

REPORT OF THE

**STATE CORPORATION COMMISSION ON THE ACTIVITIES OF THE OFFICE OF THE
MANAGED CARE OMBUDSMAN**

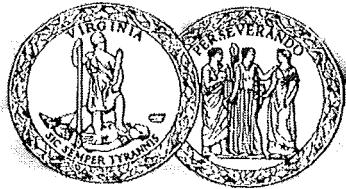
TO THE HOUSE COMMITTEE ON COMMERCE & LABOR; THE HOUSE COMMITTEE
ON HEALTH, WELFARE AND INSTITUTIONS; THE SENATE COMMITTEE ON
EDUCATION & HEALTH; THE SENATE COMMITTEE ON COMMERCE & LABOR AND
THE VIRGINIA JOINT COMMISSION ON HEALTH CARE

COMMONWEALTH OF VIRGINIA

RICHMOND

2016

COMMONWEALTH OF VIRGINIA



MARK C. CHRISTIE
COMMISSIONER

JAMES C. DIMITRI
COMMISSIONER

JUDITH WILLIAMS JAGDMANN
COMMISSIONER

JOEL H. PECK
CLERK OF THE COMMISSION
P.O. BOX 1197
RICHMOND, VIRGINIA 23218-1197

STATE CORPORATION COMMISSION

November 28, 2016

To: The Honorable Terry G. Kilgore
Chairman, House Committee on Commerce and Labor

The Honorable Robert D. Orrock, Sr.
Chairman, House Committee on Health, Welfare and Institutions

The Honorable Stephen D. Newman
Chairman, Senate Committee on Education and Health

The Honorable Frank W. Wagner
Chairman, Senate Committee on Commerce and Labor

The Honorable Charles W. Carrico, Sr.
Chairman, Virginia Joint Commission on Health Care

The report contained herein has been prepared pursuant to § 38.2-5904 of the Code of Virginia.

This report documents the activities of the Office of the Managed Care Ombudsman for the reporting period covering November 1, 2015, through October 31, 2016.

Respectfully Submitted,

Handwritten signature of James C. Dimitri in black ink.

Commissioner James C. Dimitri
Chairman

Handwritten signature of Judith Williams Jagdmann in black ink.

Commissioner Judith Williams Jagdmann

Handwritten signature of Mark C. Christie in black ink.

Commissioner Mark C. Christie

Executive Summary

This annual report on the activities of the Office of the Managed Care Ombudsman (Office or Staff) covers the reporting period from November 1, 2015 to October 31, 2016. During this period, the Office provided informal and formal assistance to more than 712 consumers and other individuals. The Office responded to general questions and specific problems and issues with managed care and health insurance coverage provided by managed care health insurance plans (MCHIPs). The Office helped consumers understand how their health insurance works, the importance of reading and understanding coverage documents, and methods to solve problems. The Office also formally helped consumers appeal adverse benefit determinations and when necessary, referred consumers to other sections within the Bureau of Insurance for assistance, or, in some cases, to another regulatory agency when the problems involved issues outside the regulatory authority of the Bureau of Insurance. Specifically, during the reporting period, the Office responded to 596 inquiries and assisted 116 consumers in filing insurance-related appeals. The Office also participated in outreach events, such as the State Fair of Virginia, and continued to monitor federal and state health insurance related legislation. Details of these and other activities are provided herein.

Background and Introduction

The Office of the Managed Care Ombudsman (Office) was established in the State Corporation Commission's Bureau of Insurance (Bureau) on July 1, 1999, in accordance with § 38.2-5904 of the Code of Virginia. This annual report is submitted as required by § 38.2-5904 B 11, which requires the Office to provide information on its activities to the State Corporation Commission for reporting to the standing committees of the Virginia General Assembly having jurisdiction over insurance and health, and also to the Joint Commission on Health Care. This is the Office's 18th annual report and covers the period from November 1, 2015 through October 31, 2016. Previous reports may be viewed on the Bureau's website located at:

