



MEMORANDUM

TO: Consumer Advocates, Providers, Insurers and Business Groups

FROM: Anne Jewel
Assistant Director Policy Division

RE: Summary of Prompt Pay/IRO meetings

DATE: July 30, 2008

The Ohio Department of Insurance (ODI) held several stakeholder group meetings on April 28, 29, and 30th in order to discuss our prompt pay and independent external medical review processes and to receive input regarding issues of concern to stakeholders.

On April 28, we hosted Consumer Advocates and discussed the activities of our consumer services division, the Patient Protection Act, our internal review of contract coverage disputes and our external independent review process.

On April 29, we hosted two Provider (including physicians, hospitals and nurses, among others) sessions. In addition to reviewing the activities of the consumer services division and the independent external medical review process, we discussed issues pertaining to prompt pay.

On April 30, we hosted Insurance Carriers and other Businesses and discussed the prompt pay and independent external medical review processes.

In each of these sessions we passed out a short survey concerning the ODI website, had brief presentations from ODI employees from various divisions discussing the mechanics of our processes and the type and location of information on the ODI website, and then opened the floor to questions and a general discussion by stakeholders

As a result of the feedback we received at the meetings, we are taking some immediate steps. We are reviewing our processes and procedures to determine ways we can make changes in response to many of the constructive comments we received. At this point, we anticipate scheduling stakeholder meetings in order to specifically discuss the collection and publication of data by our consumer services and market conduct divisions. We plan on developing a state-wide marketing plan in order to more widely publicize the existence of the external review processes. We are discussing effective ways to increase our consumer outreach activities beyond the Medicare summits, long term care forums and the other activities currently conducted by ODI personnel. We are re-tooling our web site to make the consumer section more accessible and easy to navigate. We are also working with our market conduct division to continue to develop our abilities to review prompt pay complaints in a more detailed and sophisticated manner. We look forward to

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continuing the dialogue as to how the Department can improve its prompt pay and external review processes.

Many stakeholders requested a summary of comments made in the other stakeholder meetings. We did not tape record comments, but have undertaken in these notes to reproduce as many of the comments made, and questions asked, as we were able to capture in our notes. There were times in the meetings when we did not have adequate information to answer the questions asked, and have therefore used these notes as another opportunity to answer the question more fully.

Please note that comments and questions from stakeholders are presented in **bold** type. ODI added responses to questions in *italicized* type. ODI did not respond to all stakeholder comments and does not necessarily endorse or agree with all comments.

Below are the notes reflecting the discussions at the stakeholder meetings.

Topics discussed with Consumer Advocates

April 28, 2008

1. ODI's Oversight and Authority

- **What role does ODI have in deciding the range of what is deemed medically necessary or unnecessary by carrier contracts? The audience expressed concern that there is a lack of consistency between carriers regarding what is considered to be medically necessary.**

Ohio law does not define the term medical necessity. Most plans have a definition of medically necessary or medical necessity in the policy definitions section. The definition generally asserts that the medical service in question must be necessary and appropriate and based on generally accepted current medical practice. We approve the plan's definition unless the language is determined to be misleading or deceptive. When a claim dispute centers on whether the service in question is medically necessary, we send these disputes out to Independent Review Organizations (IRO) to be answered by medical experts.

- **Explain the process by which ODI regulates individual policy rates. The audience commented that the public is not generally aware of ODI's rate approval authority.**

The Department reviews individual policy rates to be sure they are actuarially sound. Group policy rates are generally not filed with the Department but must be actuarially sound. Often, health insurance sold in Ohio's individual market is offered through group association products and they are not generally filed with the Department. With respect to insurance sold to small employer groups (2-50 employees), insurers must file actuarial certifications that the rates comply with Ohio law. Rates for health insurance sold to large employer groups are generally not filed with the Department.

- **Does ODI receive complaints mostly on Ohio based companies or companies based outside of Ohio?**

Most of the complaints we receive concern the companies that have the largest market share in Ohio. Some of these are Ohio based companies, and others are national companies based outside of the state.

- **Is information about internal appeals filed with the insurance company reported to ODI ?**

No, neither insurance companies nor Health Insuring Companies (HIC's) are required to report this information to ODI.

- **What is ODI's position on HB 384 (Mental Health Parity Legislation)?**

We are working with the sponsor, Rep. Celeste, on this bill.

2. The role of the Consumer Services Division (CSD)

- **ODI should make available to the public information about complaints made to CSD by consumers.**

Much of this information is available on our website and we are currently discussing how to make this information more easily available and accessible to consumers.

