The Taft Patient Protection Act Report for 2004

On July 13, 1999, Governor Bob Taft signed into law House Bill 4 (H.B. 4), fulfilling a campaign promise to provide broader protection for health care consumers. Many Ohio consumers now have access to a fast-track health insurance claims appeals process, information hotlines, expanded access to women's health care services, and an estimated $418 million in tax deductions to encourage the purchase of health insurance.

This is the fourth report of summary data from the Ohio Department of Insurance, representing the period from January 1, 2004 to December 31, 2004.

Summary of Patient Protection Act Requirements

The Patient Protection Act applies to health benefit plans of the following carriers:

- Traditional Health Insurers;
- Preferred Provider Organizations (PPOs);
- Health Maintenance Organizations (HMOs/HICs); and
- Public Employee Health Benefit Plans (PEHBP).

The Patient Protection Act required all health carriers to create a process allowing insureds/enrollees the right to challenge the denial of a health benefit claim. Insureds/enrollees meeting statutorily specified criteria with coverage have the right to an external review under state law.

To ensure a comprehensive review of denials, the Patient Protection Act external review is conducted through Independent Review Organizations (IROs), which are accredited by the Ohio Department of Insurance (the Department). The law established an expedited process for those insureds/enrollees, whose condition could, in the absence of immediate medical attention, result in any of the following:

- Placing the health of the insured/enrollee or, with respect to a pregnant woman, the health of the insured/enrollee or the unborn child in serious jeopardy;
- Serious impairment of bodily function;
- Serious dysfunction of any bodily organ or part.

When an external review is requested, the IRO is required to provide a decision to the health carrier and the insured/enrollee within 30 days for standard reviews and seven days for expedited reviews. The health carrier is required to provide any coverage determined by the IRO to be medically necessary or not experimentally investigative, subject to the other terms, limitations, and conditions of the related contract.

The Patient Protection Act (ORC 3901.82) requires that IROs report their findings to the Department. The Act also directs the Department to compile the information submitted by the IROs and annually publish and report the information to all of the following:

- The Governor;
- The speaker and minority leader of the Ohio House of Representatives;
- The president and minority leader of the Ohio Senate; and
- The chairs and ranking minority members of the House and Senate committees with jurisdiction over health and insurance issues.

Summary of Reviews

Patient Protection Act Contractual Reviews

The Patient Protection Act requires the Department to review disputes for health care services that have been denied, reduced or terminated by the health carrier. If the Department finds a coverage determination cannot be made because a medical issue must be resolved, the health carrier must afford the opportunity for an external review. When the Department makes a determination that the benefit or service is covered, the carrier is required to either cover the service or afford an opportunity for an external review.

Summary of External Reviews by Independent Review Organizations

An analysis of the data over the most recent 12-month period (January 1, 2004 to December 31, 2004) indicates that Ohio insured/enrollees are benefiting from the external review process. In total, IRO reviews involved benefit determinations amounting to approximately $2.5 million. IRO decisions reversing claim denials saved insureds/enrollees approximately $540,550. Without the external review process, the out-of-pocket expenses would average more than $7,800 per review. The top five cases reversed exceeded $ 170,000.

Number of External Reviews Conducted / Outcomes

For the reporting period of January 1, 2004 to December 31, 2004, 177 reviews were assigned to independent review organizations to determine the appropriateness of a health carrier's denial of services based on medical necessity or experimental/ investigative treatment.

Of the 177 external reviews completed, 175 were standard reviews that permit a 30-day maximum review period. The IROs reversed benefit coverage denials made by health carriers on 69 reviews (39 percent of the reviews conducted). Of the remaining 106 reviews (61 percent), the IRO affirmed the health carrier's denial.

Two IRO cases were expedited, requiring a seven-day maximum review period. Both of these cases dealt with experimental or investigative transplants. In both cases, the IROs upheld the health carriers' original denials.

The top five cases reversed through the external review process during this report period are as follows:

Top Five External Review Case Reversals

CASE DESCRIPTION	SERVICES REQUESTED	TOTAL BENEFIT PAID
Anorexia	Residential Inpatient Stay	$ 57,341
Amputee	Coverage of C-Leg Prosthesis	$ 48,075
Bulemia	Residential Inpatient Stay	$ 41,236
Anorexia / Nervosa	Residential Inpatient Stay	$ 32,580
Morbid Obesity	Gastric Bypass Surgery	$ 25,000

Average Time Required to Conduct a Review

Of 177 reviews, 98 percent were completed within the time required by the Patient Protection Act. The average number of days to process a standard IRO review was 19 days, while the average number of days to process an expedited review was 9 days. The reason that these reviews have taken longer than in past years is because of an increase in requests for further medical information.

