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

2013

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, 2012, through October 31, 2013.

Respectfully submitted,

Commissioner James C. Dimitri
Chairman

Commissioner Mark C. Christie

Commissioner Judith Williams Jagdmann

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, 2012 to October 31, 2013. During this period, the Office provided informal and formal assistance to over 538 consumers and other individuals by responding to general questions and specific problems with managed care and health insurance coverage provided by a managed care health insurance plan (MCHIP). The Office staff helped consumers understand how their health insurance works, the importance of reading and understanding coverage documents, and methods to solve problems. The Office also formally helped consumers appeal adverse benefit determinations, and referred consumers to other sections within the Bureau of insurance for assistance, or, in some cases, to another regulatory agency when the problems involved issues outside the Office's regulatory purview. The Office continues to promote and protect the interest of Virginia consumers in accordance with the provisions of Title 38.2, Chapter 59 of the Code of Virginia.

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 in accordance with § 38.2-5904 B 11, which requires the Office to provide information on its activities to the State Corporation Commission for reporting 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 15th annual report and covers the period from November 1, 2012 through October 31, 2013. 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 assigned it numerous responsibilities. The Office's main responsibility is to assist consumers whose health insurance coverage is provided by a managed care health insurance plan (MCHIP) i.e. a health maintenance organization (HMO), preferred provider organization (PPO) and managed care plans that provide vision and dental insurance. The Office can informally respond to consumer inquires, and upon request, formally assist a consumer in the appeal process, when the person's coverage is provided by a fully-insured policy issued in Virginia by an insurance company licensed by the Bureau. The coverage may be provided through an individual or group health insurance policy. Generally, when a consumer's health insurance coverage is provided by a company subject to the Bureau's regulatory jurisdiction as an MCHIP, the Office may formally help the consumer or refer the individual to another section of the Bureau. Commensurate with the Bureau's regulatory jurisdiction, 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 policy is issued outside of Virginia

Although the Office does not have the regulatory authority to formally assist consumers whose health insurance coverage is provided by one of the above agencies or plans, as part of its overall consumer educational efforts, staff can provide general information, suggestions, and advice regarding the problem or reason that caused a consumer to contact the Office.

Consumer Assistance

The Office provides general information and assistance to consumers and other individuals, such as healthcare providers, who have questions or concerns that involve some aspect of health insurance, managed care, or related areas. These inquiries involve a variety of issues and problems which vary in complexity. The most common inquiries concern benefits available under a consumer's coverage and how to resolve problems, such as denied authorizations and unpaid claims. Providing a clear explanation of the issues involved in an inquiry frequently involves helping consumers understand how their health insurance works, and potential methods for resolution. In some situations, the Office refers the individual to another agency for assistance, such as when the inquiry involves coverage that is self-insured, and therefore is outside of the Bureau's regulatory jurisdiction.

The Office also answers inquiries from health care providers who seek assistance on behalf of their patients. Typically this results from an MCHIP rejecting a claim and the provider appealing that denial. The Office offers general information and guidance to help a provider understand how to file an appeal. If the medical situation is urgent, the Office educates the provider on how to file an urgent care appeal, which expedites the internal appeal process with the patient's MCHIP. In some instances, providers used this information and the denial was overturned. If not, then the Office asks the provider to refer the patient directly to the staff for formal assistance with an appeal. There is no mechanism for the Office to file an appeal on behalf of a provider.

The Office also responds to inquiries and questions from federal and state legislators who submit inquiries on behalf of their constituents. The staff provides as much information as possible, and usually contacts the consumer and offers to provide assistance in the appeal process. When the individual's coverage is self-insured, the staff refers the person to other resources for help. When it appears the staff will formally help a consumer file an appeal, the Office obtains the individual's written authorization. Depending on the circumstances, the Office will provide a written response to the legislator.

The staff helps consumers filing an oral or formal written appeal of an adverse decision issued by an MCHIP. The Office provides a general overview of the appeal process, helps consumers understand their appeal rights, explains how the internal appeal process works, helps clarify any disputed information involved in the appeal, and ensures consumers have fair access to the appeal process.

Consumers, providers, and other parties may submit inquiries to the Office via several methods: a dedicated Ombudsman e-mail account, an electronic portal, telephone, and correspondence mailed or delivered via facsimile. If an inquiry falls outside the purview of the Office, 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. In some instances, inquiries involve issues that are completely outside the regulatory jurisdiction of any state or federal agency. During this reporting period,

the Office responded to 448 inquiries, which is an increase from the 336 inquiries the Office received during the previous reporting period.