- **Make information about number of complaints available.**

Complaint information including number of complaints by insurer and complaint ratios for 2006 is available on the website under Consumer Services. The 2007 complaint information is expected to be released this summer.

- **Make information publicly available about the outcomes of consumer complaints.**

We are reviewing our current complaint information to determine if we can add additional information to our website that would be useful for consumers.

- **Make the information available by type of complaint.**

Some complaint information is available by type of insurance; as well as by reason, such as claim denial or settlement delay. While our technology is not sophisticated enough to search our complaint data base for very specific queries, this is an issue we are currently exploring.

- **Make information available regarding: consumer demographics (such as income level) and affordability of healthcare plan. Do we keep track of people calling ODI regarding the un-affordability of coverage?**

At this point, we do not keep track of people calling regarding the un-affordability of coverage and do not ask people for their demographics. This information is not pertinent to resolving contractual issues, thus not requested.

- **What percentage of health complaints are premium related?**

In 2006, we had 91 complaints out of 2,906 formal written complaints that were related to the amount of premium or a rate increase, or approximately 3%.

3. External Review

- **Many consumers are so worn down by the company's many levels of appeal that they give up before making it to the external review process.**

- **The fact that Ohio has a 50% reversal rate is too high. Consumers shouldn't have to appeal and pursue their claims to such lengths to get benefits under their contracts.**

4. Advocacy for Consumers

- **Build consumer voice on Healthcare Reform**
- **Actively inform, reach out to and educate consumers**
- **Provide workshops for consumers and consumer advocates**
- **Update consumers with published reports on carriers, legislation, complaints and complaint processes (such as: the range of what is deemed medically necessary or unnecessary by carrier contracts)**
- **Better document consumer experiences**
- **Turn consumer frustrations into remedies**

5. ODI Visibility and Outreach

- **Media work is needed to effectively communicate ODI's commitment to consumers**
- **Tutorials for consumers and consumer advocates regarding what ODI offers to consumers**
- **Direct marketing and community forums (also in evenings) specifically on topics such as how to evaluate an insurance product and how to make sure you won't lose coverage once you obtain it.**
- **FAQs for consumers on website explaining what information is available on the ODI website that would be of interest to consumers, for example the annual report on outcomes of all Ohio external reviews**
- **Provide information on self insured, uninsured, and under insured on ODI website**
- **Explain ODI's oversight over individual policies**
- **Link to other Consumer Advocacy groups on website (such as UHCAN)**
- **Compare and contrast the outcomes of the Ohio external reviews versus the national statistics on outcomes of external reviews on the ODI website**

Topics discussed with Providers

April 28, 2008

1. ODI's Oversight and Authority

- **Is there a way for ODI to gain more regulatory authority over ERISA and/or self-funded plans?**

Federal preemption limits the Department's authority over these plans.

- **We would like ODI to review case law emerging from other jurisdictions regarding the state's authority to regulate TPA's.**

ODI constantly reviews and monitors legal developments regarding our authority and activities.

- **Unilateral mid-contract changes—ODI's role?**

HB 125, the Healthcare Simplification Act, which went effect on June 25th, does outline specific notification requirements for contract amendments. Complaints by providers against insurers for violation of the provisions of HB 125 should be processed through the OCHAMP system, which is currently used for prompt pay complaints.

- **How can ODI address potential for retaliation against providers from insurers as a result of complaints filed?**

ORC 3901.3810 specifically makes retaliation by an insurance company against a provider a violation of Ohio's prompt pay law. We will use our regulatory authority to enforce this statute.

- **Consumers are afraid to complain due to retaliation from companies**

ORC 3901.3810 specifically makes retaliation by an insurance company against a consumer a violation of Ohio's prompt pay law. We will use our regulatory authority to enforce this statute.

- **Why can't ODI enforce prompt pay for Medicaid Managed Care Plans? ODJFS doesn't have the expertise to handle these issues and we don't believe that these plans are paying in a timely manner.**

Medicaid law governs prompt pay applicable to Medicaid managed care plans. The Department can work with ODJFS and is looking into better coordination on these issues.

- **ODI should review the example of the Medical Care Advisory Committee that works with ODJFS to allow-stakeholder input into the Medicaid program.**

ODI is working with the other Executive Agencies in the Strickland Administration to develop a departmental Ombudsman program. The program will be tasked with making the agency more responsive to consumers and stakeholders.

