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
2009

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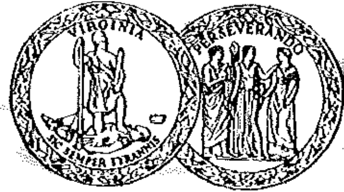
COMMONWEALTH OF VIRGINIA



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STATE CORPORATION COMMISSION

December 1, 2009

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, 2008, through October 31, 2009.

Respectfully Submitted,

Commissioner Mark C. Christie
Chairman

Commissioner James C. Dimitri

Commissioner Judith Williams Jagdmann

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 eleventh annual report of the Office and covers the period from November 1, 2008 through October 31, 2009. Previous reports may be viewed on the Bureau of Insurance's website at:

www.scc.virginia.gov/division/boi/webpages/boiombudmanreports.htm

The legislation that created the Office authorizes it to assist consumers whose health insurance is provided by a Managed Care Health Insurance Plan (MCHIP). This includes all health maintenance organizations (HMOs), preferred provider organizations (PPOs) and other forms of insured managed care coverage. In order for the Office to assist a consumer formally, the coverage must be fully insured and issued in Virginia by a company licensed by the Bureau. Within these parameters, the coverage can be a group health insurance policy, coverage issued in the individual market, or individual coverage. Generally, if a consumer's health insurance coverage is subject to the regulatory jurisdiction of the Bureau, the Office can assist the consumer. Commensurate with the regulatory jurisdiction of the Bureau, the Office is unable to formally help 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

Although the Office does not have the regulatory authority to assist consumers whose health insurance is provided by one of the above, the staff provides general information and advice, and may be able to refer these consumers to a federal or state regulatory agency for assistance. As part of its general consumer educational efforts, the Office helps these individuals understand how their health insurance is structured and explains why their health insurance is not subject to regulatory oversight by the Bureau.

Consumer Assistance

The Office informally assists consumers and other individuals, such as providers, who have questions or concerns that relate to some aspect of health insurance, managed care, or related areas. These inquiries cover a range of issues. A frequent subject is potential benefits that are available under a consumer's coverage, especially when the individual has encountered a problem. Denied authorizations and unpaid claims are a common source of questions from consumers and range from relatively simple inquiries to those involving more complex circumstances. When responding to inquiries, the staff provides general information and assistance which frequently results in helping the consumer resolve the problem. In this role, the staff educates consumers by helping them understand their health insurance coverage, how it works, and ways to resolve a variety of problems effectively.

The Office also responds to health care providers who request help on behalf of their patients. When a provider contacts the Office for assistance, the staff can help the provider informally and provide general information and guidance. The staff encourages providers to contact a patient's MCHIP and ask for reconsideration of the decision; sometimes, the provider contacting the MCHIP resolves the problem. In instances where a provider has determined a particular patient's appeal involves an urgent issue, the staff educates the provider on how to file an expedited appeal with the patient's MCHIP. In accordance with the legislation that established the Office, if the patient needs to file a formal appeal, the staff will ask the provider to refer the patient directly to the Office for personalized assistance. During the previous report period, the staff noted an increase in the volume of inquiries from providers, and the trend continued for this reporting period, which covers November 1, 2008 to October 31, 2009.

Inquires from consumers and providers are received via correspondence, telephone, facsimile, and a dedicated Ombudsman e-mail account. Typically, the staff can provide a response in one exchange if an inquiry involves a relatively simple subject. In some instances, the staff refers an inquiry to another section within the Bureau or to another state agency, federal government agency, or other source for additional information and help. Sometimes an inquiry involves an issue that is outside the regulatory purview of any regulatory agency. During this reporting period, the Office responded to 879 inquiries, which represents a slight decrease from the 951 inquiries the Office received during the previous reporting period.

The Office can formally assist consumers that want to file a written appeal in response to an adverse decision made by an MCHIP. The staff helps consumers understand how the appeal process works. Often, the first step involves the treating provider contacting the MCHIP and asking for a reconsideration of the adverse decision. If the provider's request is denied, the consumer can file a written appeal and the staff will provide personalized assistance and advice. The

Office ensures a consumer has complete access to the appeal process offered by his or her MCHIP, and ensures each individual understands how the process works. Appeals may involve services that have been requested but not authorized, as well as claims for services an individual received which were not paid for by his or her MCHIP.

