COMMONWEALTH of VIRGINIA

Sara Redding Wilson
Director

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November 27, 2013

The Honorable Stephen H. Martin
The Honorable John C. Watkins
The Honorable Terry G. Kilgore
The Honorable Robert D. Orrock, Sr.
The Honorable Linda T. Puller

Dear Senator Martin, Senator Watkins, Senator Puller, Delegate Kilgore, and Delegate Orrock,

The Code of Virginia, §2.2-2818, specifies that the ombudsman charged with promoting and protecting the interest of covered employees under the state's health plan shall "report annually on his activities to the standing committees of the General Assembly having jurisdiction over insurance and over health and the Joint Commission on Health Care by December 1 of each year."

Attached for your review and consideration is the report prepared and submitted on November 27, 2013 in response to this requirement.

Respectfully,

Sharon S. Finn
Ombudsman
Office of Health Benefits Programs
VA Department of Human Resource Management

cc: The Honorable Lisa Hick-Thomas, Secretary of Administration
Sara Redding Wilson, Director, Department of Human Resource Management

OMBUDSMAN
ANNUAL REPORT
Fiscal Year 2013

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

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ANNUAL REPORT ON
OMBUDSMAN ACTIVITIES & SERVICES
Fiscal Year 2013

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

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, 2012 through June 30, 2013. The Ombudsman's team helped to resolve issues encountered by employees, retirees and their covered dependents involving access and eligibility for health care under the Commonwealth's Health Benefits Program. As part of its responsibilities, the team assisted covered employees in understanding their rights and the processes available to them through the program. The team also guided covered employees in using available health plan resources.

In fiscal year 2013, the Ombudsman's team handled 5,540 formal case-specific inquiries and reviewed 107 formal appeals. The team achieved its goal of continuous improvement by:

- working to resolve issues and solve problems in a timely manner,
- consistently analyzing issues, identifying emerging trends and working to correct systemic issues,
- updating policies and implementing new channels of communications, and
- making every effort to maximize the accessibility and effectiveness of the Health Benefits Program.

Some of the major projects managed during this fiscal year include:

- **2013-2014 Health Benefits Plans** - the Ombudsman worked extensively with other DHRM employees to restructure the health plan options and benefits. The project included procuring services for administration of self-insured plan options, flexible spending accounts, a fully-insured Health Maintenance Organization (HMO), and a total health management program. Along with developing incentives to encourage health behaviors among the plan participants, the team worked on the development and implementation of:
    - COVA HealthAware, a new Consumer Directed Health Plan,
    - ALEX, an online health plan counseling tool, and
    - MyActiveHealth, an integrated health and wellness management program.

- **Affordable Care Act Provisions** – The Ombudsman worked with other DHRM employees to review and implement required provisions of the Affordable Care Act

(ACA) during this fiscal year and continues to work on provisions which will be implemented on or before July 2014. These include:

- Women's Preventive Coverage - providing certain preventive care services at no cost to members,
- Flexible Medical Spending Account - capping the maximum contribution to the Commonwealth's medical spending account at $2,500,
- Full-time Employee Definition - Guidelines for agencies to determine which employees qualify as full-time employees under the ACA 30 hour rule, and
- Summary of Benefits and Coverage –The Ombudsman and team worked with the plan vendors to develop twenty-four (24) summaries for the State and The Local Choice health plan to help members compare and understand their options.

- **Disease Management Reporting and Coaching Pilot Program** – the Ombudsman and team members worked with a specialized vendor and designated state agencies to implement and monitor this pilot program designed to alert participants of their risks for heart disease, stroke, and diabetes, providing comprehensive coaching as needed. Pilot program details and outcomes will be included in next year's report.

- **The Local Choice (TLC) Eligibility Migration** – the Ombudsman and team worked with the TLC program manager and the OHB systems team to incorporate the eligibility and enrollment data for over 320 TLC groups, representing more than 31,000 school and municipal employees, into the Commonwealth's Benefits Eligibility System (BES).

