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

2012

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STATE CORPORATION COMMISSION

December 1, 2012

To: The House Committee on Commerce & Labor
The House Committee on Health, Welfare and Institutions
The Senate Committee on Education & Health
The Senate Committee on Commerce & Labor
and
The Virginia Joint Commission on Health Care

The report contained herein has been prepared pursuant to § 38.2-5904 of the Code of Virginia.

This report documents the activities of the Office of the Managed Care Ombudsman for the reporting period covering November 1, 2011 through October 31, 2012.

Respectfully Submitted,

Commissioner Mark C. Christie
Chairman

Commissioner James C. Dimitri

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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, 2011 to October 31, 2012. During this period, the Office provided informal and formal assistance to over 395 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. When requested, the Office formally helped consumers appeal adverse benefit determinations. When confronted with problems outside the Office's regulatory purview, staff referred consumers to other sections within the Bureau of Insurance for assistance, or, in some cases, to another regulatory agency. The Office continues to provide a valuable service to consumers, and functions in accordance with the legislation that established the Office in 1999.

Annual report

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 pursuant to § 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 14th annual report and covers the period from November 1, 2011 through October 31, 2012. Previous reports may be viewed on the Bureau's website at:

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

The Office was assigned numerous responsibilities in the legislation that established it. 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.health maintenance organizations (HMOs), preferred provider organizations (PPOs) and other types of fully-insured managed care coverage, including plans that provide vision and dental insurance. For the Office to formally assist a consumer in the appeal process, the person's coverage must be fully-insured and the 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 assist consumers whose coverage is provided by any of the following:

- Federal government (including Medicare)
- State government (including Medicaid recipients)
- Self-insured plans established by employers to provide coverage to their employees; and
- Managed care plans when the coverage is issued outside of Virginia

While the Office does not have the regulatory authority to formally assist consumers whose health insurance 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 that caused a consumer to contact the Office. The Office may also help individuals understand how this coverage is structured and why it's not subject to the Bureau's regulatory oversight.

Consumer Assistance

In response 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, the Office provides general information and assistance. These inquiries involve a variety of issues and problems which vary in complexity. The most common inquiries concern potential benefits available under a consumer's coverage and how to resolve problems, such as denied authorizations and unpaid claims. Regardless of the nature of the inquiry the staff tries to provide a clear explanation of the issues that generated the inquiry. Frequently this involves helping consumers understand how their health insurance coverage works, and potential ways to resolve problems. In some situations, the Office refers the individual to another agency for assistance 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 ask for assistance on behalf of their patients. Usually, this occurs when an MCHIP has rejected 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 with an MCHIP. 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 cases, providers can use this information to resolve the problem. If not, then the Office encourages the provider to refer the patient directly to the Office for formal assistance with an appeal.

The Office also responds to inquiries and questions from federal and state legislators who contact the Office on behalf of their constituents. When this occurs, the staff typically contacts the consumer and offers to provide assistance in the appeal process, or depending on the type of health insurance coverage, refers the individual to the appropriate agency for assistance. The staff follows up with the legislator and may provide a written response, depending on the circumstances.

The Office helps consumers filing an oral or formal written appeal of an adverse decision issued by an MCHIP. The staff 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, 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, a new electronic portal, telephone, correspondence or facsimile. If the inquiry falls outside the purview of the Office, staff refers the matter to another section within the Bureau, such as the Consumer Services Section (CSS), or to another state agency, federal government agency or other source. Some inquiries however, involve issues that are completely outside the regulatory purview of any agency. During this reporting period, the Office responded to 336 inquiries, which represents a decline from the 626 inquiries the Office received during the previous reporting period.

If a consumer submits a written appeal with his or her MCHIP, the staff can formally assist 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 what supporting documents to include, such as copies of medical records and letters from medical providers. With written consent from the consumer, the Office also contacts the consumer's MCHIP in writing and addresses the issues involved in the appeal and provides supporting documentation.

Staff summarizes the critical issues involved in the appeal; and if any of the relevant facts are not clear or disputed, serves as a catalyst to clarify the issues. This ensures the issues are 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. For appeals that involve questions of medical necessity, the Office may ask the MCHIP to concentrate on the applicable clinical information documented in the consumer's medical record, and to carefully consider any applicable utilization review criteria the company used in making its decision. The MCHIPs usually agree to review and reconsider existing information or overlooked clinical information or, in some cases, new clinical information. As a result, in several cases, MCHIPs have revised or reversed adverse decisions after re-examing information or considering new information.

The staff reviews decisions that MCHPs 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 may 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. When the staff refers a case to another section, the MCHIP is notified that an inquiry may be sent from another section within the Bureau.

