REPORT ON THE ACTIVITIES OF THE OFFICE OF THE MANAGED CARE OMBUDSMAN

Submitted to the Chairs of the Virginia Joint Commission on Health Care, Senate Committees on Education and Health; Commerce and Labor; and the House Committees on Commerce and Energy; and Health, Welfare and Institutions; pursuant to § 38.2-5904 of the Code of Virginia

December 1, 2022

COMMONWEALTH OF VIRGINIA

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December 1, 2022

Transmitted via Email

The Honorable George L. Barker
Chair, Virginia Joint Commission on Health Care

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

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

The Honorable Kathy J. Byron
Chair, Commerce and Energy Committee
Virginia House of Delegates

The Honorable Robert D. Orrock, Sr.
Chair, Health, Welfare and Institutions Committee
Virginia House of Delegates

Dear Chairs Barker, Saslaw, Lucas, Byron and Orrock:

On behalf of the State Corporation Commission, the Bureau of Insurance hereby submits this annual report on the activities of the Office of the Managed Care Ombudsman pursuant to § 38.2-5904 B 11 of the Code of Virginia, for the period November 1, 2021, to October 31, 2022,
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Respectfully submitted,

Scott A. White
Commissioner of Insurance

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I. Executive Summary

On behalf of the State Corporation Commission, the Bureau of Insurance (Bureau) submits this annual report on the activities of the Office of the Managed Care Ombudsman (Office) pursuant to § 38.2-5904 B 11 of the Code of Virginia to the standing committees of the Virginia General Assembly having jurisdiction over insurance and health, and to the Joint Commission on Health Care. This report covers the period November 1, 2021, to October 31, 2022.

The Office is responsible for promoting and protecting the interests of covered persons under managed care health insurance plans (MCHIPs[1]) In this reporting period, the Office responded to 416 inquiries and assisted 172 consumers in filing appeals with MCHIPs, resulting in a $105,780 cost savings or cost avoidance to consumers using the internal appeal process.

The Office also helped consumers enrolled in MCHIPs understand how their benefit plans work; realize the importance of reading and understanding plan documents; understand the documentation to use in an appeal; and appeal adverse determinations. When necessary, the Office referred consumers to other sections within the Bureau or to other state and federal regulatory agencies for assistance.

II. Background and Introduction

The Office was established within the Bureau on July 1, 1999, pursuant to § 38.2-5904 of the Code. Statutorily and administratively, it is assigned the following primary responsibilities:

- Assisting MCHIP consumers, including dental and vision plan consumers, covered by fully insured policies issued in Virginia;
- Formally assisting consumers in their MCHIP internal appeal process;
- Referring consumers to the Bureau for health insurance-related

[1] A Managed Care Health Insurance Plan or "MCHIP" is an arrangement for the delivery of health care in which a health carrier agrees to provide, arrange for, pay for, or reimburse any of the costs of health care services for a covered person on a prepaid or insured basis. The most common examples of MCHIPs are Health Maintenance Organizations or Preferred Provider Organizations.

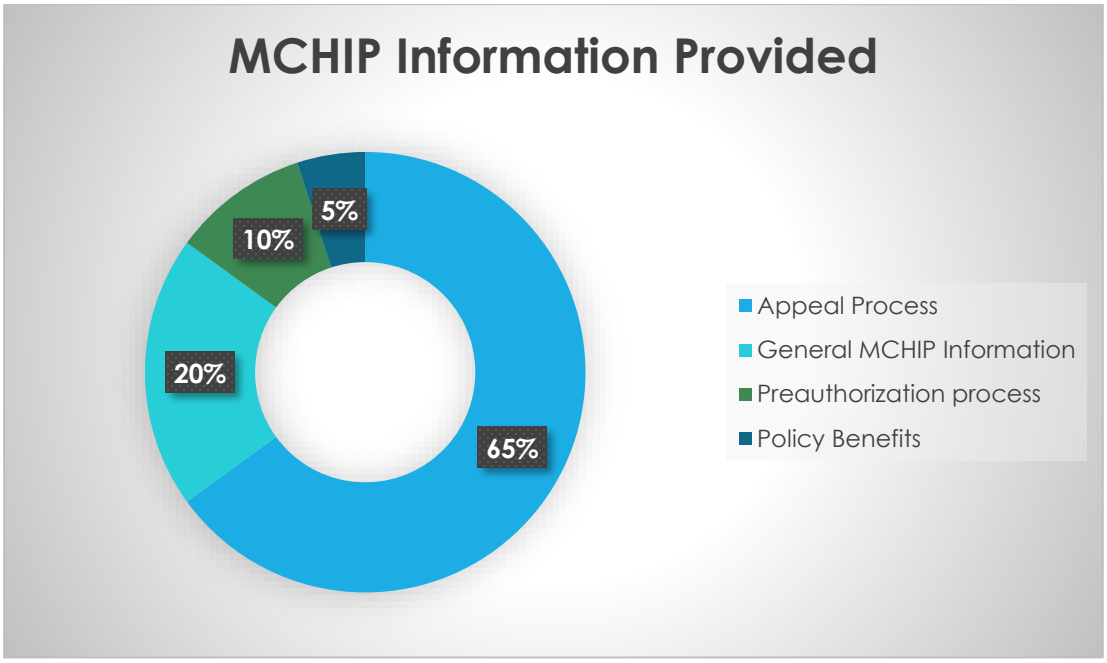
assistance or to other state or federal agencies such as the Virginia Department of Health when the Office or the Bureau lacks the regulatory authority to assist them.

