COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION

REPORT ON THE ACTIVITIES OF THE OFFICE OF THE MANAGED CARE OMBUDSMAN PURSUANT TO § 38.2-5904 OF THE CODE OF VIRGINIA

to the:
Senate Committee on Education and Health
Senate Committee on Commerce and Labor
House Committee on Commerce and Labor
House Committee on Health, Welfare and Institutions
Virginia Joint Commission on Healthcare

December 1, 2017

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STATE CORPORATION COMMISSION

December 1, 2017

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

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 Terry G. Kilgore
Chairman, House Committee on Commerce and Labor

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

Gentlemen:

The report contained herein has been prepared pursuant to § 38.2-5904 of the Code of Virginia and documents the activities of the State Corporation Commission's Office of the Managed Care Ombudsman for the period November 1, 2016 through October 31, 2017.

Respectfully Submitted,

Judith Williams Jagdmann
Chairman

Mark C. Christie
Commissioner

James C. Dimitri
Commissioner

Executive Summary

This annual report on the activities of the State Corporation Commission's ("SCC") Office of the Managed Care Ombudsman ("Office" or "Staff"), which is within the SCC's Bureau of Insurance ("Bureau"), covers the period November 1, 2016 to October 31, 2017. During this period, the Staff: provided information and formal assistance to more than 699 consumers and other individuals; responded to general questions and specific issues with managed care and health insurance coverage provided by managed care health insurance plans ("MCHIP"); assisted consumers in understanding how their health insurance plans work; emphasized the importance of reading and understanding health insurance coverage documents; and offered information on methods to resolve issues.

In total, the Staff responded to 567 inquiries and assisted 132 consumers filing appeals with MCHIPs because of adverse benefit determinations. When necessary, the Staff referred consumers to either another section of the Bureau for assistance or to another regulatory agency when the issue involved a regulatory matter outside of the Bureau's regulatory authority. The Staff also participated in outreach events and continued monitoring federal and state health insurance-related legislation. Details of these and other activities are provided herein.

Background and Introduction

The State Corporation Commission's ("SCC") Office of the Managed Care Ombudsman ("Office" or "Staff") was established in the Bureau of Insurance ("Bureau") on July 1, 1999, in accordance with § 38.2-5904 of the Code of Virginia ("Code"). This annual report is submitted as required by § 38.2-5904 B 11 of the Code, which requires the Staff to provide information on its activities to the SCC for reporting to the Virginia General Assembly's standing committees having jurisdiction over insurance and health and also to the Joint Commission on Healthcare. This is the Office's nineteenth annual report and covers the period November 1, 2016 through October 31, 2017. 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 healthcare benefits, including dental and vision, are fully insured and issued in Virginia by a Managed Care Health Insurance Plan ("MCHIP"); *i.e.* an arrangement such as a health maintenance organization ("HMO"), preferred provider organization ("PPO"), or exclusive provider organization ("EPO"). The Staff can informally respond to consumer inquiries and, upon request, formally assist a consumer in the internal appeal process with the MCHIP. When appropriate, the Staff also can 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.

While the Office lacks the regulatory authority to help consumers whose healthcare benefits are provided by one of the above-referenced agencies or plans, the Staff can provide general information and advice to these consumers and refer them to the appropriate plan sponsor or government agency for assistance when coverage falls outside the Bureau's regulatory authority.

Consumer Assistance

The Staff provides general information and assistance to consumers and other individuals, including healthcare providers, who have questions or encounter problems involving some aspect of health insurance, managed care, or related areas. These inquiries reflect a wide spectrum of concerns, issues and problems and vary in complexity. Inquiries may involve questions concerning benefits available under a consumer's policy and ways to resolve problems, including denied authorizations and denied claims. The Staff assists consumers in understanding how their healthcare benefits work by explaining key principles of the plan and managed care, such as utilization review procedures and how to file a formal appeal of a denied service. The Staff may refer consumers to another agency or resource for assistance when the individual's health plan is not regulated by the Bureau. There are, however, some inquiries involving issues that fall outside the regulatory purview of any state or federal government agency. For example,

consumers whose coverage is provided by a self-insured health plan are referred to the employer sponsoring the coverage for assistance.

