MASSACHUSETTS
HEALTH POLICY COMMISSION

2022
ANNUAL REPORT
OFFICE OF PATIENT PROTECTION

Released April 2024

ABOUT THE HEALTH POLICY COMMISSION

The Massachusetts Health Policy Commission (HPC) is an independent state agency charged with monitoring health care spending growth in Massachusetts and providing data-driven policy recommendations regarding health care delivery and payment system reform. The HPC's mission is to advance a more transparent, accountable, and equitable health care system through its independent policy leadership and innovative investment programs. The HPC's goal is better health and better care – at a lower cost – for all residents across the Commonwealth.

The agency's main responsibilities are led by HPC staff and overseen by an 11-member Board of Commissioners. HPC staff and commissioners work collaboratively to monitor and improve the performance of the health care system. Key activities include setting the health care cost growth benchmark; setting and monitoring provider and payer performance relative to the health care cost growth benchmark; creating standards for care delivery systems that are accountable to better meet patients' medical, behavioral, and social needs; analyzing the impact of health care market transactions on cost, quality, and access; investing in community health care delivery and innovations; and safeguarding the rights of health insurance consumers and patients regarding coverage and care decisions by health plans and certain provider organizations.

HISTORY OF THE OFFICE OF PATIENT PROTECTION

Prior to 1990, only two states had external review programs for denials of health insurance claims. In 1998, the Office of the Managed Care Ombudsman was created by executive order to provide assistance to managed care consumers. Two years later, the Office of Patient Protection (OPP) was established through Chapter 141 of the Acts of 2000, a law that created new protections for health insurance consumers. In January 2001, the Office of the Managed Care Ombudsman merged with OPP. OPP operated within the Department of Public Health from 2000 until Chapter 224 of the Acts of 2012 transferred OPP from the Department of Public Health to the newly established Health Policy Commission, effective April 20, 2013.

INTRODUCTION

Entering its twenty-second year, the Office of Patient Protection (OPP), operated by the Massachusetts Health Policy Commission (HPC), is responsible for regulating and administering certain health care consumer protections for the Commonwealth. OPP is a resource for individuals who want to become more informed and empowered health care consumers. This annual report provides a comprehensive overview of activities of the Office.

KEY RESPONSIBILITIES OF THE OFFICE OF PATIENT PROTECTION

OPP safeguards the rights of health care consumers by regulating the internal grievance process and administering external reviews for consumers with fully-insured Massachusetts health plans and patients of certain provider organizations, administering health insurance enrollment waivers, and providing information and education about health insurance concerns to the public. The core responsibilities of OPP are:

- Regulating the internal review process for consumers who wish to challenge denials of coverage by health plans
- Regulating and administering the external review process for consumers who seek an independent appeal to challenge adverse determinations issued by health plans
- Administering an enrollment waiver process for consumers who wish to purchase non-group health insurance
- Regulating the internal appeals processes for commercially insured patients of Risk-bearing Provider Organizations (RBPO) and HPC-certified Accountable Care Organizations (ACO)
- Regulating and administering the external review process for patients of RBPOs and ACOs who seek an independent appeal regarding a provider's decision on referrals and other concerns
- Examining, analyzing, and reporting on certain information and data received annually from Massachusetts health plans
- Providing training, education, and responding to consumer inquiries about health insurance appeal rights, open enrollment waivers, and other issues related to health coverage and services

NOTABLE UPDATES IN 2022

Issued Guidance on Federal No Surprises Act: OPP issued a bulletin notifying health insurance companies of an expansion of external review by the federal No Surprises Act, effective January 1, 2022. The bulletin details the expansion of the external review process to include review of whether a health insurance company complied with the No Surprises Act and outlines the referral process that OPP will follow to allow consumers to get a full and fair review of surprise billing issues.

Issued Guidance on State Mental Health Law: OPP issued two bulletins providing guidance on Chapter 177 of the Acts of 2022, An Act Addressing Barriers to Care for Mental Health (Chapter 177). OPP released a bulletin to notify carriers, external review agencies, and other parties about OPP's implementation of Chapter 177 pending revision of 958 CMR 3.000, the regulation that governs the internal appeal and external review process. OPP released a separate bulletin notifying external review agencies of changes to the external review process where continuation of coverage is requested by the patient.

OPP Operations: OPP provides a "no wrong door" approach for consumers and other stakeholders requesting assistance with health care and coverage concerns. To that end, OPP staff continues to implement improvements to internal operations while strengthening statewide stakeholder relations. Throughout the year, the team responded to 1,966 inquiries via its toll-free hotline. OPP fielded more calls than in previous years, due to an increased number of calls related to open enrollment waivers. In 2022, most callers had inquiries about open enrollment waivers as well as external reviews and internal appeals.

