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

2015

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STATE CORPORATION COMMISSION

November 18, 2015

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 2, 2014, through October 31, 2015.

Respectfully Submitted,

Commissioner Mark C. Christie
Chairman

Commissioner James C. Dimitri

Commissioner Judith Williams Jagdmann

Executive Summary

This annual report on the activities of the Office of the Managed Care Ombudsman (Office or Staff) covers the reporting period from November 1, 2014, to October 31, 2015. During this period, the Office provided informal and formal assistance to more than 706 consumers and other individuals. The Office responded to general questions and specific problems with managed care and health insurance coverage provided by managed care health insurance plans (MCHIPs). 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.

Specifically, during the reporting period, the Office responded to 555 inquiries and assisted 151 consumers in filing insurance-related appeals. The Office also participated in outreach events, such as the State Fair of Virginia, and continued to monitor federal and state health insurance related legislation. Details of these and other activities are provided herein.

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 17th annual report and covers the period from November 1, 2014, through October 31, 2015. 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 primary responsibility is assisting consumers whose health insurance coverage is provided by an (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 internal appeal process, when the person's coverage is fully-insured and provided by a policy issued in Virginia by a licensed insurance company. When appropriate, the Office can also refer an individual to another section of the Bureau for help. The coverage may be provided through an individual or group health insurance policy. In accordance 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
- MCHIPs when the policy is issued outside of Virginia

Although the Office does not have 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 policy 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 wants to appeal the denial. The Office provides general information and guidance to help the provider understand how to file an appeal. If the patient's medical situation is urgent, the Office educates the provider on how to file an urgent care appeal, which accelerates the internal appeals process with the patient's MCHIP. During this reporting period, as noted in previous reporting periods, there were several instances when providers used this information and as a result, the denial was overturned. If the provider was unable to resolve the problem, then 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.

In addition to consumers, federal and state legislators also contact the Office for assistance with various problems and issues on behalf of their constituents. Staff provides as much information as possible and, if necessary, contacts the constituent directly 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 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 or assistance in filing an appeal.

When the Office helps consumers file an oral or formal written appeal of an adverse decision, Staff provides a general overview of the appeal process and helps consumers understand their appeal rights. The Office also acts as a catalyst to clarify any disputed information when it contacts a consumer's MCHIP. A major objective for the Office is to help consumers obtain fair and unimpeded access to the full internal appeal process provided by an MCHIP.

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 online portal, telephone, fax, and correspondence. If an inquiry is 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. In some situations, an inquiry involves problems and issues that are completely outside the regulatory jurisdiction of any state or federal agency. During the reporting period, the Office responded to 555 inquiries, which is a slight decrease from the 569 inquiries the Office received during the previous reporting period.

When a consumer wants to submit a formal written appeal to his or her MCHIP contesting an adverse decision, Staff can help the individual file an appeal. In this capacity, 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 pertinent documents (i.e. copies of medical records and letters from medical providers), and requests an explanation of any relevant facts that are unclear or disputed.

Even though the issues involved in an appeal may be fully identified and understood by the consumer and the MCHIP, the parties do not necessarily agree on the proper resolution. Staff cultivates and maintains a productive working relationship with the MCHIPs, which facilitates effective communication between the Office and each MCHIP. For appeals during this reporting period 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 when additional medical documentation was submitted.

Staff reviews decisions that MCHIPs render on appeals, so the Office can help consumers understand why an MCHIP upholds a denial when the individual's appeal has not been successful. If necessary, 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 which produces a decision based on all the information provided by the consumer and the treating health care provider. If it appears that the circumstances or issues involved in the appeal may require further regulatory review, Staff will ask the MCHIP for additional information. When 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 benefits. Such assistance may include obtaining authorization for medical care or ensuring a claim is fully paid.

When an MCHIP denies an appeal 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 external review. In these cases, the Office typically helps the consumer file a request for an external review, explains how the external review program works, and outlines 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 Consumer Services Section 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 appeal involves a denial for medical care or some service the consumer and his or her health care provider believe is medically necessary, but the MCHIP disagrees. 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 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. 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 both reasons: (i) the service is not medically necessary and (ii) the service is contractually excluded from coverage. A common 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.