Healthcare 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 filing an appeal with a patient's MCHIP. If a patient has an urgent medical situation, the Staff 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 file an appeal on behalf of a provider. Consequently, if it appears the circumstances require the patient to file an appeal, the Staff contacts the patient to offer guidance and assistance in the appeal process.

In addition to consumers and providers, federal and state legislators acting on behalf of their constituents contact the Office for assistance. Usually these inquiries involve denied preauthorization requests 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. Frequently, inquiries received from legislators involve constituents whose coverage is self-insured. If a consumer's employer is self-insured, the Staff provides assistance and refers the individual to the employer sponsoring the plan for assistance. If a consumer is covered by a fully insured MCHIP issued in Virginia and wants assistance filing an appeal, the Staff follows its standard protocol in helping the person appeal. Depending on the case, the Staff may provide a written response to a legislator regarding the disposition of an inquiry or formal assistance provided to a constituent who files an appeal.

The Staff helps consumers submit appeals when their MCHIP issues an adverse determination, such as 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, healthcare setting, level of care, and expected clinical outcome are factors considered in determining if services are medically necessary. An MCHIP makes this determination in conjunction with its clinical criteria applicable to a specific service. The Staff can assist the consumer in accessing and understanding the applicable criteria. Examples of adverse decisions resulting from utilization review determinations include denials for the following: prescription drugs; surgery; imaging tests (CT scans, PET scans, and MRIs); therapeutic radiation; inpatient hospital services; physical or speech therapy services; and mental health services, including substance abuse treatment. Appeals also may involve consumers who disagree with their MCHIP that their particular medical condition cannot be satisfactorily treated by providers within the MCHIP's provider network. Additionally, the Staff provides assistance to consumers who receive an adverse determination related to dental benefits provided by an MCHIP. Examples of denied dental services include crowns and related services, adjunctive dental care, periodontal scaling, and root planing.

The Staff is required to obtain the written consent of the "covered person" when formally helping a consumer in the internal appeal process. The Office helps the individual understand the reason the service or claim was denied, including any applicable clinical criteria the MCHIP used in making its adverse determination. The Staff also explains the appeal process and ensures

the individual's appeal rights can be exercised. Upon request, the Staff helps the individual submit an appeal with the appropriate clinical information, such as copies of pertinent medical records or documentation from the treating provider. In the course of helping consumers submit an appeal, the Staff contacts the individual's MCHIP in writing. The Staff plays a significant role in helping to ensure an individual fully understands all the appeal levels that are available and that the individual has unimpeded access to each level of appeal.

Appeals may result from pre-service or post-service denials, or, in some cases, appeals submitted concurrently with active treatment. The latter situation involves an individual receiving ongoing medical treatment and frequently involves consumers with serious medical conditions. The Staff helps consumers navigate the entire internal appeal process with the individual's MCHIP as well as to begin any independent external review process that is available. Once the Staff establishes contact with the person's MCHIP, the Staff is then able to help resolve any disputed facts or circumstances involved in the appeal. Staff also can assist the consumer in submitting updated clinical information. The Staff is very cognizant that this can be a stressful time for consumers who have never filed an appeal and who may suffer from a serious medical condition that comes with its own set of difficulties, including medical debt.

Some appeals include a utilization review component along with an administrative denial that is based on a specific exclusion or limitation in an individual's policy documents. An example is an ongoing course of physical therapy requiring utilization review approval for a number of sessions that exceeds the allowable visits covered by 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 within the allowed limit may be subject to utilization review for medical necessity, visits over the allowed number can be denied administratively, whether or not they are medically necessary, since they exceed the maximum number of visits stated in the policy. Similarly, appeals for approval to receive care outside of a restricted 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 requesting an exception to the services 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 both utilization review and administrative denials, although the latter cases can be further investigated by another section within the Bureau.