<http://www.scc.virginia.gov/comm/reports/finreports.aspx>

The legislation that created the Office assigned it numerous responsibilities. The Office's primary responsibility is to assist consumers whose health insurance coverage is provided by a managed care health insurance plan (MCHIP), *i.e.* a health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO) or managed care plan that provides vision or dental insurance. The Office can informally respond to consumer inquiries and, upon request, formally assist a consumer in the internal appeal process, when the consumer's coverage is a fully-insured individual or group health insurance policy issued in Virginia by a licensed insurance company. When appropriate, the Office can also refer consumers to another section of the Bureau for help. The Bureau does not have regulatory authority to formally help consumers whose coverage is provided by any of the following:

- Federal government (including Medicare)
- State government (including Medicaid recipients)
- Self-insured plans established by employers to provide coverage to their employees: and
- MCHIPs when the policy is issued outside of Virginia.

Although the Office does not have regulatory authority to help consumers whose health insurance coverage is provided by one of the above agencies or plans, the Office can provide general information and advice to consumers covered by these health plans. The Office also refers these consumers to the appropriate plan sponsor or government agency for assistance, when coverage falls outside the Bureau's jurisdiction.

Consumer Assistance

The Office provides general information and assistance to consumers and other individuals, including healthcare providers, who have questions or problems associated with some aspect of health insurance, managed care, or related areas. These inquiries reflect a diverse spectrum of concerns, issues and problems, which vary in complexity. Inquiries may involve questions about benefits available under a consumer's policy and how to resolve problems, including denied authorizations and denied claims. The Office helps consumers understand how their health insurance works and key principles of the plan and managed care, such as utilization review procedures and how to file a formal appeal of a denied service. In some situations, the Office refers consumers to another agency or resource for help when the individual's health plan is not regulated by the Bureau. Consumers whose coverage is provided by a self-insured health plan are referred to the employer for assistance. There are some inquiries involving issues that fall outside the regulatory purview of any government agency.

Health care providers also contact the Office for assistance on behalf of their patients when an MCHIP rejects a claim or the provider's prior authorization request. The Office provides general information and guidance to help providers understand how to resolve problems, including how to file an appeal with a patient's MCHIP. If a patient has an urgent medical situation, the Office advises the provider to file an urgent care appeal, which accelerates the internal appeals process. The legislation that established the Office does not establish a means for the staff to directly assist a provider in filing an appeal. Consequently, if it appears it will be necessary for the patient to file an appeal, the Office contacts the patient directly to offer assistance in the appeal process.

In addition to consumers and providers, federal and state legislators acting on behalf of their constituents also contact the Office for assistance. These inquiries usually involve denied preauthorizations or unpaid claims and often concern consumers with very serious medical problems. Staff can contact the constituent directly with an offer to provide assistance either through providing general information and advice or formally helping the individual file an appeal. Many of the inquiries from legislators involve constituents whose coverage is self-insured. In this situation, the Office provides assistance and refers the individual to the appropriate resources for help. If a consumer has a fully-insured plan issued in Virginia and requires help filing an appeal, the Office will follow its standard protocol in helping the person appeal. Depending on the case, the Office may provide a written response to a legislator regarding the disposition of an inquiry or formal assistance provided to an individual appealing an adverse decision.

The Office helps consumers submit appeals when their MCHIP issues an adverse determination such as for denying a claim or refusing to preauthorize a service. Appeals typically involve a service that an MCHIP has determined is not medically necessary, or one which the company determined is experimental/investigational in nature through its utilization review process. The appropriateness of care, health care setting, level of care, and expected clinical outcome are considerations in determining when services are medically necessary. An MCHIP makes this determination in conjunction with its

clinical criteria applicable to a specific service. Examples include denials for the following: prescription drugs; surgery; imaging tests (CT scans, PET scans, and MRIs); inpatient hospital services; physical or speech therapy services, and mental health services, including substance abuse treatment. In some instances, appeals involve consumers with a medical condition that the individual believes can best be treated outside of the MCHIP's provider network but the MCHIP contends its participating providers can adequately provide the necessary care. The Office also provides assistance to consumers who have dental insurance provided by an MCHIP and have received adverse determinations for services such as denied crowns and affiliated services, and root planning and scaling.