- **Can we submit claims in a batch rather than individually to ODI?**

We are reviewing the feasibility of doing so.

- **A concern was expressed regarding the adequacy of provider panels for mental health issues and others**

We are aware of the difficulty of locating behavioral health providers in certain areas of the state. We have undertaken market conduct examinations targeting the listings of the behavioral health providers in on-line provider directories of a number of insurers. After discovering that the listings in the on-line directory of behavioral health providers in at least one county were so inaccurate as to be misleading to consumers, we have entered into a consent order with the company requiring the company to keep the on-line directory updated and current. We are continuing to review the practices of other insurers in relation to this issue.

- **ODI should add “inability for providers to remove themselves from the panel” to the on-line provider complaint form.**

Please see answer above.

- **ODI should regulate the “brown bagging” practices of mail order pharmacies.**

We believe the practice of sending dangerous chemotherapy ingredients through the mail directly to patients raises serious consumer safety issues and we have been working with the various parties involved to craft appropriate legislation.

- **Consider developing “outcome measures” to apply to insurers to incent prompt pay**

We are reviewing how we regularly report this information to the public. We monitor the insurers’ compliance with the prompt payment law by requiring quarterly reporting of specific claim data. We issue report cards to the companies, open investigations, and call exams on companies whose data may indicate a level of non-compliance with the law. There is an interest provision in the law that requires interest at the rate of 18% per annum for claims that are paid late.

- **How will the status of ODI's efforts to monitor prompt pay be communicated to the provider community?**

We are in the process of developing a prompt pay report that can be issued to the public without violating any confidential reporting statutes.

- **TPA's seem to be the #1 offender**
- **There should be greater and better oversight of HICs beyond external medical reviews and more input from consumer and medical professionals.**

2. Public Information and the Complaint Process

- **Regularly publish provider complaints and consumer complaints**

We publish an annual report of complaint ratios by company on our web site. Click complaint ratios on the Consumer Services section of the ODI website. Consumer complaint information is provided monthly to the NAIC for their complaint data publications. We collect but do not currently publish provider complaint information and are looking into what kind of information could be provided on an aggregate basis. ODI regularly responds to specific requests for information concerning consumer and provider complaints.

- **Provide breakdown of complaints by provider type and by area of the state.**

With our current data systems, we are not able to search our complaint data using these fields. However, we plan on looking into more sophisticated data gathering programs.

- **Publish company specific complaints**

We publish company specific information through the complaint ratios on our website, see answer above. We also provide company specific complaint information to the NAIC which is published by the NAIC. We publish information on external reviews by company as part of the annual Patient Protection Act Report to the legislature, also available on our website.

- **Complaints by category would be helpful**

We are reviewing our current complaint information to determine if we can add additional information to our website that would be useful for consumers. Some complaint information is available by type of insurance; as well as by reason, such as claim denial or settlement delay. While our technology is not sophisticated enough to search our complaint data base for very specific queries, this is an issue we are currently exploring.

- **Is the person complaining made known to the company?**

Yes. In order to resolve a complaint we send the specific facts of the problem, as received from the consumer, to the company and request an explanation. The company must be able to review the consumer's concerns in order to resolve the problem.

- **Are complaints monitored as they come in?**

Yes, monthly reports of complaints by category are prepared and reviewed internally by management.

- **Does it seem like consumers generally appeal through the company first?**

That is the appropriate process. When we review a complaint we ask for the date of the company's response to the appeal. The response is valuable for us to consider in determining whether there has been a violation of law.

3. External Review

- **It would be useful to have one definition of medical necessity and harmonize definitions of medical necessity among plans.**

Ohio law does not define medical necessity. Most plans have a definition of medically necessary or medical necessity in the policy definitions section. The definition generally asserts that the medical service in question must be necessary and appropriate and based on generally accepted current medical practice.

- **Can ODI provide notification to providers and/or consumers when the external medical review has begun?**

Yes, we can require the insurance company to notify the consumer or provider that the external review request has been sent to the IRO and we are changing our processes to do so.

- **Can ODI gain access to information on the percent of claims reversed as a result of the company's internal review process?**

No, we do not have access to this information on the company's internal appeal process outcomes.

- **Why don't more consumers use this external review process?**

We are trying to determine why this is so. We appreciate the provider trade associations' offers to add links to their websites and to make ODI external review brochures available to their provider members and ultimately to patients.

- **How are the IRO's regulated?**

ODI accredits IROs for participation in our external review process.

