Massachusetts Department of Public Health
Office of Patient Protection
Annual Report: January 1, 2004 through December 31, 2004

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 certain 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.

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 (Pittsford, NY)

- Island Peer Review Organization (Lake Success, NY) and
- 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, 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.

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 2004 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 2004, OPP sent 200 cases out for external review. (OPP actually received 310 requests, of which 89 cases were ineligible for external review and 21 were resolved by OPP and the health plans without further review.) In 2003, 296 cases were sent for external review. The decrease from 2003 is primarily due to the significant reduction in Magellan Behavioral Health cases from Blue Cross Blue Shield of Massachusetts.

Detailed information for 2001 through 2004 regarding specific health plans, categories of appeals, and aggregate data can be found at www.state.ma.us/dph/opp.

Resolved Cases
In 2004, 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 45% of the health plan decisions. Taken separately, the percentage of decisions overturned for cases involving behavioral health services is 57% This is comparable to 2003 when 58% of behavioral health appeals were fully or partially overturned. As discussed below, behavioral health appeals continue to be the number one category of external reviews (89), followed by infertility (26 external reviews). Please refer to www.state.ma.us/dph/opp for detailed information regarding external review decisions.

Trends and Issues in 2004

A) Behavioral Health:

Behavioral health remains the number one category for external review requests in 2004. The majority of these cases involve denials of continued inpatient care, acute residential treatment, and various levels of care for eating disorders. It is important to note that there was a significant decrease in behavioral health external appeals from 2003. This is primarily due to the improvements made by Blue Cross Blue Shield of Massachusetts and Magellan Behavioral Health in 2003 in response to a series of meetings with OPP, the Division of Insurance, and the Department of Mental Health. In contrast to 2003, when BCBSMA had 106 behavioral health external reviews, there were only 11 external reviews in 2004.

Harvard Pilgrim Health Care (HPHC) had 33 behavioral health care appeals in 2004, up from 20 in 2003. The 2004 overturn rate for the external reviews was 55%. Of note: In 2004, HPHC's behavioral health services were administered by Value Options; beginning on January 1, 2005, Pacificare Behavioral Health became the behavioral health care provider for HPHC members.

United Health Care also had a significant number of behavioral health cases. In 2004, OPP received 31 requests for behavioral health appeals from patients covered by United Behavioral Health through the Commonwealth of Massachusetts Group Insurance Commission (GIC). Of the 31 requests, 23 were eligible cases and 15 decisions (65%) were either fully or partially overturned. Given the comparatively small number of insureds covered by UBH through the GIC, OPP is concerned about the number of requests and percentage of overturns and plans to continuing monitoring the situation in 2005.

In 2004, Tufts Health Plan had 17 requests, 11eligible external reviews, and a 55% overturn rate. The remaining health plans had six or fewer requests for behavioral health.

B) 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 2003, OPP saw an increase in the number of requests for external review for denials of assisted reproductive technology (ART). In 2003, OPP received 30 requests compared with 12 in 2002 and none in 2001. In 2004, the number of requests rose to 34. 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? In 2004, 73% of these denials were upheld and 27% were overturned.

Health Plan Inspections:

In 2004, 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 continued its activities to increase awareness among consumers and providers. OPP spoke to groups of case managers and physicians at McLean Hospital, sponsored by the Massachusetts Association of Behavioral Health Providers. In October, OPP presented information on patient rights, appeals and external reviews to a group of consumers advocates and staff members from Mass Mental Health. OPP welcomes requests for informational presentations from consumer advocacy groups, hospital staff, and provider organizations.

Other Regulatory Activities

Throughout 2004, 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.

Office of the Managed Care Ombudsman

The Office of the Managed Care Ombudsman assists consumers in resolving disputes with health plans. In 2004, it again fielded more than 2000 calls. 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 fifth 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:

Karen Granoff
Director, Office of Patient Protection
617-624-5727
Karen.Granoff@state.ma.us