

OFFICE OF PATIENT PROTECTION



Annual Report | 2013

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COMMONWEALTH OF MASSACHUSETTS
HEALTH POLICY COMMISSION

ABOUT HPC

The HPC, established by Chapter 224 of the Acts of 2012, is an independent state agency governed by an 11-member board with diverse experience in health care. The HPC is leading efforts to advance Chapter 224's ambitious goal of health care cost containment. The agency works to progress informed dialogue, evidence-based policy, and innovative delivery and payment models that will accelerate transformation in the Massachusetts health care system.

The HPC's various policy committees engage in health care market research through publication of the Annual Cost Trends Reports; market monitoring through Notices of Material Change and Cost and Market Impact Reviews; market regulation through the creation of criteria for Accountable Care Organizations and the Registration of Provider Organizations Program; and market investment through the \$120 million CHART Investment Program. As part of Chapter 224, the HPC operates the Office of Patient Protection, which administers health care consumer protections and monitors access to care. Through these and other work streams, the HPC strives to monitor progress towards meeting the health care cost growth benchmark while improving the quality and access to patient care.



INTRODUCTION

Welcome to the Office of Patient Protection (OPP). The Office of Patient Protection operates within the Massachusetts Health Policy Commission (HPC), an independent state agency that develops policy to reduce health care cost growth and improve the quality of patient care. The Office of Patient Protection is responsible for regulating and administering certain health insurance consumer protections. It is a resource for individuals who want to become more informed and empowered health care consumers.

Transfer to the Health Policy Commission

In 2012, Massachusetts adopted its landmark health care cost-containment law, Chapter 224 of the Acts of 2012, *An Act Improving the Quality of Health Care and Reducing Costs through Increased Transparency, Efficiency, and Innovation*. Chapter 224 created the Health Policy Commission, and set the ambitious goal of bringing health care spending growth in line with growth in the state’s overall economy. Part of Chapter 224 transferred the Office of Patient Protection from the Department of Public Health to the Health Policy Commission. This transition took effect on April 20, 2013, when the Office of Patient Protection moved to the Health Policy Commission.

Responsibilities of the Office of Patient Protection

The main duties of the Office of Patient Protection are:

- Regulating the internal review process for consumers who wish to challenge denials of coverage by their health insurance companies
- Regulating and administering the external review process for consumers who seek a second independent appeal to challenge denials of coverage by their insurance companies
- Administering an enrollment waiver process for consumers who want to buy non-group health insurance
- Receiving, analyzing, and publishing information from annual reports by Massachusetts health plans
- Providing information to consumers about health insurance appeal rights, waivers, and other issues related to health insurance and health care

A Look Ahead

Next year’s annual report will document the first full year that OPP operated within the Health Policy Commission as well and the first year of reporting under our updated regulations. This coming year, OPP is:

- Implementing updates to the OPP regulations at 958 CMR 3.000 et seq., which require some additional data to be included in annual health plan reports
- Implementing OPP’s new, modernized database
- Improving the way data is recorded at OPP, including more detailed categories of medical/surgical and behavioral health treatments and services

