2014
ANNUAL REPORT

Office of Patient Protection

Released November 2015

About the Health Policy Commission

Established through the Commonwealth of Massachusetts' landmark cost containment law, Chapter 224 of the Acts of 2012, the Health Policy Commission (HPC) 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 HPC's mission is to advance a more transparent, accountable, and innovative health care system through independent policy leadership and programs. Our goal is better health and better care at a lower cost across the Commonwealth. 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; analysis of structure of the delivery system through the creation of criteria for Accountable Care Organizations and the Registration of Provider Organizations Program; and investment through the CHART and Health Care Innovation Investment Programs. Through these and other policy initiatives, the HPC strives to promote and incentivize the development of a high-value health care system in the Commonwealth.

INTRODUCTION

Welcome to the Office of Patient Protection (OPP). The Office of Patient Protection is a program 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.

Responsibilities of the Office of Patient Protection

OPP safeguards the rights of health insurance consumers by regulating the internal grievance process and administering external reviews for consumers with fully-insured Massachusetts health plans, administering health insurance enrollment waivers, and providing information and education about health insurance concerns to the public. 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

Changes in 2014

Updated Regulations: During early 2014, OPP issued updated regulations which brought operations into compliance with the ACA and related changes to Massachusetts law. The updates also added some enhanced reporting requirements, which are reflected in the data contained in this report.

OPP Operations: OPP staff continues to work to improve operations and to be accessible as a resource for consumers and other stakeholders.

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 Chapter 224 of the Acts of 2012 created the Health Policy Commission and transferred the Office of Patient Protection from the Department of Public Health to the Health Policy Commission. The transition took effect on April 20, 2013. This 2014 Annual Report encompasses the first full year of OPP operations at HPC.

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 60 days had passed

2014 Enrollment Waiver Data

During 2014, the Office of Patient Protection received 316 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 278 waivers to applicants. OPP staff assisted consumers who had difficulty enrolling in insurance during 2014, or had questions about the enrollment process. When working with consumers who had problems which could not be resolved through the waiver process, OPP staff provided information and referrals to other agencies or organizations as needed.

HEALTH INSURANCE APPEALS

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" 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.

Internal Review

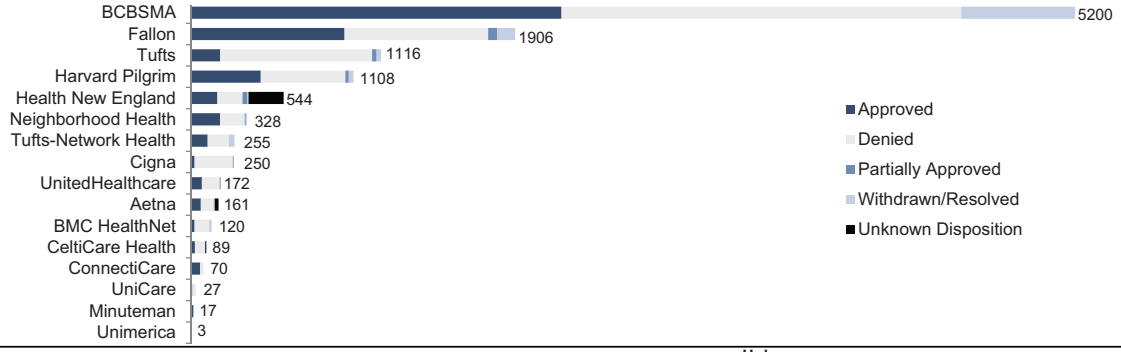
When an insurer informs a consumer that the health plan will not pay for or cover the consumer's medical or behavioral health treatment, the consumer may appeal that decision by first contacting the health plan. This first appeal, often called a member grievance, is an internal review by the health plan. 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.

2014 Internal Review Data

During 2014, Massachusetts health insurance companies reported 11,366 member grievances (**Figure 1**). These grievances include many different types of member complaints, such as disputes over coverage for treatment or cost-sharing.

