MASSACHUSETTS
HEALTH POLICY COMMISSION

2018 ANNUAL REPORT

Office of Patient Protection

Released January 2020

ABOUT THE HEALTH POLICY COMMISSION

The HPC, established in 2012, 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 innovative health care system through independent policy leadership and investment programs.

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; 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 health-related social needs; analyzing the impact of health care market transactions on cost, quality, and access; and investing in community health care delivery and innovations.

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, former Governor Paul Cellucci signed Executive Order No. 405 creating the Office of the Managed Care Ombudsman 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 eighteenth 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 process 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 2018

Collected New Health Plan Reporting: Under new authority, OPP, in coordination with the Division of Insurance (DOI), has begun to collect claims denial data from fully-insured health plans. The additional reporting is intended to provide greater transparency, broaden the data currently reported to OPP, and supplement information submitted to the DOI. Throughout 2018, OPP worked collaboratively with the DOI and health plans to refine reporting guidelines for the collection of 2018 claims data. The guidelines require reporting of the number of professional, institutional as well as laboratory claims in the categories of medical/surgical, mental health, or substance use disorder and the number of claims approved or denied in each category and the reasons for denial. The health plans submitted 2018 data to OPP and the DOI in July 2019. OPP continues to work with the DOI and the health plans to analyze the data and consider dissemination approaches.

Issued Regulation and Implemented New External Review Process: Following a multiyear stakeholder engagement process, including a public hearing and comment period, OPP issued the final regulation on RBPO and ACO appeals on September 7, 2018. Under the regulation, RBPOs and ACOs administer internal appeals for patients and report to OPP annually on the number of appeals received and their outcomes. OPP is implementing an external review process for patients who remain aggrieved following an internal appeal. To correspond with the release of the regulation and extended consumer protections, staff updated OPP webpages to provide consumer-facing information about RBPO/ACO appeals including answers to frequently asked questions and guidance on how to submit an external review request.

Issued Guidance: Pursuant to MGL c. 6D, section 16, health plans' medical necessity criteria must be made available upon request to members, prospective members, health care providers, OPP and the Division of Insurance. Medical necessity criteria are the policies and protocols that health plans use to determine whether certain services should be provided to members, based on clinical evidence. OPP's 2018 Bulletin requested all health plans submit any new or updated criteria to OPP by June 2018. Following that initial submission, OPP further requested that health plans provide prompt updates on any new or revised criteria no later than 30 days from the date of its implementation.

Contracting Update: By regulation, OPP must contract with at least three accredited external review agencies. In March 2018, OPP initiated a competitive procurement process with a Request for Responses (RFR) for external review agencies to perform clinical reviews for the health insurance and RBPO/ACO external review processes. 10 external review agencies responded to the RFR. After reviewing responses, OPP chose four external review agencies to serve OPP for an initial three year term that began in July 2018.

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 over 1,820 inquiries via its toll-free hotline. In 2018, most callers had inquiries about enrolling in health insurance through requesting an open enrollment waiver. In 2018, OPP experienced a transition in leadership, with Nancy K. Ryan assuming the role of Director of OPP in September.

Enrollment Waivers

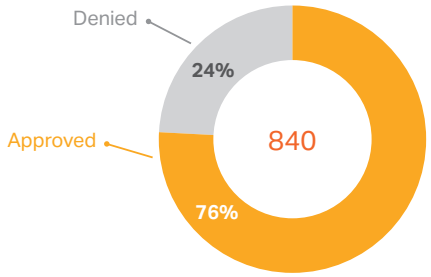
Federal and state law limit when individuals and families can buy certain health insurance plans. Most Massachusetts consumers must buy insurance during a designated open enrollment period. Massachusetts residents who missed the previous open enrollment period, and have not experienced a qualifying life 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

2018 ENROLLMENT WAIVER DATA

During 2018, the Office of Patient Protection received 840 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 642 waivers to eligible applicants or 76% of all received requests (**Figure 1**). In 2018, OPP received double the amount of waiver requests than in previous years. While there is not one specific factor driving this increase, it may be due to increasing statewide enrollment in individual health insurance plans and a greater awareness of the open enrollment waiver process.[i] OPP also provided guidance to consumers who had difficulty enrolling in a health plan. 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: 2018 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

Source: 2011-2018 Office of Patient Protection waiver data.

i CHIA Enrollment Trends (August 2019).