In the event a consumer submits a written appeal with his or her MCHIP, the staff can formally help the individual in filing the appeal. In this capacity, the staff can explain why the MCHIP denied the service, help the person understand how the appeal process works, assist the person during the entire appeal process, suggest what information to include, and suggest what supporting documents to include, such as copies of medical records and letters from medical providers. With the consumer's written consent, the Office also contacts the consumer's MCHIP in writing and addresses the issues involved in the appeal and provides copies of supporting documents related to the appeal.

As part of helping a consumer file an appeal, the staff summarizes the critical issues involved in the appeal; and if any of the relevant facts are not clear or are disputed, acts as a catalyst to clarify the issues. This ensures the issues are fully identified and understood by the consumer and the MCHIP, although it does not necessarily mean each party agrees on the proper resolution. The Office interacts with the consumer and his or her MCHIP during the entire appeal process, and serves as a resource for the consumer. The staff cultivates a productive working relationship with all of the MCHIPs, which facilitates effective communication between the Office and each MCHIP. For appeals that involve questions of medical necessity, the Office requests that the MCHIP concentrate on the applicable clinical information documented in the person's medical records and carefully consider any applicable utilization review criteria the company used in making its adverse decision. During the period covered by this report, the MCHIPs were responsive to these requests and readily reviewed and reconsidered pertinent clinical information, including information that had been overlooked or additional information the consumer provided. As a result, there were several cases where MCHIPs revised or reversed adverse decisions.

The staff reviews decisions that MCHIPs render on appeals. If the company upholds the denial, staff helps the consumer understand why the appeal was not successful. If necessary, the staff will 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. The Office strongly believes that a denial should reflect a logical reasoning process and produce a decision based on all the information the MCHIP received from the consumer and their health care practitioner. If it appears that the 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 staff notifies the MCHIP if the case is referred to another internal office within the Bureau.

If the decision on an appeal is favorable to the consumer, but the individual has difficulty obtaining the previously denied services or benefits, the Office staff can provide additional assistance. Examples include helping the individual obtain authorization for medical care, or ensuring a claim is paid. If a consumer's appeal is denied and the person has an opportunity to file another appeal, the staff will help the individual file a second

appeal. Whether or not a consumer has a chance to file another appeal depends on whether the MCHIP offers one level of appeal or two levels, since group health plans may provide either one or two internal appeals. Individual health plans however, can only offer one internal appeal. When an MCHIP issues an adverse determination that may be eligible for an independent external review involving questions of medical necessity, appropriateness, health care setting, level of care, or effectiveness, or when the services are determined by the MCHIP to be experimental/investigational, the Office will help the person file a request for an external review with the Bureau's Office of Independent External Review. In the case of final denials based on administrative or contractual denials, the Office may refer the matter to the Bureau's CSS to review as a potential consumer complaint. In some situations however, there is no further regulatory assistance the Bureau can provide to a consumer who is unsuccessful in the internal appeal process with an MCHIP.

Appeals are generally classified into one of two different types, depending on the denied service or claim and the reason an MCHIP issued a denial. One type is a request for medical care or some service that the consumer and his or her physician believe is medically necessary, but the MCHIP disagrees. This includes instances when an MCHIP determines a specific treatment is experimental or investigational in nature. Examples of these types of denials include 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 appeals involves a denial that is administrative or contractual in nature. This includes cases when an MCHIP determines the requested service, medical care, or treatment is not eligible for coverage under the terms of a consumer's health insurance policy. Frequently this means there is a specific exclusion in the consumer's health insurance policy for the requested service. Examples include appeals addressing the amount an MCHIP paid on a claim for services provided by a nonparticipating provider who balance bills a patient; a request for a service which is specifically excluded from coverage; a request to extend a service such as physical therapy beyond a benefit cap as stated in the policy; medical care which required preauthorization; and a request by an individual covered by an HMO to obtain treatment from a nonparticipating provider. In rare situations, an MCHIP may issue a denial for two reasons: the claim is denied as not being medically necessary and contractually excluded from coverage. A typical example is an appeal related to cosmetic surgery, when an MCHIP determines the surgery is not medically necessary and that the purpose of the surgery is purely for cosmetic reasons, which is a contractual denial according to the consumer's plan documents. Not all appeals during the reporting period involved medical treatment; consumers whose dental insurance or vision insurance is provided by an MCHIP also contacted the Office for help in appealing an adverse decision.

