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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December 1, 2007

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, 2006, through October 31, 2007.

Respectfully Submitted,

Commissioner Theodore V. Morrison, Jr., Chairman

Commissioner Mark C. Christie

Commissioner Judith Williams Jagdmann

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, 2006 through October 31, 2007. The Office informally and formally assisted over 1,000 consumers during the reporting period by responding to general issues or specific problems regarding a Managed Care Health Insurance Plan (an MCHIP) or related issue involving managed care or health insurance. The Office staff helped consumers understand how their health insurance works and how to solve problems. In some instances the Office staff referred potential regulatory concerns to other sections within the Bureau of Insurance for further review and appropriate action. The Office continues to provide a valuable service to consumers, and functions in accordance with the legislation that created the Office in 1999.

Background and Introduction

The Office of the Managed Care Ombudsman (the Office) was established in the State Corporation Commission's Bureau of Insurance (the Bureau) 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 ninth annual report of the Office and covers the period from November 1, 2006 through October 31, 2007.

In accordance with the legislation that established the Office, the staff provides assistance to 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 other forms of managed care written by a health insurance company licensed by the Bureau to transact business in Virginia. The Office can assist consumers whose coverage is provided in the group market or the individual market, but the coverage must be fully insured and issued in Virginia, which is consistent with the overall regulatory jurisdiction exercised by the Bureau. Therefore, 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.

Activities of the Office

Although the Office is unable to formally assist individuals insured or covered by any of the above types of coverage, the staff provides general information and refers these consumers to the appropriate federal or state regulatory agency for assistance.

The Office provides informal assistance to consumers that have a question or concern about some aspect of their health insurance or their MCHIP such as how their health insurance works and what benefits are available. Some inquiries concern a problem an individual encountered trying to obtain coverage for treatment, or in processing a claim. These issues and questions may be very specific or general in nature. Since many inquiries result from consumers who experience difficulty in understanding how their health insurance works, the Office staff educates consumers about what may be eligible for coverage and what isn't potentially eligible for coverage, along with the means to resolve simple problems. In some instances, providers contact the Office for information on how

the staff can assist a patient that has encountered a problem. When this occurs the Office staff provides basic information and asks the provider's office to have his patient contact the Office directly for assistance. Inquiries consist of correspondence, telephone calls, or e-mail which the staff typically answers in one response or exchange. During this reporting period, the Office responded to 890 inquiries which exceeds the 695 inquiries the Office received during the previous reporting period.

In addition to informally assisting consumers, the Office staff can also formally assist consumers that want to appeal an adverse decision made by their MCHIP. Although the Office cannot adjudicate appeals, the staff can help consumers navigate the internal appeal process offered by their MCHIP, by explaining how the process works and providing personal assistance to help an individual submit an appeal. The Office staff can contact the individual's MCHIP and ask the insurer to clarify and verify any information that is not clear or is in dispute; with the objective of all parties concerned understanding the relevant facts related to the appeal. In order to assist a consumer with an appeal, the Office asks consumers to complete a form, which documents that the individual has requested assistance. This documentation is provided to the person's MCHIP.

Since the majority of consumers that appeal an adverse decision are doing so for the first time, the Office is a valuable resource for both general and specific advice, guidance and suggestions. This assistance is especially beneficial to consumers suffering from serious medical problems, who may struggle to comprehend the appeal process and the information they should provide in their appeal. The Office staff has developed a general tip sheet on making an effective appeal, and several tip sheets to assist consumers with specific types of denials, This information is furnished to individuals that want to submit a written appeal to their MCHIP. Common types of appeals include denied requests for medical services, diagnostic tests, mental health services, surgery, prescription medication, treatment considered to be experimental and claim denials associated with these services. In some instances, once the Office contacts an MCHIP while assisting a consumer with his or her appeal, the insurer decides to approve the appeal, especially when it receives new information or reconsiders prior information in a different perspective. In such cases, the MCHIP terminates the appeal process and overturns its denial. During this reporting period, the Office assisted 175 consumers in filing an appeal, which is a decrease from the 191 consumers the Office assisted in the previous reporting period.

The Office reviews decisions that MCHIPs issue on appeals, and ensures consumers understand the outcome; the reason they won or lost their appeal. If the outcome is in the consumer's favor, the Office staff usually just closes the file. When the decision is not in the consumer's favor, the staff will scrutinize the reason the MCHIP did not overturn its decision. If it appears the decision is potentially not in compliance with any applicable insurance statutes or regulations, or not in accordance with the terms of the consumer's health

insurance coverage, the Office will ask the MCHIP for additional information and then determine if the matter should be referred to another section within the Bureau for further review. In the event an MCHIP renders a final adverse decision on an appeal involving a utilization review issue, the Office staff will help the consumer submit an application for the External Appeal Program, which is administered by another office within the Bureau. If the denial indicates that there is a potential quality of care issue, the Office will refer the consumer to the Office of Licensure and Certification (the OLC), in the Virginia Department of Health (the VDH) as that is the state agency which has the responsibility to regulate the quality of care that an MCHIP provides.