Health Insurance Appeals

Under Massachusetts law,[ii] 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.

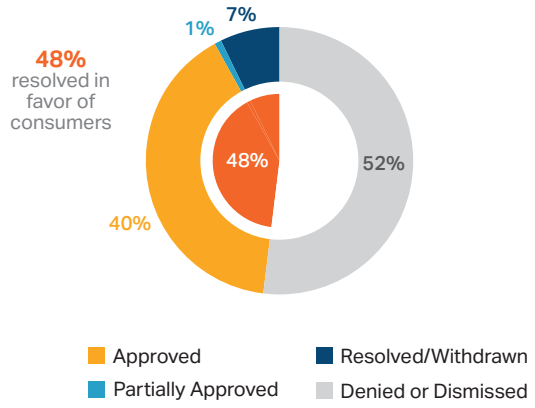
INTERNAL REVIEW

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.

2018 INTERNAL REVIEW DATA

During 2018, Massachusetts health insurance companies reported 13,416 member grievances (**Figure 2**). These grievances include many different types of member complaints, such as disputes over coverage for treatment or cost-sharing.

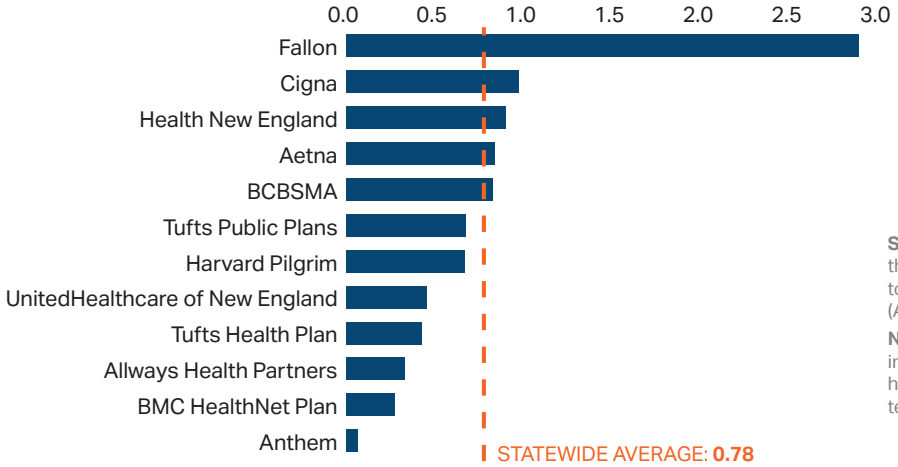
FIGURE 2



Source: 2018 insurance carrier reports to the Office of Patient Protection, pursuant to 958 CMR 3.600.

Figure 3 shows the member grievances reported by each health insurance company that provided fully-insured coverage in Massachusetts during 2018. 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.

FIGURE 3



Source: 2018 insurance carrier reports to the Office of Patient Protection, pursuant to 958 CMR 3.600; CHIA Enrollment Trends (August 2019).

Notes: Weighted by dividing number of internal reviews by an average of 2018 health plan member data reported quarterly to CHIA.

ii M.G.L. c. 176O §§ 13-14.

Under current OPP regulations, health plans report detailed information about the types and outcomes of member grievances received. For 2018, health plans reported the following figures:

- **Member grievances:** Health insurers resolved 48% or 6,444 of all member grievances fully or partly in favor of the member.
- **Medical necessity denials:** 5,558 or 41% 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 5,558 grievances based on medical necessity, 12% or 640 involved behavioral health treatment.
- **Pursuing external review:** Of those grievances denied based on medical necessity, 12% of patients or consumers sought an independent external review of the health plan's final adverse determination (**Figure 4**). While this number may seem low, it is consistent with prior year trends, indicating that a significant portion of consumers are aware of their appeal rights and are exercising them, and yet some opportunities for consumer engagement remain.

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.

