OMBUDSMAN
Activities and Services
Fiscal Year 2008

ANNUAL REPORT

Department of Human Resource Management
Office of State and Local Health Benefits Programs

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ON
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EXECUTIVE SUMMARY

This annual report on the activities of the Ombudsman for the Office of State and Local Health Benefits Programs (OHB) covers the period from July 1, 2007 through June 30, 2008. The Ombudsman's team worked diligently to resolve issues encountered by employees and their covered dependents involving access and eligibility for health care under the State's Health Benefits Program. Furthermore, the team assisted covered employees in understanding their rights and the processes available to them through their State Health Benefits Program. The team also assisted covered employees in using the procedures and processes available to them through their health plan, including all appeal procedures.

This report will detail the key accomplishments of the Ombudsman and his team during Fiscal Year 2008 (FY 2008). In this year, the Ombudsman's team handled 6,522 formal case-specific inquiries and assisted with 58 formal appeals. The team worked constantly to resolve issues and solve problems as they arose and, in every case, carefully examined the facts to identify and correct systemic issues, because this was the most effective way to achieve the team's goal of continuous improvement. Working with employees, retirees, OHB staff, and the Health Benefits Program's third-party vendors, the Ombudsman's team identified and facilitated the correction of at least eight significant systemic issues during this year.

The Ombudsman's team continued to provide a valuable service to State employees and retirees and functioned in accordance with the legislation that created the role in 2000.

INTRODUCTION

In accordance with §2.2-2818 of the Code of Virginia, the role of the Health Benefits Ombudsman was established February 1, 2000. This report is submitted by the Ombudsman to the Joint Commission on Health Care and the standing committees of the General Assembly with jurisdiction over insurance and health.

The Ombudsman worked within the Office of State and Local Health Benefits Programs (OHB) in the Department of Human Resource Management (DHRM). During this fiscal year, the Ombudsman's team consisted of two Health Benefits Specialists, four Senior Health Benefits Specialists and a Medical Appeals Examiner who was a licensed registered nurse. Core groups within OHB supplemented the needs of the Ombudsman's team when expertise was needed or when there was a spike in volume. This flexibility allowed the team to work efficiently and effectively, and produce timely and appropriate responses to members' issues.

The primary objective of the Ombudsman's team was to assist covered employees in understanding their rights and the processes available to them through their State Health Benefits Program. The Ombudsman ensured that covered employees received timely responses to their inquiries from him or his team. In addition, team members assisted covered employees in using the procedures and processes available to them from their health plan, including all appeal procedures.

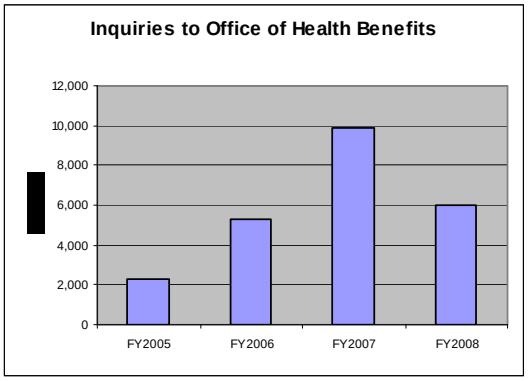
The Ombudsman's team served approximately 86,000 State employees and 28,000 local government employees in the The Local Choice Program who were covered by the State and Local Health Benefits Programs. Furthermore, they served approximately 29,500 State retirees, survivors and Long Term Disability (LTD) participants who participated in the retiree group. Total membership in the State and Local Health Benefits Programs was comprised of approximately 186,000 members (including dependents) in the plan for State employees, 47,000 members (including dependents) in The Local Choice plan, and approximately 39,000 members (including dependents) in the plan for State retirees.

The Ombudsman's team was the resource for over 300 human resource Benefits Administrators and Managers statewide who administered health benefits within State agencies and sought assistance with Program administration and policy application from the Ombudsman. The team members also served as a resource for approximately 248 Group Administrators in The Local Choice Program. The Ombudsman worked closely with the Office of the Attorney General, which was the Ombudsman's primary resource for advice and counsel concerning appeals, legal concerns, and issues of equity.

