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

State Corporation Commission
Bureau Of Insurance

December 1, 2025

COMMONWEALTH OF VIRGINIA
STATE CORPORATION COMMISSION
COMMISSIONERS
JEHMAL T. HUDSON • SAMUEL T. TOWELL • KELSEY A. BAGOT

December 1, 2025

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 subsection B 11 of § 38.2-5904 of the Code of Virginia, for the period November 1, 2024, to October 31, 2025.

Respectfully submitted,

Scott A. White
Commissioner of Insurance

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Executive Summary

In accordance with subsection B 11 of § 38.2-5904 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) from November 1, 2024, through October 31, 2025.

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 $386,798 in direct cost savings or cost avoidance by assisting them in navigating their MCHIP's internal appeal process;
- Assisted 207 consumers with formal appeal requests to their MCHIPs; and,
- Responded to 383 inquiries, with 45 percent of these being referred to other entities outside of the Bureau.

As part of its annual report, the Office is also required to include a summary of significant new developments in federal and state health insurance laws. At the federal level:

- Enhanced premium tax credits, created under the American Rescue Plan Act of 2021[2] to help qualified individuals purchase qualified health plans during the COVID public health emergency, are set to expire at year-end absent congressional legislation to extend them.
- The Centers for Medicare and Medicaid Services (CMS) issued its annual "Notice of Benefit and Payment Parameters" rules for the Health Insurance Marketplace. It followed these with the release of the "Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Final Rule." However, just prior to its August 25th effective date, key provisions of the marketplace integrity and affordability final rule were stayed by a federal court.

In the Commonwealth, the Virginia General Assembly enacted various provisions related to prior authorization for health care services, while also adding coverage requirements for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS). It also required insurers to provide coverage for mental health

[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] H.R. 1319, 117th Cong. (2021).

and substance use disorder benefits for children, adolescents, and adults, and apply the definitions of "generally accepted standards of mental health or substance use disorder care" and "medically necessary," as provided in the bill for any determination of medical necessity, prior authorization, or utilization review under such coverage.

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, 2024, through October 31, 2025.

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;
- Laws: 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 consumers through this process by assisting them in filing appeals with their MCHIPs and helping them understand why their MCHIP has issued an adverse determination; all levels of the appeal process, including

applicable appeal timeframes; and the type of documentation or clinical data to submit with an appeal request.

Appeal Results

During the reporting period, the Office assisted 207 consumers with formal appeal requests. This is nearly the same as in the previous reporting period when the Office assisted 208 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 $386,798 in direct cost savings or cost avoidance for consumers through the internal appeal process alone. This represents a 3% increase from the $377,136 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
$105,440	Authorization of applied behavioral analysis therapy
$75,000	Authorization of an air ambulance from Lithuania to Richmond, VA
$44,000	Authorization of the prescription drug Keytruda
$11,038	Payment of carpel tunnel surgery
$4,500	Payment of an abdominal MRI

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 the Office 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 approximately 75% of these requests.

