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:
Virginia Joint Commission on Health Care
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

November 26, 2019

COMMONWEALTH OF VIRGINIA

STATE CORPORATION COMMISSION

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

November 26, 2019

The Honorable Rosalyn R. Dance
Chair, Virginia Joint Commission on Health Care

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

The Honorable Glen H. Sturtevant
Acting Chair, 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

Dear Madam and Sirs:

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, 2018 through October 31, 2019.

Respectfully submitted,

Judith Williams Jagdmann
Chairman

Mark C. Christie
Commissioner

Patricia L. West
Commissioner

EXECUTIVE SUMMARY

This annual report on the activities of the State Corporation Commission's Office of the Managed Care Ombudsman ("Staff") covers the reporting period November 1, 2018, to October 31, 2019. During this period, the Staff provided information and formal assistance to more than 584 consumers and other individuals. The Staff responded to both general questions and specific problems with information about benefit coverage provided by managed care health insurance plans ("MCHIPs"). The Staff helped consumers:

- Understand how their benefit plans work
- Emphasized the importance of reading and understanding plan documents
- Offered tools to solve problems
- Helped consumers appeal adverse benefit determinations, and
- When necessary, referred consumers to other sections within the State Corporation Commission Bureau of Insurance or to other regulatory agencies for assistance.

In total, the Staff responded to 445 inquiries and assisted 139 consumers in filing appeals with MCHIPs, resulting in a $278,055 cost savings or cost avoidance to consumers using the internal appeals process. In addition, the Staff participated in outreach events and continued monitoring federal and state health insurance-related legislation. Details of these and other activities are provided in this report.

BACKGROUND AND INTRODUCTION

The State Corporation Commission's ("SCC") Office of the Managed Care Ombudsman ("Office" or "Staff") was established by 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 pursuant to Code § 38.2-5904 B 11, which requires the SCC to report on the Office's activities to the standing committees of the Virginia General Assembly ("General Assembly") having jurisdiction over insurance and health, and to the Joint Commission on Health Care. This is the Office's twenty-first annual report and covers the period November 1, 2018, through October 31, 2019. Recent prior 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 care benefits, including dental and vision benefits, 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 their 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 for their employees; and
- MCHIPs, when the policy is issued outside of Virginia.

While the Office lacks the regulatory authority to help consumers whose health care benefits are provided by one of the above-referenced agencies or plans, the Staff provides general

information and advice to these consumers. The Staff also refers them to the appropriate plan sponsor or government agency for assistance when coverage falls outside the Bureau's regulatory authority.

HOW WE PROVIDE CONSUMER ASSISTANCE

Consumers, providers, legislators, and other interested parties may contact the Office using a variety of methods: a dedicated Ombudsman's e-mail account, the Bureau's online portal, telephone, fax, or mail.

A. Who the Office Helps

Consumers. The Office receives inquiries from consumers who were referred by their health care provider, a friend, a relative, or an organization the Office has encountered while conducting outreach activities. The Staff provides general information and assistance to consumers and other individuals, including health care providers, who have questions or problems involving some aspect of health insurance, managed care, or related areas. These inquiries reflect a wide spectrum of concerns and vary in complexity. Inquiries may involve questions about benefits available under a consumer's policy and ways to resolve difficulties such as insurance-denied authorizations and claims. The Staff helps consumers understand how their health care 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. Where possible, the Staff refers consumers to another agency or resource for help when their health plans are not regulated by the Bureau.

Providers. Health care providers contact the Office for assistance on behalf of their patients when an MCHIP denies a claim or the provider's prior authorization request. The Staff 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 Office has no authority to file an appeal on behalf of a provider, but if the circumstances require the patient to file an appeal, the Staff contacts the patient to offer guidance and assistance in the appeal process.

Legislators. In addition to consumers and providers, federal and state legislators acting on behalf of their constituents contact the Office for assistance. These inquiries usually involve either denied preauthorization requests or unpaid claims relating to chronic medical conditions. The Staff can contact the constituent directly to provide general information and advice or to help the consumer file an appeal. Frequently, inquiries from legislators involve constituents whose coverage is self-insured. If a consumer's employer self-insures the coverage, the Staff provides general assistance and refers the consumer to the employer sponsoring the plan. 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. After the consumer has been assisted, the Staff provides a written response to the legislator summarizing the assistance provided and the outcome of the constituent's appeal.