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HISTORY OF THE OFFICE OF PATIENT PROTECTION

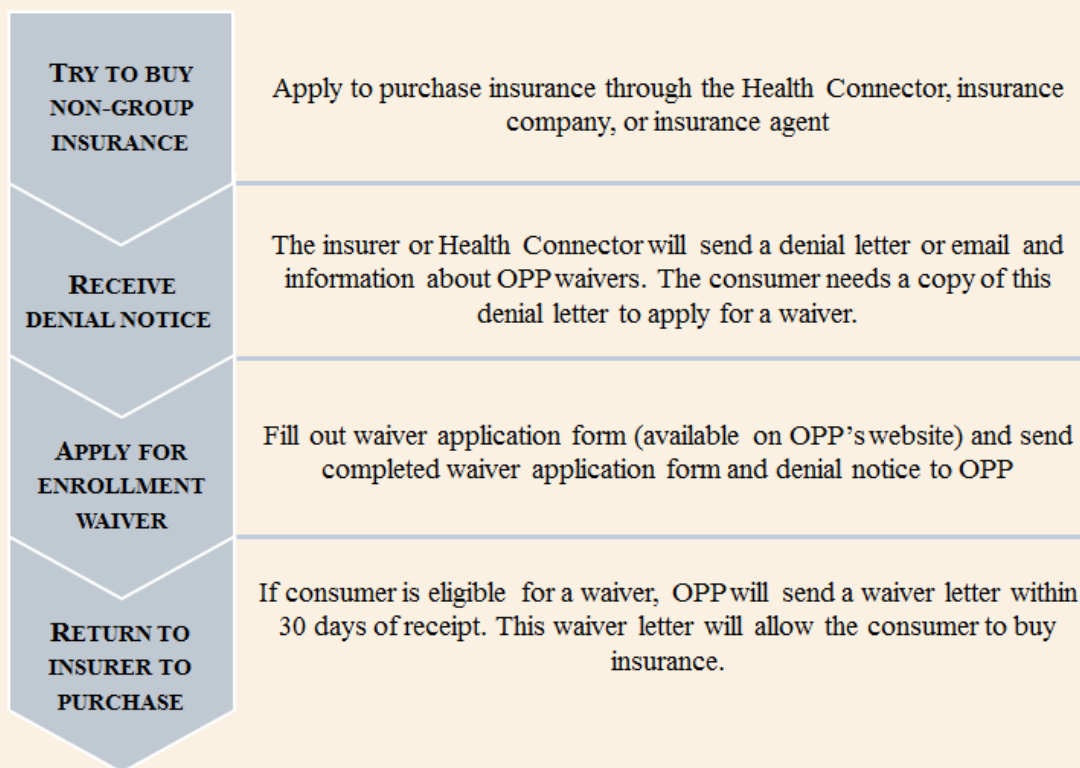
In 1998, former Governor Paul Cellucci signed Executive Order No. 405 to establish managed care protections for consumers. A section of this executive order created an Office of the Managed Care Ombudsman. Two years later, the Office of Patient Protection was established through Chapter 141 of the Acts of 2000, a law that created new protections for health insurance consumers. During January 2001, the Office of the Managed Care Ombudsman merged with OPP. OPP operated within the Department of Public Health from 2000 until moving to the HPC in 2013.

ENROLLMENT WAIVERS

Massachusetts and federal law limit when individuals and families can buy certain health insurance plans. Most Massachusetts consumers must buy insurance during the open enrollment periods. Massachusetts residents who missed the open enrollment period might 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 63 days had passed

HOW TO PURCHASE NON-GROUP INSURANCE WHEN ENROLLMENT IS CLOSED



2013 Enrollment Waiver Data

During 2013, the Office of Patient Protection received 416 requests for waivers from Massachusetts residents seeking to buy insurance from the Health Connector or directly from an insurance company or insurance agent. OPP issued 209 waivers to applicants. Many applicants who did not receive waivers were already eligible to buy insurance.

Table 1: Enrollment Waiver Decisions, 2013

Decision	Number of Cases
Approved	209
Denied	139
Withdrawn or Other	68
Total	416

Source: 2013 Office of Patient Protection internal waiver data

INTERNAL REVIEW

Under Massachusetts law,¹ health care consumers have the right to appeal certain decisions by their health plans. These laws apply to individuals with “fully-insured” commercial Massachusetts health plans (see Glossary for definitions). Consumers with other types of health plans, including self-insured plans, MassHealth, or Medicare, have different appeal rights under other state or federal laws.

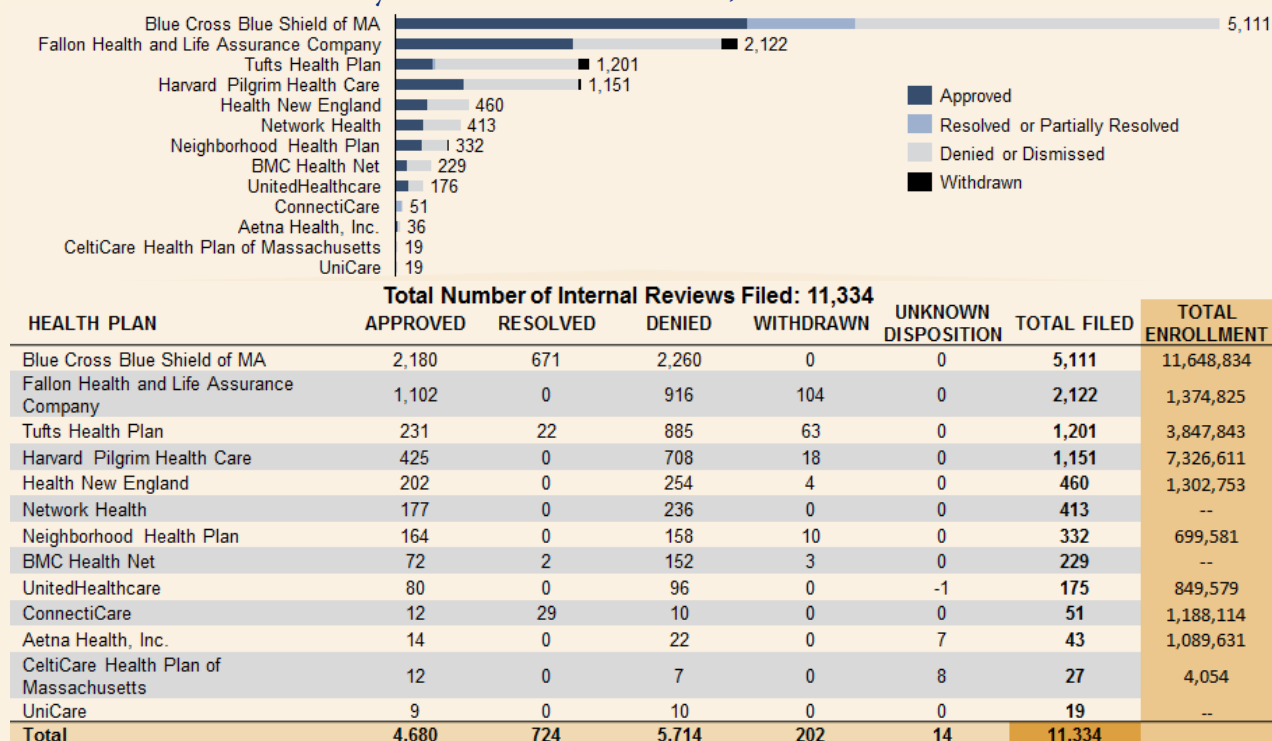
When an insurer informs a consumer that the health plan will not pay for or cover the consumer’s medical or behavioral health treatment, the consumer may appeal that decision by first contacting the health plan. This first appeal, often called a member grievance, is an internal review by the health plan. The consumer may seek an expedited internal review for urgent matters. Otherwise, the health plan will respond to the consumer within 30 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.