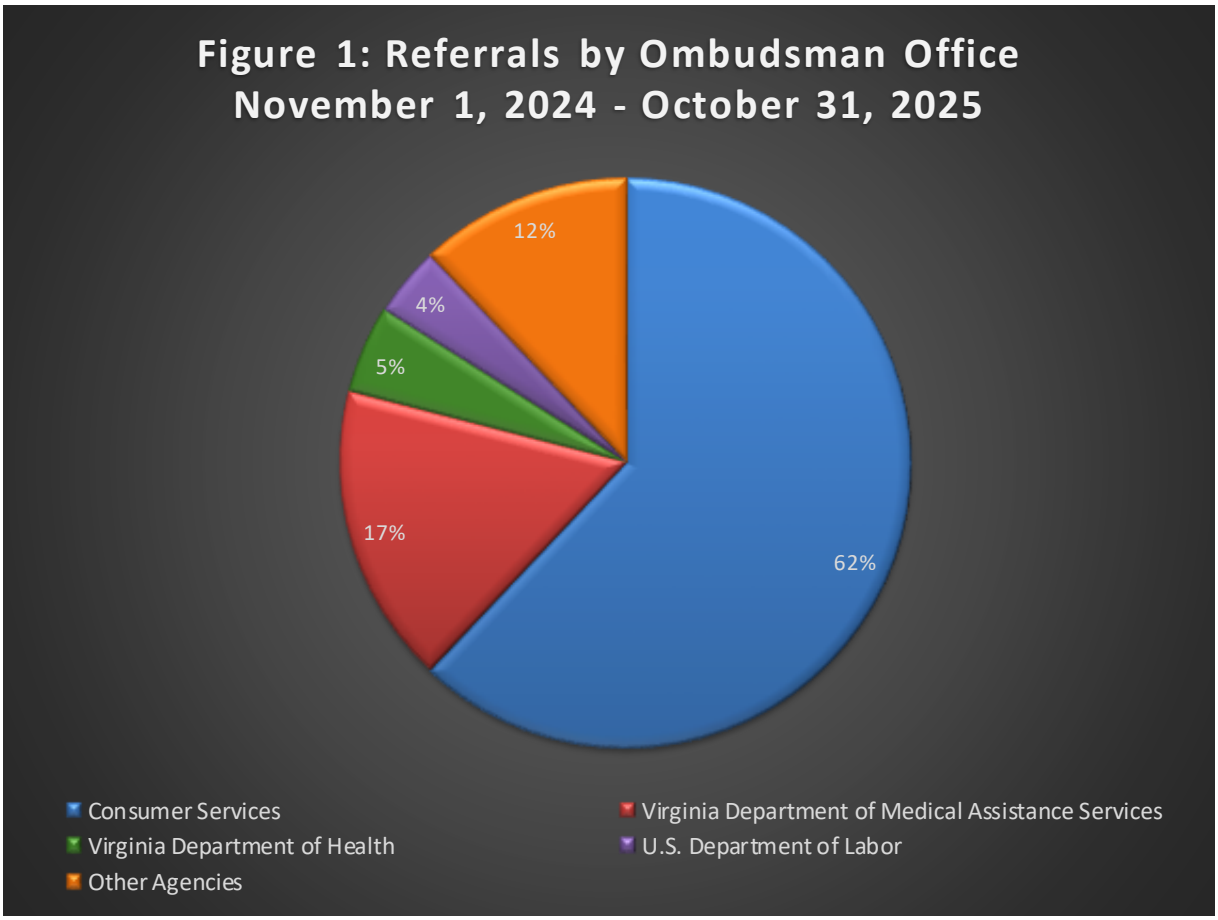
When a consumer's health insurance coverage is regulated by other state or federal agencies and not subject to Virginia insurance laws, the authority of the Office to assist these consumers is limited. Even when the Office does not have regulatory authority to assist consumers (e.g., where the source 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 within the Life & Health division.

Inquiry Results

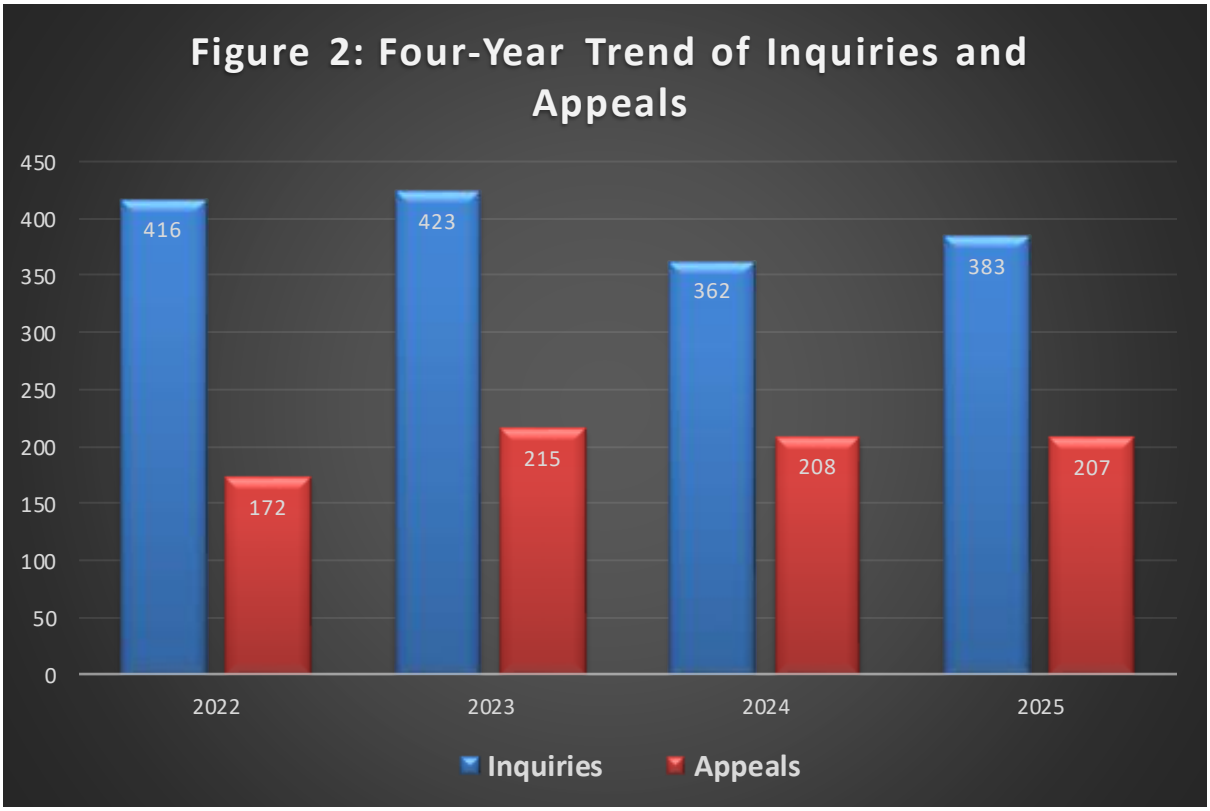
During the reporting period, the Office responded to 383 inquiries. This was a 6% increase over the previous reporting period when the Office assisted with 362 inquiries.