Appeals generally fall into one of two categories: medical necessity, which is services an MCHIP denied because the insurer determined the treatment or care was not medically necessary for an individual in accordance with the potential policy benefits; and administrative denials, which are denials based on a contractual exclusion for the treatment or care under review. Common types of medical necessity appeals involve prescription medications, surgery, imaging tests (CT scans, PET scans, and MRIs), inpatient hospital services, and mental health services. Typical examples of administrative appeals are payments for nonparticipating providers who balance bill a patient; a request for a service which is specifically not eligible for coverage under the terms of a consumer's health insurance policy; or a request to extend a service, such as physical therapy, beyond the benefit cap as stated in a consumer's policy documents.

As required by the legislation that established the Office, the staff obtains the written permission of the "covered person" when a consumer asks for help in filing an appeal. While there is no mechanism that enables the Office to file an appeal on behalf of an individual, the staff will provide guidance and assistance to help an individual write an effective appeal. The staff provides advice on what pertinent information should be presented, which may vary depending upon the circumstances. The staff has developed several consumer tip sheets on how to prepare a written appeal, and special tip sheets for specific types of denials, such as for prescription drugs, or services an MCHIP denied as experimental in nature. By reviewing the issues involved in an appeal, the staff can provide recommendations and suggestions on information a consumer should include in an appeal.

When the Office assists a consumer with an appeal, the staff will contact the MCHIP in writing, provide a copy of the individual's appeal and supporting documents, and summarize the key issues involved in the appeal. If any of the issues involved in the appeal are not clear, the staff will serve as a catalyst to ensure all the pertinent information is clearly understood by all parties. For appeals that involve questions of medical necessity, the staff asks the MCHIP to focus on the applicable clinical information contained in the individual's medical record. As noted in previous reports, there were numerous instances in this reporting period where an MCHIP overturned a denial based upon new or overlooked clinical information the Office received from a consumer and conveyed to the MCHIP. Without exception, every MCHIP reviewed and considered any new or additional information the Office provided at any stage of the appeal process. In some cases, the MCHIP reconsidered information after the MCHIP had issued the final denial.

The Office reviews decisions MCHIPs render on appeals. In the event the consumer is not successful in the appeal, the staff helps the consumer understand the decision. The Office will ask an MCHIP to clarify any reason for an adverse decision that does not appear to be supported by facts, or if the logic reflected in the denial appears to be invalid. Whether or not the Office agrees with the denial is not relevant, but a denial should reflect a logical decision based on the information the MCHIP considered. This is important because if a consumer loses his or her appeal, the staff will explain why the person lost, so that he understands the reason the decision was not favorable. If any part of an appeal or an adverse decision appears to involve a regulatory issue, the staff will ask the MCHIP for additional information and clarification of the issues. If necessary, the Office will forward the case to the appropriate section in the Bureau for further review and action as appropriate, and will notify the MCHIP accordingly. While the Office is part of the Bureau, the scope of the staff's responsibilities does not include pursuing regulatory action against an MCHIP; there are other sections for that purpose within the Bureau.

If a consumer's appeal is denied, the staff can help the individual file another appeal, if applicable, or, in some cases, staff will suggest another option for the consumer to pursue. If an MCHIP issues a final adverse decision on an appeal involving questions of medical necessity, the Office will help the individual file an external appeal with the Office of External Appeals, which is also located in the Bureau. Final denials for appeals that involve other types of denials, such as contractual or administrative denials, may be referred to the Consumer Services Section (CSS) for further review as a consumer complaint. In some instances, however, there is no further regulatory assistance that can be offered to a consumer who is not successful in the appeal process with an MCHIP.

The overwhelming majority of consumers the Office assists have never previously appealed an adverse decision by an MCHIP. The staff is cognizant of the difficulties and frustrations that consumers can experience, especially individuals suffering from serious medical problems. The staff tries to ameliorate the stress and anxiety that adversely affect consumers, and guide them through the appeal process. As noted in prior reports, the Office received positive feedback from consumers the staff assisted in filing appeals. During this reporting period, the staff assisted 177 consumers in filing an appeal, which is less than the 230 consumers the Office helped during the preceding reporting period.