For an appeal that 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 this reporting period, as in others, it 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 or updated clinical information about the patient's condition. 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 aspect of the process functions to consumer and providers.

The Office helps consumers appeal denials for a service of treatment which have not been rendered (a pre-service appeal) and Staff also helps consumers appeal denials for services or treatment 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 the individual's MCHIP has determined is no longer medically necessary (a concurrent care appeal). A common example is an individual receiving extended physical therapy services, when an MCHIP authorized an initial amount of physical therapy, but then determined that the full course on ongoing physical therapy is not medically necessary. If a consumer suffers from a serious medical condition that requires an immediate decision and response, the Office

can help the individual file an urgent care appeal, which expedites the appeal process. Examples include treatment for a life-threatening medical condition, or a serious condition which may produce a limited window of opportunity for therapeutic intervention. When an urgent care appeal is initiated, an MCHIP must issue a decision within 72 hours.

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, and many individuals are intimidated by the process. The Office attempts to reduce consumers' anxieties, along with consumers' general frustration associated with filing appeals, by offering personalized assistance and providing counseling and guidance throughout the entire 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 167 consumers in the appeal process, and in this reporting period, the Office helped 151 consumers file appeals.

Discussion

During this reporting period, most inquiries and appeals Staff encountered involved the same types of issues and problems related to health insurance and managed care as discussed in previous annual reports. In many instances, consumers encountered problems because they were not familiar with the features of their managed care plan, and the potential benefits provided by their coverage. 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). Frequently, consumers also had difficulties understanding denial letters received from their insurers, including why a service was denied, and the steps in the appeal process. As in all interactions with consumers, Staff continually stresses the importance of consumers reviewing and understanding coverage documents and correspondence, and the importance of asking for assistance when necessary. In the process of helping consumers and other interested parties, the Office continually makes every effort to educate individuals so they understand important concepts involving health insurance and managed care. This knowledge is instrumental in helping consumers solve a variety of problems.

As noted in previous annual reports, during this reporting period, the Office continued encountering consumers whose health insurance was provided by types of health plans 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 were covered through the Federal Employees Health Benefits Program (FEHBP) or other type of government plan such as Medicare or Medicaid. The Office informally advised these consumers how to resolve a problem and referred these individuals to other resources for assistance. The largest number of referrals was to employers who provided self-insured coverage for their employees, which is consistent with the Office's experience in prior reporting years. Although Staff provided informal advice and suggestions to consumers whose coverage was not regulated by the Bureau, the Office was not able to help these consumers file a formal

appeal. At times however, the informal advice Staff provided to a consumer with a self-insured health plan resulted in a positive outcome. One example was a patient who followed Staff's suggestion to contact the employer's human resource department for assistance, and the human resource department ultimately arranged for coverage for a drug used to treat ulcerative colitis.

As mentioned in prior annual reports, health care providers contacted the Office for assistance on a regular basis. Staff helped providers understand how to request a reconsideration or submit an appeal with a patient's MCHIP. In some urgent 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. In some instances, providers were able to obtain a successful outcome by following information the Office shared with the provider on how to file an appeal. In one case, Staff provided guidance to a physician whose patient required a prescription drug to treat multiple sclerosis. The physician spoke with a medical director at the patient's MCHIP, and the company approved a year's supply of the drug at a cost of $30,000 for the insurer. In another similar situation, a physician's office followed advice the Office provided, and an MCHIP approved a course of treatment for a prescription drug for a patient with Hepatitis C. In another situation, the Office provided information on the appeal process and related issues to another physician's office regarding a patient with Hepatitis C, and the individual's MCHIP approved the request. The typical cost to treat Hepatitis C with these drugs is approximately $100,000. In addition to these types of outcomes, providers were successful in obtaining approval for other types of prescription drugs and various imaging studies, including CAT scans and MRIs. In each instance when a provider was successful in obtaining an MCHIP's approval for treatment or services for a patient, there was no need for the patient to file a formal appeal.