When an appeal involves a question of medical necessity, the Office encourages the consumer to ask the treating healthcare provider to contact the MCHIP for a peer-to-peer review with a medical director as the first step in the appeal process. In some instances, this resulted in an MCHIP approving the request, especially when the treating provider had additional clinical information. When the treating provider contacts the MCHIP to discuss the medical issues involved in an appeal, and asks for a reconsideration with a

medical director, the provider may decide to request the MCHIP consult a clinical peer in the same or similar specialty as the treating provider. This ensures a review by the same type of specialist that typically treats the type of medical condition being reviewed. The Office is able to provide guidance on this part of the appeal process to consumers and providers.

The Office helps consumers file appeals for services or treatments which have not been rendered (a pre-service appeal) and the staff also helps consumers file appeals for services or treatments which the individual has already received (a post-service appeal). The staff can also help a consumer file an appeal for services the individual is currently receiving but which will soon end (a concurrent care appeal). When a consumer has a serious medical condition that requires an immediate response and decision, the Office can help the individual file an urgent care appeal, which expedites the appeal process. Examples include an impending inpatient discharge which the patient and their attending physician contend is premature or immediate treatment for a serious medical condition that is potentially life-threatening. In these situations, an MCHIP must issue a decision on an urgent care appeal within 72 hours.

As noted in prior annual reports, the overwhelming majority of consumers who ask for assistance in appealing an adverse determination had never appealed a denial. The Office attempts to reduce consumers' anxieties, along with consumers' general frustrations associated with filing appeals, by offering personalized assistance and providing counseling and guidance throughout the appeal process. During this reporting period as in previous reporting periods, the Office received very positive comments from consumers. In the previous reporting period the Office assisted 59 consumers in the appeal process, and by comparison in this reporting period the Office helped 90 consumers in the appeal process.

Discussion

During this reporting period, most inquiries and appeals involved the same types of issues and problems associated with health insurance and managed care as documented in prior annual reports. All too often consumers encountered difficulties because they were unfamiliar with how their managed care plan worked, usually because they did not read and understand their plan documents, such as the evidence of coverage (EOC), certificate of coverage (COC), and explanation of benefit forms (EOBs). Some consumers also had problems understanding the content of denial letters they received from an MCHIP. The staff continually stresses to consumers the importance of reviewing and understanding coverage documents and correspondence and applying the information to their specific situation. In the process of helping consumers and other interested parties, the Office continually makes every effort to educate individuals and help them understand basic concepts involving health insurance and managed care.

As in previous reporting periods, the Office encountered numerous consumers whose health insurance was provided by a source outside of the Bureau's regulatory jurisdiction. Usually these consumers were covered by a self-insured health plan, although some

consumers had fully-insured plans issued in another state, and some consumers had coverage via the Federal Employees Health Benefits Program (FEHBP) or another government plan such as Medicare or Medicaid. In these situations, the Office informally advised the consumer on how a problem could be solved, but the staff was unable to formally help the individual file an appeal.

During the reporting period many consumers covered by a self-insured plan did not realize they had that type of coverage, so the Office explained how self-insured coverage works and how to resolve problems by contacting the employer for help. In the case of consumers covered by a fully-insured plan issued in another state, the Office referred people to the insurance commission in the appropriate state. Similarly, consumers covered by the FEHBP were referred to the federal government's Office of Personnel Management for assistance. During this reporting period, the Office continued to encounter an ever increasing number of consumers with a health plan that was not regulated by the Bureau. In each case, the Office provided as much help as possible although it was unable to formally help the consumer file an appeal.

As noted in prior annual reports, health care providers contacted the Office for assistance on a regular basis. The staff helped providers understand how to file a request for a reconsideration or an appeal with a patients' MCHIP. In some situations, the Office guided a provider in filing an urgent care appeal, or provided information on the External Review program when the internal appeal process had been completed. Frequently, a provider was able to obtain a successful outcome using information the Office provided on how the appeal process works after the provider contacted a patient's MCHIP. Examples include physician offices that obtained approval for prescription medications, and imaging tests to include CAT scans and MRIs. In some instances, the Office was a catalyst for providers to inform patients they could file a request for an External Review because the internal appeal process had been completed.