B. Assistance in the Appeals Process

The Office helps a consumer submit an appeal when their MCHIP issues an adverse determination, such as denying a claim or refusing to preauthorize a service. Appeals may result from pre-service or post-service denials or, in some cases, issues with active treatment. The latter

situation involves a consumer receiving ongoing medical treatment and frequently involves consumers with serious medical conditions.

The Staff plays a significant role in helping consumers understand all the appeal levels that are available and accessing each level of appeal. The Staff helps consumers navigate the entire internal appeal process with their MCHIPs and begin any independent external review processes that are available. The Staff is mindful that this can be a stressful time for consumers who have not filed an appeal before and who may suffer from a serious medical condition that comes with its own set of difficulties, including medical debt.

The Office sees a variety of insurance-related issues for which consumers seek guidance or assistance. Common types of issues include:

(a) Denial of service or a prescription drug that an MCHIP has determined is not medically necessary. To determine medical necessity, MCHIPs consider factors such as appropriateness of care, health care setting, level of care, and expected clinical outcome. 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 these criteria.

(b) Decisions resulting from utilization review determinations. In such a case, the MCHIP has reviewed a consumer's medical records and has decided that a particular treatment or service is not medically necessary for that consumer's condition. Examples include denials for prescription drugs, surgery, imaging tests (CT scans, PET scans, and MRIs), therapeutic radiation, inpatient hospital services, physical or speech therapy services, and behavioral health and substance abuse services.

(c) Decisions resulting from administrative denial due to policy limitations. Such denials are based on a specific exclusion or limitation in a consumer's policy. One example is an ongoing

course of physical therapy requiring utilization review approval for the number of sessions in excess of the allowable number covered by the policy terms. 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.

(d) Disagreements between the consumer and the MCHIP about whether a specific medical condition can be treated satisfactorily by providers within the MCHIP's provider network.

(e) MCHIP disapproval for care outside of a restricted provider network or issues regarding allowable charges an MCHIP pays a nonparticipating provider. Such disapprovals may result from an administrative determination.

(f) Requests for exceptions to the services eligible for coverage as stated in the policy. One example is a request for treatment of an illness related to gastric bypass surgery; though gastric bypass surgery is usually a policy exclusion, treatment for a related illness nevertheless may be determined to be medically necessary.

(g) Adverse determination related to dental benefits provided by an MCHIP. Examples include crowns and adjunct services, periodontal scaling, and root planing.

The Office helps consumers appeal both utilization review and administrative denials, although the latter cases are generally investigated by another section within the Bureau.

In general, once contacted by a consumer, the Staff helps that 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 checks to see whether the consumer's appeal rights can be exercised or have expired.

If appeal is an option, 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. When starting the appeal process, the Staff establishes contact with the affected consumer's MCHIP to help resolve any disputed facts or circumstances involved in the appeal and assist the consumer in submitting updated clinical information, such as copies of appropriate health records or documentation from a treating physician.

When the Office assists a consumer with an appeal involving a question of medical necessity, the Staff encourages the consumer to ask the treating health care provider to conduct a peer-to-peer review with one of the MCHIP's medical directors. In many situations, after this review the MCHIP approves the requested treatment or service, negating the need for a consumer appeal. If a consumer's medical condition warrants a quick 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.

Although the Office has no means or authority to file an appeal on behalf of a consumer, the Staff assists consumers in filing their own appeals. For example, the Staff may review proposed appeal letters and provide comments and input. Such assistance is beneficial to consumers who usually have never filed an appeal before and oftentimes do not know what information to include in an appeal letter. When the Staff helps a consumer file an appeal, the Staff provides a copy of the consumer's appeal letter to the MCHIP along with any clinical documentation, the Staff's written comments, and a 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.