Discussion

As noted in prior reports, during this reporting period, the majority of inquires and appeals involved common types of issues and problems associated with health insurance and managed care. The staff encountered many instances where consumers were not familiar with how their managed care plan works. This lack of knowledge on the part of consumers resulted in problems which may have been avoided. This is a recurring theme, and the Office uses every opportunity when it interacts with consumers to educate them so they can avoid problems caused by failing to understand their health insurance.

Some appeals fell outside the normal realm; typically these involved unusual situations. In one such case, the Office assisted a consumer who appealed a denial for a prescription drug which was denied because the MCHIP determined the prescription drug was equivalent to an over-the-counter (OTC) medication. The consumer's medical condition, however, was unresponsive to the OTC drug, so it appeared the exclusion was invalid. Using this rationale, the staff helped the consumer file an appeal, and the MCHIP overturned the denial. In addition, the MCHIP revised its policy and authorized participating pharmacists to make an initial determination at the point of sale for this prescription drug. This decision not only directly benefited the consumer the Office helped, but indirectly helped other individuals covered by this particular MCHIP.

In another appeal, the staff was instrumental in the favorable outcome for a consumer who appealed a denial for mental health services provided in a Residential Treatment Facility (RTF). In this case, the MCHIP initially denied coverage due to the nature of the facility where the treatment was provided. Since the facility was properly licensed and accredited, however, the MCHIP overturned its initial denial and recognized that the services the consumer received were medically necessary and eligible for coverage. In another similar appeal, the staff helped a consumer win an appeal for denied hospital services involving inpatient treatment that the individual's MCHIP initially denied because the services could have been provided on an outpatient basis. The individual's medical condition, however, precluded effective treatment on an outpatient basis; the MCHIP reversed its denial.

During this reporting period, the Office noted an increase in the number of appeals consumers filed regarding dental services. Some of these appeals involved consumers who received porcelain crowns, but their dental insurance only covered metal crowns, which are less expensive, so the individuals were responsible for the cost difference plus their normal out-of-pocket expenses. In one instance, a crown placed over an endosteal implant was denied, which essentially made the implant nonfunctional. In this particular case, the Office was instrumental in helping the consumer achieve a favorable outcome, and the MCHIP agreed to modify language in the evidence of coverage regarding coverage for crowns. In

some instances, consumers appealed denials for bridges and periodontal work on adjacent teeth and tissue required to support the bridge adequately. These appeals were normally resolved in the consumer's favor once the MCHIP considered additional clinical information from the consumer's dentist.

The staff also noticed an increase in the number of consumers who appealed denials for treatment provided in an urgent care center. The appeals involved two types of denials: the person's medical condition did not require an urgent care visit; or, more commonly, for consumers covered by an HMO, the consumer did not follow the HMO's required process to obtain urgent care. Generally, HMOs require consumers to contact their primary care physician or a registered nurse prior to using an urgent care center. These HMO providers are available 24 hours per day via a local or toll free phone call. When consumers follow this process and receive authorization to visit an urgent care center, an HMO will pay the claim. Appeals involving utilization review decisions in which the person's medical condition was not an urgent matter were sometimes overturned. However, when this type of appeal was not successful, the consumer was usually not eligible for an external appeal because the dollar value of the claim was less than the $300 threshold for an external appeal review. Appeals for HMO enrollees who did not follow the required process prior to visiting an urgent care center were rarely overturned. As a result, the staff helped the individual understand how to avoid such a problem in the future.

The Office also received several inquiries and requests for assistance in appeals involving a balance bill from a nonparticipating emergency room physician. Typically these cases involved an individual whose coverage was provided by a HMO; while the hospital participated in the HMO's network, the emergency room physician did not. As a result, the consumer received a balance bill from the nonparticipating emergency room physician. In some cases, the consumer won the appeal; in many other instances, however, the consumer was held financially responsible for the balance bill. In some instances, the staff referred a consumer who encountered this problem to the Bureau's Consumer Services Section (the CSS) for assistance.

Outreach

The staff continued outreach activities and programs to provide information to consumers and providers about the Office and the assistance it provides to individuals whose health insurance is provided by an MCHIP. The staff disseminated a variety of publications about health insurance and managed care. During this reporting period, the staff participated in numerous outreach efforts, one of which was a telephone conference with the Down's Syndrome Association of Northern Virginia. The staff participated in programs for consumers and providers sponsored by the Legal Information Network for Cancer (LINC) which were held in Richmond at the Massey Cancer Center and Johnston Willis Hospital.