2013 Internal Review Data

During 2013, Massachusetts health insurance companies reported 11,334 internal reviews or member grievances (Figure 1). Due to differences in reporting methods, some health plans have included a wide range of member complaints, such as complaints regarding health care providers.

Figure 1 shows detailed results reported by each health plan that provided fully-insured coverage in Massachusetts during 2013. Please note that health plans with larger numbers of members are likely to report larger numbers of internal review and external review requests. A larger number of internal reviews alone does not necessarily reflect a disproportionate number of internal reviews. Some factors that affect the number of reviews reported include the number of plan members and the different reporting practices among health plans. Please see the 2013 OPP Annual Report Chart Book for more information and analysis on the relative amount of internal reviews reported by each health plan.

Figure 1: Internal Review Cases by Health Plan and Outcome, 2013



Source: 2014 Insurance carrier reports to the Office of Patient Protection, pursuant to 958 CMR 3.600
Enrollment data from the Center for Health Information and Analysis, 2012

¹ M.G.L. c. 176O, §§ 13-14.



EXTERNAL REVIEW

If a consumer pursues an internal review and the health plan upholds its initial decision, the consumer may have the right to a second appeal known as external review. External review is available when the health plan's decision was based on a determination of whether the specific treatment or service at issue was "medically necessary." Under Massachusetts law, a health plan is required to pay for treatments or services that are covered benefits under the plan and that are medically necessary.

External Review Process

The Office of Patient Protection administers the Massachusetts external review process for consumers with fully-insured health insurance plans. In most cases, a consumer must pursue an internal review or member grievance first. A consumer seeking an external review must file an external review request with OPP within four months after receiving this second denial, also called a "final adverse determination," from the insurance company.

When OPP receives an eligible request for external review, the request is randomly assigned to one of three external review agencies. The Health Policy Commission contracts with these three independent external review agencies, which are also known as independent review organizations. 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. During 2013, the HPC contracted with:

- Independent Medical Experts Consulting Services, Inc. (IMEDECS), based in Lansdale, Pennsylvania
- Island Peer Review Organization (IPRO), based in Lake Success, New York
- Medical Consultants Network (MCN), based in Seattle, Washington

As required by law, all three external review agencies are accredited by national accreditation organizations and have agreed to avoid any conflict of interest.

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.

Through 2013, external review agencies were required to issue a decision within 60 days of receiving a request for a standard external review. If the patient had requested an expedited review - initiated when the patient's treating

ELIGIBILITY FOR EXTERNAL REVIEW THROUGH THE OFFICE OF PATIENT PROTECTION

An insurance dispute is usually eligible for external review through OPP if the following are all met:

- Massachusetts health insurance plan
- Fully-insured health insurance plan
- Request for external review includes one of these:
 - final adverse determination, OR
 - adverse determination, if the patient is seeking an expedited internal review and expedited external review at the same time, OR
 - written confirmation that insurance company has waived internal review
- Final adverse determination or adverse determination is based on medical necessity
- Request for external review filed with OPP within four (4) months of receiving the final adverse determination
- Request for external review is in writing and on the external review request form issued by OPP

provider certified that there was a serious and immediate threat to the health of the patient - the decision would be issued within four days of receiving the request. These time limits have been shortened by new laws which took effect on January 1, 2014. For new cases filed with OPP, 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 outside of OPP’s external review process may be available.