ENROLLMENT WAIVERS

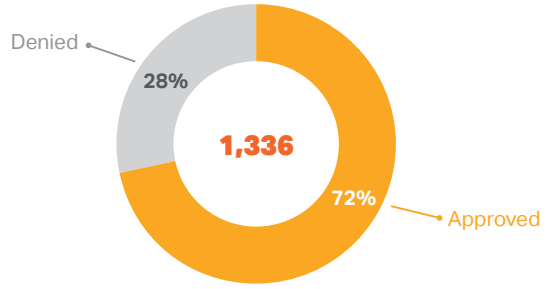
Federal and state law limit when individuals and families can buy certain health insurance plans. Most Massachusetts consumers must buy insurance during a designated open enrollment period. Massachusetts residents who missed the previous open enrollment period, and have not experienced a qualifying life event, may qualify for a waiver of the open enrollment period if they meet certain criteria. The Office of Patient Protection reviews waiver requests and typically grants open enrollment waivers to individuals and families who:

- Are uninsured and did not intentionally forgo enrollment in health insurance, or
- Lost insurance coverage but did not find out until after 60 days had passed

2022 ENROLLMENT WAIVER DATA

During 2022, the Office of Patient Protection received 1,336 requests for waivers from Massachusetts residents seeking to buy insurance from the Health Connector or directly from an insurance company or insurance agent. Upon review, OPP issued 959 waivers to eligible applicants or 72% of all received requests (**Figure 1**). In 2022, OPP saw a significant increase in the number of waivers requested by consumers, returning to the approximate number OPP received in 2019. OPP's waiver volume was depressed from 2020-2021 due to continuing protections afforded to consumers due to the pandemic. Those protections ended in 2022, so the open enrollment waiver process was necessary for many to accesss insurance. Since the waiver process cannot resolve all health plan enrollment issues for uninsured consumers, OPP staff triaged concerns and provided information and referrals to other agencies or organizations as needed.

FIGURE 1



Source: 2022 Office of Patient Protection waiver data.

Year	Total Waiver Applications
2011	276
2012	576
2013	416
2014	316
2015	562
2016	355
2017	389
2018	840
2019	1,342
2020	375
2021	226
2022	1,336

Source: 2011-2022 Office of Patient Protection waiver data.

i M.G.L. c. 176O §§ 13-14.

HEALTH INSURANCE APPEALS

Under Massachusetts law,[i] health care consumers have the right to appeal certain decisions by their health plans. This essential consumer protection provides an economical and fair process to resolve disputes between members and their health plan. These laws apply to individuals with "fully-insured" Massachusetts health plans (see Glossary for definitions). Consumers with other types of health plans, including self-insured plans, MassHealth (Medicaid), or Medicare, have different appeal rights under other state or federal laws.

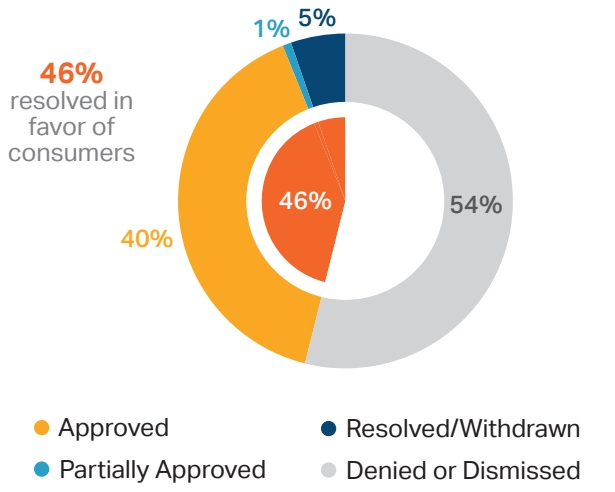
INTERNAL REVIEW

When an insurer informs a consumer that the health plan will not pay for the consumer's medical or behavioral health treatment, the consumer may appeal that decision by first contacting the health plan. This first appeal, often called a member grievance, is an internal review by the health plan. The consumer may seek an expedited internal review for urgent matters. Otherwise, the health plan must respond to the consumer within 30 calendar days, unless both parties agree, in writing, to an extension. The health plan may uphold the original decision, or it may change its decision and cover all or part of the insured's treatment.

2022 INTERNAL REVIEW DATA

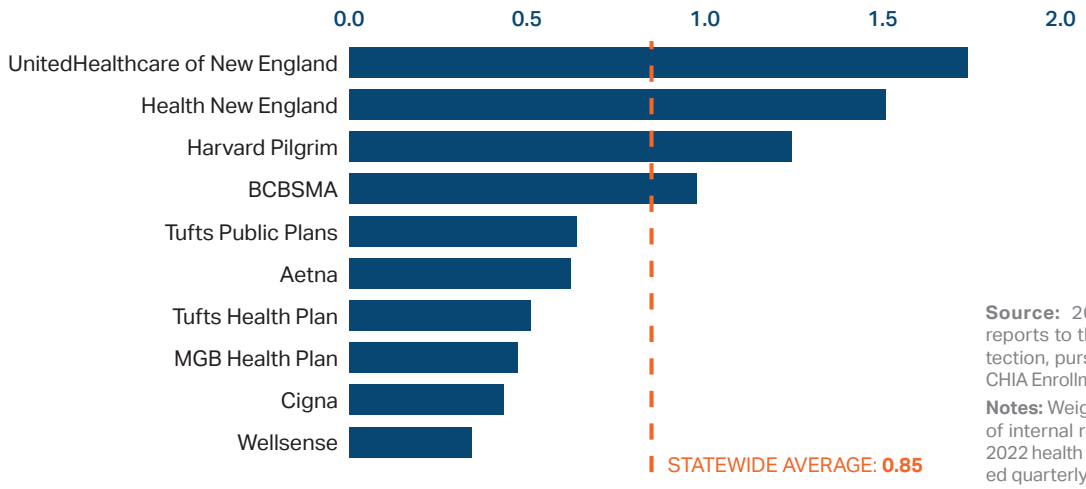
During 2022, Massachusetts health insurance companies reported 13,419 member grievances (**Figure 2**). These grievances include many different types of member complaints, such as disputes over coverage for treatment or cost-sharing.