1 M.G.L. c. 1760 §§ 13-14

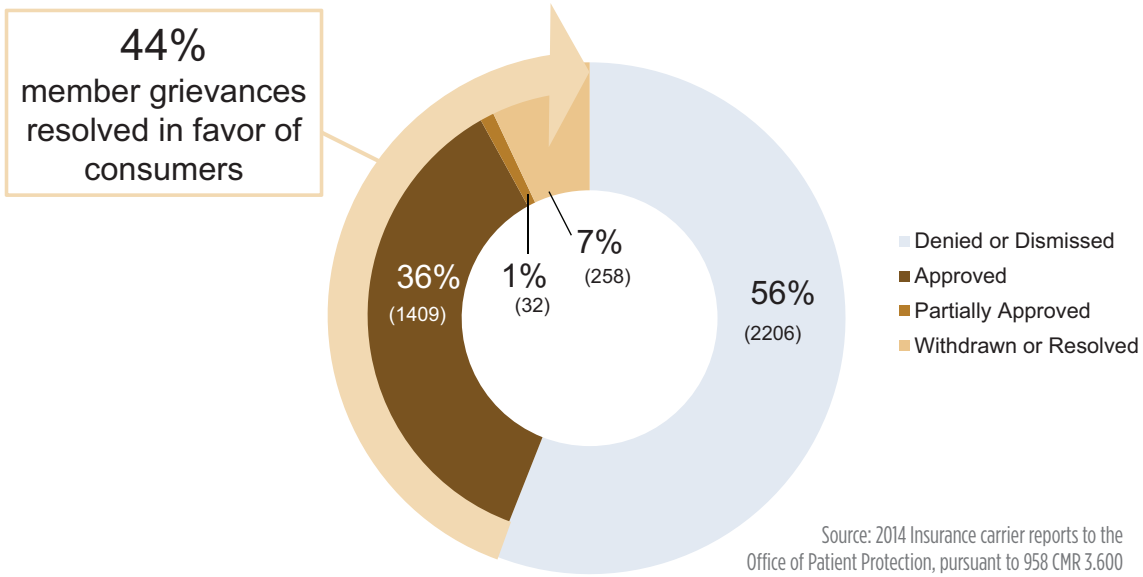
Figure 1: Insurers reported 11,366 total internal grievances filed during 2014



Health Plan	Approved	Denied	Partially Approved	Withdrawn/Resolved	Unknown Disposition	Total Filed	Total Enrollment
BCBSMA	2178	2352	N/A	670	0	5200	11,450,962
Fallon	902	845	52	107	0	1,906	1,490,291
Tufts	171	893	27	25	0	1,116	3,792,121
Harvard Pilgrim	467	593	20	28	0	1,108	7,410,792
Health New England	154	148	29	6	207	544	1,316,070
Neighborhood Health	170	145	6	7	0	328	756,745
Tufts-Network Health	97	125	0	33	0	255	2,609
Cigna	20	225	5	0	0	250	
UnitedHealthcare	63	105	3	0	1	172	933,545
Aetna	57	76	5	1	22	161	1,019,626
BMC HealthNet	20	87	1	12	0	120	5,020
CeltiCare Health	22	58	0	3	6	89	7,379
ConnectiCare	53	16	1	0	0	70	n/a
UniCare	7	20	0	0	0	27	n/a
Minuteman	14	3	0	0	0	17	n/a
Unimerica	1	1	0	1	0	3	n/a
Total	**4396**	**5692**	**149**	**893**	**236**	**11,366**	

Source: 2014 Insurance carrier reports to the Office of Patient Protection, pursuant to 958 CMR 3.600

Figure 2: Results of the 3,906 Medical Necessity Internal Reviews



Source: 2014 Insurance carrier reports to the Office of Patient Protection, pursuant to 958 CMR 3.600

Figure 1 shows the member grievances reported by each health insurance company that provided fully-insured coverage in Massachusetts during 2014. 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 (see Chartbook).

Under updated OPP regulations which took effect during 2014, health plans now report more detailed information about the types and outcomes of member grievances received.