INQUIRIES

During FY 2008, the Ombudsman's team responded to 6,522 formal case-specific inquiries from employees, retirees, agency Benefits Administrators, health care vendors, legislators, providers and other interested parties. The majority of formal contacts with the Ombudsman's team in FY 2008 pertained to eligibility and coverage for medical or surgical services for active employees and their dependents under the COVA Care plan. The COVA Care plan is a Preferred Provider Organization (PPO) plan, and was the most popular option to state employees available under the Health Benefits Program.

Examples of major issues involved in these inquiries included questions regarding: whether dependents were eligible for coverage and when they may have been enrolled, eligibility for extended coverage following the termination of employment, rules governing medical and dependent care, flexible reimbursement accounts, denial of coverage, and whether claims were properly paid. Inquiries for general information were not formally recorded. Inquiries took the form of correspondence, e-mails, telephone calls, and in-person consultations.



Overall, the number of inquiries continued to increase from FY 2005 to FY 2008, with a dramatic spike in FY 2007. There were several reasons for the changes in activity over the past few years. FY 2007 was the first full fiscal year that included the Medicare Part D prescription drug plan, known as YOURx Plan, which became available January 1, 2006 to Medicare-eligible group members in the State Retiree Health Benefits Program. Also, FY 2007 saw the implementation of various significant changes to the Health Benefits Program, such as the free flu shot program, the introduction of the COVA High Deductible Health Plan, and the enhanced wellness benefit.

Historically, whenever significant changes have been made to the Health Benefits Program, the Ombudsman's team recorded an increase in inquiries, as agency Benefits Administrators and members sought information to understand the impact of the changes. Over time, the volume of calls typically subsided. Consistent with this cycle, the number of inquiries decreased dramatically in FY 2008 as members became familiar with the various plans and benefit enhancements implemented during FY 2007. For example, the Ombudsman's team fielded far less inquiries involving Medicare Part D in FY 2008 as

retirees became more familiar with this program. In FY 2007, retirees generated 2,549 inquiries, and in FY 2008, they accounted for 1,267 inquiries.

Similarly, employees have developed more understanding of the flu shot program, the High Deductible Health Plan, and the enhanced wellness benefit. This led to a decrease in inquiries. The enhanced understanding of these benefits has been facilitated by the steady flow of communications from OHB explaining the program's nuances.

As always, the work of the Ombudsman and his team was dynamic. As issues were resolved, other issues requiring attention invariably arose. Furthermore, health care continued to grow more complex as advances were made in medical technology, care and procedures. Much of the overall increase in recorded inquiries between FY 2005 and FY 2008 was due to the ever-increasing complexity of health care.

APPEALS

Every effort was made to assure that all appellants received the full extent of the benefits to which they were entitled under the rules of the Program. There was a strong emphasis on facilitating employee understanding of the Program and providing assistance to employees who encountered difficulties navigating the sometimes complex provisions and obligations related to employee health care. The Ombudsman was charged with oversight of the appeals process and he or a member of his team was the contact for appellants throughout the process. The Ombudsman's team strove to resolve appeals as early in the process as possible.

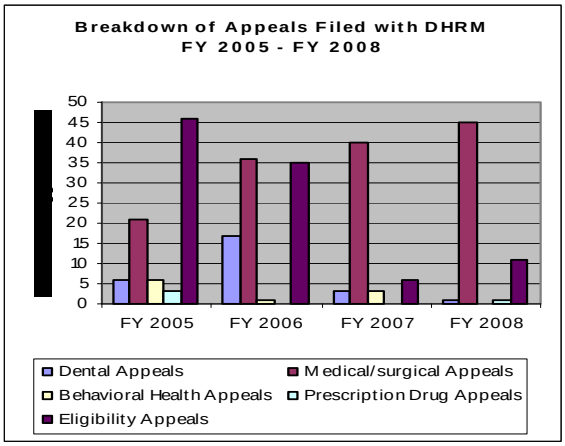
Whenever a new appeal was received, it was first evaluated to determine whether the initial denial was clearly a substantive error. If it was a substantive error, then the decision was reversed early in the process, thus relieving the appellant of the burden and stress associated with going through the entire appeal process and correspondingly increasing customer satisfaction. It should be noted that appeals were only resolved early in the process if the resolution was in favor of the appellant. These efforts resulted in significant financial savings for plan members and the Commonwealth. On average, whenever a case was resolved favorably for the appellant early in the process, it reduced costs to process the appeal by 71%. Furthermore, in a number of cases, employees who contacted OHB to discuss submitting an appeal had their issue resolved favorably before the appeal was formally filed.