III. Who the Office Assists

Four different groups account for most of the requests received by the Office for information or assistance: consumers, providers, legislators, and other interested parties, with consumers accounting for 70% of these requests.

IV. Type of Information Provided

The Office provides information on a variety of MCHIP topics, including: the appeal process, general information, the preauthorization process, and policy benefits, with nearly two-thirds related to the appeal process.



V. Type of Assistance Provided

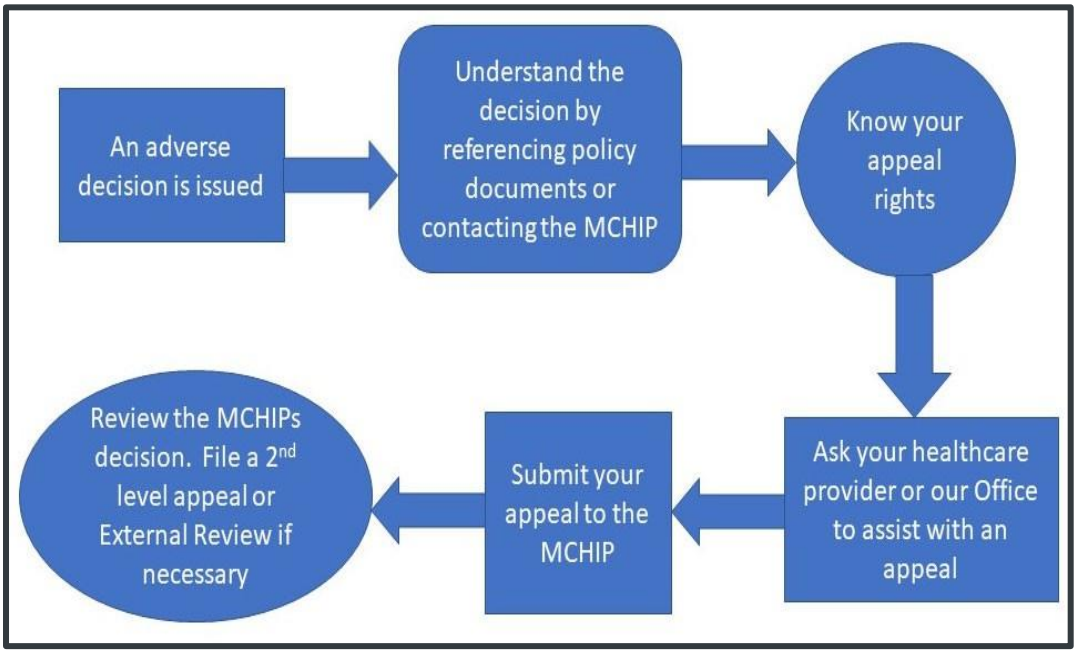
A. Assistance in the MCHIP Appeal Process

The Office can help a consumer submit an internal appeal with the consumer's MCHIP when the MCHIP issues an adverse determination, such as when it denies a claim or refuses to preauthorize a service. An appeal may result from pre-service or post-service denials or, in some cases, from issues with active treatment.

Many consumers find the appeal process to be complex and confusing. Therefore, one of the primary objectives of the Office is to help guide consumers through this process. 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 appeals with their MCHIPs.