FIGURE 2



Source: 2022 insurance carrier reports to the Office of Patient Protection, pursuant to 958 CMR 3.600.

FIGURE 3



Source: 2022 insurance carrier reports to the Office of Patient Protection, pursuant to 958 CMR 3.600; CHIA Enrollment Trends (March 2023).

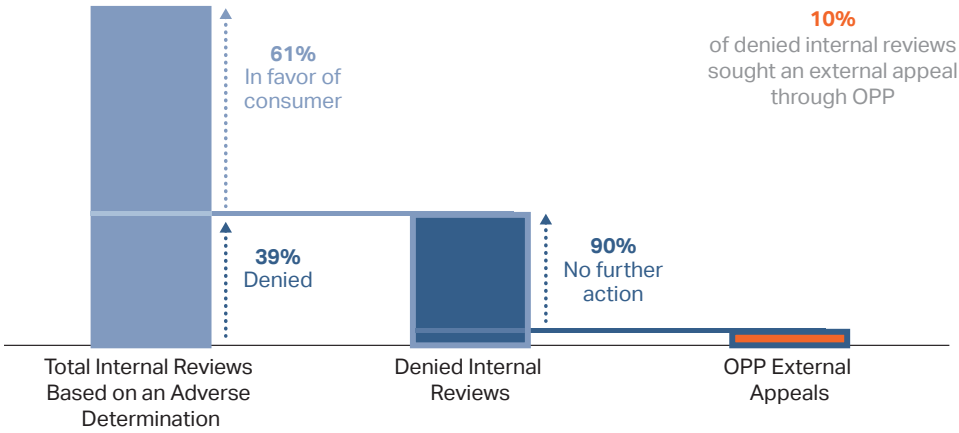
Notes: Weighted by dividing number of internal reviews by an average of 2022 health plan member data reported quarterly to CHIA.

Figure 3 shows the member grievances reported by the state's health plans with the most fully-insured members in 2022. As in past years, insurers with more members have more appeals. In order to compare health insurance company practices, OPP also analyzed the number of grievances filed per number of health plan members, to come up with a "weighted average" that gives a better indication of which insurers have the highest numbers of grievances relative to their total membership.

Under current OPP regulations, health plans report detailed information about the types and outcomes of member grievances received. For 2022, health plans reported the following figures:

- **Member grievances:** Health insurers resolved 46% or 6,166 of all member grievances fully or partly in favor of the member.
- **Medical necessity denials:** 7,291 or 54% of internal grievances resulted from adverse determinations by the health plan, which are denials of coverage based on health plan medical necessity decisions.
- **Behavioral Health:** Of the 7,291 grievances based on medical necessity, less than 4% or 267 involved behavioral health treatment.
- **Pursuing external review:** Of those grievances denied based on medical necessity, 10% of patients or consumers sought an independent external review of the health plan's final adverse determination (FIGURE 4). This number is 1% higher than in 2021. While there are a significant portion of consumers who are aware of their appeal rights and are exercising them, opportunities for consumer engagement remain.

FIGURE 4



Source: 2022 Office of Patient Protection external review data; 2022 insurance carrier reports to the Office of Patient Protection, pursuant to 958 CMR 3.600. In Favor of Consumer includes Approved, Partially Approved, and Withdrawn or Resolved.

What is medical necessity?

What is medical necessity? Health insurance companies that are licensed to do business in Massachusetts must pay for medical services and treatments that are covered benefits under the health plan and that are medically necessary. Health insurers may develop their own standards for deciding when care is medically necessary. Massachusetts law defines medical necessity in the following way –

Medical Necessity or **Medically Necessary** means health care services that are consistent with generally accepted principles of professional medical practice as determined by whether the service:

(a) is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual;

(b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or

(c) for services and interventions not in widespread use, is based on scientific evidence.[ii]

EXTERNAL REVIEW

After a health plan's internal appeals process is exhausted, the insurance provider is required by law to allow for an external appeal. The process offers health care consumers the opportunity to obtain an independent review when a health plan denies coverage as not medically necessary or as experimental or investigational; such notice is often referred to as a final adverse determination. If a consumer pursues an internal review and the health insurer upholds its original decision, the consumer may have the right to pursue an external review. An external review is a second level of appeal, conducted by an organization independent from the consumer's health plan. Health insurance companies may deny services prospectively (such as prior authorizations), retrospectively, or concurrently (during the course of treatment). External review is only available when the health plan's determination was based on whether the specific treatment or service at issue was medically necessary, including whether the health plan determined that the service was experimental or investigational.