There were two kinds of appeals. One type of appeal involved plan eligibility, meaning that these appeals pertained to whether or not an employee and/or dependent was qualified to receive coverage under the State Health Benefits Program. The other kind, medical appeals, involved medical, dental, prescription drug and behavioral health issues. When specific criteria were met, the employee had the right to appeal unresolved eligibility issues to the Director of DHRM. In regard to medical appeals, the third party vendors responsible for administering the medical, prescription drug, dental or mental health components of the Health Benefits Program each had internal appeal processes. When an employee exhausted his or her

appeals with a specific vendor, the employee had the right to appeal the denial of coverage to DHRM.

During FY 2008, there were 58 formal appeals to the Director of DHRM. Many of these appeal cases were complicated and required extensive work to prepare the member's file for external review.

Eleven (11) appeals related to eligibility and 47 were medical. The total number of formal appeals to the Director of DHRM during FY 2008 represented a 9% increase in the total number of appeals, up from 53 the previous year. As demonstrated by the chart below, the majority of this increase was comprised of appeals involving eligibility, which nearly doubled in number. Even with this increase, from a historical perspective, the number of appeals involving eligibility remained relatively low.



From FY 2005 through FY 2008, the number of appeals involving eligibility issues decreased by 76%. This decrease was primarily attributable to the fact that in July 2006, the member handbook and the appeals form were changed to clarify that certain issues were not appealable to DHRM. In regard to eligibility issues, this clarification indicated that matters in which the sole issue was disagreement with policies, rules, regulations, contract or law were not appealable. While this exclusion existed prior to 2006, emphasizing it in the handbook and on the appeals form resulted in improved communication with members, thus increasing member understanding and satisfaction. At the same time, it reduced the number of invalid appeal requests submitted.

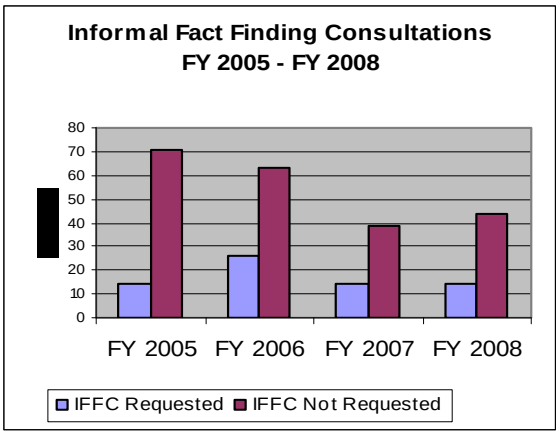
The Ombudsman's team also used other strategies to ensure that employees, retirees and their dependents received coverage to which they were entitled, and these strategies sometimes had the effect of reducing appeals to DHRM. As an example, the Ombudsman's team regularly monitored appeal trends and used the data so that OHB continuously improved the administration of the State Health Benefits Program. In FY 2006 and FY 2007, DHRM received several appeals involving dependents who were denied coverage because they were not enrolled within the required time frame. This trend was discussed, and these discussions led to the development of a poster series outlined in further detail in the "Communications and Liaison with Vendors" section

below. Following the publication and display of these posters in FY 2008 in agencies throughout the State, there was a dramatic decrease in both inquiries and appeals involving this issue, indicating that these posters were an effective tool in increasing timely enrollments.

In regard to medical appeals, beginning in July 2006, the member handbook and the appeals form were changed to clarify that issues involving contractual exclusions, matters in which the sole issue was disagreement with policies, rules, regulations, contract or law and claim amounts above the allowable charge billed by a non-participating provider were not appealable. Furthermore, issues involving claim amounts or coverage denials when the member's cost was less than $300 were deemed not to be appealable, thus aligning the State's Health Benefits Program's treatment of low-cost claims with the State Corporation Commission's Bureau of Insurance appeal rules for managed care plans. Although these issues were not appealable, whenever a member raised such an issue, the case was treated as an inquiry and the issue was evaluated to ensure that the member's claim was handled correctly. Thus, the Ombudsman and his team changed the delivery channel for analyzing de minimis claims, improving cost effectiveness while continuing to thoroughly investigate member's issues, and reducing processing costs by 79% per case. During the last two fiscal years, the number of medical appeals remained stable, but would have increased if these efforts to increase efficiency and effectiveness had not been undertaken.