If the decision on an appeal is favorable to the consumer, but the consumer experiences difficulty in obtaining the previously denied services or benefits, the Office staff can provide additional assistance. Examples include helping the individual receive 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 plans however, can only offer one internal appeal. If an MCHIP issues an adverse determination that (i) may be eligible for an independent external review involving questions of medical necessity, appropriateness, health care setting, level of care, or effectiveness: or (ii) if the services are determined by the MCHIP to be experimental/investigational, the Office will help the individual file a request for an external review with the 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.

Generally, appeals fall into one of two different types, depending on the reason an MCHP issued a denial. One type is a denial based on the insurer's determination that the service, medical care, or treatment was not medically necessary; including denials based on the company's determination the services were experimental or investigational in nature. Typical appeals of this type involve prescription medications; surgery; imaging tests (CT scans, PET scans, and MRIs); inpatient hospital services; and mental health services, including substance abuse. The other type of denial is administrative or contractual 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. Usually this means there is a specific exclusion in the consumer's health insurance policy for the requested service. Examples of this type of appeal include a request for an MCHIP to increase the amount 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 under the terms of a consumer's health insurance policy; a request to extend a service, such as physical therapy, beyond the benefit cap as stated in the policy; and a request by an individual covered by an HMO to obtain treatment from a nonparticipating provider. Occasionally, an MCHIP may issue a dual denial, when the company determined the service was not medically necessary and also not a covered benefit. In this situation, the company has determined that the service was excluded for both reasons. A common example is appeals 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 plan documents. Not all of the appeals involved medical treatment; consumers whose dental insurance or vision insurance is provided by an MCHIP also contacted the Office for assistance in appealing an adverse decision.

If an appeal involves an issue 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. In some instances, this results in an MCHIP approving the request, which negates the need for a formal written appeal. When the treating provider contacts the MCHIP to discuss the medical issues involved in a situation 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 condition. This can result in the reconsideration being vacated and the initiation of an appeal. This type of reconsideration is the result of legislation that was effective on October 1, 2011.

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). In addition, the staff can also help a consumer file an appeal for services the individual is receiving but which will soon end (a concurrent care appeal). When a consumer has a serious medical condition that requires an immediate response, the Office can help the individual file an urgent care appeal, which expedites the appeal. Examples include an impending inpatient discharge which the patient and their attending physician dispute, or immediate treatment for a serious medical condition which

is potentially life-threatening. An MCHIP must issue a decision on an urgent care appeal within 72 hours.

As mentioned in previous annual reports, the overwhelming majority of consumers who ask for assistance in appealing an adverse determination had never appealed a denial. The Office is responsive to this inexperience, especially in conjunction with consumers who are seriously ill or confront significant medical bills. The Office attempts to ameliorate consumers' anxieties, along with consumers' general frustrations, by offering personalized assistance, counseling and guidance throughout the appeal process. As in prior reporting periods, the Office received very positive feedback and comments from consumers. During this reporting period, the Office assisted 59 consumers in the appeal process, which is less than the 111 consumers the Office helped during the preceding reporting period. This lower number may reflect a decrease in the number of consumers seeking medical care who have high deductible health plans, or insurers approving more services in an effort to achieve an appropriate loss ratio to avoid rebating premiums if they fail to meet a specified minimum loss ratio.

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 mentioned in prior annual reports. Consumers frequently encountered difficulties because they were not familiar 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) or certificate of coverage (COC). Some consumers also experienced problems understanding information from their MCHIP, such as explanation of benefit forms and denial letters. The Bureau and its staff continually emphasize to consumers the importance of reviewing and understanding coverage documents and correspondence. In assisting consumers and other interested parties, the Office tries to educate individuals on the basic concepts as well as routine and intricate issues that result from the merger of managed care and health insurance. The Office has always placed great importance on serving as an educational resource in assisting consumers and helping other individuals.

The Office helped numerous consumers whose health insurance was provided by a source outside the Bureau's regulatory jurisdiction, such as coverage through a self-insured employer. As in prior years, with few exceptions, consumers whose coverage was self-insured did not understand how the coverage worked until they contacted the Office for assistance. Although the Office staff was unable to formally help these consumers in filing an appeal, the staff was usually able to make suggestions, provide general information, and encourage the consumer to contact the employer's human resource section for formal assistance in resolving an appeal. During this reporting period, the staff encountered more consumers whose coverage was self-insured than during the previous reporting period.

The Office helped health care practitioners understand how to contact a patient's MCHIP to initiate a request for a reconsideration and in critical situations, how to request an urgent care appeal, which must be decided within 72 hours. The staff has found that many physicians are not aware of how to request a reconsideration or an urgent care appeal, which as noted, can be used in emergent situations. This information produced some favorable results, such as when the Office advised a physician to request a peer-to-peer review with an MCHIP's medical director

after the company refused to authorize a shot for a pediatric patient who was vulnerable to contracting a severe respiratory disease. The physician contacted the MCHIP, presented the case to a medical director, who then approved the series of shots to potentially prevent the patient from contracting the disease. This saved the patient's family several thousand dollars since the MCHIP approved the shots.

