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 Labor and Commerce
House Committee on Health, Welfare and Institutions

December 1, 2021

SCC Commonwealth of Virginia
STATE CORPORATION COMMISSION

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December 1, 2021

The Honorable Patrick A. Hope
Chair, Virginia Joint Commission on Health Care

The Honorable L. Louise Lucas
Chair, Senate Committee on Education and Health

The Honorable Richard L. Saslaw
Chair, Senate Committee on Commerce and Labor

The Honorable Jeion A. Ward
Chair, House Committee on Labor and Commerce

The Honorable Mark D. Sickles
Chair, House Committee on Health, Welfare and Institutions

Dear Members of the General Assembly:

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, 2020 through October 31, 2021.

Respectfully submitted,

Judith Williams Jagdmann
Chair

Jehmal T. Hudson
Commissioner

Angela L. Navarro
Commissioner

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Executive Summary

This annual report on the activities of the State Corporation Commission ("SCC")'s Office of the Managed Care Ombudsman ("Office") covers the reporting period November 1, 2020 to October 31, 2021. During this period, the Office provided information and formal assistance to 633 consumers and other individuals covered by managed care health insurance plans ("MCHIPs"). The Office helped consumers with MCHIPs in the following ways:

- Understand how their benefit plans work;
- Realize the importance of reading and understanding plan documents;
- Use tools to solve problems; and
- Appeal adverse determinations.

When necessary, the Office referred consumers to other sections within the SCC's Bureau of Insurance ("Bureau") or to other regulatory agencies for assistance.

In total, the Office responded to 467 inquiries and assisted 166 consumers in filing appeals with MCHIPs, resulting in a $519,725.00 cost savings or cost avoidance to consumers using the internal appeals process. In addition, the Office continued monitoring federal and state health insurance-related legislation. Details of these and other activities are provided in this report.

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Background and Introduction

The Office was established within the Bureau on July 1, 1999, in accordance with § 38.2-5904 of the Code of Virginia ("Code"). This annual report is submitted pursuant to § 38.2-5904 B 11 of the Code, which requires the SCC to report 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.

The legislation that created the Office assigned it numerous responsibilities. The Office's primary responsibilities include:

- Assisting managed care plan consumers, including dental and vision plan consumers, who are covered by fully insured policies that were issued in Virginia;
- Formally assisting consumers in the internal appeal process with their MCHIPs;
- Referring consumers to another section of the Bureau for health insurance related assistance; and
- Referring consumers to another state or federal agency when either the Office or the Bureau does not have regulatory authority to help, such as to the Virginia Department of Health ("VDH") to address quality of care concerns.

How to Contact the Office

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. Please see the contact information below:

Office of the Managed Care Ombudsman
Virginia Bureau of Insurance
P.O. Box 1157 Richmond, VA 23218
ombudsman@scc.virginia.gov
Website: scc.virginia.gov
Phone: 1-877-310-6560, Fax: 804-371-9944