ELIGIBILITY FOR EXTERNAL REVIEW THROUGH THE OFFICE OF PATIENT PROTECTION

Requests must be eligible for external review. An insurance dispute is usually eligible for external review through OPP if all of the following are met:

- The health insurance company is licensed in the Commonwealth
- The insurance product is a fully-insured health insurance plan
- The patient's request for external review includes one of these:
  - A final adverse determination, OR
  - An adverse determination, if the patient is seeking an expedited internal review and expedited external review at the same time, OR
  - A written confirmation that insurance company has waived internal review
- The final adverse determination or adverse determination is based on medical necessity
- Request for external review filed with OPP within four (4) months of the date from when the patient received the final adverse determination (final denial by health plan).
- Request for external review is in writing and on the external review request form issued by OPP

OPP makes every effort to assist consumers in finalizing applications that are missing necessary information in their filed request. A request is considered incomplete if requisite application components are missing like attestations or signatures. The most common reasons for external reviews to be deemed ineligible in 2022 were the request was incomplete, the consumer requesting external review was covered under a self-insured plan, or the request concerned a denial related to cost-sharing.

EXTERNAL REVIEW PROCESS

When OPP receives an eligible request for external review, the request is randomly assigned to one of four external review agencies, also known as independent review organizations, which have agreed to avoid conflicts of interest. These external review agencies are not government agencies. They are private companies with panels of doctors and medical experts who work in different fields and are located

ii 958 CMR 3.020.

throughout the country. The Health Policy Commission contracts with four nationally accredited, independent external review agencies:

- Island Peer Review Organization (IPRO), based in Lake Success, New York
- Kepro DBA IMEDECS, based in Richmond, Virginia
- MAXIMUS Federal Services, Inc., based in Pittsford, New York
- ProPeer Resources, LLC, based in Schertz, Texas

After receiving the OPP case file (which includes the external review request form, denial notices from the insurer, and any additional information submitted by the patient), the external review agency assigns it to one or more of its medical experts who practice in the same or similar specialty as the service in dispute. The medical expert then reviews the information submitted by the insurance company and the patient, and reaches an independent conclusion about whether the treatment or service is medically necessary for the patient.

In accordance with state law, the external review agency issues its decision within 45 days for standard external reviews and within 72 hours for expedited external reviews. The decision of the external review agency is final and binding, though other legal rights apart from OPP's external review process may be available.

The consumer who requests external review usually pays a $25 fee toward the cost of the review. Upon request, OPP may waive the $25 fee due to financial hardship; no consumer is required to pay more than $75 in fees per year. If a consumer prevails on external review and the decision is overturned, OPP refunds the $25 fee to the consumer. The insurer pays the external review agency for most or all of the external review, a cost which can range from $475 to $2,250 depending on the time frame for the review, type of review, and the number of reviewers needed.

In making a decision, the external clinical reviewer considers the determination of the health plan, medical records of the patient, comments from a treating provider, and other pertinent documents to determine medical necessity. An external appeal decision is issued to all parties in writing and is subject to the terms and conditions of the insured's coverage with the health plan, such as cost sharing requirements, or maximum benefit limitations.

2022 EXTERNAL REVIEW DATA

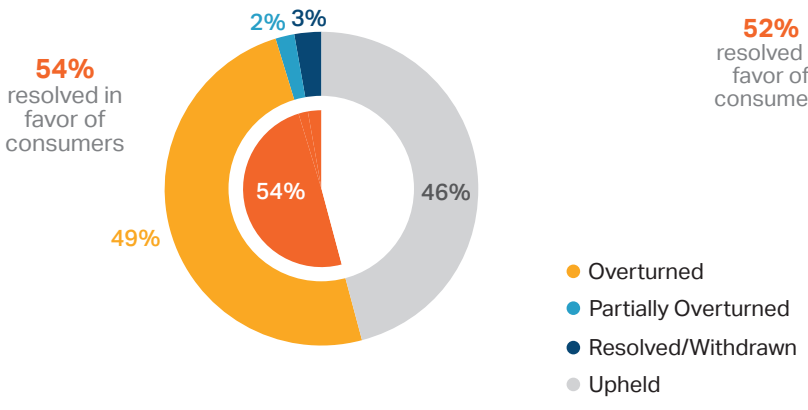
For each calendar year, the HPC analyzes overall external review data and further delineates its analysis by medical/surgical and behavioral health data.

EXTERNAL REVIEW CASES AND RESULTS FOR 2022

During 2022, OPP screened 294 external review requests for eligibility. 191 or 65% of these requests were deemed eligible for external review. Of the eligible cases, 51% were overturned in whole or in part by the external review agency in favor of the patient. Approximately 3% of the eligible cases were resolved between the patient and the insurer or withdrawn before a final determination was issued by an external review agency. The external review agencies upheld the remainder of the cases, which accounted for 46% of cases eligible for review.