When the Office assists a consumer with an appeal involving a question of medical necessity, Staff encourages the consumer to ask their treating healthcare provider to conduct a peer-to-peer review with one of the MCHIP's medical directors. In many situations, this may cause the MCHIP to approve the requested treatment or service, which obviates the need for the consumer to appeal. 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 the MCHIP must decide 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, the applicable timeframes, how the appeal is processed, and the importance of providing updated clinical information to the MCHIP.

Although the Office has no means or authority to file an appeal on behalf of a consumer, Staff will review proposed appeal letters and provide comments and input. Consumers benefit from this service since few consumers have filed written appeals with their MCHIPs and frequently, consumers do not know what information to include in an appeal letter. When the Staff helps a consumer file an appeal, they will provide a copy of the individual's appeal letter to the MCHIP along with the Staff's written comments and summary of the issues involved in the appeal. As the appeal is processed by the MCHIP, the Staff serves as a liaison between the consumer and the MCHIP and helps clarify key issues involved in the appeal.

The Staff cultivates and maintains a productive working relationship with the MCHIPs. This enhances effective communications between the Staff and the MCHIPs, which facilitates assistance provided to consumers in the appeal process and can be instrumental in resolving issues involved in an appeal. The Staff remains actively engaged with the consumer and the MCHIP throughout the entire appeal process as the Staff helps the consumer navigate the appeal process. The Staff works to help ensure that an MCHIP administers its appeal process fairly and consistently with applicable statutory requirements. The Staff does not hesitate to intervene, if necessary. The Staff believes in the integrity of the appeal process and acts to provide the individual with an appeal process that is administered fairly.

Staff reviews decisions that MCHIPs render on appeals. 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 Staff maintains that a denial should reflect a logical reasoning process which produces a decision based on all the relevant information provided by the consumer and the treating healthcare provider. The Office will analyze objectively an unsuccessful appeal and help the individual understand why the MCHIP did not overturn the denial. The Staff will review the clinical criteria an MCHIP uses in making determinations on appeal and may ask a company for clarification on how the criteria was applied. An unsuccessful appeal may require further regulatory review. If 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. Also, the Office can 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 internal appeal involving questions of medical necessity, appropriateness, healthcare setting, level of care, or effectiveness, or determines the services are experimental/investigational, the consumer may be eligible to request an independent external review. In these cases, the Staff can explain how the external review program works and help a consumer file a request for an external review. Final denials based on administrative or contractual reasons are not eligible for the external review process administered by the Bureau, but the Staff may refer the matter to the Bureau's Consumer Services Section to review as a potential consumer complaint. In some situations, however, the Bureau is unable to provide any further regulatory assistance to a consumer who is unsuccessful in the internal appeal process.

As consistently 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 Staff attempts to reduce consumers' anxieties and frustrations by offering personalized assistance and providing guidance to a consumer

throughout the entire appeal process. During this reporting period, as in previous reporting periods, the Office received very positive comments from consumers the Staff assisted.

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 healthcare provider, a friend or relative, or from an organization the Office has encountered while conducting outreach activities. In accordance with the legislation that established the Office, the Staff tracks workload data to include the disposition of each individual inquiry. During this reporting period, the Staff responded to 567 inquiries, which is less than the 596 inquiries the Office received during the previous reporting period. In the previous reporting period the Office assisted 116 consumers in filing an appeal, and in this reporting period the Staff helped 132 consumers file an appeal.

Discussion

Similar to previous reporting periods, most of the inquiries and appeals Staff encountered during this reporting period involved the same types of issues and problems related to health insurance and managed care addressed in prior years. In many instances, consumers experienced problems because they were not familiar with the features of their MCHIP 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. The Office noticed an increase in the number of consumers who stated they had not received their EOC or COC from either their employer or MCHIP. Frequently, consumers had difficulties understanding the reason a service was denied, and the successive steps in the appeal process. As in prior years, the Staff continues to stress to consumers the importance of reviewing and understanding coverage documents and correspondence from their MCHIPs and the importance of asking for assistance when necessary.

