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 30, 2018

MARK C. CHRISTIE
COMMISSIONER

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COMMISSIONER

COMMONWEALTH OF VIRGINIA

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STATE CORPORATION COMMISSION

November 30, 2018

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 Frank W. Wagner
Chairman, 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, 2017 through October 31, 2018.

Respectfully submitted,

Mark C. Christie
Chairman

Judith Williams Jagdmann
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, 2017, to October 31, 2018. During this period, the Staff provided information and formal assistance to more than 572 consumers and other individuals. The Staff responded to general questions and specific problems and issues with managed care and health insurance coverage provided by managed care health insurance plans ("MCHIPs"). The Staff helped consumers understand how their managed care plan works, the importance of reading and understanding plan documents, and methods to solve problems. The Staff formally helped consumers appeal adverse benefit determinations and, when necessary, referred consumers to other sections within the State Corporation Commission Bureau of Insurance ("Bureau") for assistance or referred them to another regulatory agency when the problems involved issues outside the regulatory authority of the Bureau.

In total, the Staff responded to 465 inquiries and assisted 107 consumers in filing appeals with MCHIPs, which resulted in a $336,976 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 herein.

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 as required by § 38.2-5904 B 11, which requires the Office to provide to the SCC information on its activities for reporting 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 twentieth annual report and covers the period November 1, 2017, through October 31, 2018. Previous 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 can provide

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

HOW THE OFFICE PROVIDES CONSUMER ASSISTANCE

A. Who the Office Helps

The Staff provides general information and assistance to consumers and other individuals, including health care providers, who have questions or encounter problems involving some aspect of health insurance, managed care, or related areas. These inquiries reflect a wide spectrum of concerns, issues, and problems and vary in complexity. Inquiries may involve questions concerning benefits available under a consumer's policy and ways to resolve problems, including denied authorizations and denied 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. The Staff may refer consumers to another agency or resource for help when the individual's health plan is not regulated by the Bureau. There are, however, some inquiries involving issues that fall outside the regulatory purview of any state or federal government agency. For example, consumers whose coverage is provided by a self-insured health plan are referred to the employer sponsoring the coverage for assistance.

Health care providers also 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

legislation that established the Office did not establish a process for the Staff to file an appeal on behalf of a provider. Consequently, if it appears the circumstances require the patient to file an appeal, the Staff contacts the patient to offer guidance and assistance in the appeal process.

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 denied preauthorization requests or unpaid claims and often concern consumers with very serious medical problems. The Staff can contact the constituent directly with an offer to provide assistance either by providing general information and advice or by formally helping the individual file an appeal. Frequently, inquiries received from legislators involve constituents whose coverage is self-insured. If a consumer's employer self-insures the coverage, the Staff provides assistance and refers the individual to the employer sponsoring the plan for assistance. 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. Depending on the case, the Staff may provide a written response to a legislator regarding the disposition of an inquiry or formal assistance provided to a constituent who files an appeal.

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, and mail. The Office also 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.

B. How the Office Assists in the Appeals Process

The Staff helps consumers submit appeals when their MCHIP issues an adverse determination, such as denying a claim or refusing to preauthorize a service. Appeals typically

involve a service that an MCHIP has determined is not medically necessary or one that the insurer has determined is experimental/investigational in nature through its utilization review process. The appropriateness of care, health care setting, level of care, and expected clinical outcome are factors considered in determining if services are medically necessary. 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 the applicable criteria. Examples of adverse decisions resulting from utilization review determinations include denials for the following: prescription drugs; surgery; imaging tests (CT scans, PET scans, and MRIs); therapeutic radiation; inpatient hospital services; physical or speech therapy services; and mental health services, including substance abuse treatment. Appeals also may involve consumers who disagree with their MCHIP about whether their specific medical condition can be satisfactorily treated by providers within the MCHIP's provider network. Additionally, the Staff provides assistance to consumers who receive an adverse determination related to dental benefits provided by an MCHIP. Examples of denied dental services include crowns and adjunct services, periodontal scaling, and root planing.

The Staff is required to obtain the written consent of the "covered person" when the Staff formally helps a consumer in the internal appeal process. The Staff helps the 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 explains the appeal process and ensures the individual's appeal rights can be exercised. Upon request, the Staff helps the individual submit an appeal with the appropriate clinical information, such as copies of pertinent medical records or documentation from the treating provider. During the process of helping consumers submit an appeal, the Staff contacts the individual's MCHIP in writing. The Staff plays a significant role in

helping to ensure an individual understands all the appeal levels that are available and has access to each level of appeal.