Staff also participated in programs for consumers and providers sponsored by the Virginia Chapter of the Leukemia & Lymphoma Society conducted in Newport News, Lynchburg, and Richmond. In each of these programs, the staff made formal presentations on the Office and distributed copies of consumer brochures and tip sheets to attendees. In working with these organizations, the Office established liaisons with the staff to facilitate referrals to the Office for assistance.

The Office also helped staff the Bureau's display booth at the State Fair of Virginia, and presented information to attendees at a job fair sponsored by U.S. Representative Eric Cantor in Richmond. In each of these outreach activities, the staff distributed consumer publications, answered questions from consumers, and spoke with individuals about specific problems related to health insurance and managed care. All of these outreach efforts combined reached hundreds of consumers.

The previous annual report noted a new Bureau outreach program oriented to consumers and health care practitioners. In reviewing the results, it is clear these efforts produced positive results. The new consumer complaint/appeal form received favorable comments as did the new publications for consumers and practitioners. As part of this expanded outreach effort, the Bureau also added new information to its Internet site to facilitate web based communications with consumers and practitioners. In addition, Bureau staff mailed or delivered information tailored to practitioners to over 100 hospitals, group practices, practitioners, and advocacy organizations over the last year. This program significantly increased the number of health care professionals who learned about the Office. The staff noted an increase in the number of inquiries from consumers and providers as a result of the outreach program.

The Office also had several opportunities to provide information to the media, such as reporters for Kiplinger's Personal Finance magazine and the Wall Street Journal which generated favorable publicity for the Office. Information contained in articles published by these organizations helped consumers understand fundamental concepts of health insurance and managed care, and were consistent with the staff's outreach efforts to educate consumers and help them develop a better understanding of managed care and health insurance. Our consumer educational efforts are directed to consumers via the media and delivered as a result of the staff providing one-on-one assistance to consumers. Both methods empower the consumer to become more knowledgeable and conversant with his or her health insurance coverage and how it works. The staff views outreach and education as key functions of the Office and intends to engage in continuing outreach efforts.

In conjunction with outreach efforts, the Office ensures information for consumers is maintained on the Bureau's Internet page, which devotes a section dedicated to the Office and the services it provides to consumers. All of the tip sheets, brochures, and the complaint/inquiry form the Office publishes are contained on

the web page, which enables consumers to access important information at any time. The Office also publishes a list of the mandated benefits and mandated offers that MCHIPs are required to provide as part of their health insurance coverage. In addition, consumers can access a dedicated e-mail account for the Office, via the web page. This e-mail account provides consumers not only with an electronic way to contact the Office for assistance, but also enables consumers to scan documents for the staff to review. Frequently, consumers use their access to the information on the web page and the Ombudsman's e-mail, and initiate contact with the Office during non-business hours. During this reporting period, the web page recorded 6,840 visits, which is greater than the 5,971 visits that occurred during the previous reporting period.

Legislation – Federal

As required by the statute that established the Office, the staff monitors changes in federal and state laws relating to health insurance. At the federal level, there were two important events the Office reported on last year: legislation designed to establish mental health parity, which is intended to require parity for the treatment of mental disorders and physical disorders; and legislation to provide financial assistance to individuals who lost their jobs by subsidizing their continuing group health care coverage. The former legislation, known as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, was incorporated into the federal Emergency Economic Stabilization Act (the Federal Bailout Bill).

The federal mental health parity requirements, as noted in the previous annual report, have the potential to expand the concept of parity beyond that currently required under existing Virginia mandates. The federal legislation prohibits large employer health plans from imposing more stringent coverage for mental health or substance abuse services than they provide for medical and surgical benefits. Any coverage limitations, including the number of days of treatment, for example, may not be imposed for mental health or substance abuse conditions unless there is a corresponding treatment restriction for other medical or surgical conditions. The federal legislation was enacted on October 3, 2008 and Bureau staff has reviewed and analyzed the potential impact on existing Virginia mental health statutory requirements. The COBRA continuation coverage assistance under the American Recovery and Reinvestment Act of 2009 provides for a 65% reduction in COBRA premiums for certain individuals for up to 9 months. This economic assistance is designed to help individuals pay their premiums for continuing group health insurance coverage. Although the federal legislation was primarily designed to apply to individuals formerly insured in the large group market, Virginia amended its statute to enable individuals formerly covered by a small group health plan to also qualify for this economic assistance. The Bureau worked with the Executive Branch in this endeavor, and published consumer information on how the subsidiary worked and also posted information on the Bureau's Internet page. When the legislation was passed, it provided continuing financial

assistance until December 31, 2009; the Code of Virginia provides for an extension of the period for which assistance will be available in the event Congress similarly extends this period in consideration of current economic conditions.

