staff participated in a major project to redesign the Office section of the Bureau webpage. The redesign enhances information about the Office, revamps the format, and displays information in a more consumer friendly manner. As mentioned in previous reports, the Office also monitored and responded to e-mail inquires submitted via the dedicated Ombudsman's e-mail account, which is located at Ombudsman@scc.virginia.gov

Federal Legislation

As required by the statute that established the Office, staff monitors changes in federal and state laws that pertain to health insurance. In previous reports, the Office commented on the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which was intended to ensure benefits for the treatment of mental health and substance abuse, are commensurate with benefits for physical illness. The federal law applies to health insurance provided by large employer groups, which is defined as 51 or more employees. The Virginia General Assembly subsequently passed legislation that changed Virginia's statutes to reflect and comply with requirements in the federal law. Once Virginia's insurance statutes were amended, Office staff tracked the number of consumers who reported problems in obtaining coverage for mental health and substance abuse as required by the legislation. The Bureau has heard from only a few consumers regarding a problem with mental health or substance abuse coverage issues since the enactment of the new law.

Previously, the Office reported on the background and passage of the Patient Protection and Affordable Care Act (ACA), which was signed into law with an effective date of March 23, 2010. Although the ACA represents expansive federal health care reform initiatives, the states are responsible for implementing many sections of the law. During

this reporting period, staff continued to review sections of the ACA, and also reviewed regulations promulgated by various federal agencies to implement the law; in particular regulations published by the Department of Health and Human Services (HHS). While there is a gradual phase-in of the entire law, some parts of it were effective just prior to the start of the last reporting period and included a prohibition on lifetime dollar limits; restrictions on annual dollar limits; coverage of preventive health services without cost sharing; increased patient protections; coverage for children up to age 26 by a parent's health insurance policy; and a prohibition against exclusions or restrictions of coverage for pre-existing conditions for children up to age 19. The Office monitored these developments, and neither the Office nor the Bureau's Consumer Services Section experienced a significant number of consumer inquiries, appeals, or complaints involving these immediate reforms noted above.

One section of the ACA established consumer assistance programs (CAPs). These programs provide services similar to existing services provided by the Office and the Consumer Services Section to consumers. The ACA also provided funding for CAPs in each state, and the Bureau applied for and received a grant. Although grant funding could not be used to fund current operations and existing services, the funding could be used to enhance existing CAP programs. During this reporting period, the grant provided funding to improve an existing automated consumer information management system and data base; expand consumer outreach events; offer written and verbal translation services for consumers; and determine production requirements for a new consumer portal that will facilitate electronic submission of inquiries, appeals, and complaints via the Bureau's Internet web site. As reported previously, Office staff participates in a project sponsored by the National Association of Insurance Commissioners (the NAIC), along with representatives of other states, the industry, and interested parties, to standardize the language and format of critical plan documents.

The ACA also established minimum loss ratios for insurers in the individual and group market, and the law created grants for the states to use to increase the ability to regulate health insurance premiums. Specifically, insurers will have to rebate premiums to policyholders if specific medical loss ratios (MLRs) are not achieved. Generally, this means rebates will be required if the MLR is less than 80% for the individual and small group markets, and 85% for the large group market. The Bureau received a grant, and is using the funds to strengthen its rate review efforts. In addition, the Bureau has participated in the Virginia Health Reform Initiative, (VHRI), which was formed by the Governor to study the establishment of a Health Insurance Exchange (Exchange). Under the ACA, every state will either operate an Exchange, or allow the federal government to operate the Exchange. An Exchange will facilitate the ability of consumers who meet certain criteria to purchase health insurance coverage.

The Bureau continues to review the provisions of the ACA and assess the impact on Virginia consumers and the health insurance industry. Staff continues its review of the federal legislation and Virginia's existing health insurance laws. It is important to note that implementation of the ACA may be influenced by what occurs in the judicial system, including various lawsuits which continue to work their way through the judicial process.

Virginia's Legislation

The Office tracks legislation that pertains to health insurance and related matters that is passed by the General Assembly and enacted by the Governor. In some instances, the staff also monitors the results of prior legislative efforts. As reported last year, legislation created "mandate-lite" plans, which created an option for health insurers or health services plans to market limited benefit policies to small employers in Virginia. Such plans would only require coverage for the following mandates:

- Coverage for mammograms
- Coverage for pap smears
- Coverage for PSA testing
- Coverage for colorectal cancer screening.