- **Results for all member grievances:** Health insurers resolved 5438 of all member grievances fully or partly in favor of the member (including those matters which were approved, partially approved, or withdrawn/resolved)
- **Medical necessity denials:** During 2014, 3906 or 34% of member grievances resulted from adverse determinations, which are denials of coverage based on health plan medical necessity decisions. See **Figure 2**. If not resolved by the insurance company, these medical necessity decisions could eventually be eligible for external review through OPP.

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.* [1]

1 958 CMR 3.020.

- **Behavioral Health:** Of the 3906 grievances based on adverse determinations, 26% involved behavioral health treatment.
- **Pursuing external review:** About 13% of patients or consumers sought an independent external review of the health insurer's adverse determination. See **Figure 3**. While a significant portion of consumers are aware of their appeal rights and choose to exercise them, continued education and outreach efforts by OPP are intended to increase awareness of patient appeal rights and of the resources available through this office to consumers, providers and other members of the public.

External Review

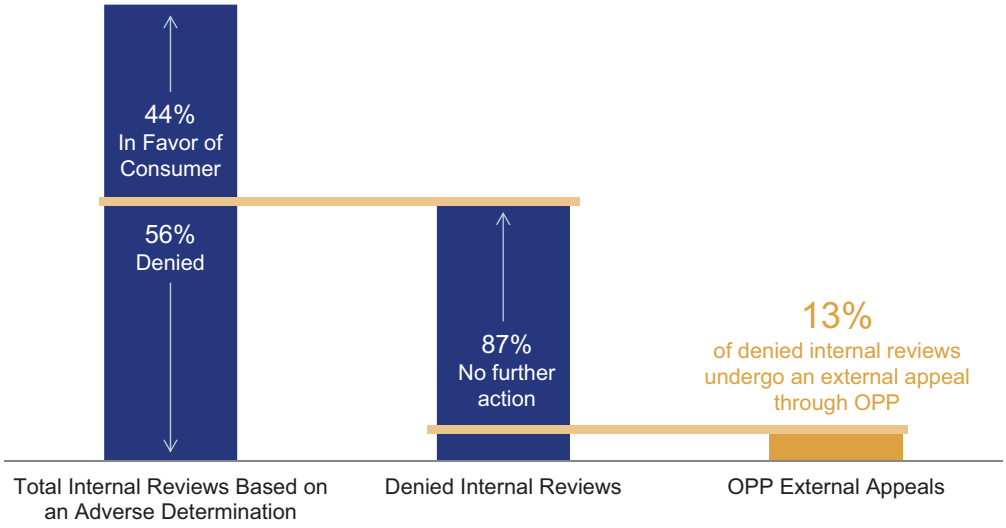
An external review is a second level of appeal, which is independent from the consumer's health plan. If a consumer pursues an internal review and the health insurer upholds its original decision, the consumer may have the right to an external review. External review is available when the health plan's decision was based on a determination of whether the specific treatment or service at issue was medically necessary.

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:

- The health insurance company is licensed to cover Massachusetts residents
- The insurance 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 the insurance company has waived internal review
- The final adverse determination (the insurance company's decision) based on medical necessity
- Request for external review filed with OPP within four (4) months of the date when the patient received the final adverse determination
- Request for external review is in writing and on the external review request form issued by OPP

Figure 3: Percentage of Patients Who Pursue External Review



Source: 2014 Office of Patient Protection external review data; 2014 Insurance carrier reports to the Office of Patient Protection, pursuant to 958 CMR 3.600

External Review Process

The Office of Patient Protection administers the external review process for Massachusetts 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 2014, 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
- ProPeer Resources, Inc., based in Centerville, Utah

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.

In accordance with the new law which took effect on January 1, 2014, 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 on the insurance company and consumer. 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 fee due to financial hardship. 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 the remaining cost of the external review, 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.