As reported in previous annual reports, the Staff helped consumers whose healthcare benefits are provided by plans outside of the Bureau's regulatory jurisdiction, such as self-insured health plans, or fully insured plans issued in another state. Some consumers are covered through the Federal Employees Health Benefits Program or other types of government plans, such as Medicare or Medicaid. The Staff advises these consumers on how they could resolve a problem and refers them to other resources for assistance. The largest number of referrals generally is made to employers who provide self-insured coverage for their employees. The Staff provides informal advice and suggestions to consumers whose coverage is not regulated by the Bureau, and consumer feedback indicates the information is extremely helpful. During this reporting period, with very few exceptions, consumers were not aware their coverage was self-insured and not subject to Virginia's regulatory authority.

Healthcare providers acting on behalf of their patients frequently contacted the Office for assistance, as noted in prior annual reports. Staff helped providers understand the appeal process, including how to initiate the first step, which is a reconsideration or a peer-to-peer review with a medical director at their patient's MCHIP. If that interchange is unsuccessful, the provider may file an appeal, or the patient can file an appeal with the MCHIP with assistance from the Staff. There were numerous instances when the information and the advice the Staff

provided were instrumental in helping the provider resolve the problem by contacting the patient's MCHIP. Consequently, the patient was able to receive treatment without having to engage the formal appeal process with their MCHIP. The Staff always verified that 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 or independently assist a provider in appealing an adverse decision. If the provider is unable to influence the MCHIP's adverse decision, the provider could refer his or her patient to the Office for assistance in filing a formal appeal.

As discussed in previous reports and occurring again during this reporting period, there were many instances in which the Staff helped a consumer obtain a favorable outcome in the appeal process. These results reflected a wide variety of denied services and benefits with direct cost savings or cost avoidance to consumers. The following are examples illustrating some favorable outcomes to consumers and are demonstrative of the range of amounts involved:

- A consumer's request for the prescription drug "Ocrevus" was approved for one year, with a projected cost to the consumer of $65,000 if the appeal had been denied.
- A consumer with eczema (atopic dermatitis) received approval for the prescription drug "Dupixent," which would have cost the consumer $36,000 annually had the appeal been denied.
- A consumer won an appeal for the injectable prescription drug "Sandostatin LAR," which would have cost the consumer $23,082 annually had the appeal been denied.
- A consumer who underwent ankle surgery was successful in the appeal process and avoided paying the billed charges of $118,576. The MCHIP paid the negotiated charges of $73,236.
- A consumer diagnosed with lung cancer won an appeal involving proton beam radiation therapy and avoided paying the billed charges of $132,000. The MCHIP paid the negotiated charges of approximately $70,000.
- A consumer transported by a non-participating air ambulance company was successful in the appeal process, and the MCHIP covered the entire $39,695 bill.
- Initially, a consumer unsuccessfully appealed a denied flu shot and was responsible for the $238 billed charges. Even though the appeal had been completed, the Staff asked the MCHIP to review the matter, and the denial was overturned.
- The Staff provided information and assistance to a consumer whose coverage was self-insured. The consumer received a bill for $29,000 from an air ambulance company. After filing an appeal, he settled the amount he owed to $7,500.
- An individual with suspected cardiac disease underwent a stress echocardiography that was denied. When the person tried to appeal, the MCHIP diverted the appeal to a quality assurance review program. Once the Office became involved, Staff insisted the MCHIP address the appeal, and the denial was overturned. As a result, the $2,240 charges were paid. The Staff advised the appropriate section in the Bureau of the systemic problem found while helping this consumer.
- The Staff helped a consumer win an appeal for a denied MRI, which the person's surgeon required prior to performing surgery. The surgery was successful in part due to the approved imaging test.
- A physician from a major medical center asked the Office for help after a patient with HIV was unable to obtain the prescription drug "Genvoya." The Staff explained how to

arrange a peer-to-peer review with a Medical Director and as a result, the drug was approved so the patient avoided having to file an appeal.

- An individual suffered severe dental injuries as the result of an accident, and successfully appealed a denied claim in the amount of $10,000.

