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

2014

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STATE CORPORATION COMMISSION

November 25, 2014

To: The Honorable Terry G. Kilgore
Chairman, House Committee on Commerce and Labor

The Honorable Robert D. Orrock, Sr.
Chairman, House Committee on Health, Welfare and Institutions

The Honorable Stephen H. Martin
Chairman, Senate Committee on Education and Health

The Honorable John C. Watkins
Chairman, Senate Committee on Commerce and Labor

The Honorable John M. O'Bannon, III
Chairman, 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, 2013, through October 31, 2014.

Respectfully Submitted,

Commissioner Judith Williams Jagdmann
Chairman

Commissioner Mark C. Christie

Commissioner James C. Dimitri

Executive Summary

This annual report on the activities of the Office of the Managed Care Ombudsman (Office) covers the period from November 1, 2013, to October 31, 2014. During this period, the Office provided informal and formal assistance to more than 736 consumers and other individuals. The Office responded to general questions and specific problems with managed care and health insurance coverage provided by a managed care health insurance plan (MCHIP). The Office 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 interests of Virginia consumers in accordance with the provisions of Title 38.2, Chapter 59 of the Code of Virginia.

Background and Introduction

The Office of the Managed Care Ombudsman (Office) was created 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 16th annual report and covers the period from November 1, 2013, through October 31, 2014. Previous reports may be viewed on the Bureau's website at:

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

The legislation that established 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) or managed care plan that provides vision and dental insurance. The Office can informally respond to consumer inquiries 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. Where appropriate, the Office also can refer the individual to another section of the Bureau. The coverage may be provided through an individual or group health insurance policy. 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 help consumers whose health insurance coverage is provided by one of the above agencies or plans, the Office can provide general information and advice as part of its overall consumer education efforts.

Consumer Assistance

The Office provides general information and assistance to consumers and other individuals, such as healthcare providers, who have questions or problems related to some aspect of health insurance, managed care, or related areas. These inquiries reflect a diverse spectrum of issues and problems which vary in complexity. The most frequent inquiries concern benefits available under a consumer's coverage and resolution of problems, such as denied authorizations and unpaid claims. Providing a clear explanation

of the issues presented in an inquiry typically involves helping consumers understand how their health insurance works and suggesting potential methods to resolve problems. In some situations, the Office refers the individual to another agency for assistance, such as when the inquiry entails coverage that is self-insured, and therefore, falls outside of the Bureau's regulatory jurisdiction.

The Office also responds to inquiries from health care providers who seek assistance on behalf of their patients. Typically, this type of inquiry occurs when an MCHIP rejects a claim and the provider is appealing the 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 accelerates the internal appeal process with the patient's MCHIP. During this reporting period, as in previous reporting periods, there were several instances when providers used this information and the denial was overturned. If the provider was unable to resolve the problem, then the staff asked the provider to refer the patient directly to the Office for formal assistance with an appeal, since there is no mechanism for the Office to file an appeal on behalf of a provider.

Federal and state legislators also contact the Office and request assistance with various issues and problems on behalf of their constituents. The staff provides as much information as possible and, if necessary, contacts the constituent and offers to provide assistance in the appeal process. Many of the inquiries that originate from legislators involve constituents whose coverage is self-insured. In this situation, the Office provides informal assistance and refers the individual to other resources for help. If the staff helps a consumer file a formal appeal, the Office obtains the individual's written authorization. Depending on the circumstances, the Office will provide a written response to the legislator regarding the disposition of a particular inquiry.

When the Office helps consumers filing an oral or formal written appeal of an adverse decision, the staff provides a general overview of the appeal process and helps consumers understand their appeal rights. The Office also explains how the internal appeal process works and what may occur if the appeal is not successful, and acts as a catalyst to clarify any disputed information. A major objective for the Office is to help consumers have fair access to the internal appeal process.

There are a variety of means consumers, providers, and other parties may use to contact the Office to submit inquiries or request help filing an appeal: a dedicated Ombudsman e-mail account, the Bureau's electronic portal, telephone, fax, and correspondence. If an inquiry is outside the purview of the Office, where appropriate 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 situations, an inquiry involves problems and issues that are completely outside the regulatory jurisdiction of any state or federal agency. During this reporting period, the Office responded to 569 inquiries, which is an increase of approximately 27% over the 448 inquiries the Office received during the previous reporting period.