The Ombudsman's team continued to provide services needed by state employees and retirees 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 works within the Office of State and Local Health Benefits Programs (OHB) in the Department of Human Resource Management (DHRM). The primary objective of the Ombudsman and the team is to help eligible members understand their rights and the processes available through their State Health Benefits Program, including all appeals procedures. The Ombudsman's team consisted of two Health Benefits Specialists, five Senior Health Benefits Specialists and an Appeals Examiner. Core groups within OHB supplemented the needs of the Ombudsman's team when additional expertise was required or when there was a spike in volume. This flexibility allowed the team to work efficiently and effectively, producing timely and appropriate responses to member issues.

The State Health Benefits Program averaged 243,000 state employees, retirees and covered family members during this fiscal year. The Local Choice Health Benefits Program averaged approximately 49,000 members. In total, the Ombudsman's team served over 292,000 state and local government employees, retirees, and their family members during this report period.

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. Team members also served as a resource for approximately 320 Group Benefit Administrators in The Local Choice Program. The Ombudsman's team provided services to over 600 human resource professionals during this period.

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.

KEY INITIATIVES

2013-2014 HEALTH BENEFITS PROGRAM OPTIONS

The Office of Health Benefits engaged in an extensive project during this fiscal year to restructure the state health plans for state employees, non-Medicare retiree plan participants and dependents of both groups. The Ombudsman and her team, along with other members of the OHB staff, contributed significantly to this project and were instrumental in the two project phases shown below.

Request for proposals (RFP) review: OHB issued two RFPs in September 2012 – one which encompassed the self-insured PPO, flexible spending account plan and fully insured plans and a second for a consumer directed health plan with a health and wellness management component. During this phase, the Ombudsman and members of her team participated in pre-proposal conferences, reviewed responses to RFPs, and assisted during the negotiations and finalist interviews.

All members put forth tremendous effort and devoted significant time to the project. With the involvement of all OHB staff, the review process was completed in three months rather than the normal procurement review time of approximately 10 months. The notices of intent to award the contracts were issued on December 14, 2012.

Implementation Phase: Immediately following the awards, the Ombudsman and team began working to prepare for the 2013-2014 plan year open enrollment which included implementing new plan options and transitioning to new third party claims administrators. The Ombudsman served as the Implementation Manager for this phase of the project. The team held weekly meetings with all vendors, covering topics such as:

- transitioning prescription drug services without disruption,
- revamping of the dental benefits to comply with ACA,
- procedures and protocols for data file transfers,
- transition of the bariatric surgery education program,
- developing the health plan decision tool,
- designing the new health reimbursement arrangement (HRA),
- designing the health and wellness portal and program including specific incentives and premium reward criteria,
- developing a comprehensive data warehouse, and
- implementing an intensive communication strategy for open enrollment and beyond.

Each of these topics involved meticulous attention to details. The team also responded to inquiries from benefits administrators, employees and retirees related to components of this project.

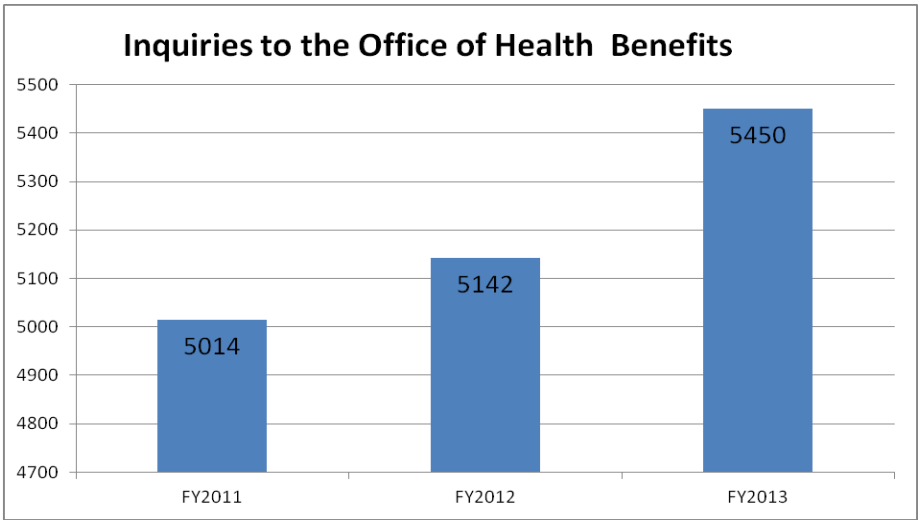
Disease Management Reporting and Coaching Pilot Program:

Volunteers in a large statewide agency are participating in a pilot program designed to provide individuals with detailed information about health risks associated with heart disease, strokes and diabetes by offering advance testing to identify hidden risk factors. The program also provides each at-risk member with a personal health coach to assist with the development of a plan for health improvement.

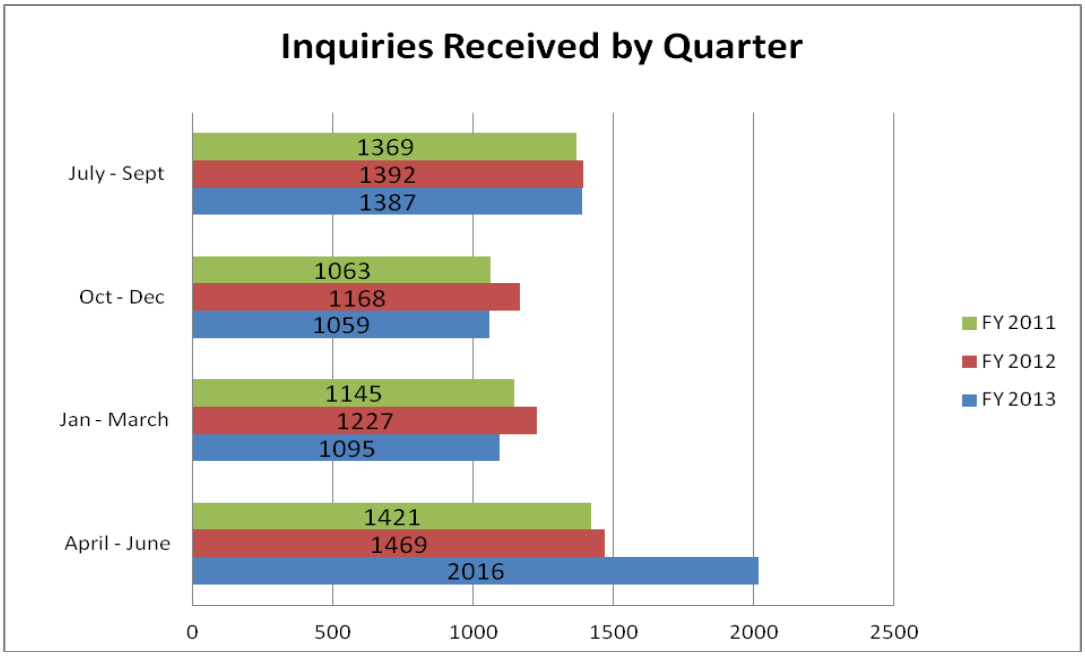
Members of the Ombudsman's team were identified to review the responses to RFPs for this pilot, and participated in the finalist interviews for a program administrator. They also worked with the DHRM and OHB Directors to identify the agency for the project. Once the selection process was complete, the team collaborated with the vendor and agency management team on the implementation plan and communication strategy for the pilot. The initial agency screenings were held in June 2013. More information about the outcomes of this pilot project will be included in the 2014 fiscal year report.

INQUIRIES

In FY 2013, the Ombudsman's team handled 5,450 formal case-specific inquiries from employees, retirees, agency Benefits Administrators, legislators, providers and other interested parties. This compares to 5,142 inquiries in FY 2012 and 5,014 in FY 2011 or a 6% increase from FY 2012 and an 8% increase from FY 2011.