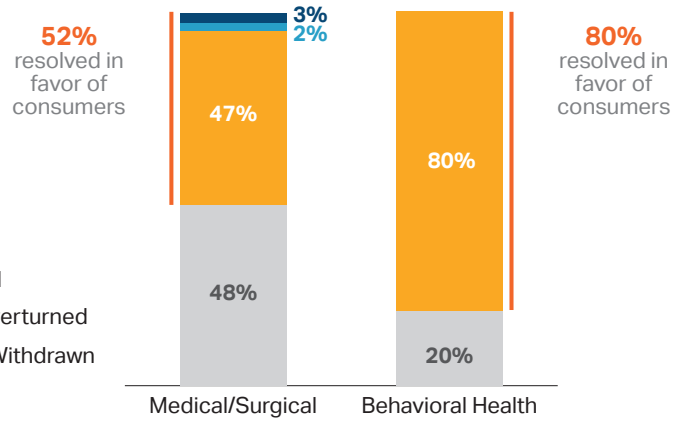
Figure 5 illustrates the dispositions or results for all eligible external reviews filed during 2022. **Figure 6** breaks down the total number of external reviews into two categories: medical or surgical care and behavioral health care.

FIGURE 5



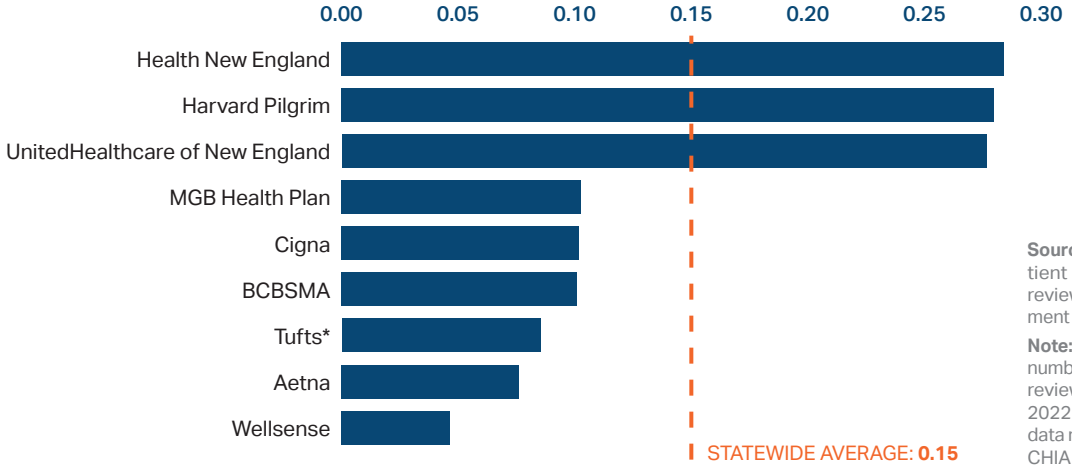
Source: 2022 Office of Patient Protection external review data.

FIGURE 6



Source: 2022 Office of Patient Protection external review data.

FIGURE 7



Source: 2022 Office of Patient Protection external review data; CHIA Enrollment Trends (March 2023).

Note: Weighted by dividing number of eligible external reviews by an average of 2022 health plan member data reported quarterly to CHIA.

*OPP records Tufts Health Plan and Tufts Public Plans as one

Figure 7 compares the frequency of eligible external reviews for each health plan. This number is calculated by adjusting the total number of external reviews for each plan by the number of members reported by each health plan in 2022. This analysis identifies an average for the number of external reviews filed by all fully-insured health plan members. Of the state's health plans with the most fully-insured members, identified in **Figure 7**, three had a rate of external review above the statewide average, with Health New England reporting the highest proportion.

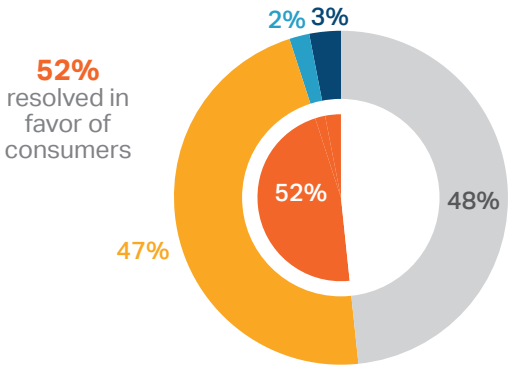
MEDICAL/SURGICAL DATA

OPP received 176 eligible external review requests involving medical or surgical services. This category encompasses appeals involving a broad range of medical care, including imaging, lab testing, pharmacy requests, and infertility treatment. External review data for behavioral health services are explored further below.

In 2022, 48% of external reviews involving medical or surgical treatment upheld the decision of the health insurer and 49% of reviews either fully or partially overturned the health insurer's decision in favor of the patient (**Figure 8**). 3% of external reviews involving medical or surgical treatment were resolved prior to an issued decision. The most common medical/surgical review requests were in the categories of pharmacy and diagnostic services. **Figure 9** details the services requested through external review.