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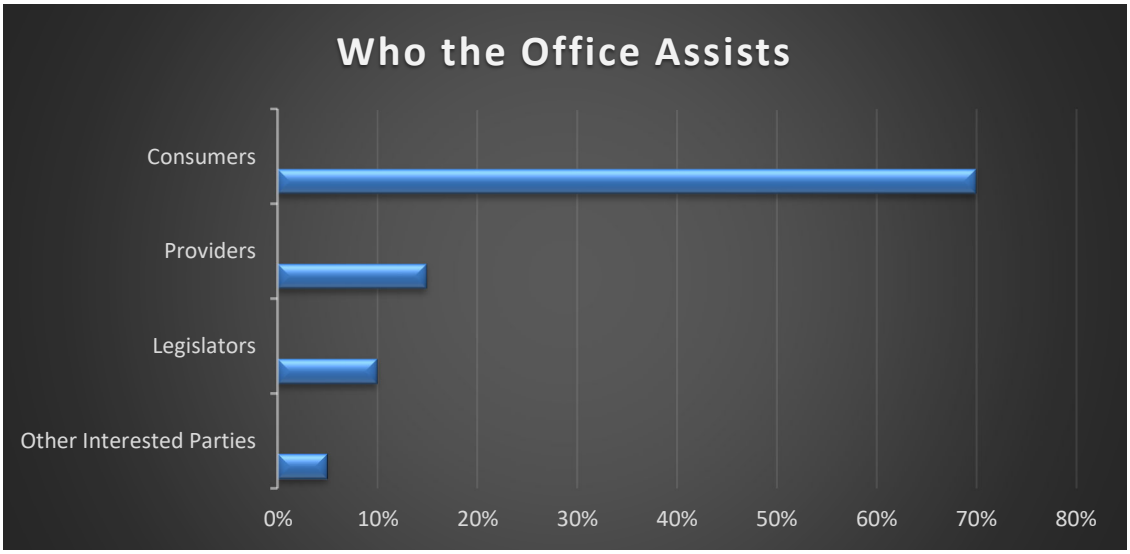
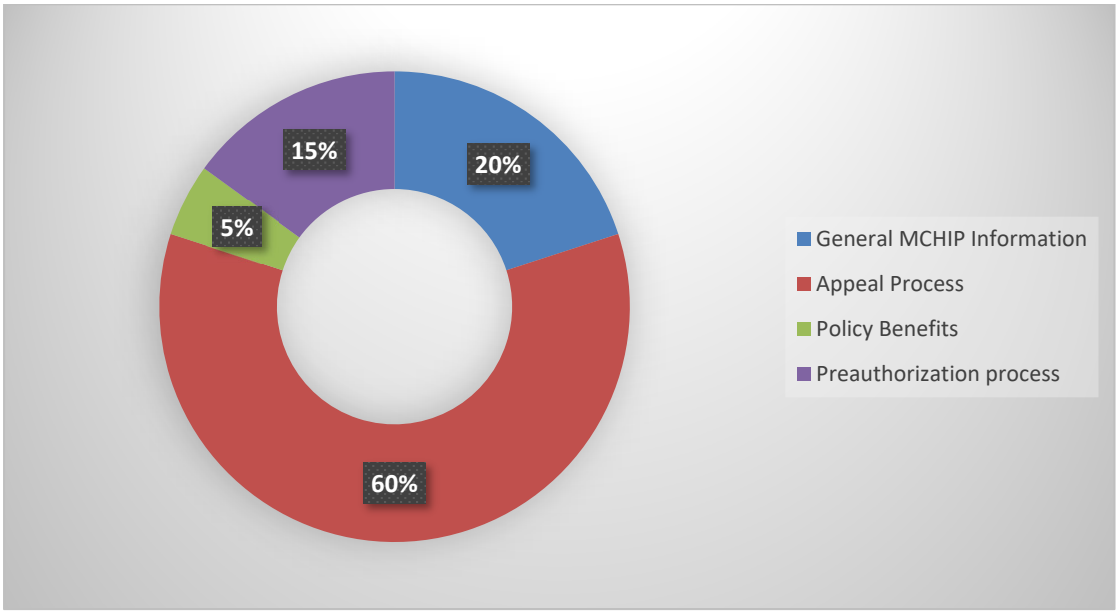
Who the Office Assists

The Office receives most requests from four groups of people:



The Types of Information the Office Provides

The Office provides information on a variety of MCHIP topics. Most of the information falls into one of these four categories:



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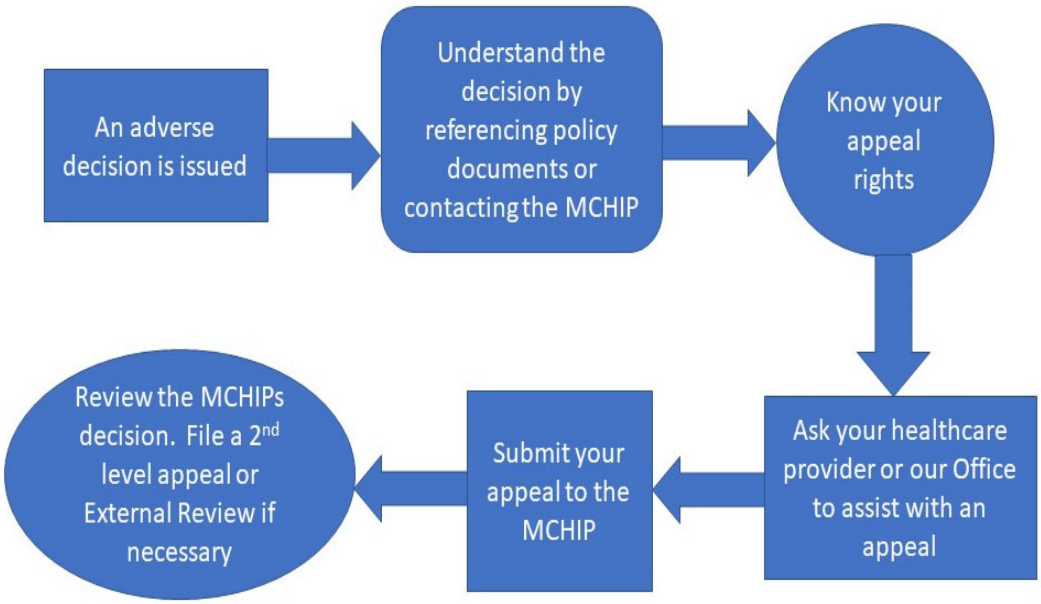
Types of Assistance