As in previous reporting periods, the Staff also helped consumers appeal denials issued by dental MCHIPs. Denied claims and services involved common dental procedures, such as crowns and related services; bridges; scaling and root planing; bone grafts in conjunction with dental services; and replacement of missing teeth. While most requests for assistance with appeals involving medical treatment originated from consumers, this is not the case with dental appeals. Usually, the treating dentist contacts the Office for assistance with an appeal, following a previous unsuccessful appeal of the case. Unlike other dental appeals the Staff helped consumers prepare during this reporting period, very few consumers were successful with appeals that were a continuation of an earlier provider appeal. One reason may be that the appeal process for these dental appeals had been completed prior to the Office being contacted for assistance. In this situation, the Staff asked the dental MCHIP to review the decision, especially in cases where it appeared there was clinical information that was not reviewed during the appeal process. While the dental MCHIPs normally complied with the request, very few denials were reversed in favor of a consumer. Also, the Staff encountered several appeals with dental MCHIPs in which the treating dentist determined there was sufficient bone structure to support a procedure to salvage a tooth in lieu of extracting the tooth and inserting an implant, but the consumer's MCHIP disagreed. Since the vast majority of consumers who asked for help appealing denied dental claims and services were covered by a Stand Alone Dental Plan ("SADP"), the denial, which involved the use of clinical criteria, was ineligible for the independent external review process administered by the Bureau. The independent external review program does not apply to SADPs.

As reported in previous annual reports, consumers maximized their chance to prevail in the appeal process when there were comprehensive medical records that fully documented a consumer's medical history, medical condition, and treatment responses. A very strong appeal letter also was instrumental in increasing the chance a consumer would win an appeal, especially documentation that addressed the clinical criteria an MCHIP used in making a utilization review decision. The Office provided personal guidance and advice to consumers on important information to include in appeal letters, to include enclosures such as medical records and physician letters of medical necessity explaining why the requested service represented the current standard of care. The Staff also stressed the importance of providing updated and current clinical information supporting an appeal, especially in cases involving denials for prescription drugs where step therapy was involved, and appeals involving serial imaging studies for cancer patients. The Staff worked to ensure consumers understood and applied the applicable clinical guidelines an MCHIP uses in issuing a denial and helped consumers document how their particular condition met the applicable criteria. Upon request, the Staff reviewed draft appeal letters and recommended changes to make the letters more effective. This effort strengthened the information presented in the external review process as well, if the appeal progressed to that level.

Another useful tool in appealing a denial is presenting research in peer-reviewed medical journal articles and other peer-reviewed scientific articles that support an appeal. This strategy was

especially useful in appeals that involved denials based on an MCHIP's determination that a requested service was experimental/investigational in nature. Usually, a successful appeal presented multiple compelling reasons why an MCHIP's denial should be reversed, rather than just presenting a single reason.

In the course of assisting individuals file appeals, the Staff works to ensure that consumers' appeal rights are protected and fairly administered by his or her MCHIP. As noted in one case, an MCHIP initially did not consider a consumer's appeal but reclassified it as a quality assurance matter until the Staff intervened. In some instances, consumers had submitted an appeal to their MCHIP but had not received a response so the Office provided the MCHIP with a copy of the appeal and asked the company to process the appeal as soon as possible. Occasionally, consumers miss the deadline to file an appeal, but when the Office requests, MCHIPs usually will agree to review the matter. Some of the cases resulted in an MCHIP overturning the denial. The Office worked to ensure that an MCHIP used an appropriate level of clinical reviewer, including an external physician consultant.

When the Office formally helped consumers file appeals, Staff wrote to the individual's MCHIP and summarized the issues and circumstances involved in the appeal. The Staff also reviewed correspondence MCHIPs generated in responding to appeals and reviewed consumers' plan documents, including the EOC and COC. In one situation, the Staff found an MCHIP's representative incorrectly sent a letter to a consumer which included incorrect information about subrogation, which is not allowed under Virginia's insurance statutes. This finding was forwarded to another section in the Bureau for further review. On several occasions, the Office reviewed correspondence from an MCHIP which indicated the consumer was not financially responsible for denied services, so the Staff explained this to consumers and they were advised not to submit an appeal unless they received a bill from the provider. In some situations, the Staff discovered problems during the course of reviewing plan documents. In one case, the Staff helped determine a policy was incorrectly issued to a consumer in Virginia because the policyholder was located in Arkansas. The matter was referred to the appropriate section in the Bureau for investigation and disposition. In another situation, the Staff reviewed an EOC which contained significantly incorrect information about the circumstances under which a consumer may contact the Bureau for assistance. Once this error was brought to the attention of the MCHIP, the company stated the incorrect information would be removed.