2014 External Review Data

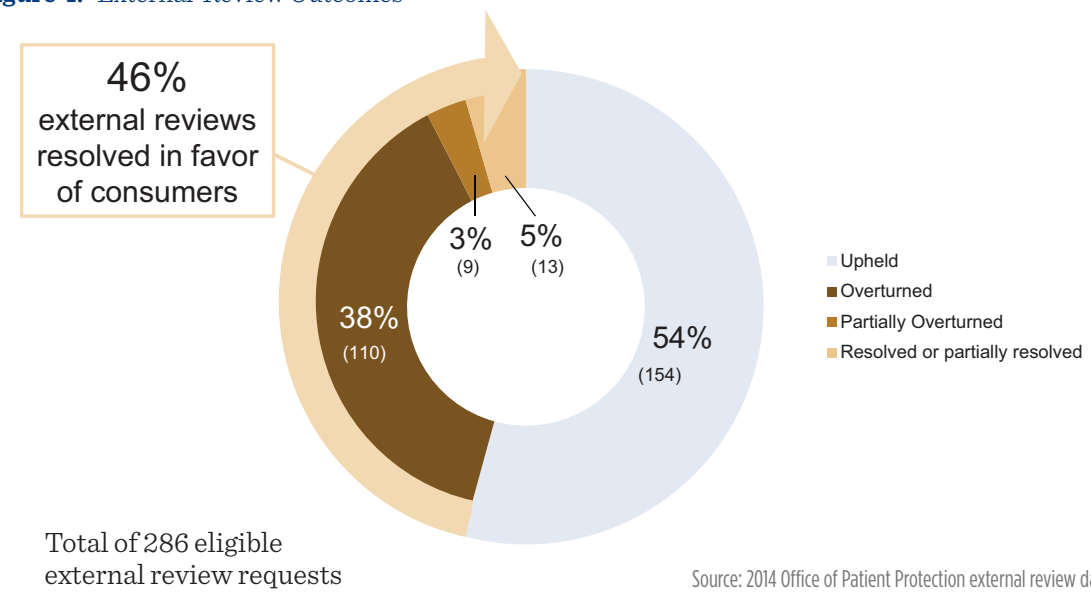
For each calendar year, the HPC analyzes overall external review data, medical/surgical data, and behavioral health data. The Chart Book for this report, which contains data from 2000 through 2014, is available on the OPP website.

External Review Cases and Results for 2014

During 2014, OPP received 354 external review requests, and 286 of these were eligible for external review. Of the eligible cases, 38% were overturned by the external review agency in favor of the patient, and another 3.1% were partially overturned in favor of the patient. Approximately 4.5% 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.

Figure 4 lists the results of all eligible external reviews filed during 2014. **Figure 5** breaks down the total number of reviews into two categories: medical/surgical care and behavioral health.