By cultivating and maintaining a productive working relationship with the MCHIPs, the Staff can communicate effectively with the MCHIPs. Good communication often facilitates assistance to consumers in the appeal process and can be instrumental in resolving the issues that form the basis of the appeal. The Staff remains actively engaged with the consumer and the MCHIP throughout the entire appeal process. The Staff helps ensure that MCHIPs administer their appeal processes fairly and consistently within applicable statutory requirements and may intervene if necessary.

C. Assistance After the MCHIP's Internal Appeal Decision

The Staff analyzes unsuccessful appeals objectively and helps consumers understand why their MCHIPs did not overturn any denial of service or coverage. The Staff reviews decisions that MCHIPs internally render on appeals, looking to see that any denial is based on logical reasoning and that the MCHIP has considered all relevant information provided by the consumer and the treating health care provider. If an appeal is denied, the Staff will ask an MCHIP to provide the rationale for the denial if it does not appear to be supported by the pertinent facts.

Specifically, the Staff will review the clinical criteria an MCHIP used in making determinations on appeals and may ask an insurer for clarification on how the criteria were applied. An unsuccessful appeal may require further regulatory review. If so, the 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 also may provide additional assistance to a consumer whose appeal decision was favorable, but who continues to have difficulty obtaining the previously denied services or benefits that were approved on appeal.

When an MCHIP denies an internal appeal involving questions of medical necessity, appropriateness of medical treatment, health care setting, level of medical care, or effectiveness of care, or when an MCHIP denies coverage for medical services that the MCHIP determines are experimental or investigational, the consumer may be eligible to request an independent external review. In these cases, the Staff can explain how the external review process 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.

ACTIVITY DURING THE REPORTING PERIOD

In accordance with the legislation that established the Office, the Staff tracks workload data for reporting purposes, including the disposition of each individual inquiry. The following chart shows the Office's most recent activity compared to the prior reporting period.

Time Period	Inquiries	Appeals Assistance
Nov. 1, 2018 to Oct. 31, 2019	445	139 consumers helped
Nov. 1, 2017 to Oct. 31, 2018	465	107 consumers helped

A. Who the Office Helped

Like previous reporting periods, most of the inquiries and appeals involved similar types of issues and problems related to health insurance and managed care. In many instances,

consumers experienced problems because they were not familiar with the provisions of and potential benefits provided by their MCHIP 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 benefits forms. A number of consumers told the Staff that 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 continued to stress to consumers the importance of reviewing and understanding plan documents and correspondence from their MCHIPs as well as the importance of asking for assistance when necessary.

To the extent allowed by law, the Staff continued helping consumers whose health care benefits were provided by plans outside of the Bureau's regulatory jurisdiction, such as self-insured health care plans or fully insured health care plans issued in other states. Some consumers were covered through the Federal Employees Health Benefits Program or other types of government plans, such as Medicare or Medicaid. As in previous reporting periods, most consumers were not aware that their coverage was self-insured and not subject to Virginia's regulatory authority.

The Staff provided informal advice on how these consumers could resolve their insurance-related problems and referred them to other resources for assistance. The Office provided the largest number of referrals to employers who provide self-insured coverage for their employees. Consumer feedback indicates the information provided by the Staff was extremely helpful.

As in prior reporting periods, health care providers acting on behalf of their patients frequently contacted the Office for assistance. 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, directly or independently, to assist a provider in appealing an adverse decision. However, the Staff informally educated providers on the appeal process, which consists of: (i) a reconsideration or a peer-to-peer review with a medical director at the patient's MCHIP; and (ii) if the review or reconsideration is unsuccessful, an appeal filed with the MCHIP by the provider or the patient. Numerous times during the reporting period the Staff provided information and advice that was instrumental in helping the provider resolve the problem by contacting the patient's MCHIP. Consequently, the patient could receive treatment or services without having to engage the formal appeal process.

B. Results During the Reporting Period

As in prior reporting periods, there were many instances in which the Staff helped a consumer obtain a favorable outcome through the appeal process. These results included $278,055 in direct cost savings or cost avoidance to consumers through the internal appeals process alone. The following examples illustrate some favorable outcomes to consumers, both through and outside of the internal appeals process, and demonstrate the range of amounts involved:

- A consumer requested assistance with authorization for radiation plaque placement to treat eye melanoma. The Staff worked with the carrier and consumer, advising the consumer on the type of appeal documentation to submit. This resulted in coverage of the requested service, a benefit of $80,717 to the consumer.