The legislation that established the Office does not contain a means for the Office to file an appeal on behalf of a consumer, so Staff assists consumers in filing their own appeals. When asked, the Office helped consumers in the filing process, including helping consumers understand what specific information to include in appeal letters. An essential component of helping consumers appeal denials of medical treatment was helping consumers understand an MCHIP's clinical criteria used to determine that a requested treatment or service was deemed experimental or investigational in nature, and helping consumers understand clinical criteria for prescription drugs that involved step therapy. The Office helped consumers construct technically sound appeals that addressed the clinical reasons for which the MCHIP denied a service, in order to optimize the chance for a favorable outcome for the consumer.

As in previous reporting periods, during this reporting period, there were numerous instances when the assistance the Office provided directly helped a consumer obtain a favorable outcome in the appeal process. In one case, the Office helped a mother obtain an inhaler for her son with severe asthma; in this situation, as soon as Staff contacted the woman's MCHIP in the course of helping her file an appeal, the MCHIP immediately overturned the denial and approved the inhaler. In this reporting period, the Office helped the parents of a deceased patient obtain approval for over $40,000 of

chemotherapy drugs. Staff helped another patient win an appeal which resulted in a claim payment by the consumer's MCHIP for surgical services totaling over $20,000. In another case, Staff helped a patient with Stage IV colon cancer obtain approval for two expensive chemotherapy drugs, which were successful in arresting further clinical progression of the disease. There were also numerous other successful outcomes for consumers in the appeal process, including imaging studies, outpatient prescription drugs, hospital stays and surgical services.

In some cases, consumers were unsuccessful in the internal appeal process with their MCHIPs. If an MCHIP denied a claim or service as not medically necessary or as experimental/investigational in nature, the Office helped the consumer transition to the External Review program. This program provides an opportunity for the consumer to continue the appeal process. Denials based on administrative or contractual reasons are not eligible for consideration under the External Review program. Examples of these denials are consumers who sought treatment for a medical condition with a provider who was outside of the network provided by the consumers' MCHIP, and consumers whose coverage provided a cap on benefits, such as the number of physical therapy visits allowed under the terms of the policy. In these situations, the Office helped the consumer understand why the appeal was denied and the health benefit plan's limitations.

In the course of helping consumers file appeals, if the Office found some irregularities in an MCHIP's appeal process, denial letters, or documentation Staff would address these issues with the MCHIP. For example, the Office noticed that one MCHIP was issuing final adverse determination letters with incorrect information about the External Review program, and advised the appropriate Bureau section. In another situation, the Office advised others in the Bureau that it appeared an MCHIP was not paying for preventive drugs with no member copay. The Office also found an MCHIP was sometimes allowing consumers with individual health plans to have more than one internal appeal. While this can be helpful to consumers, a person with individual health insurance coverage is limited to only one level of appeal.

The Office also assists consumers who encounter a problem with their vision or dental insurance, when the coverage is provided by an MCHIP. During the reporting period, consumers and dental practices contacted the Office with dental insurance related problems and issues very similar to those reported last year. These problems included appeals for both administrative/contractual denials and appeals for dental services an MCHIP determined were not dentally necessary. As one example of the former, an individual asked for assistance in appealing a denial for two routine dental services provided on one date, which the MCHIP determined exceeded the allowable amount of coverage based on a single plan year. A consumer asked for assistance appealing an MCHIP's partial payment for oral implants and a fixed bridge. The company had paid the cost of an alternative benefit, which was less than full payment for the implants and a fixed bridge. The Office helped consumers appeal denials for services an MCHIP determined were not dentally necessary, such as denied claims for scaling and root planing when an MCHIP determined the treatment was not dentally necessary. In another example, a consumer's MCHIP denied coverage for a crown because the

company determined the root structure of the affected tooth was inadequate for a positive prognosis without adequate periodontal treatment. In situations where an appeal was denied as not dentally necessary, the appellant was not eligible for the External Review program, unless the individual's dental coverage was provided by a dental plan issued in conjunction with the individual's medical coverage. Individuals whose dental insurance coverage was provided by a stand-alone dental plan, which is probably the most common type of dental coverage, were not eligible for external review.

