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 B 11 of the Code of Virginia

December 1, 2023

COMMONWEALTH OF VIRGINIA

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December 1, 2023

Transmitted via Email

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

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

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

The Honorable Terry G. Kilgore
Vice Chair, Committee on Commerce and Energy
Virginia House of Delegates

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

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 Commerce and Energy

Members of the House Committee on Health, Welfare and Institutions

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, 2022, to October 31, 2023.

Respectfully submitted,

Scott A. White
Commissioner of Insurance

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Executive Summary

On behalf of the State Corporation Commission (Commission), the Bureau of Insurance (Bureau) submits this annual report on the activities of the Office of the Managed Care Ombudsman (Office) in accordance with § 38.2-5904 B 11 of the Code of Virginia (Code) for the period November 1, 2022, through October 31, 2023.

The Office is charged with promoting and protecting the interests of persons covered under managed care health insurance plans (MCHIPs[1]). To this end, the Office reported the following results:

- Through its assistance with the internal appeal process, helping consumers secure $409,800 in direct cost savings or cost avoidance– a 287% increase over the $105,780 secured in the previous reporting period;
- Helping 215 consumers with formal appeal requests, a 25% increase over the previous reporting period; and
- Assisting with 423 consumer inquiries, a slight increase over the prior reporting period, with nearly one-third of these inquiries being 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 end of the Covid-19 public health emergency on May 11, 2022, drove many of the changes in health insurance policy, while significant developments in Virginia included revisions to the specifications for the essential health benefits benchmark plan and requirements related to electronic prior authorization and real-time benefit tools for prescription drugs that will both take effect in 2025.

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 on the activities of the Office 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 also 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, 2022, through October 31, 2023.

[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:

- Helping consumers understand their MCHIP appeal rights and processes, as well as assisting them in filing a formal appeal;
- Providing general inquiry assistance to MCHIP consumers, including dental and vision plan consumers;
- Analyzing and publishing MCHIP data, to include complaint data and mandated health insurance benefits;
- Monitoring legislation and reporting on significant developments in federal and state health insurance laws; and
- 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 may find the appeal process complex and confusing. The Office helps guide them through the appeal 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 215 consumers with formal appeal requests. This is a 25% increase over the previous reporting period when the Office assisted 172 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 $409,800 in direct cost savings or cost avoidance for consumers through the internal appeal process alone. This represents a 287% increase over the

$105,780 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
$223,393	Authorization and payment for the prescription drug Prolastin
$36,922	Payment for surgery and hospital stay in Cameroon
$29,863	Payment for inpatient hospital stay
$20,710	Payment for NICU stay for infant child
$12,548	Authorization for the prescription drug Ubrelvy

b. Inquiries

The Office provides consumers with information on a variety of MCHIP topics, including general policy information, the preauthorization and appeal processes, and policy benefits. Nearly two-thirds of the information it provides is related to the 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.

However, 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 ERISA plan or Medicaid), the Office nevertheless provides consumers with general information and guidance about appeals before making the proper referral.