The Office also helped consumers understand the multiple dynamics involved in filing an appeal, particularly in situations where an MCHIP issued a denial based on a lack of medical necessity, or experimental/investigational denials. Staff was able to help consumers whose appeals involved these types of denials understand an MCHIP's clinical guidelines, and explain how their medical condition and proposed treatment met the criteria in the guidelines. In many instances, consumers used this information to support their appeal, which often resulted in an MCHIP overturning a denial. There were successful outcomes for many consumers, to include some individuals who were overwhelmed by the severity of their medical condition or the amount of a claim, and did not know how to file an appeal. Some of these outcomes were notable, such as one consumer who owed a hospital $50,000 and with help from the staff, won his appeal. Another successful outcome involved a consumer who won their appeal for denied anesthesia services, which totaled $12,245, and a consumer who won an appeal for surgical services which totaled $7,500. In another situation, the Office helped a consumer win an appeal to recover $15,547 the individual paid for a prescription medication. In all of these cases, the consumers acknowledged the assistance the Office staff provided.

As mentioned, the staff is also able to assist consumers who encounter a problem with a dental preauthorization or claim when their dental coverage is provided by an MCHIP. During this reporting period, the Office encountered an increase in the number of consumers who asked for help in appealing a denial issued by a dental MCHIP. Typical appeals in this area involved both administrative/contractual appeals and appeals for dental services an MCHIP determined were not dentally necessary. An example of the former were consumers whose dental insurance provides coverage for one bridge within a five year period, regardless of whether it was necessary to replace a bridge prior to five years. Another common situation for this type of 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 tooth. Services denied as not dentally necessary included patients who underwent a routine prophy which was extended into a scaling and planing procedure, which the MCHIP denied as not dentally necessary because the company determine that only the routine prophy was required. While some of these appeals were resolved in favor of the consumer, in cases where the consumer was not successful, they did not have the ability to request an external review, unlike final adverse decisions rendered in appeals involving medical services. The external review program does not apply to dental coverage.

In addition to assisting consumers whose dental coverage is provided by an MCHIP, the Office can help consumers resolve problems with their vision insurance coverage, if it is provided by an MCHIP. During this reporting period, the Office received very few requests for assistance with an appeal involving vision insurance. This may be because such policies are normally very limited in the scope of coverage; typically offering routine vision exams and payment for prescription glasses and contact lens.

As mentioned above, in the event the Office encounters a situation that suggests an MCHIP may not be in compliance with applicable regulatory requirements, the staff will obtain sufficient information from the company and refer the matter to the appropriate section within the Bureau for review.

Outreach

The Office continued its outreach efforts, in coordination with the outreach program administered 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 during the course of the Fair. The Office also had an exhibit at the annual meeting of the Virginia Dental Association held in Williamsburg. During this event, staff had an opportunity to speak with dentists and dental assistants from all over the commonwealth, which provided significant publicity for the Office. It's possible this explains why the Office experienced an increase in the number of inquiries and appeals involving dental denials.

A staff member was interviewed by Kiplinger's Magazine, which is a national financial publication. The individual provided information for an article on the federal government's Health Insurance Portability and Accountability Act (HIPAA); specifically, information on how an individual can designate a person to receive protected health information, including the timing of the authorization.

As part of its outreach efforts and in conjunction with responding to consumer requests for assistance in filing an appeal, the Office developed a new initial contact letter which is sent to consumers who ask the Office for assistance with an appeal. The letter was redesigned to make it easier for consumers to understand the purpose, role, and function of the Office and how the staff can help a consumer file an appeal of an adverse decision.

Federal Legislation

As required by the statute that established the Office, staff monitors changes in federal and state laws that pertain to health insurance. In regard to federal legislation, the Office continued to monitor developments, and in some cases assisted the Bureau in establishing procedures to implement various aspects of the Patient Protection and Affordable Care Act (ACA). Although the ACA was signed into law with an effective date of March 23, 2010, several provisions have staged implementation dates. As with last year, staff continued to review sections of the ACA and some of the regulations to implement the law promulgated by various federal agencies; specifically regulations published by the Department of Health and Human Services (HHS). As was the case last year, this year neither the Office nor the CSS received a significant number of consumer inquiries, appeals, or complaints involving the ACA. This includes the immediate market reforms in the areas of a prohibition on lifetime dollar limits; restrictions on annual dollar limits; coverage of preventive health services without cost sharing; increased patient protections; coverage for children up to age 26 by a parent's health insurance policy; and a prohibition against exclusions or restrictions of coverage for pre-existing conditions for children up to age 19.