Outreach

As discussed in prior annual reports, the Office continued its outreach efforts and supported the Life and Health Division's outreach programs. The Staff was present at 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. This opportunity provided significant exposure for the Office to explain how it can help Virginia dental providers and their patients. Staff made a presentation at a meeting of the Virginia State Chapter of the American Society for Metabolic & Bariatric Surgery, which attracted approximately 35 attendees. The Office extended an invitation to the Medical Society of Virginia (MSV) to provide information on ways the Office can assist MSV members and their patients. In addition, on several occasions, the Office assisted the Legal Information Network for Cancer (LINC), by advising case workers and clients who asked for assistance appealing a denied claim or service related to cancer treatment. Staff also provided information to a reporter for Kiplinger's, a national personal financial magazine, for an article that discussed potential unexpected out-of-pocket costs consumers might incur in the course of using their health insurance.

The Office actively conducts and supports outreach programs, and uses participation in outreach events to promote effective working relationships with professional groups, such as the VDA, and advocacy groups such as LINC. Frequently these outreach programs creates opportunities for the Office to directly assist consumers in the appeal process, and also provides a means to educate providers and interested parties about the services the Office provides. The Office also ensures that the information on its web page is accurate, updated and accessible.

Federal Legislation

As required by § 38.2-5904 B 10 of the Code of Virginia, Staff monitors changes in federal and state laws that pertain to health insurance. As was the case in the previous reporting period, the Office continued to monitor develops 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, 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, pursuant to § 38.2-326 of the Code of Virginia. Under the ACA, any health benefit 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 12 carriers providing health insurance coverage and 20 carriers either providing stand-alone dental coverage in the Marketplace or providing exchange-certified stand-alone dental coverage, in the outside market. These plans were offered in the small group market and/or the individual market. The 12 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 210 QHPs offered by 12 carriers and 111 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 1, 2015 – January 31, 2016, with coverage effective on or after January 1, 2016.

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, and 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. During the 2015 General Assembly, the Office monitored several pieces of legislation that were enacted. These include House Bill 1747, which requires group and individual health insurance coverage to provide mental health and substance use disorder benefits in parity with the medical and surgical benefits the coverage provides. This legislation conforms certain requirements regarding coverage for mental health and substance use disorder with provisions in the federal Mental Health Parity and Addiction Equity Act of 2008. One section of this bill requires the Bureau to develop reporting requirements regarding denied claims, complaints, and appeals involving coverage for mental health and substance use disorder, and to compile the information and produce a report. Another bill, House Bill 1940, requires health insurers and HMOs to provide coverage for the diagnosis and treatment of autism spectrum disorder in individuals from age two through age 10; which extends the current age threshold from age six. House Bill 1942 and corresponding Senate Bill 1262 establish some new requirements for the preauthorization process for prescription drugs, including time limits for communications to the prescriber that a request is approved, or denied, or requires additional information. In addition, House Bill 2031 contains several provisions applicable to pharmacy benefits

administration. One section establishes new requirements for prior authorizations designed to accelerate the approval process and enhance communications between prescribers and insurers. Another section requires intermediary organizations and carriers to establish and maintain current pricing information on prescription drugs.

Conclusion

During this reporting period, as in previous reporting periods, the Office has accomplished its responsibilities in accordance with § 38.2-5904 of the Code of Virginia. As stated in prior reporting periods, Staff 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 coverage was structured, individuals were referred to another source for assistance. When requested, 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 consumers. This included the Office helping the consumer understand the appeal process, and serving as a catalyst to clarify any disputed facts regarding the appeal. Staff worked to ensure MCHIPs administered their appeal processes in a consistently fair manner. Staff's assistance and expertise maximized the opportunity for the appellant to prevail in the internal appeal process. When circumstances warranted, 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 coverage and managed care.