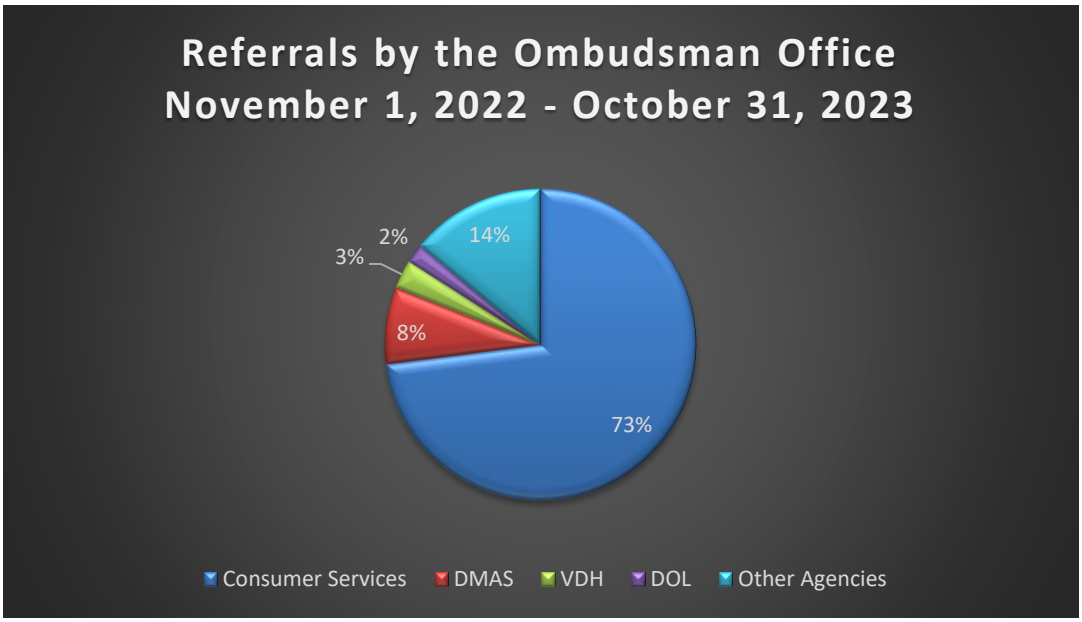
Finally, there are instances when the consumer's coverage is subject to Virginia insurance law where the Office makes an internal referral within the Bureau. For example, the Bureau classifies requests for assistance related to balance-billing, policy exclusions, and non-participating provider claims,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

Inquiry Results

During the reporting period, the Office assisted with 423 consumer inquiries. This is a slight increase over the previous reporting period when the Office assisted with 416 inquiries.

Nearly one-third (133 of 423) of the consumer 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 three-fourths going to the Consumer Services section.



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, 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 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 laws and rules, summarized as follows:

- Imposed during the Covid-19 public health emergency, the federal continuous coverage requirement that prevented state Medicaid agencies from removing Medicaid recipients from state rolls ended on March 31, 2023. As a result, state Medicaid agencies are continuing to transition to normal enrollment operations.
- The public health emergency ended on May 11, 2023, and along with that, some emergency declarations, to include the following:
    - Coverage of COVID-19 tests and testing-related services without cost sharing;
    - Coverage of COVID-19 vaccines out-of-network without cost sharing;
    - Flexibility to waive potential HIPAA violations for services provided through telehealth such as FaceTime or Skype; and
    - Extension of COBRA notice and election deadlines.
- The following fix to the "family glitch" that had existed from 2014 through 2022 was put into place for 2023. Previously, an employee who had access to employer-sponsored coverage was not eligible to receive subsidies for exchange coverage if the employee met the threshold for affordability based on the employee's cost of coverage alone. Additionally, the employee's family was ineligible for subsidies. Effective in 2023, a calculation was added to determine subsidy eligibility that is based on the cost to cover the entire family.

Virginia Legislation

During the 2023 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 1471 and Senate Bill 1261 (identical bills), which amended and reenacted § 38.2-3407.15:2 of the Code, and added § 38.2-3407.15:7, that require a single standardized prior authorization process for prescription drugs to maximize efficiency. The Office served as part of the Bureau team supporting the working group.
- House Bill 2198 and Senate Bill 1399 (identical bills), which amended and reenacted § 38.2-3418.18 of the Code, that required the Bureau to select a new essential health benefits benchmark plan for the 2025 plan year that includes (in addition to the essential health benefits package included

in the existing benchmark plan) coverage for prosthetic devices and components and formula and enteral nutrition products as medicine.

- Senate Bill 1003, which amended and reenacted § 38.2-4319 of the Code, and added § 38.2-3418.21, requires health insurers to provide coverage for hearing aids and related services for children 18 years of age or younger when an otolaryngologist recommends such hearing aids and related services.

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 Arc of Virginia. 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 appeals process. Through its assistance with the internal appeal process, the Office helped consumers secure $409,800 in direct cost savings or cost avoidance for consumers – a 287% increase over the previous reporting period.

The Office continued to monitor and report on significant new developments in federal and state health insurance laws. At the federal level, the end of the Covid-19 public health emergency on May 11, 2023, drove many of the changes in health insurance policy, while significant developments in Virginia included revisions to the specifications for the essential health benefits benchmark plan and requirements related to electronic prior authorization and real-time benefit tools for prescription drugs that will both take effect in 2025.

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