- **The administrative burden of external review is a disincentive following the long internal company appeal process.**
- **ODI needs to do more to promote use of external medical review.**
 - **Use additional mechanisms to promote greater consumer knowledge about the external medical review.**
 - **Distribute brochures to providers.**

4. Prompt Pay

- **How many and what types of prompt pay complaints does ODI get?**

There are 6 different provider complaint categories:

1) Payment Delay/Prompt Pay Violation, 2) Denial/Partial Denial of Claim, 3) Coordination of Benefits (COB), 4) Incorrect Coding, 5) Overpayment Recovery, and 6) Timely Filing Limitations. Please see the chart on page 9 for exact numbers of complaints received over the past five years.

- **Does it help to add additional information when submitting the provider complaint form?**

Not initially. We prefer that complainants just complete the form or utilize the OCHAMP system to file their complaint. After the provider receives a response from the company, we may request additional documentation, if warranted.

- **Is ODI pleased with the results of the prompt pay market data call?**

ODI is pleased with the results of the information that was requested so far. However, the call was very limited when originally developed. We are currently developing more detailed data elements that will give us a better picture of what is happening in the marketplace. Also, the information currently received is being used in conjunction with other available market analysis information to get an overall picture of the industry's activity.

For your information, ODI undertakes an annual data call regarding compliance with the prompt pay statutes. Every company with annual premium receipts of \$1,000,000 or more who writes health insurance or other applicable lines of coverage in Ohio is required to submit the following information regarding their performance in paying claims. The results for the past five years are presented below:

	<u>2007</u>	<u>2006</u>	<u>2005</u>	<u>2004</u>	<u>2003</u>	<u>Change from 1st year to 2007</u>
Total Claims Processed During the Review Period	9,474,179	8,805,590	8,956,642	8,599,166	10,755,492	-11.91%
<u>Denied</u>						
Percent of Processed Claims Denied During Reporting Period	11.68%	11.12%	11.46%	11.83%	14.67%	-20.36%
Percent of Processed Claims Denied w/in 30 Days of Receipt Date	11.02%	10.37%	11.24%	11.08%	13.53%	-18.59%
Percent of Processed Claims Denied More Than 30 Days After Receipt but within the 45 Day Statutory Processing Time	0.15%	0.05%	0.05%	0.13%	0.43%	-65.76%
Percent of Processed Claims Denied Beyond 45 Days of Statutory Processing Time	0.10%	0.07%	0.09%	0.04%	0.38%	-74.71%
Percent of Processed Claims Denied After the 30-Day Statutory Processing Time for Which No Additional Information Was Requested	1.35%	0.65%	0.24%	0.58%	N/A	131.52%
<u>Paid</u>						
Percent of Processed Claims Paid During Reporting Period	88.32%	88.88%	88.54%	88.17%	85.33%	3.50%
Percent of Processed Claims Paid w/in 30 Days of Receipt Date	85.86%	86.73%	87.59%	85.38%	82.92%	3.54%
Percent of Processed Claims Paid More Than 30 Days After Receipt but within the 45 Day Statutory Processing Time	0.83%	0.51%	0.16%	0.57%	1.49%	-44.40%
Percent of Processed Claims Paid Beyond 45 Days of Statutory Processing Time	0.57%	0.46%	0.15%	0.17%	0.74%	-23.85%
Percent of Processed Claims Paid After the 30-Day Statutory Processing Time for Which No Additional Information Was Requested	0.41%	1.30%	0.95%	1.58%	N/A	-74.21%
Percent of Processed Claims Which Included Interest Paid	1.55%	1.12%	0.48%	1.21%	1.26%	22.81%
Percent of Processed Claims Denied as Duplicative (These are also included in "Denied" count above.)	2.83%	2.72%	3.07%	4.06%	3.89%	-27.22%

5. Other Concerns of Providers

- **Transparency is critical. Consumers and providers need to hold insurers and the system accountable**
- **Highest rising cost in health care is administrative services as insurers build bureaucracy in order to deny claims.**
- **Insurers automatically “pend” high cost drug claims in order to keep the “float”.**
- **When high dollar claims are pended within the appropriate time frames of the prompt pay law the consumer must wait for the denial in order to be eligible for external review.**
- **Insurers are forcing COB (Coordination of Benefits) back on to the providers by pending the claims and requiring the providers to supply information on the patient’s secondary coverage.**
- **Providers are required to send claim information over and over because Insurance companies claim they never receive sent information.**
- **Insurers provide prior authorization for a procedure and then deny the claim anyway.**
- **High co-pays have become a barrier to consumers receiving services. Particularly when the co-pay is a percentage rather than a fixed dollar amount.**

6. ODI Visibility and Outreach

- **Can providers provide a link to ODI’s website on their own websites?**

Yes. Please contact ODI’s communications department for more information.

