REPORT OF THE

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

TO THE HOUSE COMMITTEE ON COMMERCE AND 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
2002

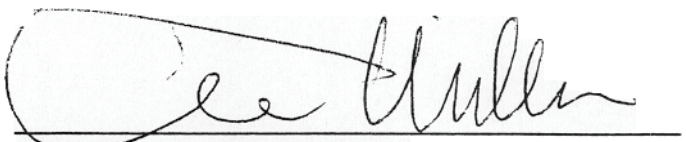
November 21, 2002

To: The House Committee on Commerce and 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

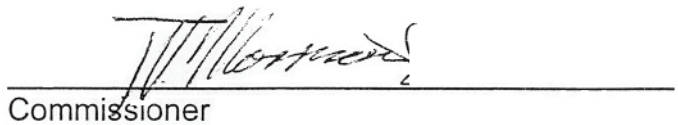
The report contained herein has been prepared pursuant to Section 38.2-5904 of the Code of Virginia.

This report documents the activities of the Office of the Managed Care Ombudsman for the reporting period covering November 1, *2001* through October 31, *2002*.

Respectfully Submitted,



Commissioner Clinton Miller
Chairman



Commissioner
Theodore V. Morrison, Jr.

Commissioner Hullihen Williams Moore

In accordance with Section 38.2-5904 of the Code of Virginia, the Office of the Managed Care Ombudsman (the Office) was established in the State Corporation Commission's Bureau of Insurance. This report is submitted pursuant to Virginia Code Section 38.2-5904 B 11, which requires that an annual report be submitted 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 fourth annual report and covers the period from November 1, 2001 through October 31, 2002.

As reflected in the three previous annual 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 created the Office.

During its fourth 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 a question and normally answered directly by the staff. During the previous reporting period, the Office responded to 1263 consumer inquiries, and during the current reporting period, the Office responded to 1936 consumer inquiries, an increase of 53 %. The Office attributes the increase to greater exposure through outreach programs and for ensuring that MCHIPs include contact information for the Office in denial letters sent to enrollees who have requested a service or benefit, or who are in the appeal process.

During the previous reporting period, the Office provided formal assistance to 248 consumers who wanted to appeal an adverse decision made by their MCHIP. During the current reporting period, the Office provided formal assistance to 257 consumers who indicated they wanted 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 Office has documented in previous annual reports that based upon assisting consumers with inquiries and appeals, the most common reason consumers experience problems with their MCHIP is that many consumers do not understand how their health insurance works. Typically, consumers are unaware of the terms and conditions of their health care coverage. Nothing has changed in the current reporting period to alter this conclusion, and the Office continues to stress that consumers should read and understand the Evidence of Coverage (EOC) and other documents that every MCHIP is required to provide to each insured individual. These documents explain how the coverage works, including noncovered benefits, exclusions, and benefits that, although available, are limited. The Office continues to make 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 sample EOCs for each MCHIP so that staff may refer to a particular EOC when counseling a consumer. The Office also continues to stress

the importance of the EOC and other plan documents in outreach programs oriented to consumers and in material the Office publishes.

In isolated instances, during the course of assisting consumers, the Office noted that information in an MCHIP's EOC was not clear, and, in one case, conflicted with information provided to an individual in other plan documents. The Office referred these issues to the Life and Health Forms and Rates Section within the Bureau of Insurance, which initiated a formal inquiry that eventually resulted in the documents being revised.

An aggressive outreach program continues to result in more consumers learning about the Office and services it provides, and may account for the increased number of inquiries received. As part of the Bureau of Insurance, the Office benefited from additional exposure it gained through a new outreach program initiated by the Bureau of Insurance. This new program directed additional resources to outreach efforts, and included a booth at the Virginia State Fair. The Office, along with the External Review section, continued to be featured in advertising in select movie theaters throughout the Commonwealth. The Office was mentioned in a consumer article that appeared in the Washington Post, and provided speakers to professional organizations and civic groups. The Office was also prominently featured in an article that appeared in "Kiplinger's Personal Finance," a national financial publication.

The Office acknowledges the support it received from the Medical Society of Virginia and its affiliates, especially the Richmond Academy of Medicine. As in previous years, the Academy has graciously invited the Office to participate in its annual Fall Expo, which allowed the Office direct access to physicians. As a result, the Office was able to educate physicians and subsequently assist patients referred to the Office by their physicians.

The Office continued to provide copies of brochures and "tip sheets" to consumers. This information contains both content and contact information, which is designed to assist the consumer and also information on how the consumer can contact the Office. In response to assisting an increased number of consumers filing appeals for denied prescriptions, the Office developed and published a tip sheet specifically designed to assist consumers appealing denials for prescription medications. The Office also developed and published a tip sheet designed to assist consumers whose coverage is provided by self-insured health plans, since such plans are not subject to the regulatory jurisdiction of the Bureau of Insurance.

