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
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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, 2005, through October 31, 2006.

Respectfully Submitted,

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Commissioner Mark C. Christie, Chairman

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Commissioner Judith Williams Jagdmann

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Commissioner Theodore V. Morrison, Jr.

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 (the Office) covers the period from November 1, 2005 through October 31, 2006. During this time, the Office informally and formally assisted over 850 consumers with general issues or specific problems regarding a managed care health insurance plan (an MCHIP). The Office continued conducting outreach and educational programs to help consumers understand the benefits available from their MCHIPs and provided tools as well as direct assistance to consumers in resolving problems they encountered. When applicable, consumers were referred to other regulatory agencies for assistance. The Office continues to provide a valuable service to consumers whose health insurance is provided by an MCHIP, and functions in accordance with the legislation that created the Office in 1999.

The Office of the Managed Care Ombudsman (the Office) was established in the State Corporation Commission's Bureau of Insurance on July 1, 1999, in accordance with § 38.2-5904 of the Code of Virginia. This report is submitted pursuant to § 38.2-5904 B 11, which requires the Office to submit an annual report of its activities 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 eighth annual report of the Office and covers the period from November 1, 2005 through October 31, 2006.

As reported in previous years, the Office is a resource for consumers whose health insurance is provided by a Managed Care Health Insurance Plan (MCHIP), which includes all health maintenance organizations (HMOs), preferred provider organizations (PPOs) and essentially any form of managed care provided by a health insurance company licensed by the Bureau of Insurance (the Bureau) to transact business in Virginia. Commensurate with the regulatory role of the Bureau however, the Office does not have the statutory authority to assist consumers unless their coverage is fully insured and issued in Virginia. As a result, the Office is unable to assist individuals whose health insurance 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.

When individuals insured by any of the above types of coverage contact the Office for assistance, the staff refers the consumer to the appropriate federal or state regulatory agency for assistance.

The Office provides informal and formal assistance to consumers that encounter a problem with their MCHIP, and also responds to general questions from consumers and other individuals. The Office provides general information and assistance to consumers or other individuals who submit an inquiry. Typical inquiries concern an issue, a question or a problem related to health insurance or some aspect of managed care. Inquiries are commonly received via correspondence, telephone calls, or e-mail. Frequently, consumer questions arise from not understanding how their health insurance works. The Office staff readily assists these consumers in developing a better understanding of their health insurance benefits. During this reporting period, the Office responded to 695 inquiries, which is slightly higher than the 661 inquiries the Office received during the previous reporting period.

The Office staff formally assists consumers who want to appeal an adverse decision made by their MCHIP, such as a denied request for medical treatment that the individual's physician determined was medically necessary. Once the consumer provides consent, which is documented on an inquiry form staff assists the individual with the appeal, contacts the individual's MCHIP and ensures that the individual has full access to the internal appeal process provided by that particular MCHIP. Staff also obtains information from the consumer and the MCHIP to clarify disputed facts or issues involved in the appeal. The objective is to establish a clear understanding of all the pertinent issues involved in the appeal and provide this information to the consumer to maximize the effectiveness of the appeal. In some instances, the person's MCHIP receives new information, which sometimes serves to resolve the appeal in the consumer's favor.

The Office also provides detailed guidance to consumers on information to include in an appeal, and stresses the importance of constructing an appeal based on logic and objective information. Office staff has created several tip sheets to assist consumers in filing an appeal, including a general tip sheet containing suggestions applicable to appealing any type of adverse decision, and some specialized tip sheets concerning specific types of appeals, such as receiving out-of-network services, denials based upon an MCHIP's assertion that the requested service is experimental, and denials for prescription medication. Other types of appeals the Office encounters involve denials for requests such as medical services, surgical procedures, diagnostic tests, hospital admissions and length of stay, mental health services, and claim payments. During this reporting period, the Office assisted 191 consumers in filing an appeal, which is an increase from the 172 consumers the Office assisted in the previous reporting period.

Once an MCHIP renders a decision on a consumer's appeal, the MCHIP informs the consumer and the Office. In the event the consumer is successful, the Office staff will normally close the file. If staff suspects there may have been a violation of an insurance statute or regulation, staff will obtain additional information and discuss the situation with other Bureau staff, who if appropriate will follow up with the MCHIP. In the event the consumer is not successful in the appeal, staff will assist the individual with any additional appeal options, such as another internal appeal or referral to another source for assistance.

When an MCHIP issues a final adverse decision on an appeal denying issues involving medical necessity, staff will help the person apply for an external appeal, a function which is administered by another section within the Bureau. Whenever an MCHIP issues a final adverse decision, Office staff will conduct a review and again refer the file to another Bureau division if a statute or regulation may have been violated.

In instances where a consumer's appeal is not successful, staff helps the individual understand why the appeal may have failed. Frequently this involves an appeal for a benefit which is excluded from the consumer's health care coverage. If an appeal may involve potential quality of care issues, then the staff will refer the individual to the Office of Licensure and Certification (OLC), in the Virginia Department of Health (VDH) for assistance, as that is the state agency which has the responsibility to regulate the quality of care that an MCHIP provides.

During this reporting period, there were several times when Office staff questioned the validity of an MCHIP's final adverse decision and referred the matter for further review. In one notable case, a consumer appealed a denial for surgery to correct vascular deficiencies in her lower extremities, but the request was denied because the MCHIP determined the requested surgery was for varicose veins and not a covered benefit. Office staff questioned this conclusion however, since the individual's physician had determined the surgery was medically necessary to treat and prevent a potentially serious vascular disease. Since the coverage was provided by an HMO, it was required by statute and regulation to provide basic health care services. When the issue was reviewed by other staff in the Bureau, it was determined that the MCHIP's denial was contrary to the HMO's obligation to provide basic health care services. As a result, the MCHIP reconsidered its position and approved the surgery, along with surgery for another consumer that had experienced a similar problem. The Bureau also directed the MCHIP to revise its policy language to remove the exclusion for surgery to treat varicose veins, along with several other exclusions which the Bureau determined must be provided by an HMO to provide basic health care services.