The consumer who requests external review usually pays a \$25 fee (prescribed by law) toward the cost of the review. Upon request, OPP may waive the fee due to financial hardship. The consumer’s insurance company then pays the external review agency for the greater part of the external review, a cost which can range from about \$475 to \$2,000 depending on the time frame for the review, type of review and the number of reviewers needed.

2013 External Review Data

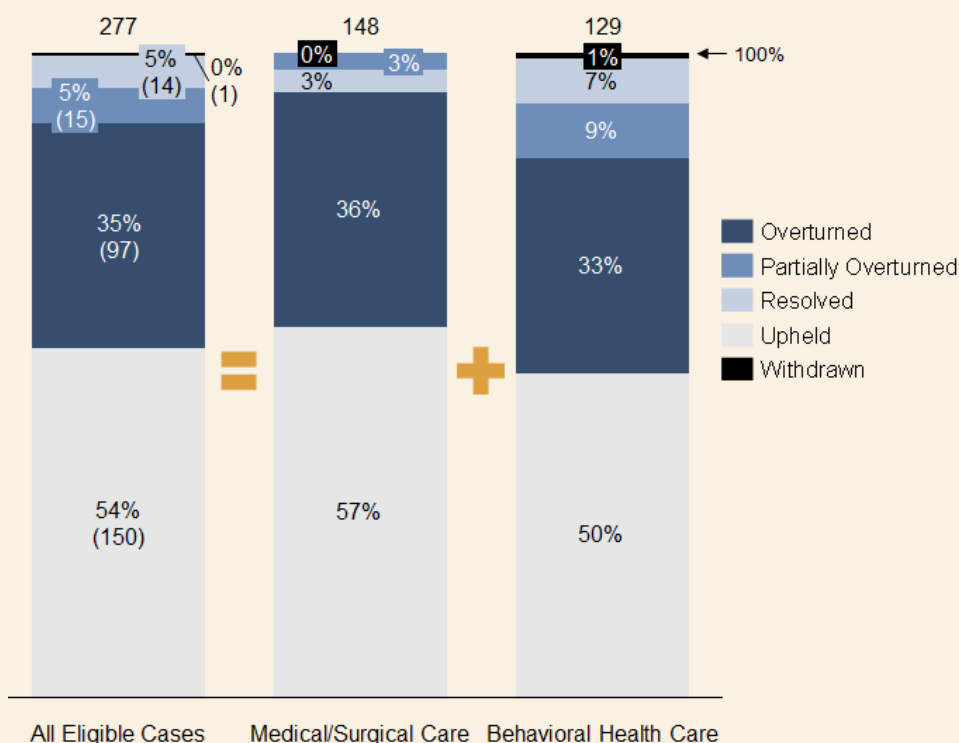
For each calendar year, the HPC analyzes overall external review data, medical/surgical data, and behavioral health data. The Chart Book for this report, which contains data from 2000 through 2013, is available on the OPP website.

Overall External Review Results for 2013

During 2013, OPP received 366 external review requests, and 277 of these were eligible for external review. Of the eligible cases, 35% were overturned by the external review agency in favor of the patient, and another 4.7% were partially overturned in favor of the patient. Approximately 5% of the cases that would have been eligible were resolved between the patient and the insurer or were withdrawn before a final determination was issued. The external review agencies upheld the remainder of the cases, which were about 54% of those eligible for review.

The far left column of Figure 2 lists the dispositions or results for all eligible external reviews filed during 2013. The center and right columns of Figure 2 break down the total number of reviews into two categories: medical/surgical care and behavioral health.