During the reporting period, there were 6,233 visits to the Office's pages on the Bureau of Insurance Internet site, which is approximately the same number as during the previous reporting period. Information on the site was updated, and additional information, such as the two new consumer tip sheets described above, was added. For the first time, information to assist MCHIPs was posted on the Internet site in the form of a checklist the Office uses in evaluating complaint system filings that MCHIPs submit to the Office for approval.

In an effort to respond more efficiently to telephonic requests for information and assistance, the Office implemented a new Interactive Voice Response (IVR) system. The IVR system allows consumers to use an automated voice menu to either obtain information regarding a particular issue or contact a staff member for assistance. Implementing IVR will make the Office even

more accessible to consumers who find it inconvenient to call during normal business hours. For example, a consumer who telephones the Office over a weekend will be able to obtain the e-mail address for the Office. If the consumer then sends an e-mail they will receive a reply on the next business day. We believe the responsiveness afforded by the IVR system compares favorably with that of any commercial enterprise.

The Office continued to work with the Virginia Department of Health's Center for Quality Health Care Services and Consumer Protection (Center) to receive and collect the annual complaint report required from each MCHIP. Every MCHIP is required to submit an annual complaint report to the Center and to the Bureau of Insurance that documents the number of complaints the MCHIP has received. Within the Bureau of Insurance, the Office is responsible for evaluating these reports. In reviewing the reports, the Office has once again determined that the ratio of enrollees who file a complaint with their MCHIP is very low, typically .01% or less. This low ratio, however, does not in any way diminish the importance of some serious problems enrollees have encountered with their MCHIP.

The Office also continued to coordinate its efforts with the Center, which has the regulatory responsibility to regulate the quality of care provided by MCHIPs. On several occasions, the Office referred consumers to the Center for additional assistance, after the consumers completed their MCHIP's internal appeal process. These appeals involved quality-related issues, such as the adequacy of the network of participating providers.

As stated in the previous annual report, the State Corporation Commission had determined that the Office would be the designated approval authority for each MCHIPs' required complaint system filing, which also addresses how appeals and grievances are processed and decided. During this reporting period, the Office received 21 complaint system filings, and approved 16 of the filings, with the remaining 5 still under review. As part of the review procedures, the Office has placed additional emphasis on information contained in correspondence that MCHIPs generate to communicate an adverse decision to enrollees. Frequently, the Office has asked MCHIPs to include more specific information regarding the appeal process and to include specific information on the Office so enrollees know that assistance is available. The Office also revised the checklist it uses to evaluate complaint system filings, and posted the checklist on its Internet site. This assists MCHIPs in submitting filings that meet the standards.

Previous annual reports have contained very little information regarding new developments in federal or state legislative efforts related to health insurance. This year is different, because the federal government's Department of Labor (DOL) issued regulations affecting the appeal procedures used by many MCHIPs in Virginia. The regulations mandated certain time limits that MCHIPs may use in deciding appeals and notifying consumers of the outcome. In an effort to comply with the new regulations, some MCHIPs reduced the number of appeal levels available to an individual from two levels to one level. This has adversely affected enrollees whose first appeal lacked sufficient strength to be effective, since there was no opportunity for an additional enrollee appeal.

The Office is convinced through experience in assisting thousands of consumers that the overwhelming majority of consumers do not fully understand how to effectively appeal an adverse decision that their MCHIP has rendered. Eliminating a second opportunity for an enrollee to file an appeal has usually placed the individual at a decided disadvantage in the appeal process. This appears to be an unanticipated consequence of the new DOL regulation. At this time, there is no indication whether or not the DOL recognizes this adverse impact on some consumers in Virginia.

During the reporting period, the Office assisted consumers directly and indirectly. As illustrated by the increased workload regarding inquiries, the number of consumers the Office assisted directly increased by 53% from the previous reporting period. As stated in the last annual report, we believe the Office, along with the Bureau of Insurance's External Review section, has indirectly assisted an untold number of consumers. We draw this conclusion in the same manner as last year, in that evidence suggests that in many instances, MCHIPs have decided an appeal in favor of an appellant when the appeal involved an issue of medical necessity. A final adverse decision that involves medical necessity is potentially subject to the External Review program. Approximately 60% of appeals reviewed by the External Review program are overturned in favor of the appellant.

Individuals that the Office has assisted in the appeal process continued to report that the involvement of the Office had a positive effect and enhanced communication between the individual and their MCHIP. At the same time, staff from several different MCHIPs have expressed their appreciation of the Office's efforts to educate consumers and help them understand how their managed care insurance works. We believe these positive comments from two sides that are at times seemingly opposed to one another may be indicative of the respect the Office has earned from both consumers and the MCHIPs. We continue to maintain that the Office of the Managed Care Ombudsman functions as one of the effective consumer-oriented sections in the State Corporation Commission's Bureau of Insurance.