REPORT OF THE

STATE CORPORATION COMMISSION ON THE ACTIVITIES OF THE OFFICE OF THE MANAGED CARE OMBUDSMAN

TO THE HOUSE COMMITTEE ON CORPORATIONS, INSURANCE AND BANKING; 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
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To: The House Committee on Corporations, Insurance and Banking
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 Section 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, 2000 through October 31, 2001.

Respectfully Submitted,

Commissioner Clinton Miller
Chairman

Commissioner Theodore V. Morrison, Jr.

Commissioner Hullihen Williams Moore

In accordance with § 38.2-5904 of the Code of Virginia, the Office of the Managed Care Ombudsman was established in the State Corporation Commission's Bureau of Insurance. This report is submitted pursuant to § 38.2-5904 B 11 which requires an annual report be submitted to the standing committees of the General Assembly having jurisdiction over insurance and health, and also to the Joint Commission on Health Care. This is the third annual report and covers the period from November 1, 2000 through October 31, 2001.

As reflected in the two previous reports, the Office of the Managed Care Ombudsman (the Office) was established and functional as of July 1, 1999, as required by legislation passed by the General Assembly. The Office has continued to build upon its success in meeting the objectives set forth in the legislation that established it.

During its third year, the Office has continued two key functions: responding to consumer inquiries and formally assisting consumers in appealing adverse decisions rendered by their Managed Care Health Insurance Plan (MCHIP). Inquiries are classified as a general request for information, assistance, or question and normally answered directly by the staff. During the previous reporting period, the Office responded to 751 consumer inquiries, and during the current reporting period, the Office responded to 1263 consumer inquiries, which represents an increase of 68%. The increase reflects greater consumer awareness of the Office through outreach programs and efforts by the Office to ensure MCHIPs notify consumers of the Office when issuing denials and adverse decisions.

During the previous reporting period, the Office provided formal assistance to 302 consumers who wanted to appeal an adverse decision made by their MCHIP. During the current reporting period, the Office provided formal assistance to 248 consumers who asked for assistance in appealing an adverse decision made by their MCHIP. This type of assistance involved the consumer submitting an inquiry form to the Office and the staff assisting and guiding the consumer through the MCHIP's internal appeal process. Frequently, the Office staff would contact the MCHIP to clarify issues involved in the individual's appeal. The 17% decrease in the number of consumers appealing an adverse decision of their MCHIP from the prior year is attributed to the staff's efforts in helping consumers clarify their understanding of the benefits provided by their particular MCHIP, as many consumers decided not to pursue appeals of services specifically excluded by their MCHIP.

Based upon assisting consumers with inquiries and appeals, the Office has determined that the most common reason consumers experience problems with their MCHIP is that consumers do not understand how their health insurance works, and they are unaware of the terms and conditions of their health care coverage. This essential information is presented in the Evidence of Coverage (EOC) or equivalent document that each MCHIP is required to provide to each insured individual. The Office makes a significant effort to educate consumers and to assist consumers in understanding the information in these documents. As part of that effort, the Office maintains current EOCs for all MCHIPs on file to use when counseling consumers. The importance of the EOC is also stressed in material published by the Office and provided to consumers, as well as in outreach efforts directed toward consumers.

The Office has continued its outreach program to increase the number of consumers that know about the services available through the Office. As in previous years, the outreach program is aggressively conducted in numerous ways. This year for instance, the Office collaborated with the Bureau of Insurance's External Review section and purchased advertising in select movie theaters throughout the Commonwealth. The Office was featured in an article in the Washington Post, which helped reach consumers in Northern Virginia. The Office provided speakers to professional organizations, civic groups, advocacy groups and other organizations around the state. For the first time, consumer information on the Office was distributed at the State Fair. Approximately 5,300 copies of consumer handouts containing both content and contact information were distributed to individuals, professional organizations, physician offices, and various advocacy groups.

Information on the Internet web site concerning the Office was updated, and the consumer inquiry form was added to the site. This allows consumers who require formal assistance with an appeal the opportunity to download the form and send it directly to the Office. During the reporting period, the Internet web site registered over 6000 visits.

The Office also worked with the Virginia Department of Health's Center for Quality Health Care Services and Consumer Protection (the Center) to receive and collect the annual complaint report required from each MCHIP. The complaint report was revised, and the Office tallied information on the number of complaints reported by each MCHIP. This raw data was then examined and compared with the staff's experience to detect any patterns or trends that indicated a potential concern with any specific MCHIP. After this analysis did not suggest any significant problems with any specific MCHIP, another analysis was performed. This analysis produced a complaint ratio, which compared the number of complaints to the number of enrollees in each MCHIP. This analysis also did not produce any meaningful result because the number of enrollees filing formal complaints with any MCHIP yielded an extremely low ratio, typically .01% or less. In many instances, the ratio was .000%. This does not, however, diminish the importance of the claims of those MCHIP enrollees whose complaint involved a very serious issue. It does appear to substantiate consumer surveys conducted by the managed care industry in which an overwhelming percentage of consumers are satisfied with their managed care plan.

During the past year, the State Corporation Commission had determined that the Office should act as the approval authority for each MCHIPs' required complaint system filing, which also addresses how appeals and grievances are processed and decided. Consequently, the Office was assigned this responsibility and has received and reviewed 32 MCHIP complaint system filings. These filings resulted from new MCHIPs having entered the market, existing MCHIPs having made changes to their complaint system, and, in selected cases, MCHIPs having revised their complaint system filing after the Office questioned the current procedures. Except in cases where the MCHIP rescinded its filing, approvals were issued to each MCHIP. This normally did not occur, however, until after the MCHIP provided additional information in response to questions and concerns raised by the Office.

The Office has continued to monitor significant new developments in federal and state legislative efforts related to health insurance. Of particular interest was proposed federal legislation establishing a Patients' Bill of Rights. In discussing that legislation, Senator John Warner directed his aide for health affairs to obtain information from the Office regarding its purpose, role, and function. The Office complied and pointed out that Virginia has already implemented most, if not all, of the issues under consideration in the proposed federal legislation. At the time of this report, the final outcome of the Patients' Bill of Rights is uncertain due to Congressional attention to the tragic events of September 11, 2001. The Office will continue to monitor the proposed legislation.

As previously discussed, the Office has directly assisted Virginia consumers during the reporting period with inquiries and appeals. At the same time, we believe the Office, along with the Bureau's External Review section, has also indirectly assisted a number of consumers. Although it is difficult to quantify, evidence suggests that in many instances, MCHIPs have ruled in favor of an appellant whose appeal involved issues of medical necessity because a final adverse decision could be subject to review by the External Review program. Individuals that the Office has assisted in the appeals process have reported that once the Office became formally involved, communications with their MCHIP were enhanced. Individuals who did not receive formal assistance with an appeal still received indirect benefits, since their MCHIP operated the appeals process in a manner subject to review by the Office. These consumer benefits are, we believe, a valuable byproduct of the legislation that established the Office. At the same time, MCHIPs have informed the Office of their appreciation of the Office's efforts in assisting MCHIP enrollees understand how their health insurance works, specifically in the area of benefits that are specifically excluded or limited under the terms of the individuals coverage.

After establishing its initial presence, having built upon its accomplishments and having obtained an additional responsibility, the Office has accelerated its efforts, while at the same time assisting a greater number of consumers. As presented in this report, we continue to believe that the Office of the Managed Care Ombudsman continues to be one of the effective consumer-oriented functions of the State Corporation Commission's Bureau of Insurance.