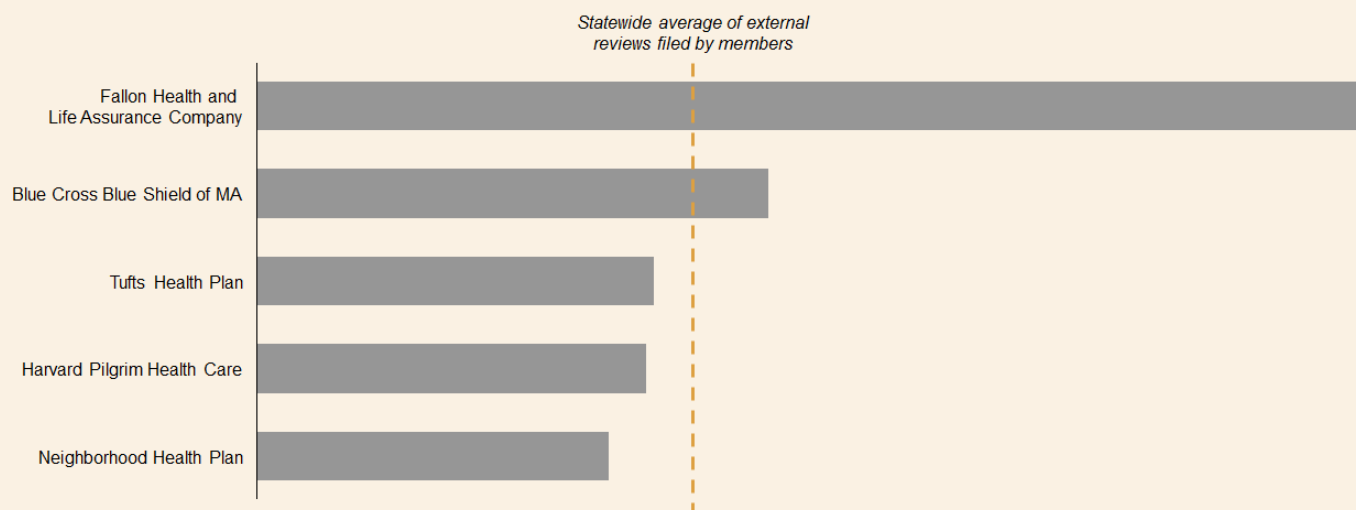
Figure 2: Disposition of Eligible External Review Cases, 2013



On the next page, Figure 3 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 2012, the most recent information publicly available.

This analysis identifies a statewide average for the number of external reviews filed by all fully-insured health plan members. Of the large health plans identified in Figure 3, two plans have rates of external reviews which are above the state average. The raw data that underpins Figure 3 is available in the OPP Chart Book and on the OPP website.

Figure 3: Proportion of Eligible External Reviews by Health Plan,* 2013



Source: 2013 Office of Patient Protection external review data

*Weighted by dividing number of claims by most recent health plan reported member month data. Data from the Center for Health Information and Analysis, 2012. Average calculated by dividing the total number of claims by the total reported member months.

Medical/Surgical Data

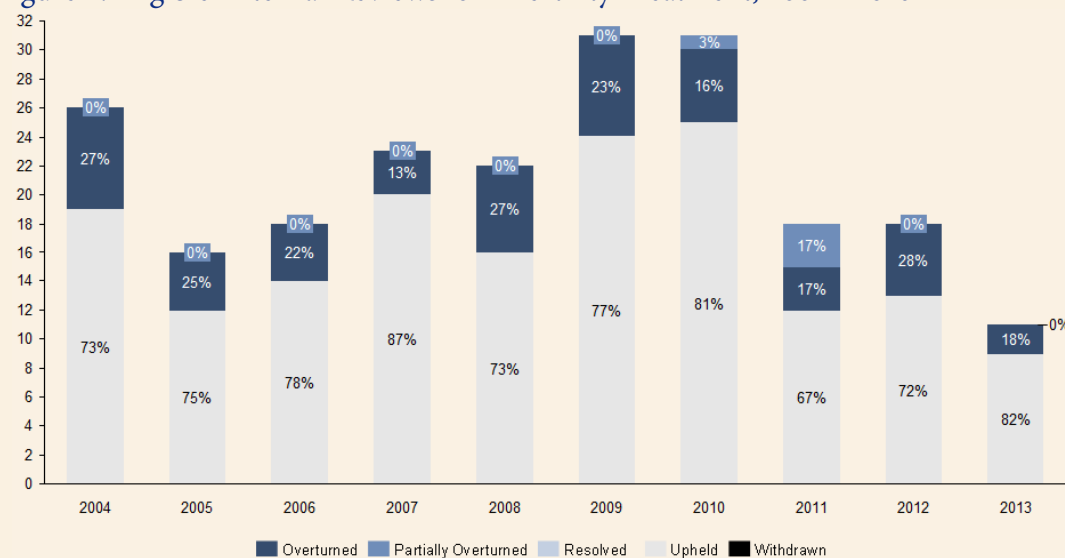
OPP received 148 eligible external review requests involving medical or surgical services. This category includes a broad range of medical care, such as pharmacy, outpatient treatment, imaging or surgical procedures. This category also includes the sub-categories of experimental or investigational treatment and infertility treatment. External review data for behavioral health services, which are generally separate from this category, are explored further below.

In 2013, 57% of external reviews involving medical or surgical treatment upheld the decision of the health plan, and the remaining 43% of these cases were resolved either fully or partially in favor of the patient (Figure 2). This is consistent with data from previous years, when roughly 60% of medical/surgical external review decisions upheld the insurance carriers' original decisions.