Appeals involving administrative and contractual issues, such as the amount of physical therapy coverage available to an individual are frequently not resolved in the consumer's favor: if the MCHIP has provided the benefits established in the health insurance policy, then it is not obligated to extend or expand those benefits. Unfortunately, most consumers do not understand these types of limitations on their health care coverage, so the Office staff explains that when this occurs, the MCHIP has not acted improperly in denying the appeal if the requested benefit is clearly not eligible for coverage. This situation also occurs when consumers appeal a service which is not identified in the coverage documents as a potential benefit. When the Office staff explains this concept to consumers that have not been successful with their appeal, the Office helps consumers understand that their health insurance coverage does not cover virtually anything that might be medically necessary. In reinforcing this concept, the Office staff asserts the importance of reading and understanding coverage documents like the Evidence of Coverage (the EOC) and other plan documents, so consumers fully understand their coverage.

When assisting consumers with appeals, the staff will question an MCHIP if a part of the MCHIP's EOC is vague or if different sections of the EOC are potentially contradictory. If staff believes the EOC may be misleading or identifies a potential statutory or regulatory violation within the EOC, it will refer the matter to the appropriate section within the Bureau for further review and regulatory action when appropriate. Notable examples this year of referrals resulting in further action involved benefits for early intervention services and off-label prescription drugs.

Findings and Discussion

In a similar manner, the Office staff reviews documents MCHIPs provide to their insureds in the appeal process, to ensure the information is accurate, conforms to applicable insurance statutes, and informs consumers of their rights. In this reporting period, while assisting some seriously ill consumers insured by one MCHIP, Office staff discovered that the MCHIP did not provide these individuals with correct information regarding expedited External Appeals. In these cases, the MCHIP refused to consider a request for an expedited appeal on an

expedited basis and issued a denial. The denial letter provided by the MCHIP did not contain mandatory information on the individual's right to request an expedited External Appeal. After properly informing the individuals of their statutory rights, the Office staff referred the issue to the appropriate section for further action, and as a result the MCHIP was administratively disciplined and changed its procedures to comply with Virginia law.

In some instances, the Office staff identified problems with Explanation of Benefit Forms (EOBs), which contained incomplete or contradictory information regarding the consumer's out-of-pocket financial responsibilities. In one case, Office staff assisted a consumer with an appeal involving a nonparticipating mental health provider. The consumer appealed the amount her MCHIP paid on the claim. After reviewing the EOB, the Office staff determined that not only was the information not clear but in addition the MCHIP could not provide the data it used to determine the reasonable and customary charge for a nonparticipating provider. The Office staff referred the matter to another section within the Bureau to review, and as a result an investigation is underway.

In the course of assisting consumers with inquiries and appeals, the Office staff helps consumers understand how their health insurance works. These educational efforts are designed to not only help consumers develop a better understanding of the principles of health insurance, but also help consumers solve a problem by using their knowledge. In many cases, consumers can avoid problems if they understand key concepts of their health insurance coverage. In addition to personal interactions with the Office staff, consumers receive educational material which contains helpful information. This information includes both general information on the Office, and other brochures and pamphlets contain detailed information on how to appeal specific types of denials. The 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.

The Office maintains an Internet web page containing general information about the Office, as well as all the educational tip sheets and brochures that have been developed to assist consumers. A list of the mandated benefits and mandated offers that MCHIPs are required to provide in Virginia is also included on the web page. The web page also provides direct access to a dedicated e-mail account that goes directly to the Office. Consumers can use this e-mail account to contact the Office at any time, and it is not uncommon for consumers to send e-mail to the Office outside of regular business hours. During this reporting period the web page recorded 6,014 visits, which is more than the 5,648 visits reported during the previous reporting period.

As in previous years, the Office staff conducted outreach programs to increase awareness of the Office and the services it provides. Staff typically makes a presentation on the Office, distributes educational material to individuals in

attendance, and responds to questions. During this reporting period, presentations were made to the West End Gluten Intolerance Group and the Autism Society of America Central Virginia Chapter. As part of its outreach efforts, a staff member appeared on the noon news broadcast of WRIC TV in Richmond, which is the local affiliate for ABC. In addition, a staff member lectured a class of graduate students in health care administration at Virginia Commonwealth University on health insurance. In another outreach program, the Office provided an article to the Medical Society of Virginia which published the information in its newsletter that is distributed to its members across Virginia. This state-wide exposure generated an increase in the number of physicians that contacted the Office on behalf of their patients. The Office also provided consumer publications for individuals that visited the display staffed by the Bureau at the Virginia State Fair. In total, the Office distributed approximately 1,750 brochures and tip sheets to consumers during this reporting period.