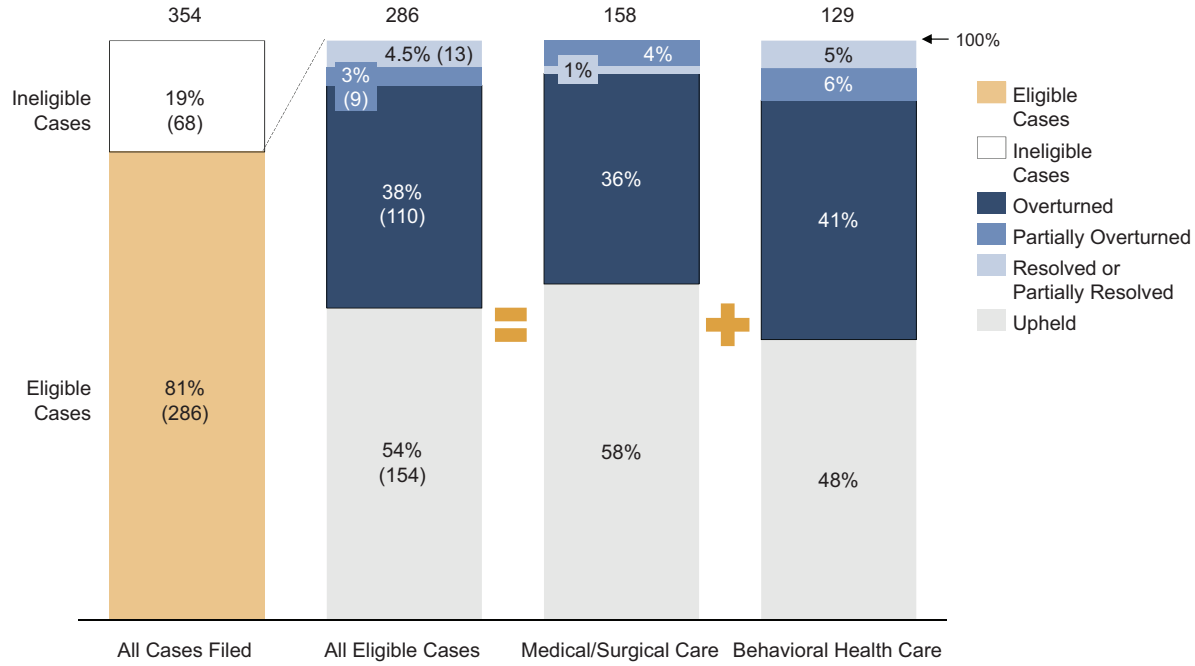
Figure 4: External Review Outcomes



Total of 286 eligible external review requests

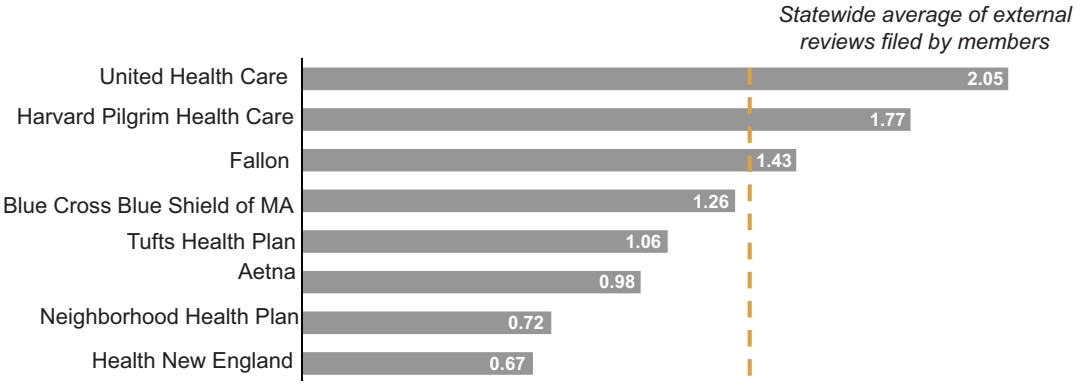
Source: 2014 Office of Patient Protection external review data

Figure 5: Detail of All External Review Requests Filed During 2014



Source: 2014 Office of Patient Protection external review data

Figure 6: Comparison of Number of External Review Requests Filed per 100,000 Member Months



Source: CHIA's 2015 Annual Report Databook: Enrollment in the Insurance Market, Commercial Premiums & Member Cost-Sharing, & Commercial Payer Use of Funds

Notes: Based on MA contract-membership, which may include non-MA residents. The enrollment reporting is by member months, and is for the commercial fully insured population.

Figure 6 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 2013, 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.