Infertility

During 2013, OPP received 12 eligible external review requests involving infertility treatment. The total number of eligible cases for 2013 was fewer than the 20 eligible cases received during 2012, and represents a general downward trend since 2010. Figure 4 compares the total number and disposition of infertility cases received from 2004-2013.

Figure 4: Eligible External Reviews for Infertility Treatment, 2004 - 2013



Source: 2004 - 2013 Office of Patient Protection external review data

Infertility data not consistently reported prior to 2004.

Experimental and Investigational Services

During 2013, OPP received approximately 26 eligible external review requests involving services deemed to be experimental or investigational by the insurance companies. These types of requests ranged from behavioral health treatments to diagnostic procedures to off-label use of medications. Results were split evenly, with 50% of these cases overturned in favor of the patient, and 50% upheld in support of the insurance company's initial determination.

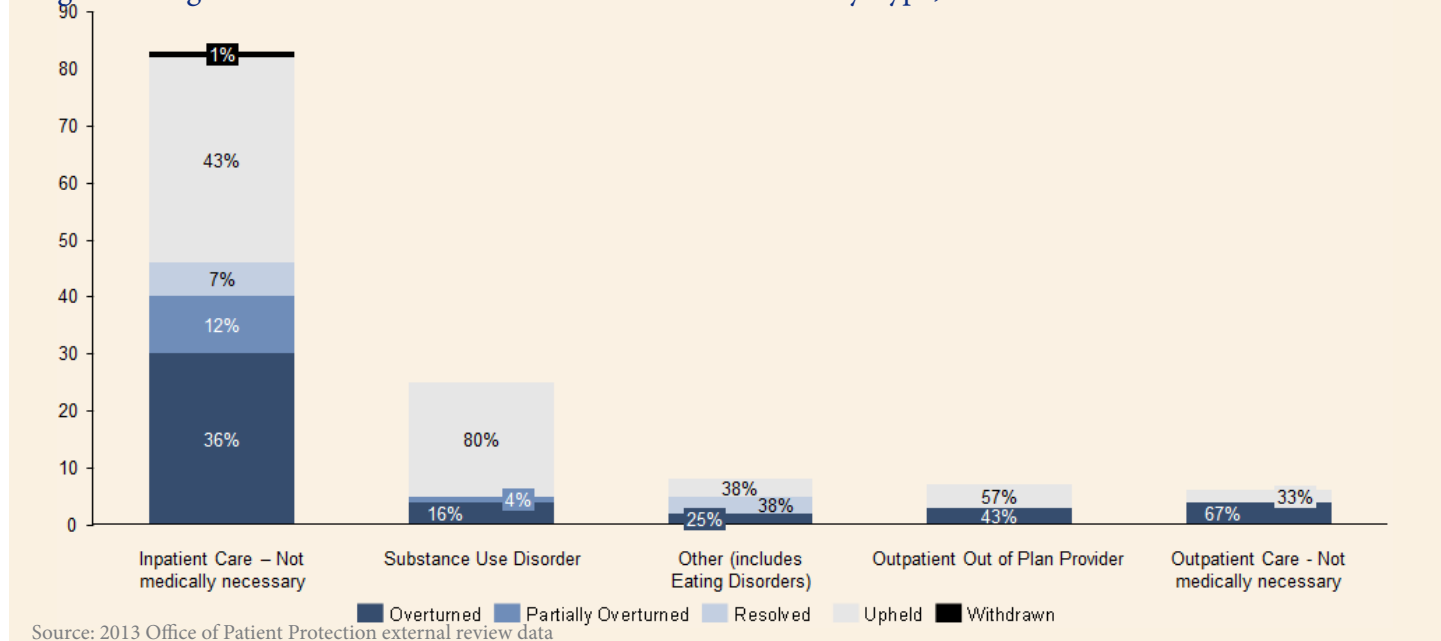
Behavioral Health

Behavioral health cases, which include mental health, substance use disorder, and some developmental disabilities, continued to represent the largest single category of cases received by OPP during 2013. This number may not reflect all behavioral health matters reviewed by OPP, since some pharmacy and other cases were recorded under other categories.

OPP received 142 behavioral health cases during 2013, and 129 of these were eligible for external review. Of the eligible cases, inpatient mental health care represents the largest subcategory, with 81 eligible requests for external review, followed by 25 eligible requests for external review for substance use disorder treatment. Other categories include eating disorder treatment, outpatient care, and outpatient or inpatient care with an out-of-network provider. Of all eligible behavioral health cases received during 2013, 42%, or 62 cases, were fully or partially overturned in favor of the patient (Figure 2).