A. Assistance in the MCHIP Appeal Process

The Office can help a consumer submit an appeal when the consumer's 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, from issues with active treatment. The Office assists in the appeal process by:

- Helping consumers understand why an adverse determination has been issued;
- Helping consumers understand all levels of the appeal process, including applicable appeal timeframes;
- Helping consumers understand the type of documentation or clinical data to submit with an appeal request; and
- Assisting consumers in filing their appeals with their MCHIPs.

The appeal process can be complex for the average consumer, so the Office tries to simplify and assist accordingly. Here is an example of how the typical appeal process works for a consumer:



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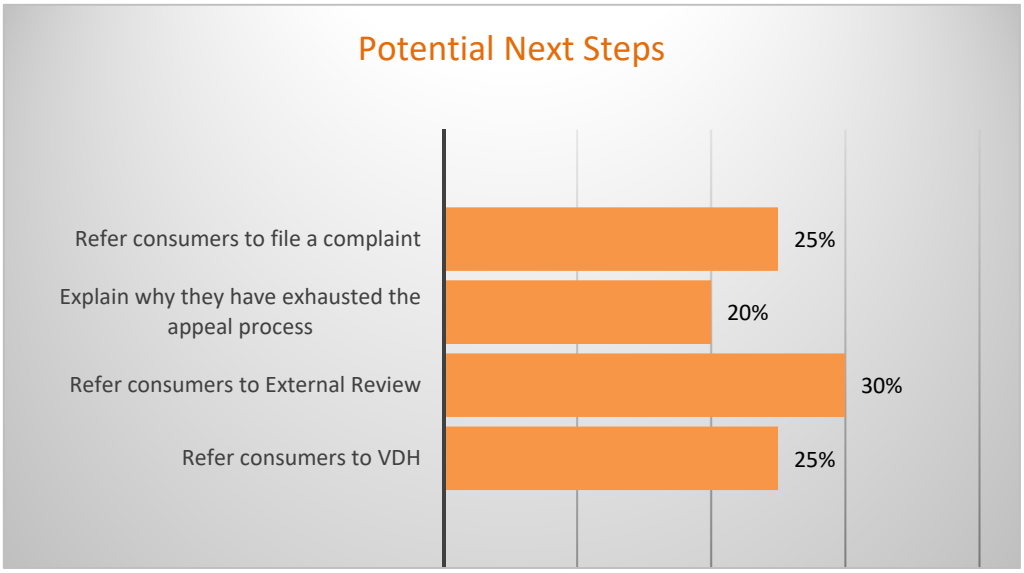
B. Timeframes After an Appeal is Submitted

The consumer has the choice to submit the appeal as a standard appeal or on an expedited basis. There are also instances when the consumer needs to submit an appeal while they also are receiving health care (concurrent). The timeframe for an MCHIP to respond to an appeal depends on how the appeal was submitted.

Type of Appeal	Timeframe to Respond
Pre-Service	30 days
Concurrent	72 hours
Urgent Care	72 hours
Post-Service	60 days