As discussed in previous reports of the Office of the Managed Care Ombudsman, staff has continued to encounter numerous instances of consumers who have experienced significant difficulties resulting from their failure to understand how their health insurance works. Staff has continued its education efforts, both in assisting consumers with inquiries and appeals and also in its outreach efforts, including information on its Internet page. Educational efforts focus on helping consumers understand the mechanics of how their health insurance works, the importance of reading and understanding the evidence of coverage, and how to properly obtain the benefits that are provided by their health insurance. Office staff believes educating consumers about health insurance and managed care is a critical function of the Office and will continue its efforts in this area.

Since the Office recognizes the importance of using every available means to provide information to consumers, it maintains an Internet web page that is designed to be as consumer friendly as possible. The web page contains information about the Office, and all of the tip sheets and brochures that have been developed to assist consumers. The web page also enables consumers to

contact the Office via a dedicated e-mail account, which has proven to be very popular and enables consumers to initiate contact with the Office at virtually anytime, including weekends. During the current reporting period, there were 5,648 visits to the Office's web page as compared to 5,112 visits during the previous reporting period.

As in previous years, Office staff conducted outreach programs to inform consumers about the Office and the assistance it provides. Staff made presentations and provided tip sheets and brochures to the Virginia Department of Business Assistance, Care Connection for Children at Virginia Commonwealth University, and the Virginia Chapter of the American Association of Healthcare Administrative Management. Staff also participated in a panel discussion at a meeting hosted by the Virginia Quality Healthcare Network. Information about the Office was also included in numerous presentations and outreach programs conducted by the Outreach section of the Bureau's Life and Health Division. Staff mailed brochures and tip sheets to consumers who asked the Office for assistance with an appeal, and also provided brochures and tip sheets at the Virginia State Fair as part of the Bureau's outreach program. These efforts resulted in approximately 2,500 tip sheets and brochures being distributed during this reporting period.

Each MCHIP that conducts business in Virginia is required by statute to submit an annual complaint report to the Office of the Managed Care Ombudsman, which reflects the number of complaints the MCHIP has received during the calendar year. The number of complaints includes those made by consumers, and other sources, such as the Life and Health Consumer Services Section of the Bureau. In reviewing these reports, staff notes that generally, the number of enrollees in any particular MCHIP that files complaints is very small as compared to the total number of enrollees. This conclusion is consistent with findings from previous years, but does not, however, diminish the severity of problems that an extremely small number of enrollees have encountered with their particular MCHIP. Staff also examines these reports to determine if any particular MCHIP's report demonstrates a pattern or trend that should be further reviewed.

The Virginia Department of Health's Office of Licensure and Certification (OLC), is responsible for regulating the quality of care provided by an MCHIP, as previously noted. The Office and OLC exchange referrals, so that depending upon the nature of their problem, consumers are able to obtain assistance from the appropriate office. The collaboration between the two offices benefited consumers, and ensured that consumers could avail themselves of the complete regulatory resources available to assist them.

In accordance with the legislation that established the Office, staff monitors changes in federal and state laws relating to health insurance. At the national level, the Office noted reports that consumer driven health plans have become more popular. The creation of Association Health Plans (AHPs) has been

discussed in Congress. These AHPs would enable unrelated small businesses to collectively purchase health insurance for their employees, even when these businesses were not all located in the same state. The Office is concerned however, that exempting such plans from state insurance laws including not having access to consumer protections afforded by state insurance laws, and denying these consumers the ability to obtain assistance from a state insurance department would be detrimental. The National Association of Insurance Commissioners (NAIC), an association which consists of the 50 state insurance commissioners and their staffs, is working with other interested parties on AHP legislation to preserve state regulatory jurisdiction over AHPs if such legislation is enacted.

The Office is following the *Health Insurance Marketplace Modernization and Affordability Act of 2006*, S.1955, sponsored by Senator Michael Enzi (R-Wyo) and the *Health Care Choice Act*, H.R. 2355, sponsored by Rep. John Shadegg (R-AZ) this year. Senate Bill 1955 would enable small businesses located in different states to collectively sponsor small business health plans (SBHPs), to purchase group health insurance. The proponents of this bill assert it would reduce the cost of health insurance, which has been a problem for small employers throughout the nation. The bill does not contain provisions to guarantee that a consumer would be protected under the insurance laws of the state in which he resides, or by comparable state insurance statutes. Essentially, H.R. 2355 would permit insurers to issue individual health insurance policies in one or more states after having received approval of the policy form in a single state. Supporters maintain that H.R. 2355 will reduce the cost of insurance for consumers that purchase individual coverage, by permitting insurers to issue health insurance policies approved in states with fewer mandates or other regulatory requirements, which would reduce the cost of individual insurance coverage, especially for consumers in states that have considerable mandated coverage requirements. The Office however, is concerned that these legislative efforts may produce legislation that prevents consumers from being protected by state insurance laws and important consumer protection provisions. Staff will continue to monitor this legislation during the next year.

In Virginia, the General Assembly passed House Bill 761; patronned by Delegate Hamilton. This legislation enables small employers to form small employer health group cooperatives to purchase health insurance for their employees. Under this concept, several small employers may band together to form a single risk pool for the purpose of purchasing health insurance from a health insurance company. Such a pooling arrangement may result in a participating small employer being able to obtain health insurance at a lower cost. The goal of the legislation is to increase the number of individuals working for small employers that are covered by health insurance, by making coverage more affordable.