- **ODI should publicize physician rankings**

We do not collect this information.

- **Providers can distribute ODI brochures to patients regarding external review**

This is an excellent suggestion and we will work to put it into practice as soon as possible.

Topics discussed with Insurers and Employers

April 30, 2008

1. Prompt Pay

- **Are complaints made by providers before companies have all the necessary information?**

Sometimes, although many times providers complain of having to send information numerous times.

- **Is Ohio complaint information sent to the NAIC?**

Yes, the ODI consumer services division sends information on closed complaints made by consumers on a regular basis to the NAIC's complaint data system. We do not send any information regarding provider complaints to the NAIC.

- **What is the number of providers that have submitted complaints- is it just a few or many?**

For fiscal year 2008, we received 2,244 complaints through our OCHAMP system. The exact number of providers is rather difficult to determine because many providers file multiple complaints against the same insurer.

- **If a provider files a complaint against a self-insured employer, do we forward the complaint to the employer even though no insurance company is involved?**

We consider our regulator authority over the matter, which may depend on the type of complaint and the type of employer. We advise the provider that the patient may want to pursue the matter directly with the employer or consider filing a complaint through the Department of Labor (EBSA).

- **To what extent do you expect to send provider complaints to self-insured companies under HB 125? HB 125, the recently passed HealthCare Simplification Act, contains provisions concerning contracts between providers and payers.**

We will send provider complaints to insurance companies under HB 125. We are reviewing our processes with respect to complaints filed in connection with self-insured plans.

- **Is ODI going to follow the same complaint process for complaints under HB 125 (meaning OCHAMP) as is used for prompt pay complaints?**

Yes, we are developing a similar process to facilitate these complaints electronically through the OCHAMP system.

- **What kind of complaints do you expect after HB 125 takes effect?**

We expect to receive complaints regarding contractual matters and credentialing issues.

- **ODI has data from an earlier prompt pay data call. Does this information help to answer whether providers have legitimate grievances and whether companies really are slow to pay claims?**

The data from the prior data calls is presented above. It does not show a large industry wide claims payment problem. Trending from these data reports does identify companies of concern and is used to call an exam on a company. However, data reports do not necessarily correlate with complaints.

- **Is the data from the prior data call sufficient to determine whether the provider's complaints are valid?**

The data is only sufficient to suggest that further investigation is merited in certain circumstances. In these circumstances, we pursue additional examinations to determine if the provider's complaints have merit.

- **Does ODI feel the number of complaints coming in is acceptable?**

The overall rate seems acceptable, however, that does not mean that there are not problems with a specific company or a specific type of complaint.

- **At what point would ODI put a stop to providers refusing to accept the outcome of a complaint?**

ODI works to educate providers as to the reasons underlying the outcomes of complaints.

- **How does ODI account for provider fraud?**

ODI has a division devoted to the prosecution of provider fraud, the Fraud and Enforcement Division. This division investigates and prosecutes larger cases.

- **A comment was made to encourage ODI not to change the provider complaint process since it works well to protect all entities.**

Please see comments from the provider sessions.

- **Look at category of complaints**

2. External Review

The Department presented data from the NAIC on number of external reviews reversed by IRO's in all states with external review which shows that Ohio is in the middle of the pack as far as number of cases reversed.

- **How are IRO's accredited?**

Questioner was referred to the ODI rule 3901-1-62 on the accreditation of independent review organizations.

Notice requirements for independent external reviews were discussed and companies were encouraged to change the address for ODI from Stella Court to 50 W. Town Street on any appeal notices that are sent to consumers following the final adjudication of a complaint. (OAC 3901-1-60) It was also noted that ORC 1751 requires HIC's to affirmatively notify consumers of their right to request an independent external review or contract review by ODI; however, there is no equivalent notice requirement in ORC 3923. Companies regulated under ORC 3923 must comply with the appeal notice requirements of 3901-1-60.

ODI is currently revising rule 3901-1-60 to add language requiring insurance companies regulated under ORC 3923 to provide consumers with a notice that the consumer has a right to an independent external review.

- **Is ODI planning to change the external review statutes?**

The NAIC has just accepted changes to the NAIC External Review Model Act. We will review the changes made to the model and determine whether to seek changes to our statutes