The Staff is required to obtain the written consent of the "covered person" when the Staff formally helps a consumer in the appeal process. The Office helps the individual understand the reason the service or claim was denied, including any applicable clinical criteria, and explains the appeal process. Staff also ensures the individual's appeal rights can be exercised and helps the individual submit an appeal with the appropriate clinical information, such as copies of pertinent medical records or documentation from the provider. In the course of helping consumers submit an appeal, the Staff contacts the individual's MCHIP in writing. A significant role for the Office is ensuring the individual understands all the appeal levels that are available, which vary depending upon plan design and other factors.

Appeals may result from pre-service or post-service denials, or in some cases appeals submitted concurrently with active treatment, such as an individual receiving ongoing inpatient treatment in a hospital. The Office is able to help consumers navigate the entire appeal process with both the individual's MCHIP as well as any external appeals that are available. Once the Office establishes contact with the person's MCHIP, the Staff is able to help resolve any disputed facts or circumstances involved in the appeal, and also assist the consumer submit any updated clinical information to the MCHIP for consideration. The staff is very cognizant that most consumers have not filed an appeal before, and in some instances, an individual suffers from a serious medical condition that may also cause financial difficulties associated with medical debt.

Some appeals involve utilization review and administrative denials, such as an ongoing course of physical therapy which requires utilization review approval that exceeds the number of visits covered under the terms of the policy. If the policy contains a visit limitation and an individual is prescribed more visits than allowable under the policy, an administrative denial is issued rather than a utilization review denial. This means that while physical therapy visits under the allowed cap may be considered as either medically necessary or not medically necessary, visits past the allowed number can be denied administratively, since they exceed the maximum number of visits as stated in the policy. Similarly, appeals for approval to receive care outside of a limited provider network may reference an administrative denial, as do appeals concerning the allowable charges an MCHIP pays to a nonparticipating provider. In some instances, consumers file appeals for services that are denied as an exception to the services that are eligible for coverage as stated in the plan documents. An example is a request for cosmetic surgery,

which is usually a policy exclusion, but in some situations may be medically necessary. The Office helps consumers appeal denials involving utilization review and administrative denials, although the latter are frequently addressed by another section within the Bureau.

For an appeal involving a question of medical necessity, the Office encourages the consumer to ask the treating healthcare provider to conduct a peer-to-peer review with one of the MCHIP's medical directors. In many situations, this may result in the MCHIP approving the requested treatment or service. If a consumer's medical condition warrants a rapid ruling on an appeal, the Office will help the consumer file an urgent care appeal which must be decided within 72 hours. Otherwise, an MCHIP has 30 days to respond to a pre-service appeal and 60 days to respond to a post-service appeal. When the Office assists consumers, the staff explains the steps involved in the appeal process, including the importance of the treating provider asking an MCHIP to reconsider its denial, and providing updated clinical information to the MCHIP.

The Office is prohibited from filing an appeal on behalf of a consumer. Staff will review and provide comments and input on a proposed appeal letter, but will not write an appeal letter for the consumer. The Staff will also provide a copy of the individual's appeal letter to the MCHIP; along with its comments as the Staff helps a consumer file an appeal. Once the appeal is being processed, the staff will serve as a liaison between the consumer and the MCHIP, and help clarify key issues regarding the events and circumstances involved in the appeal.

Staff cultivates and maintains a productive working relationship with the MCHIPs, which facilitates effective communication between the Office and MCHIP. This relationship helps resolve issues involved in an appeal that may not initially be clear. The Office can stay actively engaged with the consumer and their MCHIP throughout the entire appeal process.

Staff reviews decisions that MCHIPs render on appeals, to help ensure the appeal process was administered fairly and in accordance with applicable statutory requirements. If an appeal is denied, Staff will ask an MCHIP to clarify its rationale for the denial if it does not appear to be supported by the pertinent facts. The Office strongly believes that a denial should reflect a logical reasoning process which produces a decision based on all the information provided by the consumer and the treating health care provider. The Office will objectively analyze an appeal that is not successful, and help the individual understand why the MCHIP did not overturn the denial. In some situations, an unsuccessful appeal may require further regulatory review so Staff will ask the MCHIP for additional information. When necessary, the Office will forward the case to the appropriate section within the Bureau for further review and any necessary actions. The Office can also provide additional assistance to a consumer when the appeal decision is favorable but the individual has difficulty obtaining the previously denied services or benefits.