Outreach

As discussed in prior annual reports, the Staff supported outreach programs as an integral part of its consumer educational activities. The Staff attended the annual meeting of the Virginia Dental Association, which is an effective means of interaction with dentists, dental assistants, and administrative staff from dental practices located throughout the Commonwealth. The Staff also provided information to a reporter from the Richmond Times-Dispatch for a story on proton beam radiation therapy and provided background information to a reporter for Kiplinger's, a national personal finance magazine, for an article on the potential costs cancer patients incur when they receive treatment. The Staff provided assistance to case workers for the Legal Information Network for Cancer ("LINC") on issues involving managed care and health insurance that affected LINC clients.

The Office helped provide information to update a consumer tip sheet related to appeals involving prescription drugs and helped redesign the release/authorization statement on the Bureau's on-line consumer portal. The redesigned form on the portal will make it easier for consumers to request assistance from the Office in filing an appeal. The Staff believes it is important to provide outreach and consumer education to individuals and through public forums, such as on-line activities.

Federal Legislation

As required by § 38.2-5904 B 10 of the Code, Staff monitors changes in federal and state laws that pertain to health insurance. As reported 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.

Virginia's Legislation

The Office continued to track legislation pertaining to health insurance and related subjects passed by the General Assembly and signed into law by the Governor. During the 2017 General Assembly, the Office monitored several pieces of legislation, one of which was of special interest to the Office. House Bill 1656 was enacted as § 38.2-3407.14:1, Standard of clinical evidence for decisions on coverage for proton radiation therapy, effective March 3, 2017. This section prohibits health insurers from holding proton radiation therapy to a higher standard of clinical evidence for benefit coverage decisions than standards applied for other types of radiation therapy, and applies to policies and plans that provide coverage for cancer therapy. As mentioned, the Staff has assisted consumers with appeals that involved proton radiation therapy. This statute provides the Staff with a tool for assisting consumers who have cancer that may respond to proton radiation therapy. While it is too early to fully assess the impact of this legislation, the Staff will refer to the requirement when they help consumers with cancer appeal adverse determinations involving proton radiation therapy.

Another bill affecting consumers that the Staff followed was House Bill 2267, which was enacted as § 38.2-3407.5:2, Reimbursements for dispensing hormonal contraceptives, which will be effective for health benefit plans starting on January 1, 2018. This section requires a health benefit plan which covers hormonal contraceptives, to cover up to a 12-month supply of hormonal contraceptives when dispensed at one time by a provider, pharmacy, or other acceptable location. This section prevents a health benefit plan from imposing utilization controls or other forms of medical management that limits the supply of hormonal contraceptives dispensed by a provider or pharmacy to an amount that is less than a 12-month supply.

Conclusion

During this and previous reporting periods, the Office has accomplished its responsibilities in accordance with § 38.2-5904 of the Code. As occurred in prior reporting periods, Staff assisted consumers, providers, and other interested parties by providing general information, guidance, and assistance. Depending on how a consumer's health insurance coverage was structured, individuals may be referred to another source for assistance. When requested, Staff helped consumers appeal adverse benefit determinations and worked to ensure individuals had fair

access to the internal appeal process offered by his or her MCHIP. The Office provided personalized assistance to consumers, helped them understand the appeal process, and acted as a catalyst to clarify any disputed facts regarding an appeal. Staff worked to ensure MCHIPs administered their appeal process in a consistently fair manner, which when 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 Staff also monitored changes in federal and state laws related to health insurance coverage and managed care.