The objective of this legislation was to help make health insurance more affordable in the small group market by reducing the number of mandated benefits that a health insurance policy must provide. Last year's report noted that when the Bureau reviewed the results of this legislation, it concluded there was no impact on the market. It is not clear why the mandate-lite concept has not been successful; Its lack of success may become a moot point, however, since the ACA may require a level of benefits that exceed the scope of coverage provided by a mandate-lite health plan.

The previous annual report discussed legislation that was effective on October 1, 2010, which allows a treating provider an opportunity to initiate an immediate appeal with an MCHIP at any time during the reconsideration process. This legislation was designed to enable a treating provider quicker access to a review by an impartial peer. In practice, however, the Office found that treating providers were not aware of this provision. There were several cases when physicians contacted the Office for guidance in the reconsideration process; once staff informed the physician he or she could request an immediate appeal, the physician did so, and the matter was successfully resolved. The Office believes many MCHIPs disseminated this information to participating providers, so it is not clear why physicians were not aware of this opportunity.

There was a significant change to the internal appeal process and External Review process as a result of Chapter 788 (House Bill 1928), which was effective on July 1, 2011. The legislation modified existing Virginia requirements and incorporated changes

made to comply with the ACA, which was described in the prior section of this report. This legislation created Chapter 35.1 of Title 38.2 of the Code of Virginia, and the Bureau also promulgated implementing directives in the Commission's Rules Governing Internal Appeal and External Review (14 VAC 5-216-10 et seq.). Commensurate with the effective date, the new requirements apply to adverse benefit determinations and adverse determinations made on or after July 1, 2011. Therefore, adverse decisions made prior to the effective date of the new law were rendered in accordance with the former statute.

One of the major changes Chapter 788 (House Bill 1928) made was that previously, only MCHIPs were required to have an internal appeal process; now, however, all health carriers must have an internal appeal process. Previously, group health plans and individual health plans could offer multiple internal appeals. Now, group health plans may offer more than one internal appeal, but individual health plans can only provide one level for an internal appeal. The new law applies in Virginia even if a health plan is grandfathered and, thus, not subject to all of the ACA requirements. In addition, there is a new requirement that allows consumers the right to appeal a rescission of coverage. While generally the new requirements for internal appeals follow the same process and requirements that were effective prior to July 1, 2011, the new External Review requirements were revised substantively. The following are some of the more significant revisions: (i) external Review is no longer limited to consumers whose coverage is provided by an MCHIP; (ii) a covered person may authorize another individual to representhim; (iii) a consumer may simultaneously file an internal appeal request on an expedited basis and an expedited External Review; (iv) there is no longer a $300 dollar threshold fora denied service or claim; (v) the $50 filing fee has been eliminated; and (vi) consumers now have 120 days to file a request for an External Review instead of 30 days. Previously, the Commissioner of Insurance could change the decision of an Independent Review Organization (IRO), which was deemed arbitrary or capricious; the Independent Review Organization's (IRO) decision is now final and binding, and, in every case, the health carrier will pay for the cost of the IRO's review. The Bureau now maintains a list of approved IROs and will track annual reports from IROs and health carriers. While the Bureau does not regulate self-insured plans, such plans may request that the Bureau administer an External Review program that non-grandfathered self-insured plans are required to offer under the ACA. The Bureau issued Administrative Letter 2011-05 to all insurers licensed to write health insurance in Virginia in order to explain the new requirements and provide guidance to assist insurers. The Bureau will monitor the changes to the internal appeal process and the new External Review requirements during the next several months.

Conclusion

The Bureau believes that as reported in previous annual reports, the Office staff accomplished its responsibilities in accordance with the legislation (14 VAC §38.2-5900 et seq) that established the Office. Its staff assisted consumers, providers, and other interested parties by providing both informal and formal assistance, and attempted to use every inquiry as an opportunity to educate as well as assist consumers, providers and other individuals who contacted the Office. The staff's expertise resulted in consumers successfully resolving problems; and helped consumers learn more about managed care, health insurance, and related subjects. During this reporting period, as has occurred in prior reporting periods, the staff frequently helped consumers prevail in the internal appeal process with their MCHIPs. In many cases, consumers obtained a more favorable outcome on their appeals when they contacted the Office for help. The Office's efforts and results have been recognized by consumers, members of the General Assembly and their staffs, as well as a Member of Congress during this reporting period. Overall, the Office is a key part of the Bureau's consumer assistance services. The staff referred potential regulatory issues to the appropriate section within the Bureau, and when necessary, coordinated its activities with other state or federal agencies. Finally, staff tracked increasingly complicated federal and state legislation pertaining to health care reform.