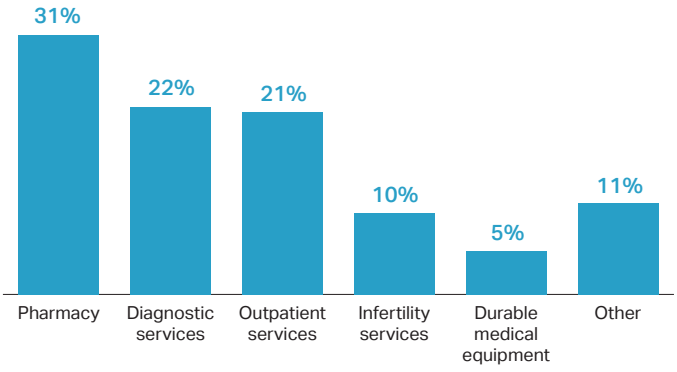
OPP received 54 eligible requests for pharmacy treatments. Of the 54 matters in this category, 31 were overturned by the external review agency, while 4 cases were resolved by the health insurance company prior to the issuance of a decision. Representing a growing area of requests, OPP received 39 eligible requests for diagnostic services, 28 of which were for cancer screenings. The external review agency overturned or partially overturned the health plan's denial in 13 of 39 cases dealing with diagnostic services.

FIGURE 8



Source: 2022 Office of Patient Protection external review data.

FIGURE 9



Source: 2022 Office of Patient Protection external review data.

Additionally, OPP received 38 eligible external review requests regarding outpatient medical/surgical care including surgeries, medical visits, and rehabilitation services, 25 of which were resolved in favor of the patient. During 2022, OPP received 17 eligible external review requests involving infertility treatment. 11 were upheld by the external review agency. 6 eligible requests involving infertility treatment were overturned in whole or in part by the external review agency. OPP received 9 eligible external review requests involving durable medical equipment in 2022, and 5 of the requests were resolved in favor of the patient.

EXPERIMENTAL AND INVESTIGATIONAL SERVICES

OPP provides consumers with the right to obtain an independent review by a panel of clinical experts when health plans consider services to be experimental or investigational. In 2022, OPP received 50 eligible external review requests involving services deemed to be experimental or investigational by the insurance companies. This is an increase from 2021. Diagnostic screenings accounted for 26 of the 50 eligible cases received, and outpatient services accounted for 17. Other requests included non-standard durable medical equipment and pharmacy treatments. Overall, 34 of the experimental/investigation requests were resolved in favor of the patient and 16 were upheld.

OUT OF NETWORK COVERAGE REQUESTS

In some instances, a consumer has the right to appeal a denial of coverage for treatment by a provider who is outside of the insurer's network. If the treatment is a covered service, and if the insurer denied coverage because it was not medically necessary to receive the services from an out of network provider, then the consumer may request external review. OPP determines whether such matters are eligible for review on a case-by-case basis. If eligible, the reviewer then decides whether the treatment is medically necessary and if so, could any in-network provider perform the procedure or provide the service at issue.

During 2022, OPP received 25 requests for external review involving coverage for an out of network provider. 16 of these were eligible for external review and 11 were resolved in favor of the patient.

BEHAVIORAL HEALTH

OPP received about the same number of external review requests pertaining to behavioral health services than in years past, but fewer eligible requests. Behavioral health services include treatment for mental health conditions, substance use disorders, and some developmental disabilities.

OPP received 26 requests for external review of behavioral health services during 2022, and 15 of these were eligible for external review.

Eligible behavioral health cases: Of all eligible behavioral health cases received during 2022, 12 cases or 80% were fully or partially overturned by the external review agency in favor of the patient.

Mental health treatment: Of the eligible cases, OPP received 7 eligible requests for mental health treatment. Acute residential mental health treatment represented the largest subcategory, with 4 eligible requests for external review. 6 out of 7 eligible requests for mental health treatment were overturned at external review.

Eating disorder treatment: OPP received 4 eligible requests for eating disorder treatment in 2022; 2 of the requests were overturned at external review.

Developmental Services: OPP received 4 eligible requests for developmental or autism services in 2022. All of the requests were for outpatient services, and all were overturned at external review.

Substance use disorder treatment: OPP received no eligible requests for treatment related to substance use disorders.

HEALTH INSURANCE APPEALS OVERVIEW

In general, a consumer who receives an adverse determination from an insurance company, denying coverage based on medical necessity grounds, has a significant chance of modifying or overturning the decision through the appeals process. According to figures reported to OPP by health plans, 63% of members who received adverse determinations from their health plans were able to have their disputes partially or fully resolved in their favor through the internal review or external review process.

In 2022 OPP saw 27% more requests for health insurance external reviews than in 2021. The percentage of reviews deemed eligible, were largely consistent with recent years. OPP saw increases in requests for reviews of prescription medications, diagnostic services, including cancer screenings, and requests for reviews of out-of-network services. Consistent with past years, OPP received a decreasing number of eligible requests for reviews of behavioral health services.

APPEALS PROCESS FOR PATIENTS OF ACCOUNTABLE CARE ORGANIZATIONS (ACO) AND RISK-BEARING PROVIDER ORGANIZATIONS (RBPO)

Under Massachusetts law[iii], OPP is responsible for administering a first in the nation consumer protection for patients of HPC-certified Accountable Care Organizations (ACO) and Risk-bearing Provider Organizations (RBPO). This new consumer protection provides an opportunity for patients attributed to an ACO or RBPO to appeal provider determinations about referrals restrictions or other potential limitations of care. This process is available for patients with commercial health insurance only; Medicare or MassHealth (Medicaid) patients have separate appeal rights.