If a consumer wants to submit a formal written appeal to his or her MCHIP regarding an adverse decision, the staff can help the individual in filing the appeal. In this capacity, the staff can explain why the MCHIP denied the service, help the consumer understand how the appeal process works, and assist the consumer during the entire life cycle of the appeal. With the consumer's written consent, the Office also contacts the individual's MCHIP in writing, addresses the issues involved in the appeal, provides copies of the documents related to the appeal (i.e. copies of medical records and letters from medical providers), and requests an explanation of any relevant facts that are unclear or disputed.

Although the issues are fully identified and understood by the consumer and the MCHIP, it does not necessarily mean each party agrees on the proper resolution. The staff cultivates and maintains a productive working relationship with all of the MCHIPs, which facilitates effective communication between the Office and each MCHIP. During the reporting period, for appeals that involved questions of medical necessity, the Office requested that the MCHIP carefully review the applicable clinical information documented in the consumer's medical records, along with the applicable utilization review criteria the company used when making its adverse decision. The MCHIPs were always responsive to these requests; in some instances denials were overturned after further review of the clinical information, or additional medical documentation was submitted.

Since the staff reviews decisions that MCHIPs render on appeals, the Office can help consumers understand why an MCHIP upholds a denial when the individual's appeal has not been successful. If necessary, the staff will ask an MCHIP to clarify the rationale for an adverse decision if it does not appear to be supported by the pertinent facts. The Office strongly believes that a denial should reflect a logical reasoning process that produces a decision based on all the information provided by the consumer and the health care practitioner. If it appears that the circumstances or issues may require further regulatory review, the staff will ask the MCHIP for additional information. If necessary, the Office will forward the case to the appropriate section within the Bureau for further review and any necessary actions. The Office can provide additional assistance when the appeal decision is favorable to the consumer but the individual has difficulty obtaining the previously denied services or benefit. Such assistance may include obtaining authorization for medical care or ensuring a claim is fully paid.

When an MCHIP issues an adverse determination involving questions of medical necessity, appropriateness, health care setting, level of care, or effectiveness, or when the MCHIP determines the services are experimental/investigational, the decision may be eligible for an independent external review. In such cases the Office typically will help the consumer file a request for an external review, explain how the external review program works, and outline the applicable requirements for filing a request for an 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 classified into one of two types, depending on the nature of the denied service or claim and the reason an MCHIP issued a denial. One type of denial involves a request for medical care or some service the consumer and his or her health care provider believe is medically necessary. This includes instances when an MCHIP determines a specific treatment is experimental or investigational in nature, which is a form of a medical necessity denial. Examples of such denials include prescription medications; surgery; imaging tests (CT scans, PET scans, and MRIs); inpatient hospital services; and mental health services, including substance abuse treatment. The other type of appeal involves a denial that is administrative or contractual in nature. This type of denial 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. 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: (i) the claim is denied as not being for a medically necessary service and (ii) for a service which is 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 the consumer's plan documents.

When an appeal involves a question of medical necessity, the Office encourages the consumer to ask the treating healthcare provider to conduct a peer-to-peer review with one of the MCHIP's medical directors. Generally this is the first step in the appeal process, and in some instances during the reporting period, resulted in an MCHIP approving the requested service. This outcome was more likely when the treating provider was able to provide the MCHIP with new clinical information about the patient. When the treating provider contacts the MCHIP to discuss the medical issues involved in a particular patient's treatment and asks the MCHIP to reconsider the decision, the provider may decide to ask the MCHIP to 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 provides guidance on how this part of the appeal process works to both consumers and providers.

The Office helps consumers appeal denials for a service or treatment which have not been rendered (a pre-service appeal) and the staff also helps consumers appeal denials for services or treatments which the individual has already received (a post-service appeal). The Office can also assist a consumer in appealing a denial for a service that is ongoing, i.e. treatment the individual is currently receiving but which is scheduled to conclude because the MCHIP will no longer issue an authorization (a concurrent care appeal). A common example is an individual receiving extended physical therapy services. If 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. When a consumer initiates an urgent care appeal, an MCHIP must issue a decision within 72 hours.

As stated 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 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 90 consumers in the appeal process, and in this reporting period, the Office helped 167 consumers file an appeal.