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:

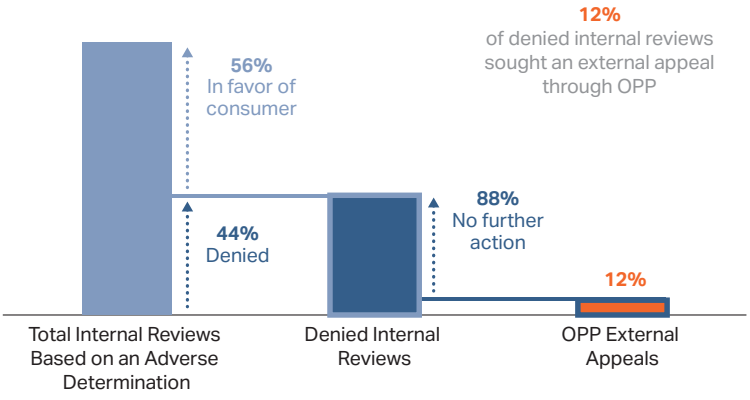
Medical Necessity or **Medically Necessary** means health care services that are consistent with generally accepted principles of professional medical practice as determined by whether the service:

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.[iii]

FIGURE 4



Source: 2018 Office of Patient Protection external review data; 2018 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.

iii 958 CMR 3.020.

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 2018 were the consumer requesting external review was covered under a self-insured plan and the request concerned a benefit that was explicitly excluded from coverage.

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 throughout the country. In 2018, the Health Policy Commission contracted with four nationally accredited, independent external review agencies; they were:

- Independent Medical Experts Consulting Services, Inc. (IMEDECS), based in Lansdale, Pennsylvania
- Island Peer Review Organization (IPRO), based in Lake Success, New York
- MAXIMUS Federal Services, Inc., based in Pittsford, New York
- ProPeer Resources, LLC, based in New Braunfels, 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.

2018 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 2018

During 2018, OPP screened 302 external review requests for eligibility. 231 or 76% of these requests were deemed eligible for external review. Of the eligible cases, 37% were overturned in whole or in part or modified by the external review agency in favor of the patient. Approximately 5% 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 58% of cases eligible for review.

Figure 5 illustrates the dispositions or results for all eligible external reviews filed during 2018. **Figure 6** breaks down the total number of external reviews into two categories: medical or surgical care and behavioral health.

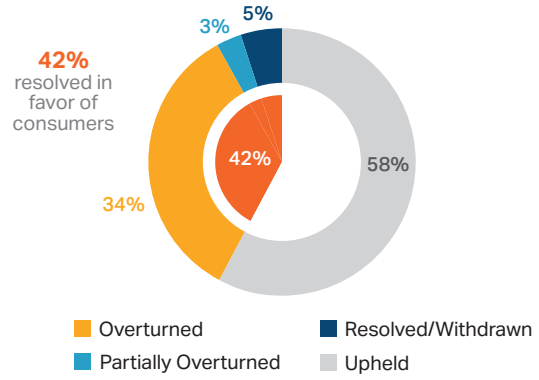
Figure 7 compares the frequency of eligible external reviews for each health plan. This number is calculated by adjusting the total number of external reviews for each plan by the number of members reported by each health plan in 2018. This analysis identifies an average for the number of external reviews 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 Fallon reporting the highest proportion.

MEDICAL/SURGICAL DATA

OPP received 195 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.

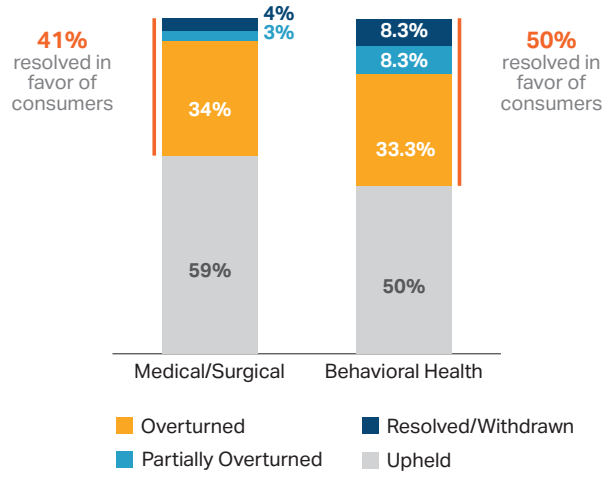
In 2018, 59% of external reviews involving medical or surgical treatment upheld the decision of the health insurer and 37% of reviews were resolved either fully or partially in favor of the patient (**Figure 8**). 4% of external reviews involving medical or surgical treatment were resolved prior to an issued decision. The most common medical/surgical review requests were in the categories of outpatient care

