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 and Commerce and Labor, and the House Committees on Labor and Commerce and Health and Human Services, pursuant to § 38.2-5904 B 11 of the Code of Virginia

State Corporation Commission
Bureau Of Insurance

December 1, 2024

COMMONWEALTH OF VIRGINIA

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Transmitted via Email

The Honorable Rodney T. Willett
Chair, Joint Commission on
Health Care

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

The Honorable R. Creigh Deeds
Chair, Committee on Commerce and Labor
Senate of Virginia

The Honorable Mark D. Sickles
Chair, Committee on Health and Human
Services
Virginia House of Delegates

The Honorable Ghazala F. Hashmi
Chair, Committee on Education and Health
Senate of Virginia

Members of the Joint Commission on Health Care

Members of the Senate Committee on Commerce and Labor

Members of the Senate Committee on Education and Health

Members of the House Committee on Labor and Commerce

Members of the House Committee on Health and Human Services

Dear Senators and Delegates:

On behalf of the State Corporation Commission, the Bureau of Insurance 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, 2023, to October 31, 2024.

Respectfully submitted,

Scott A. White
Commissioner of Insurance

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Executive Summary

In accordance with § 38.2-5904 B 11 of the Code of Virginia (Code) and on behalf of the State Corporation Commission (Commission), the Bureau of Insurance (Bureau) submits this annual report of activities of the Office of the Managed Care Ombudsman (Office) for the period November 1, 2023, through October 31, 2024.

The Office is charged with promoting and protecting the interests of persons covered under Managed Care Health Insurance Plans (MCHIPs[1]). To this end, during the reporting period, the Office:

- Helped consumers secure $377,136 in direct cost savings or cost avoidance by assisting them in navigating their MCHIP's internal appeal process.
- Assisted 208 consumers with formal appeal requests to their MCHIPs.
- Responded to 362 inquiries to the Office, with just over one-third of these referred to other entities.

In addition, the Office is responsible for reporting on new developments in federal and state health insurance laws. At the federal level, the Centers for Medicare and Medicaid Services (CMS) adopted final rules establishing specific consumer disclosures for short-term, limited-duration health insurance and hospital and other fixed indemnity policies, as well as rules clarifying the implementation of the Mental Health Parity and Addiction Equity Act. Virginia aligned coverage guidelines for colorectal cancer screenings with federal rules and will allow a carrier to revoke, change or restrict a prior authorization for prescription drugs only in specific circumstances.

1. Introduction

As required in § 38.2- 5904 of the Code, the Commission established the Office within the Bureau on July 1, 1999, "to promote and protect the interests of covered persons under [MCHIPs] in the Commonwealth." The Commission is required to submit an annual report of Office activities to the standing committees of the Virginia General Assembly having jurisdiction over insurance and health and to the Joint Commission on Health Care. The report must include a summary of significant new developments in federal and state laws relating to health insurance. The Bureau has prepared this report on behalf of the Commission for the period November 1, 2023, through October 31, 2024.

[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.

2. Primary Responsibilities of the Office

The Office's statutory responsibilities can be summarized into five primary areas:

- Appeals: helping consumers understand their MCHIP appeal rights and processes, as well as assisting them in filing a formal appeal;
- Inquiries: providing general inquiry assistance to MCHIP consumers, including dental and vision plan consumers;
- Data: analyzing and publishing MCHIP data, to include complaint data and mandated health insurance benefits;
- Legislation: monitoring legislation and reporting on significant developments in federal and state health insurance laws; and
- Other: performing other Commission-assigned activities pursuant to Chapter 59 of Title 38.2 of the Code.

3. Activities and Results Within Each Area of Responsibility

a. Appeals

The Office assists consumers in submitting internal appeals with their MCHIP following an adverse determination (e.g., denial of a claim or refusal to preauthorize a service). An appeal may result from pre- or post-service denials or issues with active treatment. Many consumers find the appeal process complex and confusing. The Office guides them through this process by:

- Helping consumers understand why their MCHIP has issued an adverse determination;
- 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.

Appeal Results

During the reporting period, the Office assisted 208 consumers with formal appeal requests. This is a 3% decrease over the previous reporting period when the Office assisted 215 consumers with formal appeals.

