# Massachusetts Department of Public Health
# Office of Patient Protection
# Annual Report: January 1, 2006 through December 31, 2006

## Introduction

The Massachusetts Department of Public Health's Office of Patient Protection (OPP) operates pursuant to §217 of chapter 111 of the Massachusetts General Laws. Among its duties is enforcement of certain provisions of Chapter 176O of the Massachusetts General Laws, which provides protections to health insurance consumers. In addition to the consumer protections, Chapter 176O contains health insurance licensure and accreditation requirements that are administered by the Massachusetts Division of Insurance. It is important to note that Chapter 176O applies only to insured health plans that are issued or delivered in the Commonwealth; it does not apply to Medicare, Medicaid, federal employee plans, or self-insured plans. However, as a result of health reform in Massachusetts signed into law in 2006 (Chapter 58), the four Medicaid managed care plans offered through the Commonwealth Connector Authority (known as Commonwealth Care) are also subject to the consumer protections of Chapter 176O.

**Under Chapter 176O, OPP is responsible for:**

- Monitoring and regulating health plan compliance with requirements for internal grievances and appeals;
- Maintaining contracts with at least three independent external review agencies and administering the external appeal process;
- Ensuring that health plans comply with regulations concerning continuity of coverage under specific circumstances;
- Receiving and posting information reported by health plans; and
- Creating and maintaining a website with information for consumers about managed care.

The Office of the Managed Care Ombudsman, which was created in 1998 under Executive Order 405, merged with OPP in January, 2001. As a result, OPP has an ombudsman and a nurse reviewer who work together to assist consumers with issues and problems concerning managed care.

Chapter 176O contains a remedy for denial of coverage by health plans based on medical necessity. Once an insured has exhausted the health plan's internal appeal process and received a final adverse determination, he/she may be eligible for an independent external review through OPP. Requests for external reviews must be received by OPP within 45 days of the date on which the insured receives the final adverse determination letter.

## External Review Agencies

DPH contracts with three independent external review agencies. OPP assigns cases on a random basis to one of the three agencies, which then forwards it to a physician reviewer

who practices in the same or similar specialty as the physician performing the service in dispute. The three agencies DPH contracts with are:

- Maximus Center for Health Dispute Resolution (Victor, NY)
- Island Peer Review Organization (Lake Success, NY) and
- Imedecs (formerly Hayes Plus) (Lansdale, PA).

All three agencies are accredited by URAC (the American Accreditation HealthCare Commission formerly known as the Utilization Review Accreditation Commission).

Except in cases of extreme financial hardship (which is determined by income based on the federal poverty level), the insured pays the first $25 of the cost of the review. The health plan pays the remainder of the cost, which averages $500 for a standard review and $700 for an expedited review. The $25 filing fee is waived for all members enrolled in Commonwealth Care, since the criteria for eligibility for Commonwealth Care is income below 300% of the federal poverty level.

**Screening Requests for External Review**

When OPP receives a request for external review, it screens the request to ensure that:

1. The insured is enrolled in a health plan that is governed by Chapter 176O;
2. The health plan has complied with all of the applicable requirements of 105 CMR 128.000 (the regulation that governs health plan appeals);
3. The insured has exhausted the health plan's internal appeal process;
4. The health plan's decision meets the definition of an adverse determination (medical necessity denial);
5. The request is submitted on the required form and is accompanied by the required signatures and a check for $25 (waived in cases of extreme financial hardship); and
6. The request does not involve a service or supply that has been explicitly excluded from coverage by the health plan in its evidence of coverage.

**Summary of 2006 External Review Activity**

When reviewing OPP statistics, it is important to understand that the numbers OPP reports are absolute numbers. They are not broken down to reflect the membership of each health plan. Thus, although a very large plan may have more appeal requests,when membership is considered, the actual percentage of appeals may be considerably lower that that of a small plan. For example, a plan with 850,000 members and 50 external reviews has fewer external appeals per member than a plan with 50,000 members and five external reviews. For more information on actual health plan membership, visit the Division of Insurance website at www.mass.gov/doi.

In 2006, OPP sent 218 cases for external review. (OPP actually received 325 requests, of which 86 cases were ineligible for external review and 21 were resolved by OPP and the health plans without further review.) These statistics are fairly consistent with those of

previous years. Detailed information for 2001 through 2006 regarding specific health plans, categories of appeals, and aggregate data can be found at www.mass.gov/dph/opp.

**Resolved Cases**

In 2006, 21 of the requests that were eligible for external review were resolved prior to being sent for review. In some cases, this occurred because the health plan decided to overturn its original denial based on additional clinical information. In other cases, OPP noted compliance issues under 105 CMR 128.000 that required that the health plan resolve the case in favor of the member. OPP also investigated cases in which there was a question of adequate access to network providers and determined that because there was no clinically appropriate facility or provider in the health plan's network, the health plan must cover the out-of-network provider that was the subject of the appeal.