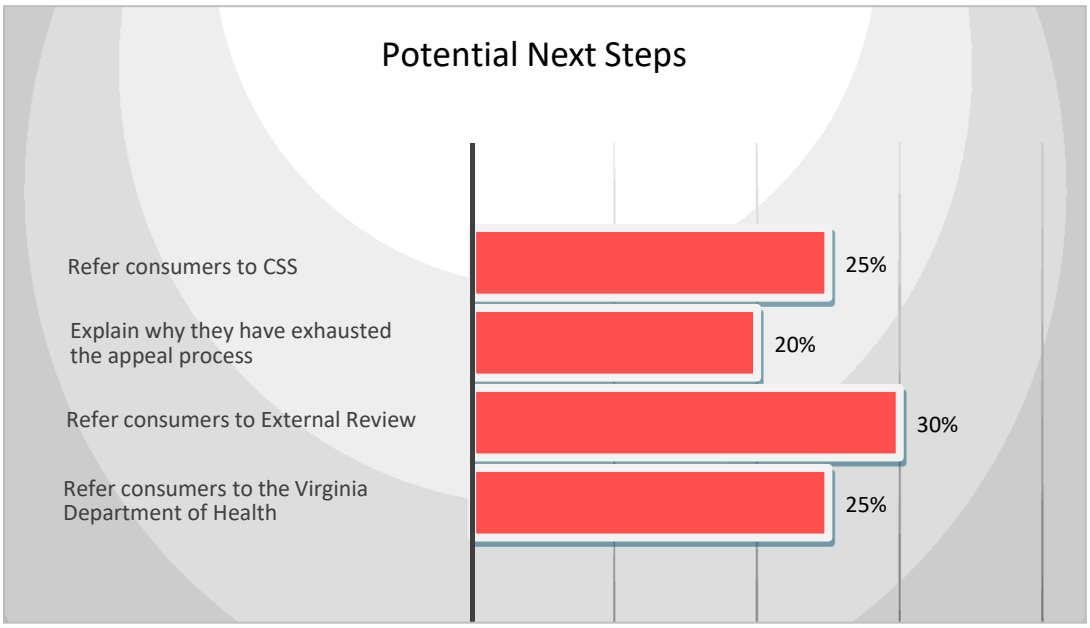
The following diagram shows the steps in the typical appeal process:



B. Assistance After the MCHIP's Internal Appeal Decision

If a consumer is unsuccessful in the internal appeal process, there are several additional steps the Office can take to assist the consumer. For example, when consumers have received a utilization review denial and have exhausted their internal appeal process, they may have external appeal rights and are referred to the Bureau's Office of External Review. In some instances, consumers have exhausted their internal appeals, but are not eligible for an external appeal. The Office will then refer them to the Consumer Services section of the Bureau to file a complaint. When it is determined that a consumer's denial is related to the quality of health care services rendered, then the Office refers consumers to the Virginia Department of Health.

The following table demonstrates the types of assistance the Office provided following the appeal process, during this reporting period.



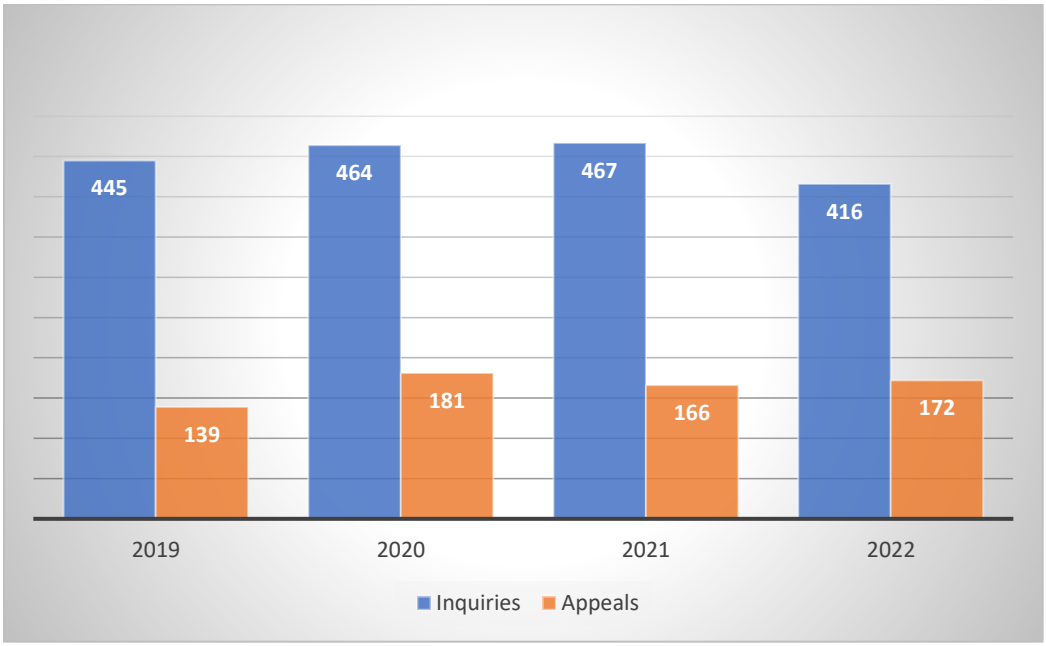
C. Assisting Consumers with Plans Beyond the Bureau's Jurisdiction