Cost of External Reviews

The cost of an external review varies depending on whether the review is a standard 30-day review, or an expedited seven-day review, and whether the review is to determine medical necessity or experimental investigative treatment for an individual with a terminal illness. Reviews to determine medical necessity require only one reviewer while reviews of experimental services for terminal illness require a panel of three reviewers. The cost of the review is paid by the health carrier at an average cost of $584. The total cost of IRO reviews to Ohio health carriers was $103,432. Of that, $4,234 was spent on expedited reviews.

Summary of Services and Procedures

External reviews were conducted for numerous types of services. The majority of the reviews were for surgery and therapy. These two services account for approximately $ 338,210 (63 percent) of the estimated $ 540,550 in total benefits reversed by the IRO. Hospitalization and durable medical equipment, while comprising a smaller number of reviews, had benefits awarded totaling $181,436 (34 percent). In all, these four services combined for an approximate $519,646 (96 percent) of the $540,550 in benefits reversed. See Attachment 1, IRO Reviews by Services and Procedures.

Medical Specialty or Type of Provider

When a health carrier contacts the Department to request an independent review organization, it identifies the medical specialty category required for the review. The

categories of medical specialties are identified in *Attachment 2, IRO Reviews by Medical Specialty.*

The top five medical specialty cases were as follows:

MEDICAL SPECIALTY	TOTAL NUMBER OF REVIEWS	TOTAL BENEFITS REVIEWED	TOTAL BENEFITS PAID
Surgery, Gastric	27	$ 451,935	$271,935
Emergency Medicine	20	$ 38,555	$ 4,862
Plastic Surgery	16	$ 93,880	$ 13,732
Orthopedics	11	$ 84,907	$ 53,697
Surgery, General	9	$ 53,218	$ 8,434

Summary of Contractual Reviews by the Ohio Department of Insurance

From January 1, 2004 to December 31, 2004, 361 cases were closed by the Department under contractual review. The Department devotes significant resources to the review of Patient Protection Act contractual dispute cases and has established a review team comprised of Department specialists from the Office of Legal Services, the Office of Life & Health Services, and the Consumer Services Division. As a result of Department reviews, Ohio consumers received $ 319,691 previously denied health benefits.

Outcome of Contract Reviews

Health insurance company denials based on either benefit limits or services not covered by the contract were upheld in 83 percent (299 cases) of all cases. The company's denial based on these criteria was reversed in 7 percent (26 cases) of all cases. In 35 cases (10 percent), the Department referred the question to an IRO for external review, of which 13 were reversed.

Summary of Services and Average Time Required to Conduct a Review

The average time for the Department to currently review a contract denial is 10 days. Many factors such as complexity and the need for legal review of a consumer's contract impact the amount of time needed to conduct a comprehensive review. Contract reviews are requested for various reasons.

The top five requested services are the following:

REQUESTED SERVICES	TOTAL NUMBER OF REVIEWS	TOTAL BENEFITS PAID *
Non-Network Providers	44	$ 1,351
Emergency Room Services	36	$ 1,084

Bariatric Surgery	35	$ 50,435
Dental Services	26	$ 11,592
Cosmetic Surgery	20	$ 8,710

*Total benefits paid are for the period of January 1, 2004 - December 31, 2004.

The average benefit amount recovered for Ohio consumers was $ 9,932.

Conclusion

With enactment of the Taft Patient Protection Act, Ohio health benefit consumers are no longer at a dead-end if they have been denied coverage by their health carrier. Since the enactment in 1999, more than $ 5.5 million in previously denied benefits have been recovered. The Department has reviewed 2,401 cases through IROs and contract reviews. Each year more consumers are exercising their right to another opinion regarding a health benefit denial.

The total number of IRO and contract review cases in 2004 was relatively equal to the number of cases in 2003. Utilization of services varied slightly between 2003 and 2004.

The Department continues to devote additional resources to the review of contract dispute issues. The complex nature of resolving contract disputes and the importance of ensuring a thorough review of case files requires an extensive investment of staff resources. The Department continues to monitor this situation and utilizes existing resources at the most efficient level. Internet access to the Department's secure web page offers easy access to both health carriers and IROs. The Internet has proven very efficient in facilitating the external review process. The Department of Insurance believes this report illustrates that the Patient Protection Act provides valuable and effective methods for resolving these disputes.