- A consumer received approval for an obturator prosthetic device to treat an oronasal fistula. The device was previously denied as not pre-authorized and not provided by an in-network provider. The authorization resulted in a payment of $5,800.

- A consumer requested assistance with claims for lab services that were applied to the consumer's out-of-network deductible. The Staff worked with the MCHIP and authorized representative to have two years of lab claims reprocessed as in-network, which released the member from a financial liability of $15,707.

- A consumer sought assistance for proton beam radiation to treat prostate cancer. The services initially were denied as not medically necessary. The Staff advised the consumer that more clinical documentation was needed as part of the appeal. The MCHIP's Senior

Medical Director determined the services were medically necessary and issued a payment to the provider of $7,377, leaving the consumer with no financial responsibility.

- A consumer requested assistance with authorization for CT scans related to stomach cancer. The Staff suggested that the consumer work with the provider to submit an updated appeal letter and medical records, resulting in authorization for the CT scans and cost avoidance of $4,000.

- A consumer needed assistance for a spinal cord stimulator device to relieve spinal pain. The Staff worked with the provider's office and the consumer to clarify and submit the correct treatment classification codes to the MCHIP, which resulted in approval of the device and implantation services. Without insurance coverage, the procedure and device would have cost the consumer $25,632.

- A consumer sought assistance with approval of dental services from their medical MCHIP because the services were related to a dental injury. The Staff worked with the consumer, provider's office, and MCHIP to clarify the type of medical documentation necessary for an appeal. This assistance resulted in approval and a cost avoidance of $3,280.

- A consumer requested assistance with a concurrent care appeal request for a stay in a rehabilitation hospital. The Staff advised the consumer to have their treating physician provide the insurance company with updated information on the consumer's health status. The insurance company subsequently authorized the extended stay, and the consumer avoided the $129,600 cost for the extension.

During the reporting period, 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. Most consumers who asked for help appealing denied dental claims and services were covered by a Stand Alone Dental Plan ("SADP"). Unlike health carriers, the final claim decision of an SADP is not subject to the independent external review process administered by the Bureau. Therefore, even if the SADP's denial involves the use of clinical criteria, these appeals are ineligible for the independent external review process.

C. Helpful Tools in the Appeals Process

As in previous reporting periods, the Staff worked to educate consumers and physicians on understanding and applying the clinical guidelines MCHIPs use in approving or denying services and helped consumers document how their specific conditions met the applicable criteria. Consumers maximized their chances to prevail in the appeal process when they submitted comprehensive and current health records to the MCHIP to fully document their health history, medical condition, and treatment responses. A strong appeal combined with documentation addressing the clinical criteria an MCHIP used in making a utilization review decision was particularly effective.

The Staff provided personal guidance and advice to consumers on important information to include in and with appeal letters, such as health records and physician letters of medical necessity explaining why the requested service represented the current standard of care. The Staff specifically stressed the importance of providing the most up-to-date clinical information supporting an appeal, especially in cases involving denials for prescription drugs where step therapy was involved.

During the reporting period, another useful tool in persuading an MCHIP to overturn a previous denial involved presenting research in peer-reviewed medical journals and other scientific literature supporting the consumer's request. This strategy was especially useful in appeals that involved denials based on an MCHIP's determination that a requested service was experimental or investigational in nature. Usually, a successful appeal presented multiple compelling reasons why an MCHIP's denial should be reversed.

The Staff also worked to ensure that consumers' appeal rights were protected and fairly administered by their MCHIP. In some instances, consumers had submitted an appeal to their

MCHIP but had not received a response. In these cases, the Office provided the MCHIP with a copy of the appeal and asked the carrier to process the appeal as soon as possible. Consumers occasionally missed the deadline to file an appeal; however, in such cases the Office requested, and MCHIPs usually agreed, to review the matter even if the timely filing requirement had passed. Some of these cases resulted in an MCHIP overturning the denial. The Office also worked to ensure that an MCHIP used an appropriate level of clinical reviewer, including an external physician consultant when appropriate.