Since there is no mechanism in the legislation that established the Office to enable it to file an appeal on behalf of a consumer, the staff assists consumers in filing their own appeals. As in the past, during this reporting period, the Office explained the appeal process to consumers and helped them understand how the appeal process works and when asked, the Office helped consumers file appeals. An important part of helping consumers appeal denials for medical treatment was helping consumers understand an MCHIP's clinical criteria and why an MCHIP denied a request or an appeal that involved medical treatment. This assistance included helping consumers understand clinical criteria an MCHIP used to determine that a requested treatment or service was deemed experimental or investigational in nature. The Office helped consumers construct appeals that addressed the clinical reasons an MCHIP denied a service, which increased the possibility the consumer would prevail.

There were many instances when the assistance the Office provided helped a consumer achieve a favorable outcome in the appeal process. In one case, an individual won an appeal for a denied air ambulance bill for $21,000. In another case, an individual won an appeal for a denied hospital bill that totaled $6,000. The Office also helped a consumer

win an appeal for a denied prescription drug which costs $12,000 for a year's supply, and helped other consumers win appeals for various prescription drugs. With help from the Office, a consumer avoided a $6,000 charge for blood products administered during a hospital stay, and another consumer avoided an $8,000 hospital bill. The Office helped a consumer prevail on an appeal for denied laboratory services, and several consumers won appeals for various types of imaging studies to include MRIs, CAT scans, and a PET scan. There were consumers who won appeals for denied speech therapy services, and there was a case where a consumer obtained full coverage for a nonparticipating emergency room physician's bill, after initially being charged for more than the person's MCHIP recognized as the usual and customary charge.

In some cases, consumers were not successful in the internal appeal process with their MCHIPs. For example, some consumers sought treatment for mental health conditions without obtaining required preauthorization from the MCHIP. As a result, the MCHIP denied coverage even though the treatment the individual received may have been medically necessary. Another example includes consumers who did not realize there was a cap on the number of covered physical therapy or speech therapy visits. In these situations, the Office helped the consumer understand why his or her appeal was denied and educated the individual on the health plan's limitations. When a consumer was unsuccessful in the internal appeal process and the appeal involved a utilization review determination, the Office referred the individual to the Office of Independent External Review for assistance. This ensured an individual had an opportunity to continue in the appeal process, and protected the person's rights as a consumer whose health insurance was provided by an MCHIP.

In the course of helping consumers file appeals, the Office identified potential regulatory problems in several areas. One problem involved an HMO that failed to provide coverage for basic health care services, which is a statutory requirement. Another situation concerned an MCHIP that did not use an outside physician consultant to review appeals, which is also a statutory requirement. Recently, the Office obtained preliminary information indicating an MCHIP may not be following regulatory requirements in providing applied behavioral analysis services for autistic children. In these situations, after collecting preliminary information from the MCHIP, the Office referred the matter to another section of the Bureau for appropriate disposition.

The Office is also able to help consumers who experience a problem with their dental insurance coverage when it is provided by an MCHIP. During this reporting period the Office encountered fewer consumers who asked for assistance with dental problems than last year, but the problems consumers reported were similar to those reported last year. Dental practices also contacted the Office for assistance with the same types of problems as reported last year. Appeals included both administrative/contractual appeals and appeals for dental services an MCHIP determined were not dentally necessary. As an example of the former, some consumers needed coverage for another bridge prior to the expiration of a limited coverage benefit period, which is typically five years. In these appeals, a consumer's dental plan would only provide a bridge every five years, so if a bridge became unserviceable prior to that time, it was not a covered benefit. Another

common administrative/contractual appeal involved alternate services, which substituted a covered service for an excluded benefit. Typically, this involved the allowance of a partial denture in lieu of replacing a fractured or unserviceable tooth. An example of services denied as not dentally necessary include a patient who underwent a routine prophy which was extended into a scaling and planing procedure; the MCHIP denied the procedure as not dentally necessary because the company determined that the patient only needed a routine prophy. There were also appeals involving bridges, where the MCHIP determined the buildup of adjacent teeth to stabilize the bridge was not dentally necessary.

Outreach

The Office continued its outreach efforts, in coordination with the outreach program conducted by the Life and Health Division. As in prior years, the Office helped staff the Bureau's exhibit at the State Fair of Virginia and had an opportunity to interact with dozens of consumers there. The Office also had an exhibit at the annual meeting of the Virginia Dental Association (VDA). During this meeting, staff had an opportunity to speak with dentists and dental assistants from all over the Commonwealth, which provided significant exposure for the Office and provided an opportunity for the Office to advise Virginia dental providers how the Office can assist them and their patients.