The Department will continue its efforts to publicize the H.B. 4 process to ensure that all eligible Ohio consumers have access to and knowledge of this important consumer right. To effectively promote this important right, the Department web site, www.ohioinsurance.gov, includes explanations of external reviews by IROs and contract reviews by the Department. In addition, the Department's award-winning consumer guides provide information about external reviews.

For more information about this report or any aspect of the Patient Protection Act report, please contact the following individuals:

Consumer Inquiries: Nancy Colley, Consumer Advocate, (614) 644-3378.

Legislative Inquiries: Dan Tierney, Legislative Liaison; (614) 644-2334.

Media Inquiries: Mike Fulwider, Director of Communications; (614) 644-3481.

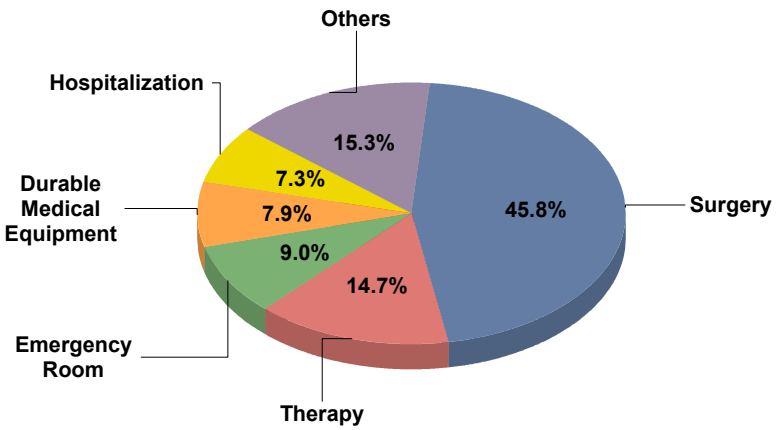
ATTACHMENT 1

TOP 5 SUMMARY - IRO REVIEWS BY "TYPE OF TREATMENT"

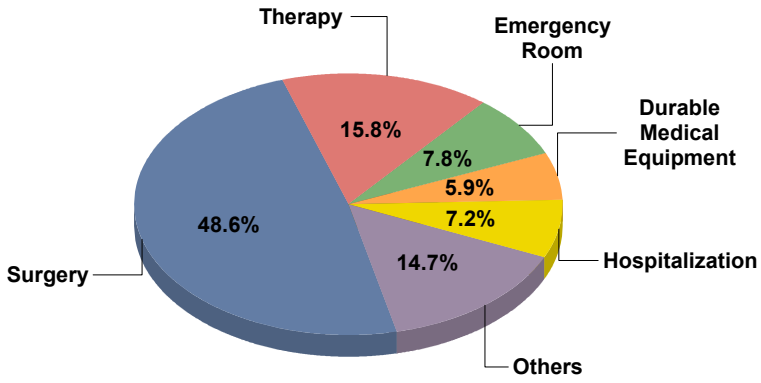
JANUARY 1, 2004 - DECEMBER 31, 2004

TYPE OF TREATMENT	# OF REVIEWS	IRO COSTS	BENEFIT $'s REVIEWED	BENEFIT $'s PAID (Reversed)
Surgery	81	$50,259	$1,568,210	$329,771
Therapy	26	$16,342	$320,415	$8,439
Emergency Room	16	$8,044	$18,169	$4,862
Durable Medical Equipment	14	$6,071	$74,965	$66,294
Hospitalization	13	$7,479	$282,518	$115,142
Others	27	$15,237	$259,095	$16,042
Grand Totals:	177	$103,432	$2,523,372	$540,550