When a health plan member appealed to the Director of DHRM, the opportunity for an informal fact finding consultation (IFFC) with the Director was offered to the appellant. If the appellant chose not to have an IFFC, the case was decided based on the evidence submitted by the appellant and the Health Benefits Program.

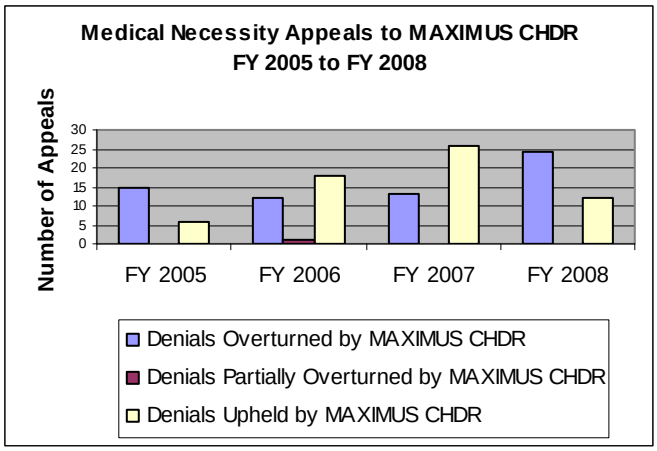
Fourteen (14) IFFCs were conducted during this fiscal year. The Ombudsman's team conducted in-depth research on behalf of the appellant and the Director. A packet of information was then developed and given to both the appellant and the Director prior to the IFFC. This packet included all information containing relevant contract or policy provisions, full case-related information (including relevant medical records), and a chronology of relevant actions and communications. During the IFFC, the appellant was given the opportunity to describe the issue as he or she saw it, state the relief he or she sought and ask questions. The Director and Ombudsman then collaborated with the appellant concerning the issue and determined any additional information that could be useful in deciding the appeal. The Ombudsman's team assisted with the development of all additional information.



As depicted in the chart above, the number of appellants requesting an IFFC with the Director of DHRM remained consistently low compared to the number of appeals requested. A relatively high percentage of appeals concerned medical issues. Anecdotal evidence suggested that many appellants believed that an IFFC was not necessary because their medical records provided sufficiently relevant and convincing evidence. During FY 2008, 24% of appellants requested an IFFC.

For appeals pertaining to medical necessity, DHRM had a contract with MAXIMUS Center for Health Dispute Resolution (MAXIMUS CHDR) to conduct an independent, impartial third party review. Medical necessity was defined as a service requested to treat an illness, injury or pregnancy-related condition which a provider had diagnosed or reasonably suspected. To be medically necessary, the service had to: 1) be consistent with the diagnosis of the condition; 2) be in accordance with standards of generally accepted medical practice; 3) not be for the convenience of the patient, the patient's family, or the provider; 4) be the most suitable cost-effective supply (i.e., medications, durable medical equipment, etc.) or level of service which can be safely provided; and 5) be a covered benefit under the Commonwealth's Health Benefits Programs.

For appeals involving medical necessity, the Ombudsman's team sent the entire case record to MAXIMUS CHDR to be reviewed. After reviewing the material, MAXIMUS CHDR rendered a decision, which was binding on DHRM. After MAXIMUS CHDR sent its decision to DHRM, the Director of DHRM made the final decision relating to the appeal and communicated that decision, in writing, to the appellant. During FY 2008, 36 appeals were sent to MAXIMUS CHDR for independent external clinical review. Of those, 24 denials were overturned.



From FY 2005 through FY 2007, there was a significant downward trend in the number of appeals overturned by MAXIMUS CHDR. However, in FY 2008, the annual percentage of denials overturned increased by approximately 46%. Most of the denials that MAXIMUS CHDR overturned during FY 2008 involved services that were considered by the third party vendor to be experimental or investigational.