As in prior reporting periods, the Office helped many consumers with the appeal process, resulting in favorable outcomes for the consumers. This assistance produced $377,136 in direct cost savings or cost avoidance for consumers through the internal appeal process alone. This represents an 8% decrease from the

$409,800 secured in the previous reporting period. These totals fluctuate from one year to the next based on the nature of the appeals.

Table 1 provides examples of favorable financial outcomes and their value to consumers during the reporting period:

Table 1. Examples of Favorable Consumer Outcomes on Appeal

Amount	Basis of Appeal
$95,194	Payment for surgery and inpatient hospital services
$90,000	Payment for Remicade infusions
$27,301	Authorization for chemotherapy treatments
$10,754	Authorization for the prescription drug Invega Sustenna
$10,000	Authorization for TMJ (temporomandibular joint) surgery

b. Inquiries

The Office provides consumers with information on a variety of MCHIP topics, including general policy information, preauthorization and appeal processes, and policy benefits. Nearly two-thirds of the information it provides is related to questions about the MCHIP appeal process. These types of requests are classified as inquiries, and the Office receives most inquiries from four groups: consumers, providers, federal and state legislators, and other interested parties, with consumers typically accounting for 75% of these requests.

When a consumer's health insurance coverage is regulated by other state or federal agencies and not subject to Virginia insurance laws, the authority of the Office to assist these consumers may be limited. Even when 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 provides consumers with general information and guidance about appeals before making the proper referral.

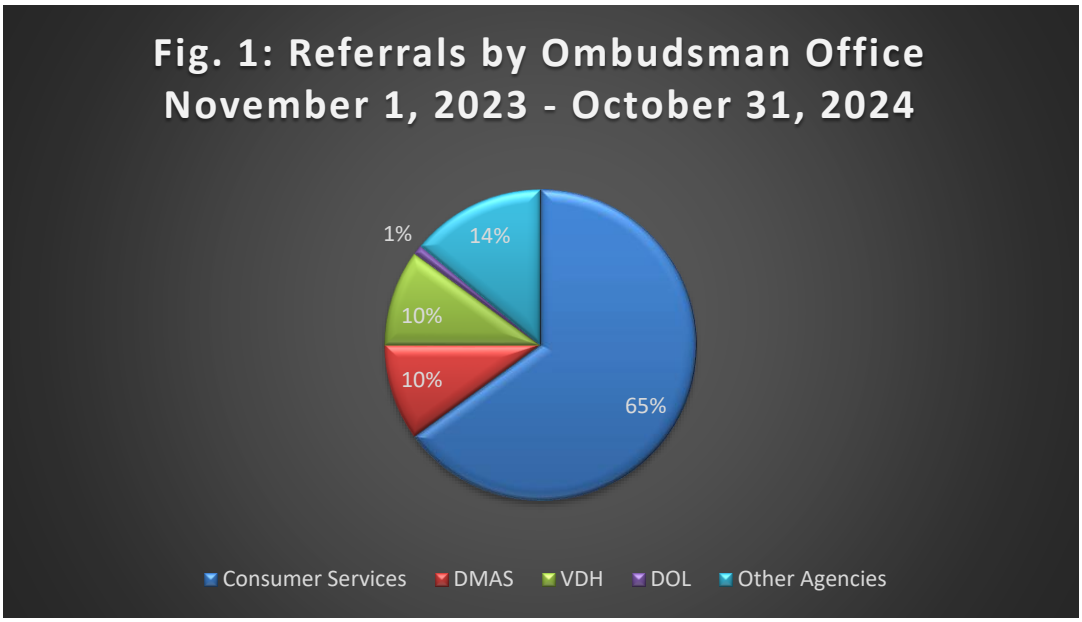
Finally, when the consumer's coverage is subject to Virginia insurance law, there are instances when the Office makes an internal referral within the Bureau. For example, the Bureau classifies requests for assistance related to balance-billing, policy exclusions, and non-participating provider claims as complaints, and these are referred to the Bureau's Consumer Services section.

Inquiry Results

During the reporting period, the Office responded to 362 inquiries. This is a 14% decrease over the previous reporting period when the Office assisted with 423 inquiries.