Discussion

During this reporting period, most inquiries and appeals the staff encountered involved the same types of issues and problems associated with health insurance and managed care as discussed in previous annual reports. All too often, consumers encountered difficulties because they were not familiar with how their managed care plan worked. Many consumers 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). In some situations, consumers also had problems understanding their denial letters and why a company denied a particular service. The staff continually stresses to consumers the importance of reviewing and understanding coverage documents and correspondence and applying the information to their specific situation to resolve problems. During 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, and how to solve problems.

Consistent with previous reporting periods, the Office encountered an increase in the number of consumers whose health insurance was provided by a type of health plan that is 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. The Office informally advised these consumers on how a problem could be solved and referred consumers to other resources for assistance. The largest number of referrals was to employers who provided self-insured plans for their employees. Although the staff provided advice and suggestions, they were unable to help these consumers file a formal appeal.

As discussed 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 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 regarding the External Review program when the internal appeal process had been completed. In some instances, providers were able to obtain a successful outcome using information the Office provided that explained how the appeal process functions and how to contact a patient's MCHIP. Examples include physician offices that obtained approval for prescription medications and imaging tests including CAT scans and MRIs. In some instances, the Office was a catalyst for the provider contacting a patient and encouraging the patient to request 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. During this reporting period, as in previous ones, the Office explained the appeal process to consumers and helped them understand how the appeal process works. When asked, the Office helped consumers file appeals. An essential component of helping consumers appeal denials of 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. The assistance the Office provided included helping consumers understand clinical criteria an MCHIP used to determine that a requested treatment or service was deemed experimental or investigational in nature, and helping consumers understand clinical criteria for prescription drug use that involved step therapy. The Office helped consumers construct technically sound appeals that addressed the clinical reasons an MCHIP denied a service, in order to optimize the chance of a favorable outcome.

As in previous reporting periods, there were many instances when the assistance the Office provided helped a consumer obtain a favorable outcome in the appeal process. In one case, an individual's provider was successful in a peer-to-peer review with an MCHIP, and, as a result, the company approved $26,500 in claims for inpatient services and a medical device. With assistance from the Office, a consumer obtained approval for spinal fusion surgery after the staff helped the individual provide updated medical records for the MCHIP to review. As a result, the company approved the surgery, which costs $40,000. In another case, the Office informally provided assistance to a consumer whose coverage was provided by a self-insured plan, and, as a result, the person won the appeal for a sophisticated artificial leg. The Office helped numerous consumers file appeals for denied prescription drugs and imaging tests, which were resolved successfully.

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 provided by a nonparticipating provider. Another example is that some consumers did not realize that services such as physical therapy contained a limit on the number of visits that would be covered. In these types of situations, the Office helped the consumer understand why his or her appeal was denied and the health plan's limitations. When a

consumer was not successful 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 referral provided an opportunity for an individual to continue the appeal process.

In helping consumers file appeals, the Office noticed some irregularities in some MCHIPs' appeal processes, denial letters or documentation. When irregularities were discovered, the staff asked the MCHIP to reissue corrected information to the consumer and to update its internal appeal procedures. In some cases, the Office referred the issue to another section of the Bureau for appropriate review.

The Office is also able to assist consumers who encounter a problem with their vision or dental insurance when it is provided by an MCHIP. During this reporting period the problems consumers presented to the Office with dental insurance coverage were very similar to those reported last year. Dental practices also contacted the Office for help with the same types of problems as reported last year. These commons problems included appeals for both administrative/contractual denials and appeals for dental services an MCHIP determined were not dentally necessary. As an example of the former, some consumers needed coverage for a new bridge prior to the expiration of a limited coverage benefit period for an initial bridge, which is typically five years. If a bridge became unserviceable prior to that time, it was not a covered benefit. Examples of services denied as not dentally necessary included several patients who underwent scaling and planing procedures, but MCHIPs denied the procedures because it was determined the procedures did not meet the applicable clinical criteria. Consumers covered by stand-alone dental plans were not eligible to have these types of adverse decisions reviewed in the External Review program.

Outreach

As reported in prior annual reports, the Office continued its outreach efforts and provided support for the Life and Health Division's outreach program. The Office helped staff the Bureau's exhibit at the State Fair of Virginia, which presented an opportunity to interact with numerous consumers. The Office had an exhibit at the annual meeting of the Virginia Dental Association (VDA). During the meeting, staff had a chance to speak with dentists and dental assistants from various locations in the Commonwealth, which provided significant exposure for the Office among Virginia dental providers as to how the Office can assist them and their patients. The Office also participated in a Bureau outreach program with the Office of the Attorney General, and provided information to the consumer assistance staff regarding the ways the Office assists consumers. Staff also provided information to a reporter for Kiplinger's, a national personal financial magazine, for an article that explored potential problems consumers may encounter obtaining preventive care services with no cost share.