Fifty percent of the appeals overturned by MAXIMUS CHDR during FY 2008 involved a single medical test which had recently been developed and which was consistently deemed experimental by the vendor. This trend was identified and meetings were held with the vendor to discuss its coverage rules regarding this test. Ultimately, the vendor changed its guidelines and approved this test when specific criteria were met. The vendor also applied the same updated criteria to its commercial plans. Thus, the efforts of the Ombudsman and his team were potentially beneficial to many Virginians who did not participate in the State's Health Benefits Program. After the new guidelines were implemented, the number of appeals involving this test dropped substantially.

DHRM relied on MAXIMUS CHDR's network of highly qualified clinical reviewers, consisting of board-certified physicians, dentists or other certified health care practitioners, to provide clear and impartial reviews based on evidence and accepted standards of practice.

As evidenced by the example above, when MAXIMUS CHDR overturned a medical decision, information regarding the decision was provided to the vendor who issued the initial denial so that the vendor was able to learn from the final decision. In this way, the Ombudsman's team facilitated the evolution of the standards of care, and thus promoted continuous learning and improvement in the administration of the Health Benefits Program.

An independent review was not required for appeals involving eligibility issues or medical appeals involving contractual issues. After thorough review of the evidence, the Director decided those appeals and communicated decisions to appellants by letter. The Director's appeal decision was final and binding.

In all appeals to DHRM, if the original denial was upheld, the appellant was advised that he may appeal under the provisions of the Administrative Process Act (APA), Rules of the Supreme Court, within 30 days of the final denial by the Director. There was one APA appeal filed during FY 2008. The Court's decision in that case was still pending at the end of FY 2008. Three APA appeals filed during the prior year were resolved during FY 2008. In two of those cases, the Court ordered that the appeals be denied and the matters were dismissed. In the third case, the appellant withdrew the appeal before the court date.

CUSTOMER FEEDBACK

Inquiries from plan members and appeals were handled case by case. Frequently, plan members who submitted inquiries were asked to provide feedback. Furthermore, at the close of each IFFC, the appellant was asked to suggest any area where OHB may improve the appeals process, Program communications, or any other aspect of the Health Benefits Program. Feedback from employees who experienced a problem was a very important tool for improving the Program, because the Program regularly acted on employees' suggestions. The more that OHB understood the needs of employees, the better OHB was able to serve those needs. In particular, feedback from employees informed several communication efforts, including efforts to educate members in regard to their wellness benefits and the rules involving adding and dropping dependents.

Inquiries from Benefits Administrators provided rich data for the Health Benefits Program. Their feedback was used in similar ways to that of employees. Furthermore, whenever similar questions were received from several Benefits Administrators, it indicated potential training opportunities, and these patterns were communicated to OHB staff responsible for training new and experienced Benefit Administrators. These efforts resulted in improved training. Also, feedback from Benefits Administrators, in the form of a survey, was also used to evaluate the quality of the customer service they received during FY 2008. Ninety-five (95) percent of respondents rated customer service as "good" to "excellent."

During the State's Human Resources Conference in October 2007, the Ombudsman facilitated a session for Benefits Administrators (BAs) called "Finding the Ultimate Win-Win – Enhancing the BA/OHB Partnership." At this session, Benefits Administrators were asked to discuss any aspects of OHB's performance they wished, including both areas in which they believed OHB was performing well, and areas in which they believed there were opportunities for improvement. Furthermore, they were asked to present suggestions for improvement. Following this session, the Ombudsman assembled a team of DHRM and OHB staff that analyzed this feedback and implemented a number of cost-effective and practical suggestions to improve the administration of the Health Benefits Program.

COMMUNICATIONS AND LIAISON WITH CONTRACTORS

The Ombudsman took an active role in the development of communications for all State Health Benefits Program publications, web site information, and vendor communications to employees. The Ombudsman's team constantly reviewed communications from OHB and its various vendors (i.e., Anthem, Medco, Delta Dental, and ValueOptions). Furthermore, the Ombudsman's team communicated frequently with vendors to discuss coverage, eligibility and claims issues. During this fiscal year, the Ombudsman participated, with other OHB staff, in an extensive project to re-write the Health Benefits Program's member handbooks for the plan year beginning July 1, 2008.