When an MCHIP denies an appeal involving questions of medical necessity, appropriateness, health care setting, level of care, or effectiveness, or when an MCHIP determines the services are experimental/investigational, the adverse decision may be eligible for an external review. In these cases, the Office can help a consumer file a request for an external review, and Staff can explain how the external review program works and the applicable requirements for requesting an external review. In the case of final denials based on administrative or contractual denials, the Office may refer the matter to the Bureau's Consumer Services Section to review as a potential consumer complaint. In some situations when a consumer is unsuccessful in the internal appeal process with an MCHIP, there is no further regulatory assistance the Bureau can provide.

As noted in previous annual reports, the overwhelming majority of consumers who ask for assistance in appealing an adverse determination had never appealed a denial, and many individuals were intimidated by the process. The Office attempts to reduce consumers' anxieties, along with consumers' general frustrations frequently associated with filing appeals, by offering personalized assistance and providing counseling and guidance throughout the entire appeal process. During this reporting period as in previous reporting periods, the Office received very positive comments from consumers.

Consumers, providers, legislators, and other interested parties can contact the Office using a variety of methods: a dedicated Ombudsman's e-mail account, the Bureau's online portal, telephone, fax, and correspondence. The Office also receives inquiries from consumers who were referred by their health care provider, friend or relative, or from an organization the Office has contacted during its outreach activities. The staff tracks workload data in accordance with the legislation that established the office, to include the disposition of each individual inquiry. During this reporting period, the Office responded to 596 inquiries, which is slightly more than the 555 inquiries the Office received during the previous reporting period. In the previous reporting period the Office assisted 151 consumers file appeals, and in this reporting period, the Office helped 116 consumers file appeals.

Discussion

During this reporting period, most of the inquiries and appeals Staff encountered involved the same types of issues and problems related to health insurance and managed care as discussed in previous annual reports. In many instances, consumers experienced problems because they were not familiar with the features of their managed care plan and the potential benefits provided by their coverage as stated in the policy. Many consumers did not read and understand their plan documents, such as the evidence of coverage (EOC), certificate of coverage (COC), and explanation of benefit forms (EOBs). Frequently, consumers also had difficulties understanding the reason a service was denied, and the steps in the appeal process. Staff continually stresses the importance of consumers reviewing and understanding coverage documents and correspondence, and the importance of asking for assistance when necessary.

As reported in previous annual reports, the Office encountered consumers whose health insurance was provided by types of health plans outside of the Bureau's regulatory jurisdiction. Typically these consumers were covered by a self-insured health plan, although some consumers had fully-insured plans issued in another state, and some consumers were covered through the Federal Employees Health Benefits Program (FEHBP) or other types of government plans such as Medicare or Medicaid. The Office informally advised these consumers how they could resolve a problem and referred these individuals to other resources for assistance. The largest number of referrals was to employers who provided self-insured coverage for their employees. Although Staff provided informal advice and suggestions to consumers whose coverage was not regulated by the Bureau, consumer feedback indicated the information was extremely helpful. With very few exceptions, these consumers were not aware their coverage was self-insured and not subject to Virginia's regulatory authority.

As noted in prior annual reports, health care providers acting on behalf of their patients frequently contacted the Office for assistance. Staff helped providers understand the appeal process including how to initiate the first step, which is a peer-to-peer review with a medical director at their patient's MCHIP. If that interchange was unsuccessful, then the provider, or the patient, can file an internal appeal with the individual's MCHIP with assistance from the Office. There were many instances where the information and the advice the Office provided were instrumental in helping the provider resolve the problem. Consequently, the patient was able to receive treatment instead of having to engage the formal appeal process with their MCHIP. The Office always ensured the provider understood that the purpose of the Office is to assist the "covered person" and that there is no mechanism for the Office to directly and independently assist a provider in appealing an adverse decision. If the provider was unable to influence the MCHIP's adverse decision, the provider knew their patient could contact the Office for assistance in filing a formal appeal.