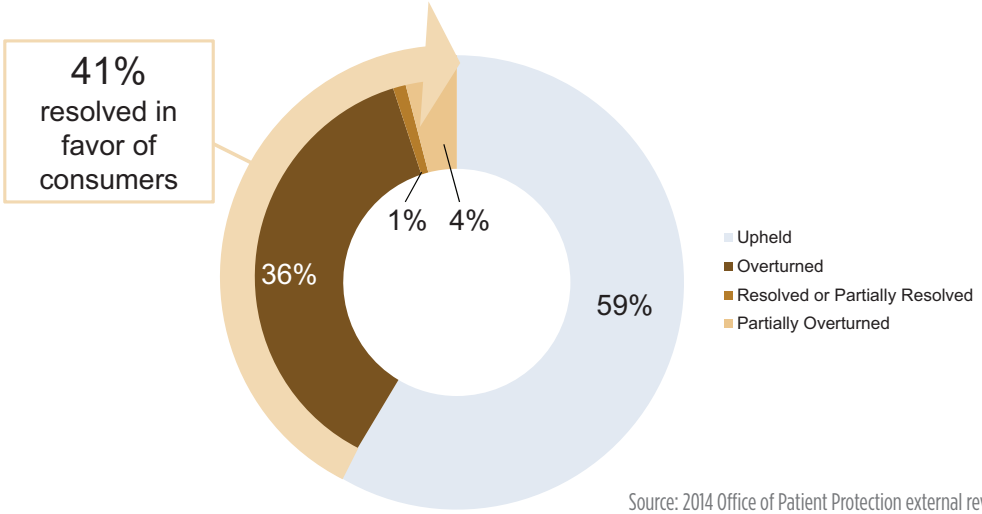
Medical/Surgical Data

OPP received 158 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 2014, 59% of external reviews involving medical or surgical treatment upheld the decision of the health insurer, and the remaining 41% of these cases were resolved either fully or partially in favor of the patient (**Figure 7**). This is consistent with data from previous years.

The most common medical/surgical requests were in the category of outpatient care. OPP received 52 external review requests regarding outpatient medical/surgical

Figure 7: External Reviews Involving Medical/Surgical Services



Source: 2014 Office of Patient Protection external review data

care including surgeries and medical visits, 33 of which were eligible for external review. Additionally, 34 requests were received for pharmacy services, 28 of which were eligible for external review.

During 2014, OPP received 23 eligible external review requests involving infertility treatment. **Figure 8** compares the total number and disposition of infertility cases received from 2004-2014. Out of the eligible cases, 10 were upheld by the external review agency, 10 were overturned, 1 was partially overturned and 2 were resolved by the insurance company in favor of the patient.

Experimental and Investigational Services

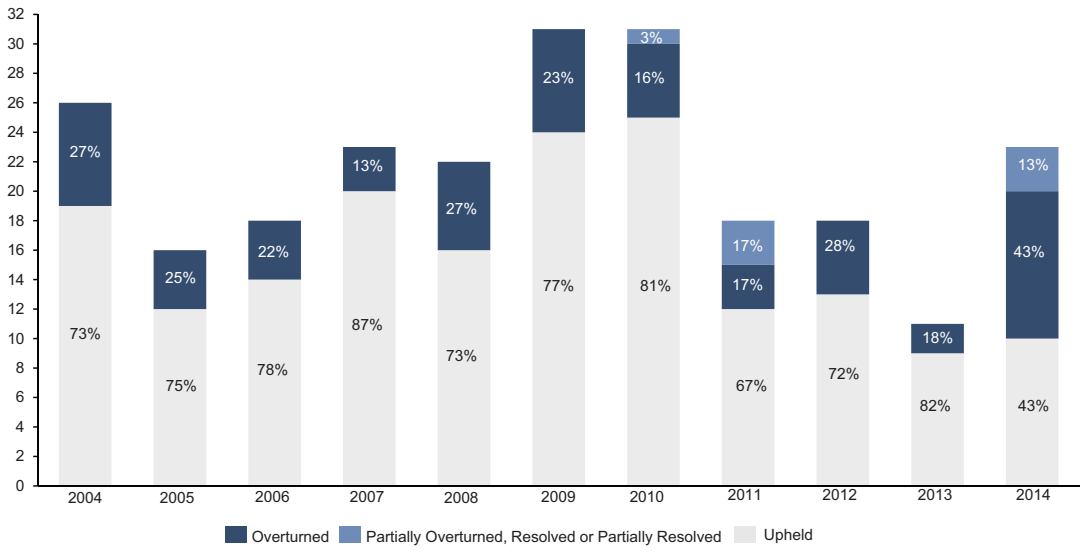
In 2014, OPP received approximately 36 eligible external review requests involving services deemed to be experimental or investigational by the insurance companies. These types of requests included, for example, diagnostic procedures, compounded medication requests and non-standard surgical procedures or treatments. In 2014, 13 of these requests were overturned in favor of the patient, and 23 were upheld. These results differ from those noted in 2013, when 50% of these cases were overturned in favor of the patient, and 50% upheld the insurance company's initial decision. However, since the absolute number of OPP cases is small, it is difficult to draw comparisons based on such a small sample size.