The Office is closely monitoring and tracking federal legislative efforts that pertain to health care reform. At the time of printing of this report, several proposals are actively being considered. The staff has concentrated on reviewing three primary sources: the Senate Finance Committee, the Senate Health Education Labor and Pensions Committee (Senate HELP Committee) and the House Tri-Committee. All of the bills that have emerged from these three committees are complex and contain numerous provisions that relate to all aspects of health insurance and the delivery of medical care. The proposals from all three committees are designed to increase the number of individuals who are insured and provide financial assistance to some categories of individuals to help them pay their premiums. The bills also expand the number of individuals that will be eligible for Medicaid. All of the proposals also contain provisions to encourage employers to provide health insurance to their employees, either through a tax credit or a fee based on the number of employees who are not covered by a group health insurance plan. In addition, each bill requires health insurers to adhere to community rating, guarantee issue, no restrictions on covering pre-existing conditions, and no benefit caps. These requirements represent significant changes to Virginia's statutes that pertain to health insurance.

There is variation among the three committees' proposals regarding many other factors. One of the major differences is whether or not the federal government will provide health insurance through a public option health plan. While the Senate Finance Committee bill does not include a public option, both the Senate HELP Committee and House Tri-Committee contain different provisions to establish a public option. The Senate HELP Committee bill creates state-based American Health Benefit Gateways which would offer a community health insurance option. The House Tri-Committee creates a National Health Insurance Exchange that will offer a public health insurance option, which would be a more comprehensive public plan than that provided by American Health Benefit Gateways under the Senate HELP Committee bill.

These bills have been introduced in the Senate and House, and will move through the legislative process. In the Senate, members and their staff will meet and discuss the two bills and then offer a single bill to the full Senate. The House will follow the same process. If each respective chamber passes a bill the members will hold a conference committee to resolve the differences between the Senate and House bills, which will result in a single bill for a Congressional vote. The final bill will be presented to the President. It is anticipated that the complexity and scope of the proposed legislation, the legislative process, and whatever final legislation may result will generate considerable debate, especially in regard to any proposed public option health plan.

Legislation - Virginia

During this reporting period, the General Assembly passed, and the Governor signed, two important pieces of legislation impacting health insurance. One bill created § 38.2-3406.1 of the Code of Virginia, which establishes requirements applicable to "basic health insurance policies'", exclusive of one or more mandates, which may be offered by health insurers or health services plans to small employers in Virginia. These policies must contain the following mandates:

- Coverage for mammograms
- Coverage for pap smears
- Coverage for PSA testing
- Coverage for colorectal cancer screening

The proponents of this legislation believe that health insurance which provides limited or fewer mandated benefits will be less expensive than coverage which includes all of Virginia's mandated benefits, making the premiums more affordable for small businesses and their employees. The Bureau will track the market's response to this legislative initiative and assess its impact on health insurance provided in the small employer market.

Another important piece of legislation addresses the requirement for health insurers providing individual or group accident and sickness policies to offer coverage for prosthetic devices, if the policy holder wants to include the benefit as a covered service. In the case of all mandated offerings, the insurer must offer to provide the coverage, and the policy holder may or may not elect to purchase it.

Conclusion

During this reporting period, the Office assisted consumers and accomplished its responsibilities in accordance with the legislation that established the Office. The staff provided informal and formal assistance to consumers and other parties, and continually took advantage of opportunities to educate people who contacted the Office for assistance. Frequently the staff's expertise resulted in consumers successfully resolving issues and minor problems, and often helped consumers prevail in the internal appeal process with their MCHIPs. In some instances, the Office encountered potential regulatory problems and referred the matter to another section within the Bureau. The Office participated in numerous outreach efforts to increase its exposure within Virginia and ensured the consumers who contacted the Office for assistance received assistance in a timely manner. During the past year, the staff tracked legislation at both the federal and state level, and will continue to review pending national health care reform legislation which has been introduced in the U.S. Senate and House of Representatives.