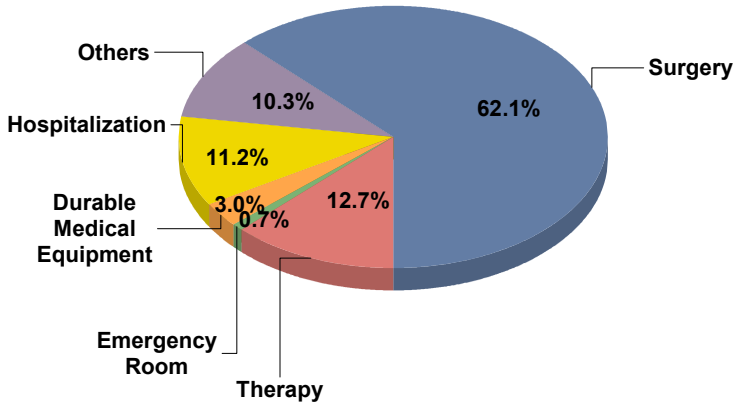
IRO Cases



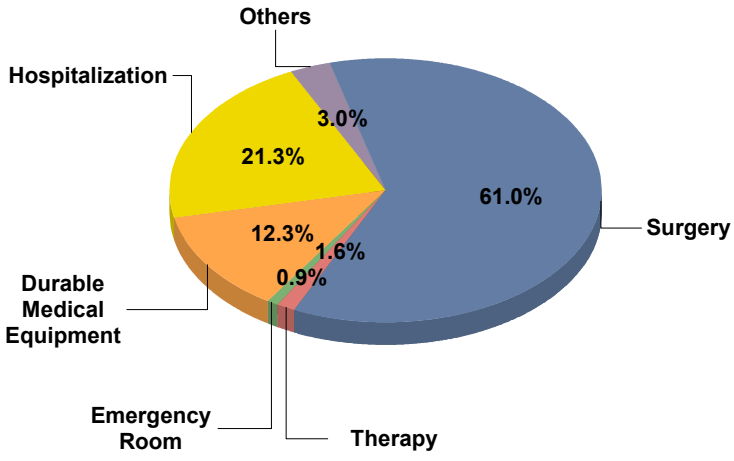
IRO Review Costs



IRO Benefit $'s Reviewed



IRO Benefit $'s Paid (Reversed)



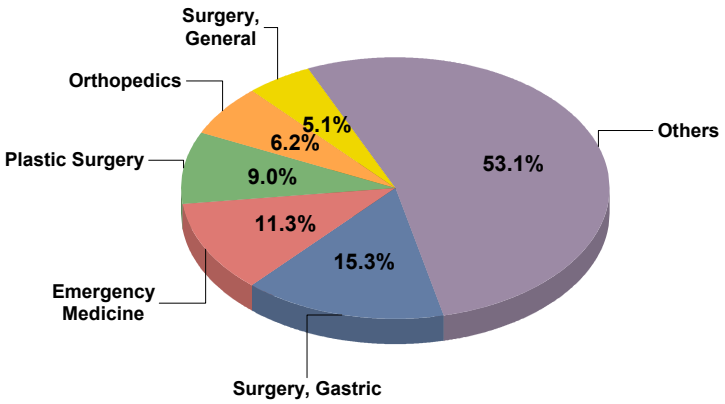
ATTACHMENT 2

TOP 5 SUMMARY OF IRO REVIEWS BY "MEDICAL SPECIALITY"

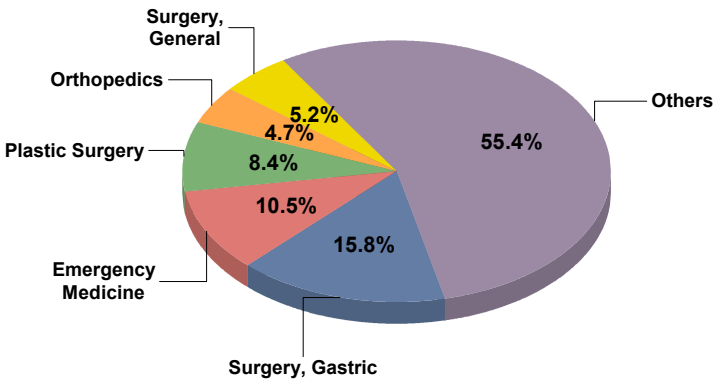
JANUARY 1, 2004 - DECEMBER 31, 2004

MEDICAL SPECIALITY	# OF REVIEWS	IRO COSTS	BENEFIT $'s REVIEWED	BENEFIT $'s PAID (Reversed)
Surgery, Gastric	27	$16,307	$451,935	$271,935
Emergency Medicine	20	$10,842	$38,555	$4,862
Plastic Surgery	16	$8,688	$93,880	$13,732
Orthopedics	11	$4,906	$84,907	$53,697
Surgery, General	9	$5,398	$53,218	$8,434
Others	94	$57,291	$1,800,877	$187,890
Grand Totals:	**177**	**$103,432**	**$2,523,372**	**$540,550**