Section 38.2-5804 C of the Code of Virginia requires each MCHIP that is licensed in Virginia to submit an annual complaint report to the Office of the Managed Care Ombudsman. The report reflects the number of complaints the MCHIP received during the calendar year, and includes complaints made by consumers, as well as from other sources, such as individuals that contacted the Life and Health Consumer Services Section of the Bureau for assistance with a complaint. In reviewing the annual complaint reports this year, as in previous years, the Office staff has noted that generally, the number of enrollees in any particular MCHIP that files a complaint is very small when compared to the total number of enrollees in that MCHIP. While only a small number of individuals file a complaint, there are isolated incidents when an enrollee has encountered a serious problem with his MCHIP. The Office staff also examines these reports to determine if any MCHIP's current report indicates a need for further review. if a further review is needed, the Office staff compares the report to previous annual reports to determine if a pattern or trend has developed which is analyzed and if necessary, referred to the appropriate section within the Bureau for further action.

The Office continued working with the Virginia Department of Health's Office of Licensure and Certification (OLC), which is responsible for regulating the quality of care provided by an MCHIP. In some cases, the Office staff referred consumers to the OLC to file a quality of care complaint, when it appeared the care was substandard or in instances when an MCHIP did not have a sufficient provider network to meet the requirements of its enrollees. Periodically the two offices discussed problems they had encountered while assisting consumers or other relevant regulatory issues. These joint efforts assure strong state regulatory oversight of managed care in Virginia, albeit from different perspectives in accordance with applicable statutes.

Legislative Issues

The Office staff monitors changes in federal and state laws relating to health insurance, in accordance with the legislation that established the Office. Currently the Office is tracking Congressional legislation regarding mental health parity: S. 558: Mental Health Parity Act of 2007 and H.R. 1424: Paul Wellstone Mental Health and Addiction Equity Act of 2007. These two bills, introduced in the Senate and House of Representatives respectively, seek to enhance federal legislation that requires health plans to cover mental health conditions commensurate with coverage for other types of health problems. At this point it is difficult to predict if this legislation will be passed and signed into law. Virginia insurance statutes requiring coverage for mental health contain parity provisions, and the Senate bill is expected to preserve any state law that provides more protection for consumers. Consequently the Office staff and other sections within the Bureau will continue to track this pending legislation at the federal level to further assess any potential impact upon Virginia insurance statutes.

The previous annual report discussed pending federal legislation that would have enabled small businesses located in different states to collectively sponsor small business health plans to purchase group health insurance. The concept was to allow small businesses to combine their separate risk pools into a larger pool, thereby lowering the costs of health insurance which could result in more small businesses being able to offer health insurance to their employees. Although this legislation did not materialize, legislation enacted in Virginia provided the same opportunity within the Commonwealth for small employers to use group cooperatives to band together to form a single risk pool; thereby accomplishing the same purpose.

In a similar manner, while various legislative proposals have been discussed at the federal level to provide some form of universal health insurance, nothing definitive has resulted; but several states have considered or passed legislation to increase the number of individuals with access to health insurance. California considered, but did not pass, a legislative mandate to require individuals to purchase health insurance. Massachusetts enacted a universal coverage mandate that requires citizens to purchase health insurance. In Massachusetts, most individuals must either obtain health insurance or be subject to financial penalties, and small employers must provide health insurance to their employees. It will also provide subsidized health insurance for certain individuals, and Massachusetts also created a government operated "insurance connector" to provide assistance to consumers that want to purchase health insurance. In an effort to target the uninsured population employed by small businesses, Tennessee passed legislation creating CoverTN, which created limited benefit policies. The coverage is capped at $25,000 per year, and the premium is paid by the state, the employer and the employee, with each entity responsible for one third of the premium.

The Office will continue monitoring these types of legislative initiatives at the state level since future legislative efforts will likely be generated at the state level

rather than at the federal level due to the multiple complexities of legislative programs to increase the number of individuals that have access to health insurance. In addition, the Office staff will continue surveillance of consumer driven health plans, such as high deductible plans, which feature a large deductible before coverage is available. During this reporting period, the Office encountered more individuals with this type of coverage than during the last reporting period, and it expects these types of plans will increase as they become more available in the market place.

Conclusion

The Office has continued to assist consumers and fulfill its other responsibilities contained in the legislation that established the Office. In the course of assisting consumers, the Office staff has helped consumers fully understand issues related to their health insurance and managed care, and served as a catalyst to facilitate solving problems. When a potential regulatory concern arose, the Office staff gathered additional information and when necessary, referred the issue to the appropriate section within the Bureau for further review and action. During this reporting period, this situation occurred more frequently than in any previous reporting period. The Office continued its outreach efforts to ensure consumers are aware of the Office and the services it provides, continued reviewing MCHIP complaint system filings, and monitored legislative efforts related to health insurance.