During this fiscal year, DHRM unveiled a series of health benefits posters designed to inform employees of the rules involving adding or dropping dependents due to life events. These posters were well-received and effective, and they garnered a National Communications Award from the National Association of State Personnel Executives. DHRM's Communications Manager for Health Benefits was primarily responsible for developing these posters, and the Ombudsman and members of his team worked closely with her in developing both the concept and the finished posters. This project led to a reduction in the number of appeals involving these issues. More importantly, this reduction in appeals indicated that these posters resulted in more employees taking appropriate actions to ensure that dependents were correctly covered.

During FY 2008, as in previous years, the Ombudsman's team continued to assist and educate employees in understanding their rights and available processes under their health plan, including the appeals process.

TRAINING

During FY 2008, the Ombudsman served as an ex officio member of the Board of Directors of the United States Ombudsman Association (USOA). Through relationships with other ombudsmen, the Ombudsman stayed abreast of best practices in the field. The Ombudsman co-facilitated a USOA training workshop for new ombudsmen, instructing participants in critical skills including communication, investigation, reporting, and emotional intelligence.

KEY INTERVENTIONS AND RESULTS

As outlined throughout this report, the Ombudsman's team made many efforts to maximize the accessibility and effectiveness of the Health Benefits Program. Below are examples of some key activities of the Ombudsman's team during FY 2008.

The Ombudsman led an extensive project in which he and other OHB staff worked very closely with the Information Technology Department during FY 2008 to develop and implement a new Customer Relationship Management (CRM) system designed to track and manage customer contacts through telephone calls, e-mails, letters and faxes. This system was designed to increase efficiency and effectiveness. Furthermore, its reporting capability allowed OHB to better identify trends and gaps in health care service. Thus, CRM was and will remain an important tool for OHB in its efforts to achieve continuous improvement in all business areas. OHB staff was trained in the use of CRM and it became operational on June 2, 2008.

The Ombudsman's team recognized the importance of identifying and resolving systemic issues. Therefore, the team consistently analyzed issues, paying particular attention to emerging trends, to determine whether they involved systemic problems. The Ombudsman and his team helped to correct at least eight significant systemic issues during FY 2008. One key example involved the processing of several appeals. In these cases, inconsistencies were discovered in the way several out-of-state claims were paid by one of OHB's third-party vendors. Upon investigation, it was learned that due to systems issues, this vendor paid some out-of-state claims in error. Working with other OHB staff, the Ombudsman's team held a series of meetings with the vendor to discuss and resolve this matter. One outcome of these meetings was that the vendor corrected these systems problems. Another outcome was that the vendor took steps to improve its internal review process, including implementing an oversight process for OHB appeals, so that if similar issues should arise, they may be identified directly by the vendor before the case was known to OHB.

During the latter part of FY 2008, a random review of a vendor's appeals was initiated for accuracy and consistency. This process has not been completed. Upon completion, findings will be reported to OHB staff and the vendor. If findings warrant, discussions will be held with the vendor to identify areas for improvement and an action plan will be developed.

CONCLUSION

In the pursuit of excellence, the Ombudsman's team focused on delivering quality service, in a cost-effective manner, to covered State employees and retirees and members of the Local Choice program. The Ombudsman and his team continued to provide a valuable service to State employees and retirees, Local Choice enrollees, and their dependents, making a real difference in a number of ways. As always, the team continued to solicit and act on customer feedback. The team thoroughly investigated inquiries and appeals, dealing with each issue fairly and consistently. The team paid particular attention to trends as they developed, in order to identify and resolve systemic issues, thus promoting continual and lasting improvement of the State's Health Benefits Program. In doing so, the Ombudsman and his team made a positive impact on OHB's vendors, both for employees and retirees of the State and the general public.

As the State's Health Benefits Program moves into the next fiscal year, the Ombudsman and his team remain committed and look forward to providing valuable services to members covered under the Program and the citizens of Virginia. The Ombudsman and his team will continue to be mindful of their responsibility to act efficiently and effectively, always striving to meet high standards in a cost-effective manner.