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 2014, OPP received 33 requests for external review involving coverage for an out of network provider. Only 18 of these were eligible for external review. Medical reviewers upheld the original decision of the health plan in 14 of these 18 external reviews.

Figure 8: Infertility Services



Note: Data on external reviews related to infertility were not recorded in a consistent manner prior to 2004.

Source: 2004-2014 Office of Patient Protection external review data

Behavioral Health

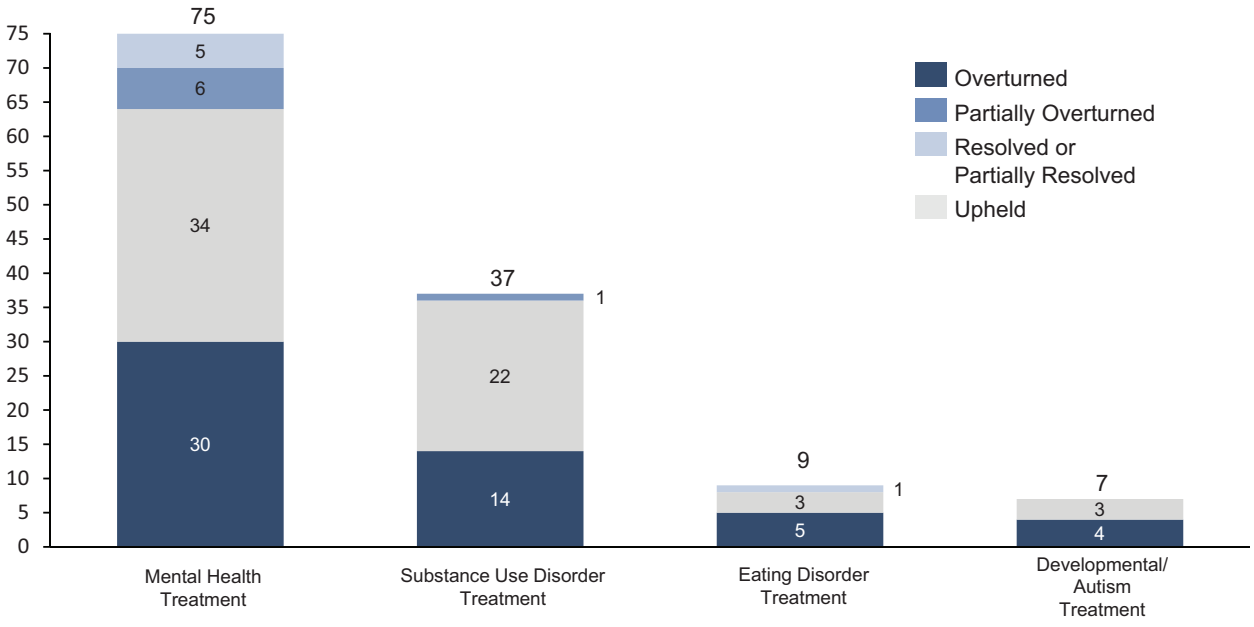
Behavioral health cases, which include treatment for mental health conditions, substance use disorders, and some developmental disabilities, continued to represent the largest single category of external review cases received by OPP during 2014. See **Figure 9**.

OPP received 139 requests for external review of behavioral health services during 2014, and 129 of these were eligible for external review.