About 45% (175 of 383) 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 62% going to the Bureau's Consumer Services section.



Historical Trends of Appeals and Inquiries

The Office tracks inquiries and appeals on a four-year basis. In 2025, for the second consecutive year, the number of appeals the Office assisted with decreased slightly, from 208 in 2024, to 207 in 2025. The number of inquiries increased slightly in 2025 following a decrease in 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 is used internally within the Bureau for such purposes as market conduct exams and general inquiries of MCHIPs.

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.[3]

[3] https://scc.virginia.gov/pages/Office-of-the-Managed-Care-Ombudsman

Data Results

During this reporting period, the Office reviewed the annual complaint data and calculated the complaint ratio for all 84 MCHIPs licensed in Virginia.

d. Laws

Pursuant to subsection B 10 of § 38.2-5904 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 July 4, 2025, President Trump signed the One Big Beautiful Bill Act, H.R.1, into law.

- The bill allows all marketplace bronze and catastrophic plans to be paired with a health savings account.
- The bill places additional restrictions on premium tax credit eligibility and removes existing ceilings on the amount that marketplace enrollees must repay for incorrect income projection calculations related to premium tax credits received.
- Additionally, a 10-year moratorium on artificial intelligence regulation by state health insurance regulators, which was initially in the bill, was removed, allowing state insurance departments to continue to have oversight over the use of artificial intelligence by insurers.

Enhanced premium tax credits created under the American Rescue Plan Act of 2021[4] to help qualified individuals purchase qualified health plans during the COVID public health emergency, are set to expire at year-end absent congressional legislation to extend them.

Federal Rules

On June 4, 2025, CMS issued the Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Final Rule, 45 C.F.R. Parts 147, 155, and 156, a regulation that was to become effective August 25, 2025. However, a federal court stayed several key provisions of the rule nationwide. One change that did remain in effect revised the methodology for determining the annual maximum out-of-pocket

[4] H.R. 1319, 117th Cong. (2021).

limit. This resulted in an increase above that finalized in the 2026 Notice of Benefit and Payment Parameters, which had previously set a lower limit for plan year 2026.

Virginia Legislation

During the 2025 Regular Session 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 2099 and Senate Bill 1215 (identical bills), amended and reenacted § 38.2-3407.15:2 of the Code by adding § 38.2-3407.15:8, requiring health insurer contracts under which an insurance carrier has the right or obligation to require prior authorization for a health care service, to include provisions governing the prior authorization process. These include time limits for carriers to respond to prior authorization requests; a prohibition on carriers revoking, limiting, making conditional, modifying, or restricting a previously approved prior authorization (except under certain circumstances); and requiring carriers to provide the reasons for denying a prior authorization request. The bill requires carriers to make publicly available on their websites a list of health care services and codes for which prior authorization is required.

- House Bill 1641 amended and reenacted § 32.1-325 and d § 38.2-4319 of the Code by adding § 38.2-3418.22, requiring coverage for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections (PANDAS) and pediatric acute-onset neuropsychiatric syndrome (PANS). The coverage requirements include payment for treatment using antimicrobials, medication, and behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medicines, plasma exchange, and intravenous immunoglobulin therapy. The law prohibits insurers from denying or delaying the coverage of PANDAS or PANS, because the enrollee previously received treatment or because the enrollee was diagnosed with or received treatment for his condition under a different diagnostic name, including autoimmune encephalopathy.

- House Bill 2738 amended and reenacted § 38.2-3412.1 of the Code, requiring insurers to provide coverage for mental health and substance use disorder benefits for children, adolescents, and adults. The law requires such coverage to apply the definitions of “generally accepted standards of mental health or substance use disorder care” and “medically necessary,” as provided in the bill for any determination of medical necessity, prior authorization, or utilization review under such coverage.

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. It responded to consumer inquiries, equipped consumers with the information and guidance necessary to understand their MCHIP policies and processes and helped them navigate the MCHIP's internal appeal process. It also monitored and reported on significant new developments in federal and state health insurance laws.

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