INTERNAL APPEAL

RBPOs and ACOs are comprised of health care providers who work together to coordinate patient care and enter into financial arrangements with health plans to do so. Patients may have disagreements with their health care providers about the care that they are receiving. For example, a health care provider may refer a patient to a certain specialist within the RBPO or ACO, but the patient prefers to see another specialist affiliated with a separate provider group due to past medical history. By requesting an internal appeal, the patient is asking the RBPO or ACO to reconsider the health care provider's decision about that referral. Patients may appeal issues related to referrals, the type or intensity of services, the timeliness of care available within the RBPO or ACO, or other issues related to RBPO/ACO financial incentives.

The RBPO or ACO must resolve the appeal in writing within 14 calendar days of receiving the request. If there is an urgent medical need, the RBPO or ACO must resolve the appeal within 3 business days. The RBPO or ACO may uphold the original decision, or it may change the decision and provide the referral or requested treatment or service.

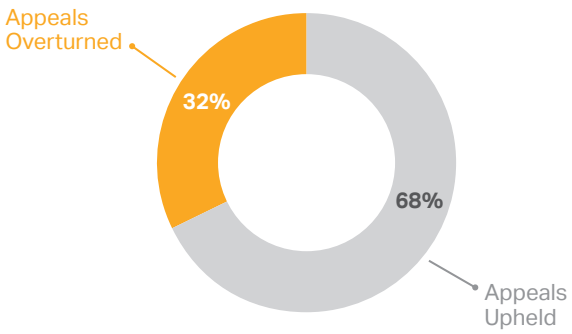
2022 RBPO/ACO INTERNAL APPEAL DATA

In 2022, the provider organizations reporting to OPP administered a total of 132 internal appeals, an increase from the previous year. Of those 132, 68% upheld the initial decision by the ACO or RBPO (**Figure 10**). **Figure 11** shows that the vast majority of the internal appeals, 81%, concerned referral restrictions. The second largest category of internal appeals reported, accounting for 16%, concerned the type or intensity of treatment or services recommended by the ACO or RBPO. In the course of reporting, ACOs and RBPOs also submitted a copy of the patient notice used by the ACO or RBPO to notify patients about this process, standards or guidelines used to review appeals, and information about the individual at the ACO or RBPO charged with reviewing appeals.

EXTERNAL REVIEW

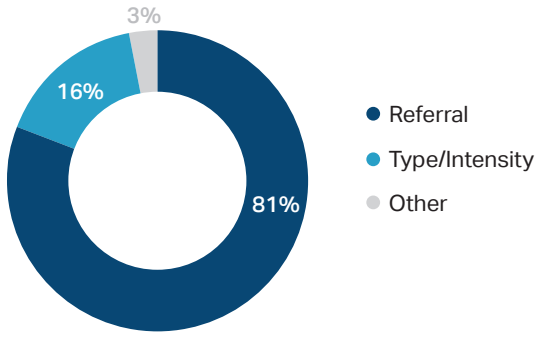
If the RBPO/ACO upholds the health care provider's denial of the requested referral, treatment, or service, the patient may request an external review of that decision through OPP. The external review process offers patients the opportunity to obtain an independent review of a health care decision. OPP began implementing the external review process in 2018.

FIGURE 10



Source: 2022 RBPO/ACO reports pursuant to 958 CMR 11.23

FIGURE 11



Source: 2022 RBPO/ACO reports pursuant to 958 CMR 11.23

iii M.G.L. c. 176O, § 24, M.G.L. c. 6D, §§ 15 and 16.

ELIGIBILITY FOR EXTERNAL REVIEW THROUGH THE OFFICE OF PATIENT PROTECTION

Requests must be eligible for external review. A request is usually eligible for external review through OPP if all of the following are met:

- The patient receives care from a health care provider within an ACO or RBPO
- The patient has a commercial health insurance plan for which the ACO or RBPO is at some financial risk
- The patient submitted the request for external review within 30 days of the date the patient received written notice of the internal appeal decision
- The request for external review is in writing and on the external review request form issued by OPP
- The request includes a copy of the written determination letter issued by the RBPO or ACO

EXTERNAL REVIEW PROCESS

The RBPO/ACO external review process mirrors the health insurance external review process, described on pages 4–5, with a few minor differences. Just as in the health insurance external review process, when OPP receives an eligible request for external review, the request is randomly assigned to one of the four contracted external review agencies. The external review agency assigns the case to one of its medical experts who practices in the same or similar specialty as the service in dispute.

The medical expert then reviews the information submitted by the ACO or RBPO and the patient and reaches an independent conclusion about whether the requested referral, treatment or service is likely to produce a more clinically beneficial outcome for the patient than the referral, treatment or service recommended by the RBPO or ACO. This standard is different than in the health insurance external review process. In making a decision, the external clinical reviewer must consider the following factors: the patient's clinical history, including prior clinical relationships; the availability, within the RBPO or ACO, of a health care professional with the appropriate training and experience to meet the particular health care needs of the patient, including timely access; generally accepted principles of professional medical practice; the efficacy of the requested treatment or service, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; and other factors considered relevant to the patient's ability to access the requested referral, treatment, or service.