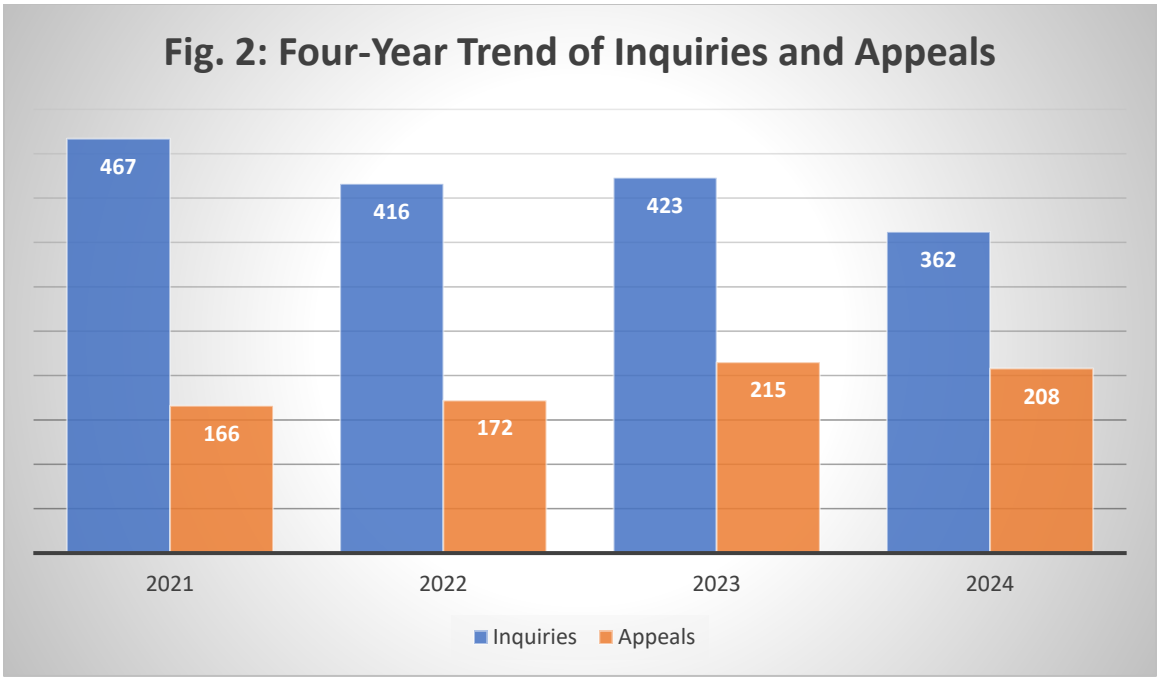
Just over one-third (128 of 362) of the inquiries received by the Office were subsequently referred to outside agencies or the Bureau's Consumer Services

section. Figure 1 shows the distribution of outside referrals among agencies, with nearly two-thirds going to the Consumer Services section.



Historical Trends of Appeals and Inquiries

The Office tracks inquiries and appeals on a four-year basis. In 2024, for the first time in three years, the number of appeals the Office assisted with decreased slightly. The number of inquiries decreased in 2024 following a small increase the previous year. See Figure 2.



c. Data

The Office analyzes and publishes MCHIP data. This includes MCHIP complaint data related to administrative and service issues, billing issues, and denied claims. The Office reviews denied claims data to determine the complaint ratio for each MCHIP. Once the Office has calculated the complaint ratios, this data can be used internally within the Bureau for such purposes as market conduct exams and general inquiries of companies.

The Office also monitors new mandated health insurance benefits and mandated offers of coverage and posts this information on the Commission's website for use by consumers.[2]

Data Results

During this reporting period, the Office reviewed the annual complaint data and calculated the complaint ratio for 82 MCHIPs licensed in Virginia.

d. Legislation

Pursuant to § 38.2-5904 B 10 of the Code, the Office is required to monitor changes in federal and state health insurance laws and summarize any significant new developments.