As discussed in previous reports and occurring again during this reporting period, there were numerous instances when the Office helped a consumer obtain a favorable outcome in the appeal process. These outcomes reflected a wide variety of denied services and benefits with a cost savings or avoidance benefiting the consumer ranging from a few hundred dollars to a substantial amount. The following are selected examples illustrating some favorable results for consumers:

- Individual received reimbursement for acute care services received in China and Japan.
- Individual's back surgery was approved, with a projected cost of \$60,000.
- Individual with cardiomyopathy received payment for dental services which were a potential complication associated with the individual's medical condition.
- Individual diagnosed with psoriasis received approval for a prescription drug, Humira, costing \$6000.
- Individual received approval for most laboratory charges at a nonpar hospital; the balance bill was cancelled after the person contacted the hospital administrator.
- Urgent care claim for \$684 was paid after the facility recoded the claim.

- Individual received approval for a prescription drug, Harvoni, to treat hepatitis – C with a cost of \$90,000.
- Individual with a HMO was reimbursed for visiting a nonpar specialist.
- Individual with a HMO underwent open heart surgery at a nonparticipating hospital and the entire \$90,000 bill was covered after appealing \$10,466 in denied charges.
- Individual received additional payment of \$2800 for denied emergency room charges at a nonpar hospital.
- Individual obtained approval for imaging services at a nationally known hospital, and the results influenced the course of treatment.
- Individual received approval for a prescription drug, Ritalin, costing \$2,616, for a dependent child.
- Individual and family members who received mental health services and medical services at a nonpar hospital received benefits at the in-network rate and saved over \$30,000 from billed charges.
- Parents of deceased child received reimbursement for imaging services costing \$500.

The Office also helped several consumers successfully appeal denials issued by their dental MCHIP, including the following:

- Individual received approval for a crown costing \$539.
- Individual received approval for scaling and root planing costing \$270.
- Individual received approval for a crown costing \$505.
- Individual whose child required dental anesthesia for dental surgery performed in a hospital received payment for the anesthesia charges.
- Individual received approval for dental services costing \$139.

Some individuals who successfully appealed a denied dental claim achieved a Pyrrhic victory. They expended considerable time and effort in appealing a denial, and although they won, the actual amount of money they recovered was limited because the amount exceeded the coverage cap of their policy. In some instances, consumers had completed the appeal process before contacting the Office for assistance, but their MCHIP conducted a courtesy review which in some cases overturned the denial. Most of the consumers the Office helped appeal dental denials were covered by stand alone dental plans (SADPs) so a final adverse determination was not eligible for an external review. Just as the case was for denied medical claims, most consumers who appealed denied dental claims had never received an adverse decision from their dental insurer and appealed, so the assistance the Staff provided was very beneficial.

There were several common factors that characterized successful appeals for denied medical and dental services. A major component was comprehensive medical records that contained high quality entries that documented a consumer's medical history, medical condition, and treatment response. Another important factor was a strong appeal letter that presented the relevant facts in a logical manner and addressed each clinical criterion the insurer cited in denying the service or claim. It was also helpful for a

consumer to have a convincing letter from their attending physician explaining why the service was medically necessary. In cases where a consumer had been treated by multiple physicians, it was very helpful for the consumer to include all relevant clinical information from multiple providers, to include ones the person had seen that were not readily identifiable by their current MCHIP. It was also helpful for consumers and physicians to provide medical and scientific evidence in support of an appeal, especially peer-reviewed medical journal articles and other peer-reviewed scientific articles. This approach was especially instrumental in appealing denials based on an MCHIP's determination that a requested service was experimental/investigational in nature.