- **Eligible behavioral health cases:** Of all eligible behavioral health cases received during 2014, 46.5%, or 50 cases, were fully or partially overturned in favor of the patient, and another 6 cases, or 4.7%, were resolved in favor of the patient by the health plan.
- **Mental health treatment:** Of the eligible cases, OPP received 75 requests for mental health treatment. Inpatient mental health care represents the largest subcategory, with 46 eligible requests for external review.
- **Substance use disorder treatment:** OPP received 37 eligible requests for substance use treatment, including for residential substance use disorder treatment.

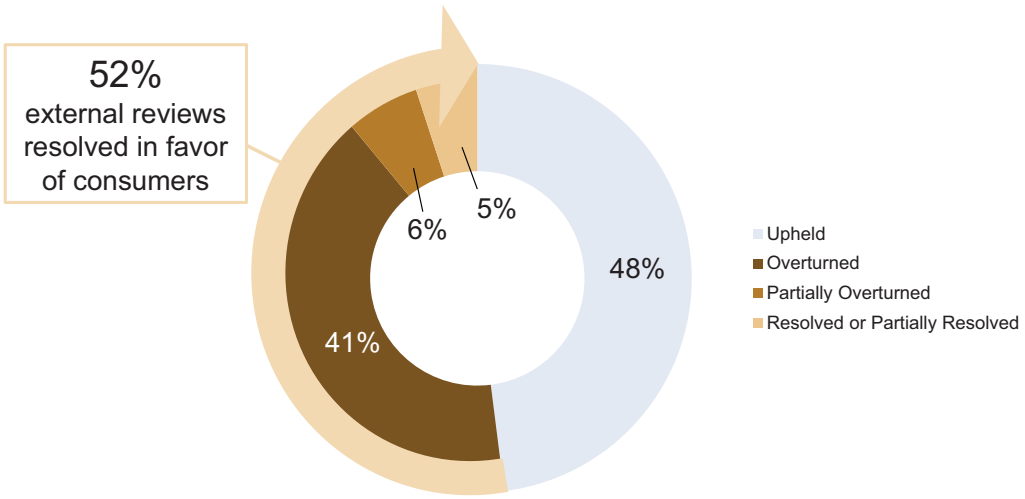
While close to half of the eligible behavioral health cases were resolved in the patient's favor, the majority of substance use disorder cases were upheld in favor of the health plan. Of the 37 eligible substance use disorder cases, 22 were upheld by the independent medical reviewer because care was not found to be medically necessary (**Figure 9**).

Figure 9: Behavioral Health Services



Source: 2014 Office of Patient Protection external review data

Figure 10: Behavioral Health External Reviews



Eligible external reviews related to behavioral health treatment by outcome, 2014

Source: 2014 Office of Patient Protection external review data

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, 47% 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 2014, and the numbers of eligible external reviews received, were broadly consistent with recent years. Of note, a slightly higher percentage of behavioral health external reviews resulted in full or partial coverage of the disputed treatment. In 2014, 52% of behavioral health external reviews were overturned, partially overturned, resolved or partly resolved in favor of the consumer. See **Figure 10**.

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 2014 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 with hearing impairments may call the TTY Relay at 711 or use the Video Relay service of their choice. 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, insurance companies, government agencies and other interested groups. Staff is available to provide trainings and to answer questions.

GLOSSARY

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.

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

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, 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.

ACKNOWLEDGMENTS

Jenifer Bosco, Director of the Office of Patient Protection, along with Stephanie Carter, OPP Program Coordinator, Deborah Steinberg, OPP Program Assistant, and Eric Rollins, OPP Program Assistant, prepared this report with the guidance of Executive Director David Seltz.

Commission staff made significant contributions to the preparation of this report. Kelly Mercer and Emma Gaquin prepared content and analyses for this report. Megan Wulff, Erica Koscher and Aaron Pervin assisted with data analysis. Coleen Elstermeyer and Lois Johnson reviewed the contents and provided comments. Ashley Johnston formatted the report and provided valuable assistance.

The Commission acknowledges the efforts of other government agencies in the development of this report, including the Center for Health Information and Analysis and the Department of Public Health.

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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