



Consumer Ombudsman Program

Grants for Ombudsman Programs

Section 2793 of the Public Health Act, as amended by Section 1003 of the Patient Protection and Affordable Care Act (PPACA) calls for HHS to provide grants to states to establish and operate independent offices of health insurance consumer assistance or health insurance ombudsman programs. Consumer advocacy groups whole heartedly support this program and want to ensure the offices have the independence, resources and authority and are organized to best serve the interests of consumers.

Background

The PPACA makes \$30 million in the first fiscal year for health insurance consumer assistance or health insurance ombudsman programs, with additional funding for later years. These programs, which we refer to as ombudsman programs for the purposes of this brief, are to:

- Assist with the filing of complaints and appeals;
- Collect, track, and quantify problems and inquiries;
- Educate consumers on their rights and responsibilities;
- Assist consumers with enrollment in plans; and
- Resolve problems with obtaining subsidies.

As a condition of receiving a grant, a state must collect and report to HHS data on the types of problems and inquiries encountered by consumers. The data shall be used to identify areas where enforcement action is necessary and shall be shared with state insurance regulators, the Secretary of Labor and the Secretary of Treasury.

Principles For Allocating Grant Funds

Grant dollars should be allocated to fund high-quality programs and reach consumers with the greatest need.

Characteristics of a “good” ombudsman/consumer assistance program include:

- Projects completed or in process that document their skill at policy advocacy, intervention on behalf of consumers, or successful outreach or educational efforts.
- Prepared to assist consumers who have limited English proficiency, low health literacy, and/or limitations that make it difficult for them to make informed health care choices.
- Demonstrates their independence as a consumer assistance organization by submission of documentation regarding their mission as primarily serving consumers. The bill requires that the ombudsman operate an *independent* office. Ombudsman programs must be independent so they can assist consumers in filing appeals and focus on the consumer’s side of the case.

- Protects the consumers' confidentiality, yet includes mechanisms to access the data needed to resolve the consumers' problems.¹ To that end, the program should have or establish good working relationships, with relevant state agencies including the health insurance regulatory agencies. Ombudsman programs should also secure provider/insurer cooperation working within the patient privacy protections afforded by HIPAA.² Finally, it is critically important that ombudsman programs coordinate with insurance departments to address violations of state insurance laws.³
- Regularly reports to legislators and the public, so policymakers benefit from the valuable and timely information about problems consumers face in the health care system. Data collection and reporting is key to systemic change. Quarterly aggregated consumer data should specify plan names and patient gender, age, location and condition. This data should inform consumers and purchasers of health care regarding the number, content, and resolution of inquiry and complaints. This data should be readily accessible to the public.
- Ensures that consumers get information about the Ombudsman program at the points they most need such assistance. For example, plans should notify consumers of the availability of these programs on coverage determination notices.
- Is adequately staffed and has the resources to competently and efficiently assist consumers with a wide range of grievances and other substantive tasks. Staff training must include detailed knowledge of state and federal laws regarding health insurance and group health plans. Staff knowledge must also include capacity to help resolve consumer problems with obtaining subsidies.

Problems That Consumers Might Encounter

The new grant funds won't help consumers unless they are aware of these resources. Unfortunately, many consumers don't know about the assistance resources available to them today. For example, no participant in a 2006 Consumers Union focus group was aware of the state health insurance resources available to them.⁴

Consumers should not have to struggle to determine regulatory jurisdiction if they have a complaint. States should avoid having the consumer be batted back and forth between the ombudsman office and insurance department. Ideally, the state will establish a "no wrong door" policy and insurance department staff and the consumer assistance department will work seamlessly and cooperatively to ensure the consumer receives the correct services.

Consumers need a coherent system of for tracking complaints and letting them influence policy. Today's multiplicity of agencies involved in oversight of health insurance plans makes it difficult to develop a comprehensive picture of how well insurance plans are performing on consumer complaints.⁵ Many other federal, state and private agencies are also involved in oversight of health insurance plans or complaints management. There is no system or universal model of health insurance complaints management across these states and federal agencies.⁶

Recommendations

Grants to the states must be conditioned on meeting specified standards that ensure the goals of the program are realized, maximum benefit for consumers is obtained, and maximum value for tax payer dollars achieved. To that end, we recommend that priority be given to grant applicants that:

Demonstrate a Broad Ability to Help Consumers

- Grant applicants should be empowered to direct people to coverage, take and respond to complaints, and advocate with regulators, health plan internal appeals panels, and external reviewers on consumers' behalf.
- Have access to relevant data collected at relevant state agencies (e.g., complaints lodged with state attorneys general or the insurance department). In addition, ombudsmen need strong working relationships with staff in the other relevant agencies.
- Grant applicants should explain their plans for tracking complaints, which can be complex, including whether it seeks to aggregate complaints data from other agencies. Some complaints may be filed directly with the state regulatory agency, others may go to the insurance company directly and be resolved/not resolved there, others may go to a private attorney in the case of an individual who wants to sue.
- Grant applicants should demonstrate an intention and capacity to analyze and publicly report consumer complaint data they receive (in addition to forwarding it to HHS), in an effort to proactively assist consumers. For example,

a pattern of similar complaints might indicate that the office should contact the insurer being cited or issue a consumer advisory. Grant applicants should demonstrate a willingness to use their casework to aid in state and local policy development.⁷