The Office provided guidance and advice to consumers on key information to include in appeal letters and enclosures, and when requested, reviewed draft appeal letters and offered suggestions. The chance of an MCHIP overturning a denial on appeal was commensurate with the quality of information a consumer submitted in their appeal, especially when consumers provided multiple valid reasons why their position was correct. The Office encouraged consumers to submit medical records and supporting letters from their physicians to present a strong argument that the disputed claim was valid and should be approved. Ideally, a consumer submitted information to convince the individual's MCHIP that the treatment or service the person was appealing represented the current standard of care for that particular medical condition.

By providing comprehensive information supporting their position, the consumer not only maximized the chance to win an internal appeal, but if they lost, the information already submitted to their MCHIP was on file so the information could be readily submitted to an independent review organization if the individual requested an external review.

The Office also ensured that consumers' appeal rights were protected and fairly administered by his or her MCHIP. This included helping consumers file appeals and writing to an individual's MCHIP and providing important information regarding the issues and circumstances involved in the appeal. In a few instances, consumers had missed the deadline to file an appeal, but the person's MCHIP conducted a courtesy review which sometimes led to a denial being overturned. In one situation, a person's MCHIP initially refused to process a second level appeal due to lack of timely filing by the consumer. The Office pointed out that the MCHIP had missed the deadline to respond to the first level appeal, so the company agreed to process the second level appeal even though it was late. As a result, the denial was partially overturned. In other situations, the Staff noted denial letters generated by MCHIPs contained incorrect information, such as whether or not a consumer was potentially financially responsible for a denied claim. In these cases, the MCHIP responded by generating a corrected letter which replaced the incorrect information previously provided. This enabled the consumer to clearly understand any potential financial liability, and helped the person determine whether or not to proceed in the appeal process. In one situation, the Staff reviewed a denial letter and ultimately it was determined an MCHIP incorrectly issued a group policy in Virginia although the employer was headquartered in Washington, D.C. The Staff helped the person prevail in the appeal process, and referred the matter to the

appropriate section within the Bureau, which contacted the MCHIP. The Staff found that upon request, the MCHIPs were always cooperative and agreed to review adverse determinations and denial letters, including the process used to reach a decision and if necessary, provide corrected information to a consumer. In some cases, this reversed an adverse determination and produced a favorable consumer outcome.

Outreach

As discussed in prior annual reports, the Office believes outreach programs are an integral part of its consumer educational activities. The staff conducted its own outreach and also supported the Life and Health Division's outreach program. During this reporting period, the Office helped staff the Bureau's exhibit at the State Fair of Virginia. This was an excellent opportunity to interact with numerous consumers in an informal environment. The Office had an exhibit at the annual meeting of the Virginia Dental Association (VDA), which was an effective means to interact with dentists, dental assistants, and administrative staff from dental practices located throughout the Commonwealth. Staff was a presenter at Enroll VA Navigator's meeting hosted by the Southern Poverty Law and provided information about the Office and how it can help consumers. The Staff has also discussed the Office and its functions with the health care reporter from the Richmond Times-Dispatch, who used the information in an article. As reported in previous annual reports, Staff advised case workers for the Legal Information Network for Cancer (LINC) on issues involving managed care and health insurance that affected LINC clients.

Outreach programs create opportunities for the Office to directly assist consumers in the appeal process, and also provide a means to educate providers and interested parties about the services the Office provides. The Office also ensures the information on its web page is accurate, accessible and up-to-date.

Federal Legislation

As required by § 38.2-5904 B 10 of the Code of Virginia, Staff monitors changes in federal and state laws that pertain to health insurance. As was the case in the previous reporting period, the Office continued to monitor developments related to the Affordable Care Act (ACA) and reviewed selected federal regulations published to implement the ACA. In addition, and as reported in prior annual reports, Staff contributed to the Bureau's ongoing efforts to analyze and implement various components of the ACA.

Virginia's Legislation

The Office continues to track legislation pertaining to health insurance and related subjects passed by the General Assembly and signed into law by the Governor. During the 2015 General Assembly, the Office monitored several pieces of legislation, one of which was effective on January 1, 2016. House Bill 1940 amended and reenacted § 38.2-3418.17 Coverage for autism spectrum disorder. This section requires health insurers to provide coverage for the diagnosis and treatment of autism spectrum disorder in

individuals from age two through age 10, which was an increase from the age limit of age 6. Notably however, the requirement still does not apply to policies issued in the individual market or the small group market.