While close to half of the eligible behavioral health cases were resolved in the patient's favor, the majority of substance use disorder cases were upheld in favor of the health plan. Of the 25 eligible substance use disorder cases, 20 were upheld by the independent medical reviewer because care was not found to be medically necessary (Figure 5).

Figure 5: Eligible External Reviews for Behavioral Health Care by Type, 2013



Comparison with Past Years

Overall, OPP has received a smaller number of eligible external review requests each year since 2010. While we cannot draw conclusions about the reasons for this steady decline, factors could include the market-wide trend toward higher rates of membership in self-funded health plans² and the trend toward decreased utilization of health care services.³ The self-funded plans do not fall within OPP's jurisdiction. While members of these plans generally have similar appeal rights, appeals for self-funded plans are regulated by a federal process which was recently established under the Affordable Care Act. Figures 6 and 7 compare numbers and results of external reviews from 2001 through 2013.

² See, e.g., Office of Attorney General Martha Coakley, *Examination of Health Care Cost Trends and Cost Drivers Pursuant to G.L. c. 6D, § 8* (April 24, 2013).

³ See Health Policy Commission, *2013 Cost Trends Report, July 2014 Supplement* (July 2014).

Figure 6: Eligible External Review Cases, 2001 - 2013

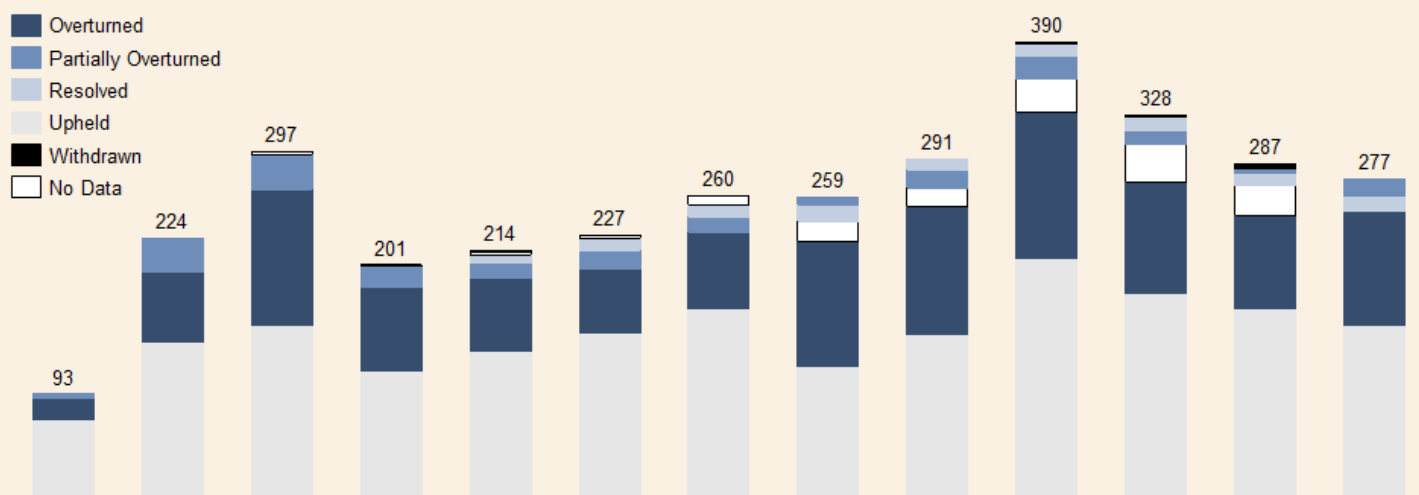


Table 2: Eligible External Review Cases, 2001 - 2013

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Overturned	18	59	115	71	62	53	66	107	109	125	95	80	97
Partially Overturned	4	29	30	18	13	17	12	6	15	19	12	4	15
Resolved	0	0	0	0	8	10	11	15	9	11	11	10	14
Upheld	70	136	150	111	128	144	164	115	143	206	177	164	150
Withdrawn	0	0	0	0	1	0	0	0	0	1	1	3	1
No Data	1	0	2	1	2	3	7	16	15	28	32	26	0
Total	93	224	297	201	214	227	260	259	291	390	328	287	277

Figure 7: External Review Requests (Eligible & Ineligible) by Category, 2001 - 2013