- In their consumer education efforts, grant applicants should indicate they will proactively identify the type of information that is most useful to consumers. These consumer materials should be appealing, use plain language, be written in the languages of state residents, and be understandable by those with lower literacy levels.⁸ Applicants should use a variety of methods to “push” this information out to consumers so it is available when they need it (for example, at the point where they are purchasing an insurance policy or at the doctor’s office). Educational efforts that rely on consumers to visit the website on their own initiative are insufficient.
- Grant applicants should document the independence of the ombudsman program they propose to fund. Independence can be enhanced through legislative authority and dedicated funding.⁹ If the applicant part of a state agency, documentation should specify all relevant reporting lines. If a free-standing non-profit, this documentation should also include governance structure, organizational funding, and board composition (which should be free from conflicts of interest involving plans, providers and pharmaceutical and device manufacturers). The ombudsman office should have no other programmatic responsibility than to assist consumers with complaints and educate them as to their insurance coverage options as set forth in the Patient Protection and Affordable Care Act.¹⁰

Demonstrate Easy Consumer Access

- Grant applicants should demonstrate the myriad ways in which they will make consumers aware of their office and services. For example: including a toll-free number staffed during hours that go beyond 9-5 weekdays; perhaps social media such as Facebook; coalitions with state organizations and agencies who educate and assist health care consumers, and a welcoming physical and online presence (institutional look/government look can be off putting; some people who need help may deeply distrust the government).
- A state law should require health plans to provide, in all consumer-facing materials, contact information for the office.
- Grant applicants should designate a central entry point for health insurance consumer complaints with referrals to other agencies as relevant. If state responsibility for insurance products is split across several agencies, this should be invisible to the consumer.¹¹ They should state their intent to establish a cooperative relationship with other relevant agencies and consumer groups and provide transfers to the correct agency/consumer help organization if the consumer problem is beyond their mandate.

Demonstrate Ability and Willingness to Contribute to a National Knowledge Bank of Consumer Experiences

- Applicants should demonstrate they will track and analyze complaints by health status, age, race, ethnicity, language, geographic location and gender¹² in order to identify any problems that particular populations are facing, and make timely and regular reports of this information to the public.
- HHS should work with programs to establish a simple, standardized reporting format and common definitions of terms (such as what constitutes a complaint).¹³ HHS, after public comment, should determine what common data elements should be reported the first year, and then further enhance data reporting in future years as grants continue. They should also use the standard insurance/medical terms required as part of PHSA Section 2717. Report to the federal government on how they are spending the grant dollars, and make this report publicly available.

It makes sense that ombudsman program duties be construed as broadly as possible, allowing flexibility for varying needs among the states. At minimum, ombudsman offices should serve as a portal for consumers to complain about plan behavior in enrollment and appeal handling, and consumer access to subsidies; and as an information source to help consumers understand public and private insurance options, supplementing what the State Exchanges may provide.¹⁴ Prior to soliciting grant applications, HHS should clarify the following with respect to the scope of their duties:

- Are the ombudsman programs expected to help with complaints filed with insurers or also with complaints filed with the insurance department (e.g., in a case where the consumer didn’t get a satisfactory response from the company or what about a complaint about the insurance department itself)?
- Will insurance departments refer consumers with complaints to the ombudsman offices and/or vice versa?
- Are ombudsman programs responsible for helping consumers enrolled in ERISA plans?

- Are ombudsman programs responsible for helping eligible small employers obtain tax credits as well as helping individuals to get subsidies? If not, who is?

As a condition of getting a grant, PPACA requires that states collect and report data on the types of problems encountered by consumers, as well as other types of inquiries. We recommend that HHS take their own steps to maximize the utility of the information being reported by grantees:

- HHS should standardize the reporting format and establish common definitions of terms (such as what constitutes a complaint). For example, HHS may want to distinguish between: complaints where the insurance company is not at fault compared to those where it is at fault. HHS may also want to track at what stage the issue was resolved (e.g, whether it required a formal internal appeal or was resolved through the external appeals process with a third party) and the number of days to resolution. Further, HHS should work with programs to determine what categories of complaints are useful to track. For example, in addition to tracking complaints and appeals regarding denials by diagnoses (a common data element in many states), HHS may want to track complaints about pre-existing condition exclusions, rate-ups, benefit limitations, etc. The use of standardized reporting format and common definitions of terms will allow the agency, states, and consumer advocates to effectively assess trends and respond to issues across states and regions. These standard terms should also be consistent with the standard insurance/medical terms required as part of PHSA Section 2717.
- HHS should develop a strategy for incorporating consumer complaint data from non-grantee states and the other federal and private agencies that receive complaints about health insurance (such as the SHIP offices for seniors or DOL for ERISA plans). HHS must move toward a coherent system for analyzing health insurance complaints management across the states and federal agencies so we have a truly comprehensive picture of how well insurance plans are performing from the perspective of the consumer.
- HHS should use the information provided by states to help guide the necessary standards and rules for the reforms scheduled to take effect in 2014. The information also should be available to researchers under the HIPAA constraints for health services research.

Finally, we recommend that HHS provide resources to help ensure the success of the grantees and the wise use of tax payer dollars:

- States that do not currently have this capability may be reluctant to apply. HHS should encourage them to do so, and help arrange for mentoring by states or non-profit organizations that already have strong, centralized consumer health insurance assistance programs.
- Provide an easy-to-use summary of best practices (commission one if necessary), and a list of experts to provide just-in-time assistance, as necessary.
- Require grantees to document their successes and failures, in such a way that helps future grantees and contributes to an accessible, usable store of knowledge.
- HHS should require and fund annual face to face training events and develop materials by consultation with grantees. HHS could use the services of an outside entity [nonprofit organization] that has experience with consumer assistance to provide this type of back-up support.

We encourage you to look at programs such as Connecticut's Office of the Healthcare Advocate and the consumer assistance programs run by Health Care for All in Massachusetts (the HelpLine), The Health Consumer Alliance in California, and the Community Service Society of New York as proven models of providing consumers with assistance on health insurance issues.