The external clinical reviewer uses medical records provided by the patient and the RBPO or ACO and other pertinent documents to determine whether the patient's request is likely to produce a more clinically beneficial outcome. An external review decision, including an analysis of medical evidence and an explanation of the decision, is issued to all parties in writing within 21 days for standard external reviews and within 72 hours for expedited external reviews. The decision of the external review agency is final and binding, though other legal rights apart from OPP's external review process may be available.

The insurer pays the external review agency for the external review, a cost which can range from $475 to $750 depending on the time frame for the review. Unlike the health insurance external review process, the RBPO or ACO patient does not pay a fee to request an external review.

2022 RBPO/ACO EXTERNAL REVIEW DATA

During 2022, OPP received 9 requests for external review from patients of RBPOs and ACOs. Of those 9, 8 requests were eligible for external review and concerned referral restrictions. In 5 cases the external reviewer upheld the decision of the RBPO/ACO deciding that the requested referral was not likely to produce a more clinically beneficial outcome for the patient than the referral recommended by the RBPO or ACO. In 2 cases the external reviewer overturned the decision of the RBPO/ACO meaning the patient was able to receive the requested referral. 1 case was resolved in the patient's favor before a decision by the external review agency.

HEALTH CARE CONSUMER PROTECTIONS

HEALTH PLAN REPORTING

Massachusetts fully-insured health plans submit annual reports to the Office of Patient Protection, providing information about the following:

- Internal reviews
- External reviews
- Sources of information about consumer satisfaction
- Rates of provider disenrollment and reasons for disenrollment
- Medical loss ratio
- Claims and claim denials
- Other health plan information

OPP works with other agencies and seeks input from stakeholders, like health insurance companies and consumer groups, to implement Massachusetts health insurance laws. Where inter-agency questions or concerns arise, OPP works closely with the Massachusetts Division of Insurance, the Office of the Attorney General, the Health Connector, the Office of Medicaid, and other state and federal agencies to address concerns, minimize duplicative efforts, reduce regulatory burden, and ensure compliance.

CONSUMER INFORMATION AND ASSISTANCE

The Office of Patient Protection serves as a resource for consumers, through our hotline, website, and educational guides. OPP assists with questions about health insurance appeals, enrollment waivers, and other health care problems through our hotline, at 800-436-7757. Telephone translation services are available for callers who speak non-English languages or for those who are hearing impaired; staff is also accessible by email or by fax. On our website at http://www.mass.gov/hpc/opp, consumers can find relevant forms in English and Spanish, instructions for pursuing an external review or requesting an enrollment waiver, reports, and answers to frequently asked questions.

TRAINING AND OUTREACH

OPP welcomes requests for informational presentations from consumer organizations, health care providers, government agencies, and other interested groups. Staff is available to provide trainings and to answer questions. To request a training session, contact OPP at HPC-OPP@mass.gov or at 1-800-436-7757.

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Since its inception, the Office of Patient Protection has worked effectively to safeguard health care consumer protections in the Commonwealth. OPP has continued to solicit and act on feedback and promote awareness of external appeal and waiver rights. OPP strives to address each inquiry, waiver, and appeal in a fair and consistent manner. OPP's efforts contribute to the provision of high quality patient care while advancing a more transparent, accountable, and innovative health care system.

"Thank you and your office staff so much during this whole process! Our medical system seems broken, but you are making concrete progress in fixing it – at least from this citizen's perspective. I so appreciate your time."

GLOSSARY

EXTERNAL REVIEW AGENCY	An independent third-party medical review resource that provides objective medical determinations based on evidence that includes medical reports, health plan guidelines, and evidence-based criteria. Each review agency offers a panel of clinical providers to review appeals fairly and impartially. ERAs are required to be accredited by URAC or another nationally recognized accrediting entity.
FULLY-INSURED	A health insurance plan purchased by an individual, a family, an employer, or another entity. The purchaser of the health insurance plan pays premiums to the insurance company and, in return, the insurance company pays the claims for certain health care services. Fully-insured plans can be regulated by the state government. This is also referred to as fully-funded.
HEALTH PLAN	In this report, a "health plan" refers to an insurance product or insurance plan offered by a health insurance company.
MEDICAL NECESSITY OR MEDICALLY NECESSARY	Refers to health care services that are consistent with generally accepted principles of professional medical practice as determined by whether the service:, is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual;, is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or, for services and interventions not in widespread use, is based on scientific evidence.
NON-GROUP INSURANCE	Non-group insurance means health insurance that you buy for yourself or your family from the Health Connector or from an insurance company or insurance agent.
OPEN ENROLLMENT	Under Massachusetts and federal law there are only certain times during the year when individuals and families may buy non-group health insurance coverage. The time when individuals and families can apply – the time when health insurers open plans to new members – is called "open enrollment." This is similar to the process employers use to allow their employees to sign up or change plans during specific times.
SELF-INSURED/ SELF-FUNDED	Under a self-insured or self-funded plan, your employer pays the costs for its employees' health care directly instead of paying premiums to buy health insurance. Some self-insured employers hire insurance companies to process the paperwork and it may be difficult to discern if a plan is self-funded. Contact your employer to find out if your plan is self-insured. Self-insured plans are usually regulated by the federal government and governed by "ERISA" or the Employee Retirement Income Security Act of 1974.

ACKNOWLEDGMENTS

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