FIGURE 5



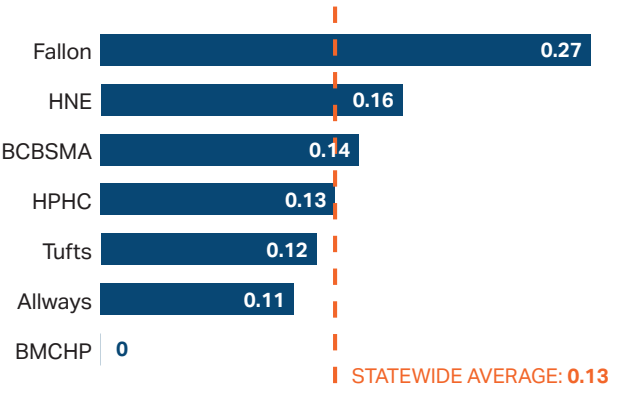
Source: 2018 Office of Patient Protection external review data.

FIGURE 6



Source: 2018 Office of Patient Protection external review data.

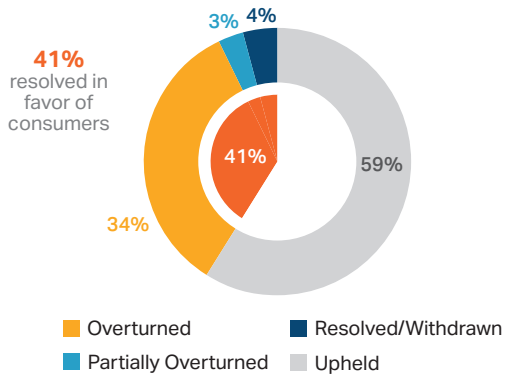
FIGURE 7



Source: 2018 Office of Patient Protection external review data; CHIA Enrollment Trends (August 2019).

Note: Weighted by dividing number of eligible external reviews by an average of 2018 health plan member data reported quarterly to CHIA.

FIGURE 8



Source: 2018 Office of Patient Protection external review data.

and pharmacy. OPP received 74 external review requests regarding outpatient medical/surgical care including surgeries, medical visits, and rehabilitation services, 59 of which were eligible for external review.

Additionally, 31 requests were received for pharmacy treatments, of which 24 were eligible for external review. Of the 24 matters in this category that were eligible for review, 11 were overturned or partially overturned by the external review agency.

During 2018, OPP received 24 external review requests involving infertility treatment. Out of the 19 eligible cases, 14 were upheld by the external review agency. 4 eligible cases were overturned by the external review agency, while 1 case was resolved by the health insurance company prior to the issuance of a decision.

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 2018, OPP received 32 eligible external review requests involving services deemed to be experimental or investigational by the insurance companies. This is nearly triple the amount received in 2017 and 2016. Diagnostic cancer screenings accounted for 11 out of the 32 cases received, and in all of those cases the ERA upheld the insurer's original decision. Other requests included non-standard surgical procedures or treatments. Overall, 10 of the experimental/investigation requests were overturned in favor of the patient and 21 were upheld (1 was resolved by the health insurance company prior to the issuance of a decision).

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 2018, OPP received 33 requests for external review involving coverage for an out of network provider. 18 of these were eligible for external review and 8 were resolved in favor of the patient.

BEHAVIORAL HEALTH

OPP received fewer external review requests pertaining to behavioral health services than in years past. Behavioral health services include treatment for mental health conditions, substance use disorders, and some developmental disabilities in 2018.