The Office's authority to assist certain consumers may be limited when coverage is not subject to Virginia insurance law or is regulated by other state or federal agencies. For example, when a consumer with a Medicaid policy contacts the Office for assistance, they are referred to the Department of Medical Assistance Services – the

state agency with regulatory authority over Medicaid. Even in cases where the Office does not have regulatory authority to assist consumers (e.g., where the source of health coverage is through a self-funded plan or Medicaid), the Office nevertheless attempts to provide consumers with general appeal information and guidance, before making the proper referral.

VI. Historical Trends

The Office tracks inquiries and appeals on a four-year basis. In 2022, the number of inquiries decreased for the first time in four years. The number of appeals the Office assisted with increased slightly, after a small decrease the previous year.



VII. 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 $105,780 in direct cost savings or cost avoidance to consumers through the internal appeal process alone. This amount is a decrease from previous recent years,

as the amount of cost savings increased from 2019 through 2021. The previous amount of cost savings or cost avoidance was $278,055 in 2019; $318,296 in 2020; and $519,725 in 2021.

The following examples illustrate favorable financial outcomes and their value to consumers during the reporting period:

Benefit	Appeal
$40,077	Payment for a stay at a mental health facility
$21,309	Payment for surgery related to a gastrointestinal tumor
$10,200	Authorization for the prescription drug Trulicity
$7,200	Authorization for the prescription drug Xyosted

VIII. Outreach

As in previous years, the Office supported outreach programs as an integral part of its consumer education activities. During this reporting period, the Office attended the Virginia Dental Association's Annual Meeting. The Office provided information on the regulatory role of the Bureau, how the Office provides appeal assistance to consumers, and information about how the Bureau can assist providers with contract disputes.

IX. 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 concerning the No Surprises Act contained in

Division BB of the Consolidated Appropriations Act 2021 (Pub. L. 116-260), signed into law on December 27, 2020;

- Monitor the new requirements of the Consolidated Appropriations Act 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]";
- 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; and
- Monitor developments of the Inflation Reduction Act (Pub. L. 117-169) signed into law on August 16, 2022, that continues the financial assistance for health insurance coverage provided under the American Rescue Plan Act.

B. Virginia Legislation

During the Regular and Special Sessions of the 2022 General Assembly, the Office monitored and tracked legislation pertaining to health insurance and related laws passed by the General Assembly and signed into law by the Governor.

Legislation the Office tracked included Senate Bill 428, which amended § 38.2-3407.15:2 of the Code and added a section numbered 38.2-3407.15:7, requiring the Bureau to establish a work group to evaluate and make recommendations for a single standardized prescription drug prior authorization process to maximize efficiency. The Office served as part of the Bureau staff that participated in the working group.

X. Conclusion

During this reporting period, as in prior periods, the Office continued to fulfill its responsibilities in accordance with § 38.2-5904 of the Code. The Office assisted consumers, providers, legislators, and other interested parties by providing general information, guidance, and assistance concerning MCHIPs in the Commonwealth. When

requested, the Office helped consumers appeal adverse determinations and worked to provide consumers with fair access to the internal appeal process offered by their MCHIPs. This assistance produced $105,780 in direct cost savings or cost avoidance to consumers through the internal appeal process alone. The Office also monitored changes in federal and state laws related to health insurance coverage and managed care.