Appeals may result from pre-service or post-service denials or, in some cases, appeals submitted concurrently with active treatment. The latter situation involves an individual receiving ongoing medical treatment and frequently involves consumers with serious medical conditions. The Staff helps consumers to navigate the entire internal appeal process with the individual's MCHIP as well as to begin any independent external review process that is available. Once the Staff establishes contact with the person's MCHIP, the Staff can help resolve any disputed facts or circumstances involved in the appeal and assist the consumer in submitting updated clinical information. The Staff is conscious 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.

Some appeals include a utilization review component along with an administrative denial that is based on a specific exclusion or limitation in an individual's policy documents. An example is an ongoing course of speech therapy requiring utilization review approval for a number of sessions that exceeds the allowable visits covered by the terms of the policy. If the policy contains a visit limitation and an individual is prescribed more visits than allowable under the policy, an administrative denial is issued rather than a utilization review denial. This means that while speech 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. Similarly, appeals for approval to receive care outside of a restricted provider network may reference an administrative denial, as do appeals concerning the allowable charges an MCHIP pays to a

nonparticipating provider. In some instances, consumers file appeals requesting an exception to the services eligible for coverage as stated in the plan documents. An example is a request for treatment of an illness related to gastric bypass surgery; through gastric bypass surgery is usually a policy exclusion, treatment for a related illness nevertheless may be determined to be medically necessary. The Office helps consumers appeal both utilization review and administrative denials, although the latter cases can be further investigated by another section within the Bureau.

When the Office assists a consumer with an appeal involving a question of medical necessity, the Staff encourages the consumer to ask his or her treating health care provider to conduct a peer-to-peer review with one of the MCHIP's medical directors. In many situations, this may cause the MCHIP to approve the requested treatment or service, which negates the need for the consumer to appeal. If a consumer's medical condition warrants a rapid 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. When the Office assists consumers, 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.

Although the Office has no means or authority to file an appeal on behalf of a consumer, the Staff will review proposed appeal letters and provide comments and input. Consumers benefit from this service since few consumers have filed written appeals with their MCHIPs 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 individual'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.

The Staff cultivates and maintains a productive working relationship with the MCHIPs. This enhances effective communications between the Staff and the MCHIPs, which facilitates assistance provided to consumers in the appeal process and can be instrumental in resolving issues involved in an appeal. The Staff remains actively engaged with the consumer and the MCHIP throughout the entire appeal process while helping the consumer navigate the appeal process. The Staff ensures that an MCHIP administers its appeal process fairly and consistently with applicable statutory requirements and may intervene if necessary.

C. How the Office Assists After MCHIPs Decisions on Appeals

The Staff reviews decisions that MCHIPs render on appeals. 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. The Staff maintains that a denial should reflect a logical reasoning process that produces a decision based on all the relevant information provided by the consumer and the treating health care provider. The Staff will analyze objectively an appeal that is not successful and will help the individual understand why the MCHIP did not overturn the denial. The Staff will review the clinical criteria an MCHIP uses 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. Also, the Office can provide additional assistance to a consumer when the appeal decision is favorable but the individual has difficulty obtaining the previously denied services or benefits.

When an MCHIP denies an internal appeal involving questions of medical necessity, appropriateness, health care setting, level of care or effectiveness, or determines the services are experimental/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.

As noted in previous annual reports, the majority of consumers who ask for assistance in appealing an adverse determination have never previously appealed an adverse decision, and many individuals are intimidated by the process. The Staff keeps this in mind and tries to reduce consumer anxiety and frustration by offering personalized assistance and guidance throughout the 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. During this reporting period (November 1, 2017 through October 3, 2018), the Staff responded to 465 inquiries and helped 107 consumers to file appeals. These figures are down slightly compared to the previous reporting period (November 1, 2016 through October 31, 2017), when the Office received 567 inquiries and assisted 132 consumers in filing an appeal.

A. Who the Office Helped

Like previous reporting periods, most of the inquiries and appeals involved the same 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 features of their MCHIP and the potential benefits provided by their coverage, as stated in their policies. Many consumers did not read and understand their plan documents, such as the evidence of coverage ("EOC"), certificate of coverage ("COC"), and explanation of benefit forms. The Staff continued to hear from a number of consumers who stated 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.