When the Office formally helped consumers file appeals during the reporting period, the Staff wrote to the consumer'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 such as the EOC and COC. On several occasions, the Staff reviewed correspondence from an MCHIP indicating the consumer was not financially responsible for denied services. In these cases, the Staff explained to consumers that they were not financially responsible and advised them not to submit an appeal unless they received a bill from the provider. On other occasions, the Staff reviewed EOCs that 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 amended the policy document to provide the correct information.

OUTREACH DURING THE REPORTING PERIOD

During the reporting period, as in prior periods, the Office supported outreach programs as an integral part of its consumer educational activities. The Staff attended the annual meeting of the Virginia Dental Association to interact with dentists, dental assistants, and administrative staff

from dental practices located throughout the Commonwealth. The Office assisted in representing the Bureau at the Virginia State Fair, which provided opportunities for the Staff to interact with consumers to help them understand nuances in their managed care plans, to explain appeal rights to consumers, to urge consumers to read and understand their policies, and to provide contact information for the Office and the Bureau.

The Staff attended the Virginia Society of Otolaryngology's annual meeting during the reporting period. There the Staff presented information on the regulatory role of the Virginia Bureau of Insurance, how the Office provides appeal assistance to consumers, and information about how the Bureau can assist providers with contract disputes.

Additionally, the Staff reviewed previously prepared managed care tip sheets to confirm this material contained the most current information related to managed care plans and consumers' appeal rights. This educational material offers basic information and guidelines regarding appeals and how to navigate a managed care plan.

LEGISLATION

A. Federal Legislation

As required by § 38.2-5904 B 10 of the Code, the Staff monitors changes in federal and state laws that pertain to health insurance. During the reporting period, the Office continued to monitor developments related to the Federal Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 *et seq*. (2010) ("ACA"), including reviewing changes to associated federal regulations. Specifically, the Office continued to monitor changing requirements for Short Term Limited Duration ("STLD") insurance policies issued by health carriers. Broadly speaking, STLD plans do not have to comply with ACA coverage requirements, may offer coverage for less than a year,

and cost less than ACA-compliant health insurance plans. STLD coverage issued in Virginia is still subject to Virginia's external review and internal appeal process requirements, and the appeal processes must be approved by the Bureau when the STLD plan is used in conjunction with an MCHIP.

B. Virginia Legislation

During the 2019 General Assembly session, the Office monitored and tracked legislation pertaining to health insurance and related subjects passed by the General Assembly and signed into law by the Governor. Of note, House Bill 1916 and Senate Bill 1161, signed by the Governor on April 3, 2019, amended §§ 38.2-3559 through 38.2-3562 of the Code of Virginia, involving external review of adverse decisions related to the treatment of cancer. These bills state that a covered person shall not be required to have exhausted a health carrier's internal appeal process before seeking an external review of an adverse determination regarding coverage of treatment for cancer. Rather, a covered person may request an expedited external review of an adverse determination related to cancer treatment. The measure also requires health carriers' notices of the right to an external review to inform covered persons of this provision. The Staff worked with Virginia MCHIPs to ensure that appropriate changes were made to complaint and appeal processes to reflect the requirements of the new legislation.

CONCLUSION

During this reporting period, the Office has accomplished its responsibilities in accordance with § 38.2-5904 of the Code. As in prior years, the Staff assisted consumers, providers, legislators, and other interested parties by providing general information, guidance, and assistance concerning health insurance. Depending on how a consumer's health insurance coverage was structured, consumers may have been referred to another section of the Bureau or another source for assistance. When requested, the Staff helped consumers appeal adverse benefit determinations and worked to provide consumers with fair access to the internal appeal process offered by the consumer's 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. The Staff worked to ensure MCHIPs administered their appeal processes in a consistently fair manner, which helped appellants in the appeal process. The Office also monitored changes in federal and state laws related to health insurance coverage and managed care.