OPP received 43 requests for external review of behavioral health services during 2018, and 36 of these were eligible for external review.

Eligible behavioral health cases: Of all eligible behavioral health cases received during 2018, 15 cases were fully or partially overturned in favor of the patient. Half of the eligible behavioral health cases were resolved in the patient's favor.

Mental health treatment: Of the eligible cases, OPP received 20 requests for mental health treatment. Inpatient or residential mental health care represents the largest subcategory, with 11 eligible requests for external review.

Substance use disorder treatment: OPP received 9 eligible requests for treatment related to substance use disorders; 8 of which were for residential or inpatient substance use disorder treatment. Of the 9 eligible cases regarding substance use disorder, 4 were overturned or partially overturned by an independent medical reviewer because care was found to be medically necessary.

Other: OPP received 7 eligible requests for other behavioral health services, primarily requests for therapies to treat developmental disabilities.

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, 58% 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.

The numbers of external review requests filed during 2018, and the numbers of reviews deemed eligible, were largely consistent with recent years. However, 2018 saw a lower overall number of requests for reviews of behavioral health services and treatments. Consistent with past years, a higher proportion of external reviews for behavioral health services were resolved in favor of the consumer than external reviews for medical/surgical services. In 2018, 50% of behavioral health external reviews were resolved in favor of the consumer, compared to 41% of reviews for medical or surgical services.

Appeals Process for Patients of Accountable Care Organizations (ACO) and Risk-bearing Provider Organizations (RBPO)

Under Massachusetts law[iv], 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 referral 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.

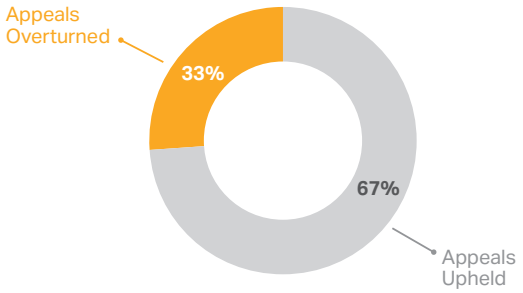
INTERNAL APPEAL

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.

2018 RBPO/ACO INTERNAL APPEAL DATA

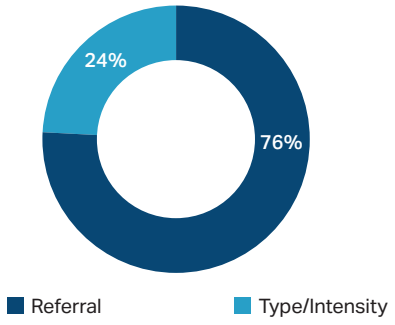
OPP collected a full year of data on internal appeals in 2018. Over the course of the year, the provider organizations reporting to OPP administered a total of 55 internal appeals. Of those 55, 67% upheld the initial decision by the ACO or RBPO (**Figure 9**). **Figure 10** shows that the vast majority of the internal appeals, 76%, concerned referral restrictions. The next largest category of internal appeals, accounting for 24%, concerned the type or intensity of treatment or

FIGURE 9



Source: 2018 Office of Patient Protection ACO/RBPO appeals data.

FIGURE 10



Source: 2018 Office of Patient Protection ACO/RBPO appeals data.

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

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 on September 7, 2018, the effective date of the final regulation. OPP did not receive any requests for external review from September 2018 through the end of the year.

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 page 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 RBPO or ACO 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.

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.

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.

> "I cannot say enough about how much my son and I appreciate all that you have done to help us out at this difficult time. We fully recognize and appreciate the role you play for patients like my son who need advocacy and support with major insurers. It shouldn't have to be this way —- but knowing you are out there to help makes a huge difference. Thank you from the bottom of our hearts. You really made a difference."

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.

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The Commission would like to thank the insurance companies, risk-bearing provider organizations, and accountable care organizations that submitted information included in this report. The Commission acknowledges the critical input of both consumers and marketplace stakeholders, and we hope that this report provides useful information for navigating health care consumer protections in Massachusetts.

HEALTH POLICY COMMISSION
50 Milk Street, 8th Floor
Boston, MA 02109
www.mass.gov/HPC