C. Assistance After the MCHIP's Internal Appeal Decision

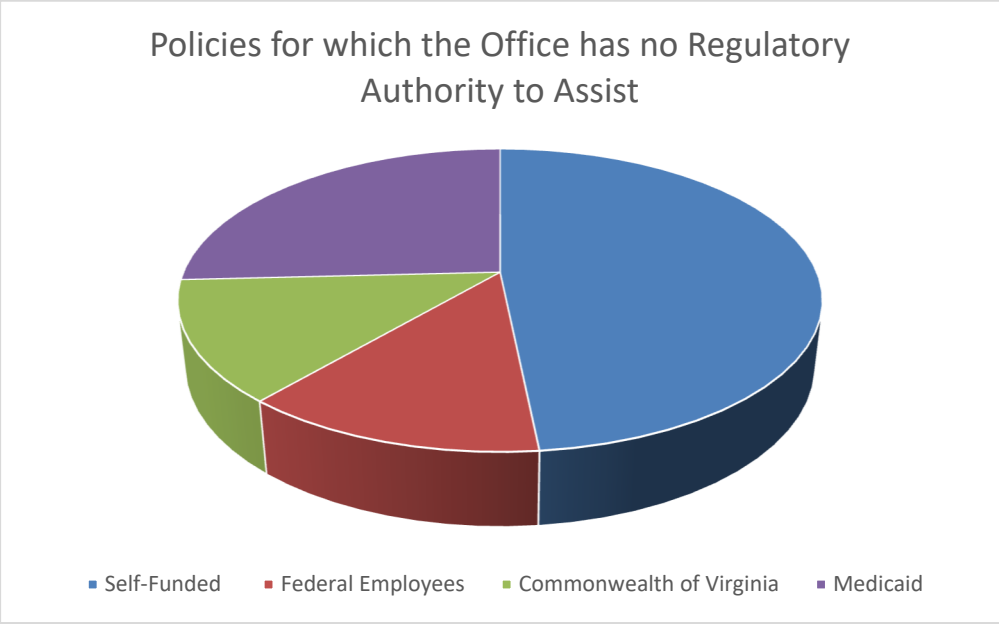
If a consumer is unsuccessful in the appeal process, there are several steps the Office can take to assist.



In some instances, the Office can no longer offer formal assistance after the appeal process is completed.

D. Assisting Consumers with Plans Beyond the Bureau's Jurisdiction

The Office also assists consumers whose health care benefits are provided by managed care plans outside of the Bureau's authority. Here are examples of managed care plans that fall outside the regulatory scope of the Bureau:



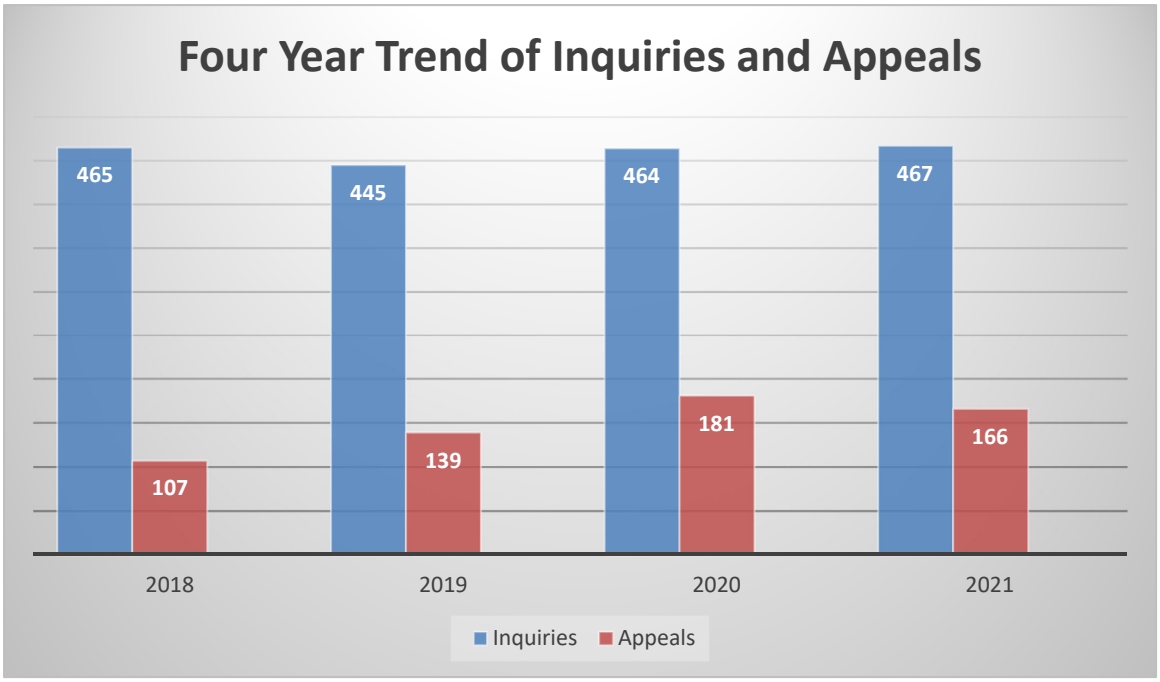
E. Activity During the Reporting Period

The Office tracks workload data for reporting purposes, including the disposition of each MCHIP inquiry and appeal.