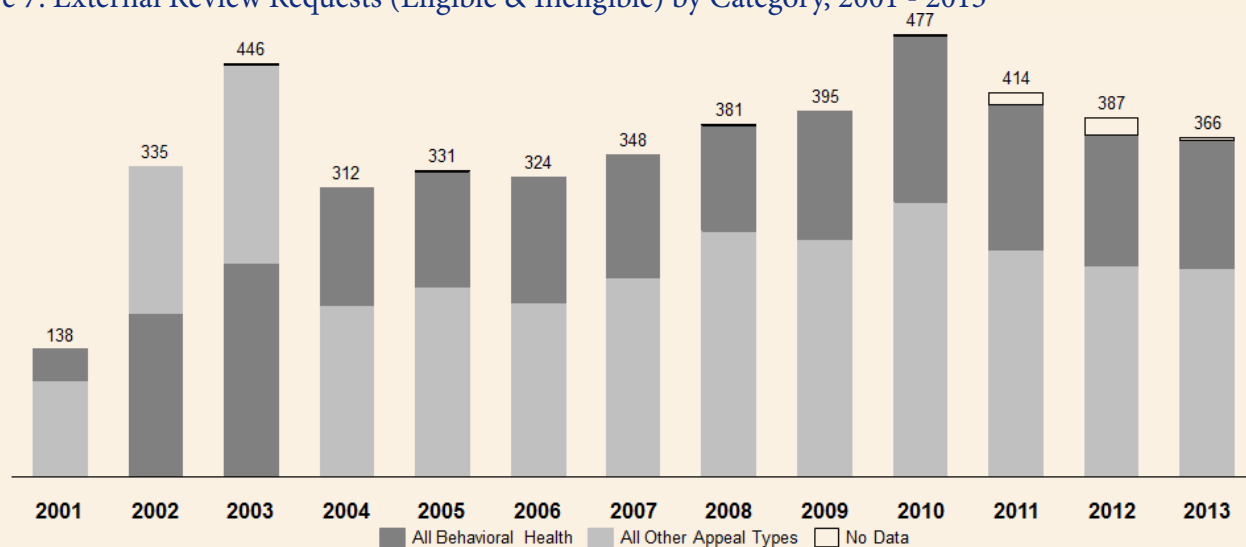


Table 3: External Review Requests (Eligible & Ineligible) by Category, 2001 - 2013

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
All Behavioral Health	35	176	230	128	126	136	133	114	139	178	158	142	140
All Other Appeal Types (medical/surgical)	103	159	215	184	204	188	215	265	256	297	244	227	224
No Data	0	0	1	0	1	0	0	2	0	2	12	18	2
Total	138	335	446	312	331	324	348	381	395	477	414	387	366

Source: 2001 - 2013 Office of Patient Protection external review data



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
- Other health plan information

Please see the OPP website for data compiled from the 2013 health plan reports.

OPP also works with insurance companies and with our partners in other agencies to implement Massachusetts health insurance laws. Where questions or concerns arise, OPP works closely with the Massachusetts Division of Insurance, the Office of the Attorney General, the Health Connector, and other state and federal agencies to address concerns and work with insurance companies to ensure compliance.

Consumer Information and Assistance

The Office of Patient Protection is a resource for consumers with questions about health insurance appeals, enrollment waivers, and other health insurance problems. While OPP does not represent individual consumers, we provide consumer education and assistance through our hotline, at 800-436-7757. Telephone translation services are available for callers who speak non-English languages. Consumers can also reach OPP by email or by fax.

OPP also provides information about health insurance appeals, enrollment waivers, and other health-related resources on our website at www.mass.gov/hpc/opp. On our website, consumers can find relevant forms in English and Spanish, instructions for pursuing an external review or requesting an enrollment waiver, and a comprehensive list of government and other resources to assist with matters related to health care.

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.

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 the insurance company then pays the claims for health care services. Fully-insured plans can be regulated by the state government.

Health Plan

In this report, a “health plan” refers to an insurance product or insurance plan offered by a health insurance company.

Self-Funded/Self-Insured

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, so it is not always easy to tell if you are in a self-funded plan. Contact your employer to find out if your plan is self-insured. Self-insured plans are usually regulated by the federal government.

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.

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
 - for services and interventions not in widespread use, is based on scientific evidence
-



ACKNOWLEDGMENTS

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Jenifer Bosco, Director of the Office of Patient Protection, along with Stephanie Carter, OPP Program Coordinator and Deborah Steinberg, OPP Program Assistant, prepared this report with the guidance of Executive Director David Seltz, and input from Commissioner Marylou Sudders and members of the Quality Improvement and Patient Protection Committee.

Commission staff made significant contributions to the preparation of this report. Kelly Mercer and Asha Ayub prepared content and analyses for this report. Coleen Elstermeyer and Lois Johnson reviewed the contents and provided comments.

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The Commission would like to thank the insurance companies that submitted information included in this report. The Commission acknowledges the input of consumers and stakeholders, and we hope that this report provides useful information for navigating health insurance consumer protections in Massachusetts.

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