The Office actively supports outreach programs, and uses participation in outreach events to promote working relationships with professional groups as well as opportunities to

help consumers in person. In addition, the Office ensures information on its web page is accurate and current.

Federal Legislation

As required by the legislation that established the Office, staff monitors changes in federal and state laws that pertain to health insurance, and has the ability to compile 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, the Office continued to monitor developments related to the Affordable Care Act (ACA) and reviewed selected federal regulations published to implement the ACA. In addition, and as reported in prior annual reports, the staff has contributed to the Bureau's ongoing efforts to analyze and implement various components of the ACA.

The Bureau continues to perform plan management functions for the federal Health Insurance Exchange in Virginia, also known as the Marketplace (Marketplace), by recommending Qualified Health Plans (QHPs) and Stand-Alone Dental Plans (SADPs) for certification, recertification and decertification pursuant to § 38.2-326 of the Code of Virginia. Under the ACA, any health insurance plan or stand-alone dental plan sold on the Marketplace must be certified. Once the plan is certified, it is designated as a QHP or SADP. This year, the Bureau reviewed submissions from nine carriers providing health insurance coverage and 19 carriers providing stand-alone dental coverage either in the Marketplace or exchange-certified but sold in the outside market. These plans were offered in the small group market and/or the individual market. The nine carriers providing health insurance coverage offered a variety of plans in the different "metal levels" (bronze, silver, gold and platinum) which represent different premium levels with concurrent varying out-of-pocket costs for consumers. The Bureau recommended certification for 181 QHPs offered by nine carriers and 119 SADPs offered by 19 carriers. The recommendations were submitted to HHS for final approval. Approved plans are available for consumers to purchase during open enrollment, November 15, 2014 – February 15, 2015, with coverage effective on or after January 1, 2015.

One of the important coverage provisions of the ACA and Virginia law is that a QHP is required to provide coverage for Essential Health Benefits (EHBs). Essential Health Benefits represent various 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, chronic disease management, and pediatric oral and vision care.

Virginia's Legislation

The Office continues to track legislation pertaining to health insurance and related subjects passed by the General Assembly and signed into law by the Governor. This year, as was the case last year, there were several pieces of legislation that were enacted. One bill, HB308/SB201, requires health carriers using a formulary to notify policyholders no less than 30 days in advance of a change during the plan or policy year that moves a prescription drug to a higher cost-sharing tier in the formulary. This advance notification may enable consumers to collaborate with their providers to substitute a less expensive drug, which could reduce the cost of the prescription. Another bill, HB 1176, requires health carriers to provide 75 days' advance written notice of intent to increase premiums or deductibles at renewal in the individual market, starting with policy years beginning on or after January 1, 2015. This additional notification time may allow consumers more time to shop for a plan that better meets their need. The current requirement for 60 days' advance written notice of intent to increase premiums by more than 35 percent still applies to proposed group renewals.

Additionally HB 1005 contained one provision which removes the mandated offer for the coverage of treating morbid obesity in the individual and small group markets. This means that an MCHIP does not have to offer a policy holder the option to purchase coverage to treat morbid obesity, which could potentially include treating the complications from prior treatment of morbid obesity.

Conclusion

During this reporting period, as in previous reporting periods, the Office has worked to accomplish its responsibilities, in accordance with § 38.2-5904 of the Code of Virginia. As stated in prior reporting periods, the staff has assisted consumers, providers, and other interested parties by providing general information, guidance, and assistance. In some instances, 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, the Office personalized assistance to meet the needs of the consumer. This included the Office helping the consumer understand the appeal process, and working as a catalyst to clarify any disputed facts regarding the appeal. The staff worked to ensure MCHIPs administered their appeal processes in a consistently fair manner. The staff's assistance and expertise maximized the opportunity for the appellant to prevail in the internal appeal process. When required, the staff referred potential regulatory concerns to the appropriate section within the Bureau for further review. The Office also monitored changes in federal and state laws related to health insurance and managed care.