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 another state. Some consumers were covered through the Federal Employees Health Benefits Program or other types of government plans, such as Medicare or Medicaid. The Staff advised these consumers on how they could resolve their insurance-related problems and referred them to other resources for assistance. As in prior years, the Office provided the largest number of referrals to employers who provide self-insured coverage for their employees. The Staff also provided informal advice and suggestions to consumers whose coverage is not regulated by the Bureau. Consumer feedback indicates the information was

extremely helpful. As in previous reporting periods, most consumers were not aware that their coverage was self-insured and not subject to Virginia's regulatory authority.

Health care providers acting on behalf of their patients frequently contacted the Office for assistance during the reporting period, as was the case in prior reporting periods. The Staff helped providers understand 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 by the patient. There were numerous instances during the reporting period when the information and advice the Staff provided were instrumental in helping the provider resolve the problem by contacting the patient's MCHIP. Consequently, the patient was able to receive treatment or services without having to engage the formal appeal process with their MCHIP. 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.

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 $336,976 in direct cost savings or cost avoidance to consumers through the internal appeals process alone. The following are examples illustrating some favorable outcomes to consumers, both through and outside of the internal appeals process, and are demonstrative of the range of amounts involved:

- A consumer received a favorable appeal decision providing coverage for Intravenous Immune Globulin therapy for an autoimmune disease for one year, with a projected cost saving of $86,808.
- A consumer received approval for specialized food to treat inborn errors of protein metabolism, which cost $10,000 annually without insurance authorization.

- A consumer initially lost in the internal appeal process for an inpatient hospital stay related to an emergency room visit and received assistance from the Office, which resulted in the hospital writing off an $11,000 bill.

- A consumer with a denied inpatient mental health stay for a wilderness therapy program was assisted after losing his first level appeal. Initially the consumer's second level appeal was rejected as untimely filed, but the Office encouraged the carrier to waive the timely filing requirement given the carrier's failure to send the consumer a written response to the first-level appeal. The Staff suggested the consumer provide detailed clinical information to the carrier, which overturned the appeal and resulted in a $14,268 cost savings.

- A consumer diagnosed with giant cell arteritis received authorization for the drug Actemra after the Office suggested the appropriate clinical information to provide to the carrier, which resulted in a $50,000 coverage benefit to the consumer.

- The Staff advised a consumer, who missed the timely filing requirement to appeal an intra-hospital transfer, to request that the provider accept payment at the in-network rate as payment in full. The facility wrote off the entire bill with a cost avoidance to the consumer of $39,800.

- The Staff advised a consumer in need of an implantable cardioverter defibrillator to work with the hospital billing office to resubmit the claim to the MCHIP, which resulted in a cost avoidance to the consumer of $93,166.

- A consumer received a denial for authorization for reconstructive surgery to remove excess skin following a panniculectomy procedure. The carrier did not timely respond to the consumer's appeal request. The Staff advised the consumer of additional clinical documentation to submit, and the carrier of its failure to respond appropriately, which resulted in both a retroactive authorization and a $20,000 cost avoidance to the consumer.

- A consumer received authorization for the prescription drug Rituximab to treat an autoimmune disease. The carrier denied authorization as an off-label use of the drug. The Staff advised the consumer to work with the treating physician to submit updated clinical information, resulting in a one-year authorization at a cost avoidance of $44,000 to the consumer.

- A consumer encountered obstacles in an appeal process, including the MCHIP's confirmation of receipt of the appeal request. The Staff, in cooperation with the MCHIP, determined the consumer was not liable for the inpatient hospital admission at issue because the participating hospital failed to follow admission procedures with the carrier. The consumer avoided a $6,289 bill.

- A consumer lost an internal appeal related to a denied hospital stay associated with a previous gastric bypass surgery on the basis that the hospital stay was related to a non-covered benefit. Technically, the appeal process had been completed, but the Staff

worked with the consumer to obtain a letter from the attending surgeon. The surgeon refuted the determination as the basis for the administrative denial. The denial was overturned, and the consumer avoided a $101,232 bill.