**Decisions**

In general, the three external review agencies overturned or partially overturned 32% of the health plan decisions. Taken separately, the percentage of decisions overturned for cases involving behavioral health services is 37% while the percentage of overturns for non-behavioral health services is significantly smaller at 27%. As discussed below, behavioral health appeals continue to be the number one category of external review requests (137), followed by experimental (35 requests). Please refer to www.mass.gov/dph/opp for detailed information regarding external review decisions.

**Trends and Issues**

- **Behavioral Health**

Behavioral health remains the number one category for external review requests in 2006. The majority of these cases involve denials of continued inpatient care, acute residential treatment, and various levels of care for eating disorders.

Harvard Pilgrim Health Care (HPHC) had 38 eligible behavioral health care external appeals in 2006 (overturn rate 29%), followed by Blue Cross Blue Shield of Massachusetts with 27 eligible cases (overturn rate 52%).

United Health Care also had a significant number of behavioral health cases. In 2006, OPP received 24 requests for behavioral health appeals from patients covered by United Behavioral Health through the Commonwealth of Massachusetts Group Insurance Commission (GIC). Forty percent of the eligible cases were either fully or partially overturned. Given the comparatively small number of insureds covered by UBH through the GIC, and the fact that this trend was first noted in 2004, OPP performed an inspection of behavioral health grievances in September of 2006. A summary of the findings is available through OPP.

Tufts Health Plan had 12 external reviews and a 25% overturn rate. The remaining health plans had five or fewer requests for behavioral health.

- **Experimental/Investigational**

The second largest category of appeal requests was for coverage of services deemed experimental or investigational by the health plan. In 2006, this category accounted for 31 eligible requests with a 19% overturn rate. The relatively large number of requests reflects the rapid technological developments in medicine, with insureds often seeking coverage for services and procedures that are not yet in widespread use. The small number of overturns by the external review agencies demonstrates that in the majority of cases, health plans have made decisions that can be supported by peer reviewed journals and evidence based medicine.

- **Assisted Reproductive Technology (ART)**

Massachusetts law requires that insurers provide coverage for medically necessary expenses for diagnosis and treatment of infertility, which is defined in the law as "the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year."

In 2006, OPP received 28 requests for ART services; 18 of these were eligible for external review and 28% were overturned. This is consistent with statistics from previous years. The majority of these requests continue to be from women in their forties, and the disputes focused on whether their requests for ART fall within the state-mandated coverage, i.e., was the appellant seeking treatment for a medical condition covered under the state mandate or were the ART services being requested by a patient for whom infertility is part of the normal aging process?

**Health Plan Inspections:**

In 2006, OPP continued to inspect health plan grievance files. Where OPP noted deficiencies, it requested and received corrective action plans. OPP's inspection reports and the corresponding corrective action plans are on file with OPP and available to the public for review.

**Outreach Activities**

The Office of Patient Protection welcomes requests for informational presentations from consumer advocacy groups, hospital staff, and provider organizations. In past years, OPP has worked with the Mass. Association of Behavioral Health Systems, the Mass. Psychiatric Association, Mass. Psychological Association, Mass. Mental Health, PAL, MOAR, and MHA as well as with staff from individual hospitals.

**Other Regulatory Activities**

Throughout 2006, OPP met regularly with the Division of Insurance (DOI) to discuss managed care issues under Chapter 176O and to refer cases to DOI for investigation and enforcement. OPP and DOI also met regularly with the Department of Mental Health to discuss issues related to the provision of mental health services, to define intermediate care services and to develop a consistent policy around provision and coverage of intermediate care services.

With the inception of health reform, OPP worked with the Commonwealth Connector Authority and with the four Medicaid Managed Care plans on insuring that the consumer protection provisions of Chapter 176O were incorporated into the plans' Evidences of Coverage. OPP continues to provide information and expertise to both the Connector and the Commonwealth Care plans on issues related to appeals and grievances.

**Office of the Managed Care Ombudsman**

The Office of the Managed Care Ombudsman assists consumers in resolving disputes with health plans. These calls, primarily from consumers, involved questions about health plan denials, appeals, benefits, and policies. The Ombudsman's office also answers general questions from consumers and providers about managed care and Chapter 176O, and refers callers with other health insurance questions to the DOI or other appropriate state or federal agency.

**Summary**

As OPP enters its seventh year of operation, it continues to monitor compliance by health plans with Chapter 176O. OPP will continue to inspect health plan grievance files and to refer patterns of non-compliance to the DOI for enforcement. Through consultation with other state agencies, such as DOI and DMH, OPP will continue to address concerns about managed care.

OPP and the Ombudsman's office have developed excellent working relationships with health plans and will continue to work closely with health plans, provider organizations, hospitals and other state agencies to provide consumers with the means to resolve disputes with managed care organizations.

Any questions regarding this report should be directed to:

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