The General Assembly enacted legislation in its 2016 session which includes the following that were followed by the Office. House Bill 58, which was enacted as §§ 38.2-3406.1, 38.2-3431, and 38.2-3551 deleted provisions that changed the definition of a “large employer” for purposes of a group health plan. The effect of this legislation was that “large employer” continues to be defined as an employer that employs an average of 51 employees or more and the definition of a “small employer” continues to be defined as an employer that employs an average of 50 or fewer or fewer employees.

Another bill, Senate Bill 562, was enacted and amends § 38.2-3454.1 Health benefit plans; federal law changes. This measure authorizes a health carrier to sell or renew a health benefit plan that would not otherwise be permitted to be sold or issued because the plan does not meet the requirements of the ACA; to the extent the appropriate federal authority suspends enforcement of the ACA or related requirements. This section applies to both the individual and group markets, and allows carriers to sell coverage or renew coverage consistent with the absence of federal enforcement or regulations regarding specific coverage requirements, which otherwise would have prohibited the sale of a particular plan.

In addition, House Bill 87 amended provisions of § 30-343 dealing with the responsibilities of the Health Insurance Reform Commission, for which the Bureau serves as staff. This section specifies that if applicable federal rules require an agency of the Commonwealth to identify any state-mandated benefits that are in addition to the essential health benefits, the Bureau will be the applicable agency unless a specific state agency is otherwise designated. Further requirements specify the Bureau’s role in the evaluation process to assess the social and financial impact and medical efficacy of a proposed mandate.

The Bureau continues to perform plan management functions for the federal Health Insurance Exchange in Virginia, also known as the Marketplace (Marketplace), by recommending Qualified Health Plans (QHPs) and Stand-Alone Dental Plans (SADPs) for certification, pursuant to § 38.2-326 of the Code of Virginia. Under the ACA, any health benefit plan or stand-alone dental plan sold on the Marketplace must be certified. Once the plan is certified, it is designated as a QHP or SADP. This year, the Bureau reviewed submissions from 12 carriers providing health insurance coverage and 15 carriers either providing stand-alone dental coverage in the Marketplace or providing exchange-certified stand-alone dental coverage in the outside market. These plans were offered in the small group market and/or the individual market. The 12 carriers providing health insurance coverage offered a variety of plans in the different “metal levels” (bronze, silver, gold and platinum) which represent different premium levels with concurrent varying out-of-pocket costs for consumers. The Bureau recommended certification for 208 QHPs offered by 12 carriers and 99 SADPs offered by 15 carriers. The recommendations were submitted to the federal government’s Department of Health

and Human Services (HHS), for final approval. Approved plans are available for consumers to purchase during open enrollment, November 1, 2016 – January 31, 2017, with coverage effective on or after January 1, 2017.

One of the important coverage provisions of the ACA and Virginia law is that a QHP is required to provide coverage for Essential Health Benefits (EHBs). Essential Health Benefits represent various categories of services: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, and chronic disease management, and pediatric oral and vision care.

Conclusion

During this reporting period, as in previous reporting periods, the Office has accomplished its responsibilities in accordance with § 38.2-5904 of the Code of Virginia. As occurred in prior reporting periods, Staff assisted consumers, providers, and other interested parties by providing general information, guidance, and assistance. In some instances, depending on how a consumer's health insurance coverage was structured, individuals were referred to another source for assistance. When requested, Staff helped consumers appeal adverse benefit determinations and ensured individuals had fair access to the internal appeal process offered by his or her MCHIP, and provided personalized assistance to the person. The Office helped consumers understand the appeal process, and acted as a catalyst to clarify any disputed facts regarding the appeal. Staff worked to ensure MCHIPs administered their appeal process in a consistently fair manner, which combined with the Staff's expertise maximized the opportunity for an appellant to prevail in the appeal process. When circumstances warranted, Staff referred potential regulatory concerns to the appropriate section within the Bureau for further review. The Office also monitored changes in federal and state laws related to health insurance coverage and managed care.