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. While most requests for assistance with appeals involving medical treatment originated from consumers, several dental appeal requests were sent by providers. In a typical scenario, the treating dentist contacts the Office for assistance with an appeal following a previous unsuccessful appeal of the case. During the reporting period, the Office was successful in assisting consumers with dental appeals, but very few consumers were successful pursuing appeals that were a continuation of an earlier provider appeal. One reason may be that the appeal process for the latter type of dental appeals had been completed prior to the consumer contacting the Office for assistance. In these types of situations, the Staff asked the dental MCHIP to review the decision, especially in cases where it appeared there was clinical information that was not reviewed during the appeal process. While the dental MCHIPs normally complied with the request, very few denials were reversed in favor of a consumer. The Staff also encountered several appeals with dental MCHIPs in which the treating dentist determined there was sufficient tooth structure to support a crown to salvage an existing tooth, as opposed to extracting the tooth and inserting an implant, but the consumer's MCHIP disagreed and upheld the denials in most cases. Since the vast majority of consumers who asked for help appealing denied dental claims and services were covered by a Stand Alone Dental Plan ("SADP"), the denial, which involved the use of clinical criteria, was ineligible for the independent external review process administered by the Bureau. The independent external review program does not apply to SADPs.

C. Helpful Tools in the Appeals Process

As in previous reporting periods, consumers maximized their chance to prevail in the appeal process when comprehensive medical records were provided to fully document a consumer's medical history, medical condition, and treatment responses. A very strong appeal letter also was instrumental in increasing the chance a consumer would win an appeal, especially documentation that addressed the clinical criteria an MCHIP used in making a utilization review decision. The Staff provided personal guidance and advice to consumers on important information to include in and with appeal letters, such as medical records and physician letters of medical necessity explaining why the requested service represented the current standard of care. The Staff also 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. The Staff worked to ensure that consumers and their requesting physicians understood and applied the applicable clinical guidelines an MCHIP uses in issuing a denial and helped consumers document how their particular condition met the applicable criteria. Upon request, the Staff reviewed appeal letters and recommended changes to make the letters more effective.

Another useful tool in appealing a denial is presenting research in peer-reviewed medical journals and other peer-reviewed scientific literature that support an appeal. This strategy was especially useful in appeals that involved denials based on an MCHIP's determination that a requested service was experimental/investigational in nature. Usually, a successful appeal presented multiple compelling reasons why an MCHIP's denial should be reversed, rather than just a single reason.

The Staff also worked to ensure that consumers' appeal rights were protected and fairly administered by his or her 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. As noted above, consumers occasionally miss the deadline to file an appeal; however, the Office will request, and MCHIPs usually agree, to review the matter even if the timely filing requirement has 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 the Office formally helped consumers file appeals during the reporting period, the Staff wrote to the individual'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 they were advised 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, which is an effective means of interaction with dentists, dental assistants, and administrative staff from dental practices located throughout the Commonwealth.

The Office also 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 recommend that consumers read and understand their policies, and to provide contact information for the Office and the Bureau.

The Staff also 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. As reported previously, the Office has 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. The Office has 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, offer coverage for less than a year, and cost less than ACA-compliant health insurance plans. STLD coverage is still subject to Virginia's 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 2018 General Assembly session, the Office monitored several pieces of legislation that were of interest to the Office 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 234, signed by the Governor on March 30, 2018, amended the Code by adding § 38.2-3407.9:04 relating to a consumer's prescription drug coverage and synchronization of medications. This bill requires health plans providing prescription drug coverage to allow and apply a prorated daily cost-sharing rate to prescriptions that are dispensed by network pharmacies for a partial supply if the prescribing provider or the pharmacist determines the fill or refill is in the best interest of the consumer and if the consumer requests or agrees to a partial supply for the purpose of synchronizing medications.

Additionally, House Bill 778, signed by the Governor on March 9, 2018, and Senate Bill 663, signed by the Governor on March 30, 2018, both add new subsection B 21 to Code § 32.1-127, regarding hospital notices to patients prior to a provider arranging non-emergency air medical transportation. These bills require hospitals to provide notification that informs consumers who are not experiencing an emergency medical condition of the choices of air or ground transportation and notice that the consumer is responsible for charges incurred if the transportation provider is a non-participating provider, or if the charges are not otherwise covered in full or in part by the consumer's health insurance plan.

CONCLUSION

During this reporting period, the Office has accomplished its responsibilities in accordance with § 38.2-5904 of the Code. In short, 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, individuals may have been referred to another source for assistance. When requested, the Staff helped consumers appeal adverse benefit determinations and worked to provide individuals 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 when combined with the Staff's expertise, helped appellants in the appeal process. When circumstances warranted, the Staff referred potential regulatory concerns to the appropriate section within the Bureau for further review. The Office also monitored changes in federal and state laws related to health insurance coverage and managed care.