The Virginia Association of Hematologists and Oncologists invited the Office to speak at the Association's Fall Membership Conference. A staff member presented information on how the Office can assist consumers in the appeal process with a MCHIP. In addition, the Office also participated in an outreach program the Bureau conducted at a church and provided general information on health insurance and related topics. The Office also provided information to a reporter for Beacon Newspapers.

As noted in prior annual reports, the Office actively supports outreach programs, and uses participation in outreach events to foster working relationships with professional groups, such as the VDA and the Virginia Association of Hematologists and Oncologists, who can refer providers to the Office for general information and assistance.

Federal Legislation

As required by the Code of Virginia, staff monitors changes in federal and state laws that pertain to health insurance and compiles a summary of significant new developments in both federal and state laws pertaining to health insurance. As was the case in the previous reporting period, this year the Office continued to monitor developments related to the Patient Protection and Affordable Care Act (ACA) and reviewed selected regulations the federal government published to implement the ACA. The Office also contributed to the Bureau's ongoing efforts to implement various aspects of the law.

One major area the Office monitored and provided assistance for was the Bureau's responsibility to provide Plan Management functions to recommend Qualified Health Plans (QHPs) and Stand-Alone Dental Plans (SADPS) for certification. Under the ACA,

any health insurance plan or stand-alone dental plan sold on the Health Insurance Exchange, also known as the Marketplace (Marketplace), must be certified. Once the plan is certified, it is designated as a QHP or SADP. The Bureau reviewed submissions from nine different insurers and 13 carriers providing stand-alone dental coverage that wanted to sell coverage in the Marketplace. These plans included coverage to be provided in the small group market and the individual market. The nine insurers, as required by the ACA, offered a variety of plans in the different "metal levels" - bronze, silver, gold and platinum. The metal levels represent different premium levels with concurrent varying out-of-pocket costs for consumers. The Bureau recommended for certification 209 QHPs offered by 8 insurers (one insurer from the original 9 withdrew from selling on the Marketplace) and 119 SADPs offered by 13 carriers. The recommendations were submitted to The Centers for Medicare & Medicaid Services (CMS) for final approval.

An important component of the ACA and of Virginia law is the requirement that a QHP provide coverage for Essential Health Benefits (EHBs), which represent 10 categories of services: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, and chronic disease management, and pediatric oral and vision care.

Virginia's Legislation

The Office continues to track legislation that pertains to health insurance and related matters passed by the General Assembly and signed into law by the Governor.

During the last General Assembly, the Code of Virginia was amended to add new sections to address requirements under the ACA effective January 1, 2014. In addition, a new section was created, § 38.2-3455 *et seq.*, which describes prohibited activities for Navigators. Under the ACA, Navigators can assist consumers in the process of selecting a health plan, but Navigators are not allowed to perform functions that would require licensure as an insurance agent. In some instances, existing Virginia insurance laws were amended to bring them into compliance with requirements of the ACA. Legislation was also passed that requires the Commission, with the assistance of the Virginia Department of Health, to perform plan management functions, provided certain funding requirements are met, and to review and approve rates in the individual and small group markets. The Commission amended the Rules Governing the Filing of Rates for Individual and Certain Group Accident and Sickness Insurance Policy Forms, 14 VAC 5-130-10 *et seq.* Efforts are underway to review other regulations in the Virginia Administrative Code to ensure they are consistent with state requirements; the Office is monitoring this function.

Conclusion

During this reporting period, the Commission believes the Bureau has accomplished its responsibilities, through the Office, in accordance with § 38.2-5904 of the Code of Virginia. As in previous reporting periods, the staff has assisted consumers, providers, and other interested parties by providing general information, guidance, and assistance. In some cases, depending on how a consumer's health insurance was structured, individuals were referred to another source for assistance. When requested, the staff helped consumers appeal adverse benefit determinations and ensured individuals had fair access to the internal appeal process offered by his or her MCHIP. In these situations, assistance was personalized to meet the needs of the consumer; the Office helped the person understand the appeal process and worked as a catalyst to clarify any disputed facts regarding the appeal. The staff ensured an MCHIP administered its appeal process in a consistently fair manner. The staff's assistance and expertise maximized the opportunity for the appellant to be successful in the appeal process. When necessary, the staff referred potential regulatory concerns to the appropriate office within the Bureau for further review. The Office also monitored changes in federal and state laws related to health insurance coverage.