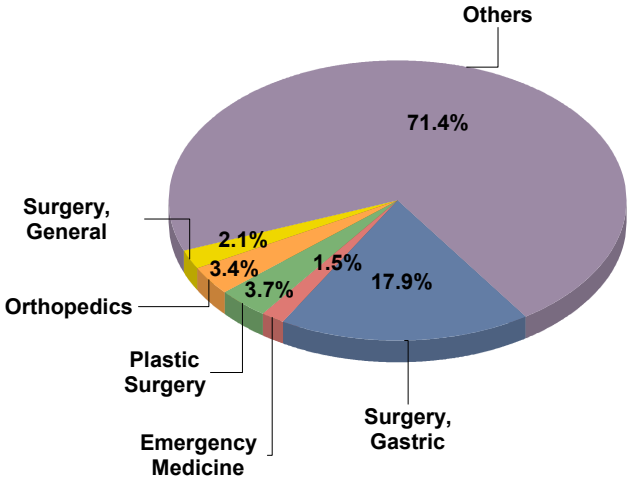
IRO Cases



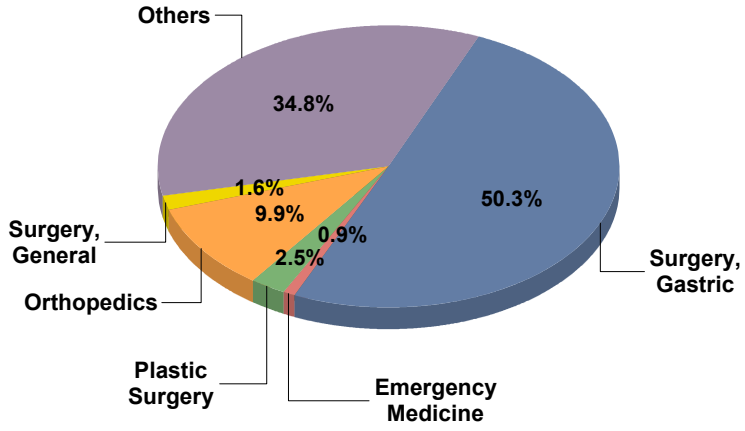
IRO Review Costs



Benefit $'s Reviewed

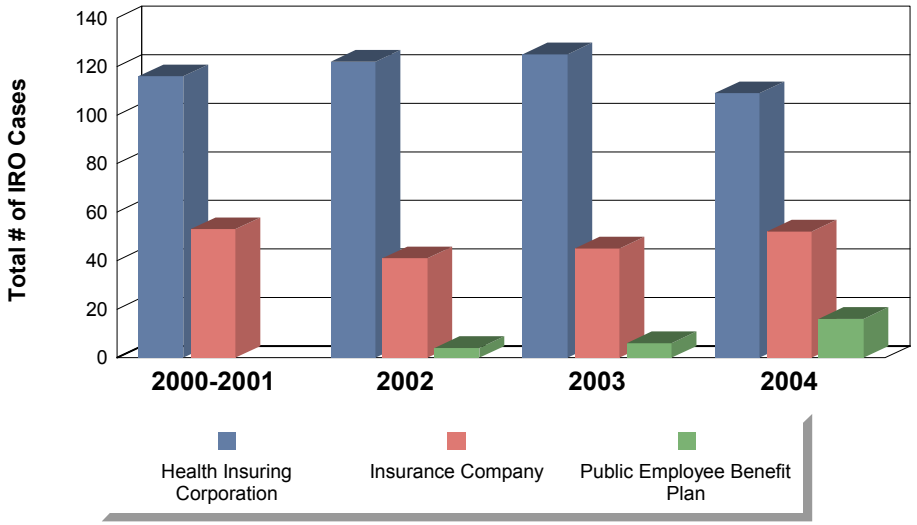


Benefit $'s Paid (Reversed)