Federal Legislation

During the reporting period, the Office monitored several significant developments in federal health insurance statutes and rules, summarized as follows:

- On April 3, 2024, the CMS issued final rules establishing specific consumer disclosures for short-term, limited-duration health insurance policies, and enrollment and marketing materials, as well as for hospital indemnity and other fixed indemnity (HI/FI) insurance policies and materials. The disclosures required for these materials define and more clearly distinguish these coverages from comprehensive health insurance coverage that are subject to the requirements and protections under the Public Health Services Act.[3] These rules may limit the coverage term for short-term limited duration insurance to be more restrictive than allowed under Virginia law.

- On September 9, 2024, the CMS released final rules implementing the Mental Health Parity and Addiction Equity Act.[4] In the group market, the rules generally will become effective the first day of the first plan year on or after January 1, 2025; however, portions of the rules will not become

[2] https://scc.virginia.gov/pages/Office-of-the-Managed-Care-Ombudsman
[3] 45 CFR Parts 144, 146, and 148.
[4] 45 CFR Parts 146 and 147.

effective until the first day of the first plan year on or after January 1, 2026. The rules are not effective for individual health insurance coverage until January 1, 2026. The rules:

- Clarify that plans must not impose financial requirements or treatment limitations that present a greater burden on access to mental health/substance use disorder benefits than on medical/surgical benefits.
- Clarify that insurers must not design and cannot use nonquantitative treatment limitations (NQTLs) (i.e., prior authorization requirements, network composition standards and out-of-network reimbursement rate methodologies) that are more restrictive than the predominant NQTLs applied to substantially all medical/surgical benefits in the same classification.
- Require insurers to proactively conduct comparative analyses and take necessary action to address material differences in access to mental health/substance use disorder benefits compared to medical/surgical benefits, resulting from NQTLs imposed.
- Require NQTLs to contain a minimum of six required elements of a comparative analysis.
- Require an insurer to provide benefits for at least one core treatment for each mental health condition or substance use disorder in each classification in which the insurer provides benefits for a core treatment for one or more medical conditions or surgical procedures.

Virginia Legislation

- During the 2024 Regular and Special Sessions of the General Assembly, the Office monitored legislation pertaining to health insurance and related laws passed by the General Assembly and signed into law by the Governor, including: House Bill 238, which amended and reenacted § 38.2-3418.7:1 of the Code, that requires health insurers to provide coverage for colorectal cancer screening, examinations and laboratory tests in accordance with the most recently published A- and B-rated recommendations established by the U.S. Preventive Services Task Force. The law also codifies federal guidance that requires follow-up colonoscopies following certain positive screening tests to be covered without cost share.

- House Bill 1134 and Senate Bill 98 (identical bills), which amended § 38.2-3407.15:2 of the Code, to require a provision in the participating provider contract with a carrier that only in certain, specific circumstances may a carrier revoke, change or restrict a prior authorization for prescription drugs once approved.

e. Other: Outreach

As in previous years, the Commission considered Office-supported outreach programs to be an integral part of its consumer education activities. The Office receives various requests to provide insurance-related consumer education activities through speaking engagements and attendance at consumer events.

Outreach Results

During this reporting period, the Office attended the State Fair of Virginia and the Statewide Annual Meeting of the Virginia Dental Association. The Office provided information on the regulatory role of the Bureau, the appeal assistance it provides to consumers, and information about the many ways the Bureau can assist consumers with complaints.

4. Conclusion

The Office continues to fulfill its responsibilities to promote and protect the interests of MCHIP consumers in accordance with § 38.2-5904 of the Code. Most notably, the Office continued to respond to consumer inquiries, equip consumers with the information and guidance necessary to understand their MCHIP's policies and processes, and help them navigate the MCHIP's internal appeal process. Through its assistance with the internal appeal process, the Office helped consumers secure $377,136 in direct cost savings or cost avoidance.

The Office continued to monitor and report on significant new developments in federal and state health insurance laws such as the implementation of CMS rules related to disclosures for short-term, limited-duration health insurance and hospital and other fixed indemnity policies, and the Mental Health Parity and Addiction Equity Act, along with Virginia revisions to guidelines for colorectal cancer screenings prior authorization for prescription drugs.

The Office will continue to promote and protect the interests of persons covered under MCHIPs.