As mentioned last year, one section of the ACA established funding for consumer assistance programs (CAPs). These programs provided expanded consumer services similar to services that were already provided by the Office and the CSS to consumers. Using a CAP grant from HHS, the Bureau enhanced its consumer outreach services, improved an automated case management system, and established an electronic portal to allow consumers a means to submit complaints on-line. These programs were all highly successful, and contributed to the ability of the Office and the CSS to assist consumers. Another accomplishment using grant funds was conducting more outreach programs, which included special outreach efforts oriented to Virginia's Latino population, and translating some consumer booklets into Spanish. In addition, during the last reporting period the staff participated in a project sponsored by the National Association of Insurance Commissioners (NAIC), along with representatives of other states, the industry, and interested parties, to create and standardize the language and format of two important plan documents. This project was completed, and the mandatory changes to these plan documents were effective during the later part of this reporting period. Consequently, it is premature to determine the effectiveness of these changes and the impact they may have on the ability of consumers to understand how their health insurance works.

The Office also monitored the implementation of minimum loss ratios for insurers, which is a requirement of the ACA. This part of the legislation requires insurers to rebate premiums to policyholders if specific medical loss ratios (MLRs) are not achieved. Generally, this means rebates will be required if the MLR is less than 80% of premiums in the individual and small group markets, and 85% of premiums in the large group market. The Bureau received a grant from HHS to strengthen its rate review efforts. In addition, the Bureau continued to participate in the Virginia Health Reform Initiative, (VHRI), which was formed by the Governor to study the establishment of a Health Insurance Exchange (HIX); specifically, whether to create a HIX operated by Virginia, allow the federal government to run the HIX, or establish a collaborative state-federal model. Regardless of the format, a HIX is designed to enable consumers in the individual and small group market the opportunity to purchase health insurance in one central location.

As a result of new requirements of the ACA and changes to existing programs, the Bureau revised its consumer guide entitled "Federal Health Care Reform" to update the ACA's requirements and how they may affect consumers. The Office believes that if consumers have this information they may be able to make informed choices and better understand the complexities of health care reform.

Virginia's Legislation

The Office tracks legislation that pertains to health insurance and related matters that is passed by the General Assembly and enacted by the Governor. In some cases, the Office also monitors the results of legislation passed in a previous Session of the General Assembly. This past Session, legislation was passed and enacted in § 38.2-3407.18 Requirements for orally administered cancer chemotherapy drugs. It appears the legislation was initially designed to protect a consumer from exorbitant out-of-pocket costs when undergoing treatment for cancer and receiving oral chemotherapy drugs, by limiting the out-of-pocket costs for these drugs to the

same amount as chemotherapy drugs delivered intravenously or by injection. At this point, the effectiveness of the legislation has not been determined, but the Bureau has received one consumer complaint which was not resolved in favor of the individual. The Office will continue to monitor the impact of this legislation.

As reported last year, legislation that affects internal and external appeals was passed and enacted in Chapter 35.1 Health Carrier Internal Appeal Process And External Review. This legislation resulted from provisions of the ACA which required Virginia to modify the process insurers use to address complaints and appeals. As a result of this new law, the Bureau promulgated a regulation to outline the new requirements that apply to both the internal appeal and external review process. The new requirements were effective last year, and the Office has monitored the results of MCHIPs implementing these changes and the effects on consumers. The changes did not have a major impact on the internal appeal process; with one major exception. Under the ACA, there is a significant increase in the amount and complexity of information an MCHIP has to provide when it notifies a consumer of an adverse benefit determination. This requirement has increased the amount and complexity of information MCHIPs provide to consumers, when companies issue denials.

As reported last year, the ACA made several changes to the external review program, and these changes were effective on July 1, 2011. One change eliminated the $300 cost threshold for an appeal to be potentially eligible for an external review, and another change eliminated the $50 filing fee, which the Bureau was authorized to waive. Another significant change is the final decision is made by the Independent Review Organization that reviews the appeal and the decision is not subject to review by the Commissioner of Insurance. The Office has monitored the effect of these changes, and it does not appear they had any discernable impact on the number of external review cases the Bureau processed.

Conclusion

During this reporting period, the Commission believes the Bureau has ensured the Office accomplished its responsibilities in accordance with the legislation that established the Office. 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, the staff referred individuals to another source for assistance. When requested, the staff has helped consumers in appealing an adverse benefit determination, and ensured individuals had fair access to the internal appeal process offered by his or her MCHIP. In these situations, the staff personalized its assistance to the needs of the consumer, and helped the person navigate 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 expertise maximized the opportunity for the appellant to be successful in the appeal process, and in most cases consumers who were successful would not achieved a favorable outcome without the help they received from the Office. 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.