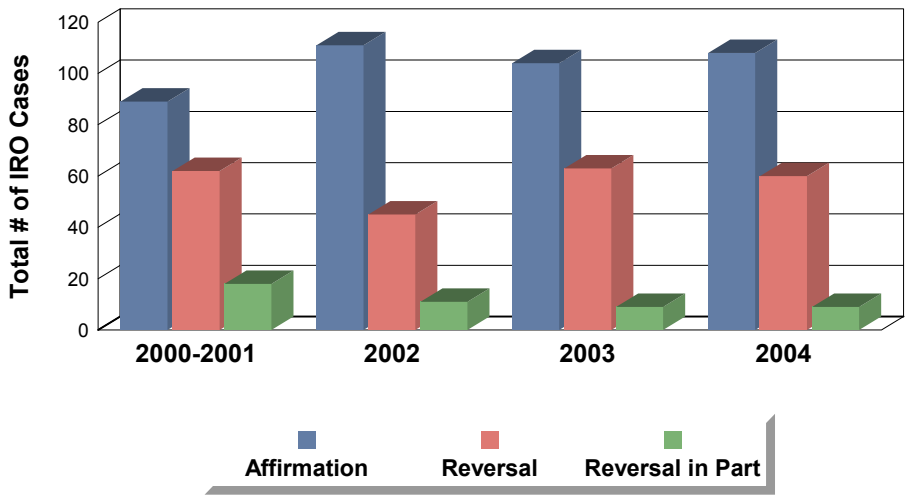


ATTACHMENT 3
COMPARISON OF IRO CASES BY REPORT YEAR
May 1, 2000 - December 31, 2004

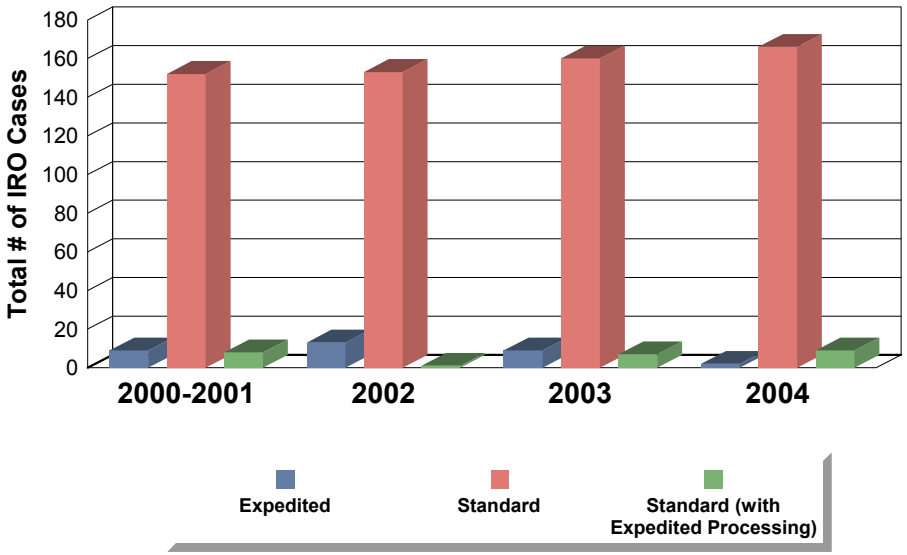
TYPE OF HEALTH CARRIER



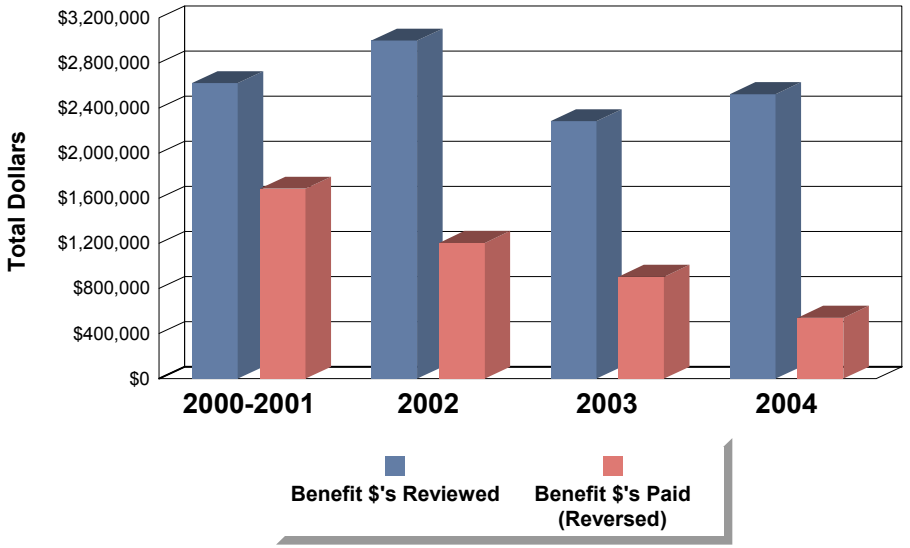
IRO OUTCOME DECISIONS



IRO REVIEW TYPE



IRO BENEFIT $'s REVIEWED vs. $'s PAID



February 22, 2005

Ohio Department of Insurance /
Office of Life & Health Services