Explanation of Benefits Notice Requirements for Health Carriers

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Introduction

All health carriers are required to include information about external reviews administered by the Virginia Bureau of Insurance (Bureau) in the Explanation of Benefits (EOB) notices in the case of an adverse determination or final adverse determination. Refer to § 38.2-3559 of the Code of Virginia (the Code).

If the required language is used on **all** EOBs, instead of **only** the EOBs that are adverse determinations or final adverse determinations, the EOB notice language must include additional information as explained in this document.

The Bureau developed a recommended EOB insert notice on page 7 of this document. A carrier has the option of providing the exact wording of the EOB insert notice developed by the Bureau or re-submitting any EOB forms (or separate notices included with the EOB) to the Bureau for approval to ensure that the carrier's language complies with the minimum requirements.

This document contains the minimum requirements for carriers that choose to develop their own EOB insert notice language and submit it to the Bureau for review.

It also includes requirements for EOBs that involve balance billing and out-of-network providers.

External Review Notice Minimum Requirements and Instructions

Bureau-administered Independent External Review Rights in EOBs (Refer to § 38.2-3559 of the Code.)

If a notice of External Review rights will be provided with all EOBs, the following, or substantially similar language, must be included in either the EOB or a separate notice included with the EOB:

> If we have denied your request for the provision of or payment for a health care service or course of treatment, you may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested by submitting a request for external review to the Commission.

Additional required language if the notice of External Review Rights will be provided with all EOBs (Refer to subsection B of § 38.2-3559 of the Code.)

If a notice of External Review rights will be provided with all EOBs, all of the following language must be included in either the EOB or in a separate notice included with the EOB:

> If the covered person's adverse determination involves (i) cancer or (ii) a medical condition where the time frame for completion of an expedited internal appeal of an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function, the covered person or his authorized representative may file a request for an expedited external review pursuant to § 38.2-3562;
>
> If the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, the covered person or his authorized representative may file a request for an expedited external review pursuant to § 38.2-3563;
>
> If the covered person or his authorized representative files a request for an expedited internal appeal with the health carrier, he may file at the same time a request for an expedited external review of an adverse determination pursuant to § 38.2-3562 or 38.2-3563. The independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited internal appeal prior to conducting the expedited external review; and
>
> If the covered person or his authorized representative files a standard appeal with the health carrier's internal appeal process, and the health

carrier does not issue a written decision within 30 days following the date the appeal requesting a review is filed and the covered person or his authorized representative did not request or agree to a delay, the covered person or his authorized representative may file a request for external review and shall be considered to have exhausted the health carrier's internal appeal process.

The Bureau also recommends including the following:

- The federally-administered Balance Billing External Review process is available when your insurer covers a service but indicates that the provider can balance bill you or bill you for a cost share that is higher than that allowed under the federal No Surprises Act (NSA). Additional information about the NSA External Review process can be found at: https://externalappeal.cms.gov.

Required contact information for the Bureau's External Review section

EOBs or separate notices must include contact information for the:

State Corporation Commission
Bureau of Insurance - External Review section:
ExternalReview@scc.virginia.gov
(804) 371-9032 or
1-877-310-6560; option #4

The Bureau also recommends including the following:

- You are encouraged to contact the Bureau to discuss your situation and what options are available to you before submitting External Review forms.

Required wording offering consumer assistance from the Bureau

In order to reduce consumer confusion, carriers must include an additional explanation of External Review eligibility and examples of adverse benefit determinations that are not eligible for External Review. Health carriers have the option of providing examples or the web address for the External Review section.

EOBs or separate notices must include one of the following:

- Examples of adverse benefit determinations that are not subject to either External Review process are any administrative denials, such as benefit exhaustion and policy exclusions.

- Learn more about the External Review process in this document and by visiting the Bureau's External Review webpage at: scc.virginia.gov/pages/External- Review-(1)

EOBs or separate notices must include the following:

- Contact the Bureau of Insurance if you have a complaint related to an administrative denial:

State Corporation Commission
Bureau of Insurance – Consumer Services section:
BureauofInsurance@scc.virginia.gov
1-877-310-6560

EOB must include information about the carrier's internal appeals process

Wording regarding the internal appeals process must be included. The following minimum requirements apply:

- As required by § 38.2-5804 A 2 of the Code and 14 VAC 5-216-30 B, the health carrier must include notice of its available internal appeals procedures (including urgent care appeals), including timeframes for submission of an appeal, as well as the health carrier's review and response.

- The notice must also include the **name**, **address**, and **telephone number** of the person or organizational unit designated to coordinate the review of the appeal for the health carrier.

- If the plan is a managed care health insurance plan (MCHIP), the mailing address, telephone number, and email address for the Office of the Managed Care Ombudsman must also be included:

PO Box 1157
Richmond, VA 23218
Ombudsman@scc.virginia.gov
1-877-310-6560; option #3

Requirements for letters:

Letters the carrier sends expressing an adverse determination in response to a request for coverage or authorization, or denial of an appeal or complaint, must include all the language required by the Code and Virginia Administrative Code stated above.

Letters expressing an adverse benefit determination (that is not subject to external review) in response to a request for coverage or authorization, or denial of an appeal or complaint, must **not** include this language, except for information as required by § 38.2-5804 A 2 of the Code and 14 VAC 5-216-30 B.

Balance Billing

There are requirements for EOBs that involve balance billing and out-of-network providers. Health carriers should be aware of these requirements and take them into consideration when developing and filing EOBs for approval.