Time Period	Inquiries	Appeals Assistance
Nov. 1, 2020 to Oct. 31, 2021	467	166 consumers assisted
Nov. 1, 2019 to Oct. 31, 2020	464	181 consumers assisted

Historical Breakdown of Recent Years

The number of inquiries has increased for the second straight reporting period. The number of consumers the Office formally helped with appeals slightly decreased in 2021, after increasing the two previous years.



Results During the Reporting Period

As in prior reporting periods, there were many instances in which the Office helped a consumer obtain a favorable outcome through the appeal process. This assistance produced $519,725.00 in direct cost savings or cost avoidance to consumers through the internal appeals process alone. The following examples illustrate favorable financial outcomes and their value to consumers:

Benefit	Appeal
$250,000	Able to retroactively purchase more comprehensive coverage to pay outstanding claims
$105,556	Payment for residential treatment facility services
$46,423	Payment for the treatment of soft-tissue sarcoma cancer
$38,108	Payment of a total knee replacement surgery
$25,315	Payment of infusions to treat a pulmonary condition
$10,304	Authorization of a colonoscopy
$8,000	Payment of testing for Autonomic Dysfunction
$1,053	Authorization of the prescription drug l-methylfolate calcium

Outreach During the Reporting Period

In previous years, the Office has supported outreach programs as an integral part of its consumer education activities. During this reporting period, the Office was unable to attend events because of cancellations due to the COVID-19 pandemic. Under normal circumstances, the Office participates in outreach programs such as the events below.

Event Attended	Office Activities
Virginia Dental Association Annual Meeting	Directly interact with dental professionals.
Virginia State Fair	Answer questions on managed care plans. Recommend best practices for understanding policies. Provide the contact information for the Office of the Managed Care Ombudsman.
Virginia Society of Otolaryngology Annual Meeting	Present information about the regulatory role of the Bureau, and specifically how the Office provides appeal assistance. Provide information about how the Bureau could assist providers with provider contract disputes.

Legislation

A. Federal Legislation

As required by § 38.2-5904 B 10 of the Code of Virginia, the Office monitors changes in federal and state laws relating to health insurance. During the reporting period, the Office continued to perform the following activities:

- Monitor developments related to the Federal Patient Protection and Affordable Care Act, 42 U.S.C. § 18001 *et seq*. (2010) ("ACA");
- Monitor developments of the No Surprises Act contained in Division BB of the Consolidated Appropriations Act ("CAA") 2021 (Pub. L. 116-260), signed into law on December 27, 2020;
- Monitor the new requirements of the CAA as they relate to the requirement for health insurers to "perform and document comparative analyses of the design and application of NQTLs [Non-Quantified Treatment Limitations]"; and
- Monitor developments of the American Rescue Plan Act (Pub. L. 117-2) signed into law on March 11, 2021, that provides extended and new financial assistance for health insurance coverage.

B. Virginia Legislation

During the 2021 General Assembly regular session and Special Sessions, 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.

Legislation the Office tracked included Senate Bill 1269, which amended § 38.2-3407.15:2 of the Code, requires that if a provider contract between a carrier and a participating health care provider contains prescriptive authority, and the carrier has previously approved prior authorization for a drug, then, subject to certain conditions, no additional prior authorization may be required for any drug prescribed for the treatment of a mental disorder listed in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. This legislation also requires a carrier to honor a prior authorization issued by the carrier for a drug regardless of whether the drug is removed from the carrier's prescription drug formulary after the

initial prescription for that drug is issued, provided that the drug and prescription are consistent with the applicable provisions of subdivision 13 of the statute.

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Conclusion

During this reporting period, the Office has continued fulfilling its responsibilities in accordance with § 38.2-5904 of the Code. As in prior years, the Office assisted consumers, providers, legislators, and other interested parties by providing general information, guidance, and assistance concerning health insurance coverage in the Commonwealth. Depending on how a consumer's health insurance coverage was structured, consumers may have been referred to another section of the Bureau or another resource for assistance. When requested, the Office helped consumers appeal adverse determinations and worked to provide consumers with fair access to the internal appeal process offered by the consumers' MCHIPs. 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 Office 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.

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