- 14 VAC 5-405-70 B 3 requires that the health carrier provide an enrollee with an EOB that clearly indicates whether the enrollee may or may not be subject to balance billing if it contains claims from out-of-network providers.

- Section 38.2-3445.01 B of the Code requires the health carrier to provide an EOB that reflects the enrollee's cost-sharing requirement as determined under the subsection. The subsection has additional requirements relating to the use of the in-network cost-sharing requirement and the carrier's median in-network contracted rate to determine the enrollee's obligation for specified services from out-of-network providers.

Balance Billing External Review

- The federal No Surprises Act (NSA) provides persons covered by non-grandfathered plans the right to request an External Review following internal appeal and reconsideration of matters involving surprise billing and cost-sharing protections. We refer to this as a Balance Billing External Review. Persons covered by grandfathered plans must also be provided the right to a Balance Billing External Review under the federal NSA, even if no internal appeals are available.

- The External Review process established in Virginia law does not include an External Review for adverse benefit determinations related to surprise billing and cost-sharing protections. Since Virginia's External Review process does not accommodate this broader scope, the U.S. Department of Health and Human Services (HHS) offers the opportunity for states to refer these balance billing adverse benefit determinations to the federal HHS-administered External Review process.

- Carriers should provide information about the federal Balance Billing External Review process to direct consumers to: https://externalappeal.cms.gov when a consumer receives an adverse benefit determination related to surprise billing or cost-sharing protections.

Form Filing Requirements

Carriers are required to submit EOB forms for approval as explained in § 38.2-3407.4 of the Code.

If a carrier deletes language from or adds required language to an existing filed and approved EOB (not to a separate notice included with the EOB) **and** this results in changes not described in the Statement of Variability, a new EOB form must be submitted for approval.

Changes related to the required language made solely to a separate notice included with the EOB do not need to be submitted for approval in SERFF. However, if the carrier does not use the exact wording in the EOB insert notice developed by the Bureau, the carrier's separate notice must be submitted to the Office of the Managed Care Ombudsman (OMCO) for review. Once the separate notice has been reviewed by the OMCO and is acceptable, the carrier must submit the separate notice as an informational filing in SERFF.

Going forward, if the carrier will be sending the required language in a separate notice included with the EOB, the notice must be included in the supporting documents when the EOB is filed for approval with the Bureau.

Changes to a carrier's required complaint system

If the addition of the required language to a separate notice, letter or EOB represents a material change to the carrier's existing approved complaint system, the carrier must contact the OMCO to update its complaint system.

Going forward, a copy of any separate notices, letter templates or EOBs containing the required language must be submitted to the OMCO when the carrier's complaint system is filed for approval.

External Review Insert Notice

Know Your Rights – External Review of Denials

Your denial may be eligible for an Independent External Review. An External Review is a free service to help you if your health carrier denies coverage of certain covered benefits as explained below.

There are two types of External Review available:

1. The Independent External Review process administered by the Virginia Bureau of Insurance (Bureau). This process is available when your insurer denies coverage of certain services. Learn more about the process in this document and by visiting the Bureau's External Review webpage. scc.virginia.gov/pages/External-Review-(1). **You are encouraged to contact the Bureau to discuss your situation and what options are available to you before submitting External Review forms.**

   State Corporation Commission
   Bureau of Insurance - External Review section:
   ExternalReview@scc.virginia.gov
   (804) 371-9032 or
   1-877-310-6560; option #4

2. The federally-administered Balance Billing External Review process, which is available when your insurer covers a service but indicates that the provider can balance bill you or bill you for a cost share that is higher than that allowed under the federal No Surprises Act (NSA). Additional information about the NSA External Review process can be found at: https://externalappeal.cms.gov.

Examples of adverse benefit determinations that are not subject to either External Review process are administrative denials, such as benefit exhaustion and policy exclusions.

Contact the Bureau of Insurance if you have a complaint related to an administrative denial:

State Corporation Commission
Bureau of Insurance – Consumer Services section:
BureauofInsurance@scc.virginia.gov
1-877-310-6560

If the plan is a managed care health insurance plan (MCHIP), include the following language: For help with an appeal and understanding your rights, you may contact the Office of the Managed Care Ombudsman at:

State Corporation Commission
Office of the Managed Care Ombudsman
Ombudsman@scc.virginia.gov
1-877-310-6560; option #3

External Review Eligibility Information

Independent External Review Administered by the Virginia Bureau of Insurance

Required by § 38.2-3559 of the Code of Virginia

If we have denied your request for the provision of or payment for a health care service or course of treatment, you may have the right to have our decision reviewed by health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment you requested by submitting a request for external review to the Commission.

If the covered person's adverse determination involves **(i) cancer or (ii) a medical condition where the time frame for completion of an expedited internal appeal of an adverse determination would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function**, the covered person or his authorized representative may file a request for an expedited external review.

If the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is **experimental or investigational** and the covered person's treating physician certifies in writing that the recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, the covered person or his authorized representative may file a request for an expedited external review.

If the covered person or his authorized representative files a request for an expedited internal appeal with the health carrier, he may file at the same time a request for an expedited external review of an adverse determination. The independent review organization assigned to conduct the expedited external review will determine whether the covered person shall be required to complete the expedited internal appeal prior to conducting the expedited external review.

If the covered person or his authorized representative files a standard appeal with the health carrier's internal appeal process, and the **health carrier does not issue a written decision within 30 days** following the date the appeal requesting a review is filed and the covered person or his authorized representative did not request or agree to a delay, the covered person or his authorized representative may file a request for external review and shall be considered to have exhausted the health carrier's internal appeal process.