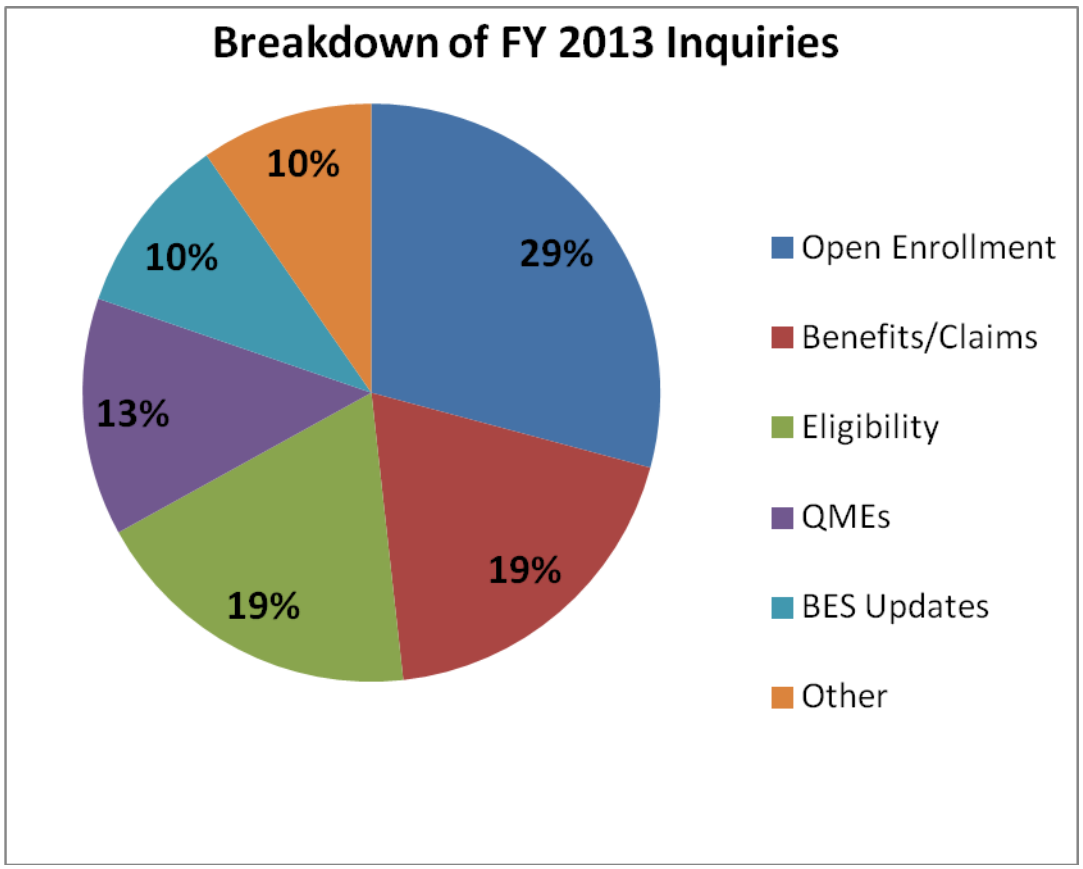


While the number of inquiries remained fairly consistent for the first three quarters of the last three plan years, OHB recorded a 28% increase in the number of inquiries for the fourth quarter of this plan year. Targeted communications generated member questions regarding the new wellness portal, ALEX, premium incentives, and vendor changes before and during the May open enrollment, and was the driver of the increased contacts with OHB during this period.



Over 1,500 of this year's inquiries were related to open enrollment and premium issues (29%) including incentive and rewards programs. The other top issues for formal contacts during the 2013 fiscal year were related to:

- eligibility requirements for employees, retirees, and dependents (19%),
- health care claims and benefits available under the program (19%), and
- qualifying midyear events (QMEs) election change requests (13%).



APPEALS

Charged with the oversight of the appeals process, the Ombudsman or a member of the team serves as the contact for appellants. Every effort is made to assure that all appellants receive the full extent of the benefits to which they are entitled under the rules of the program.

There are two categories of appeals:

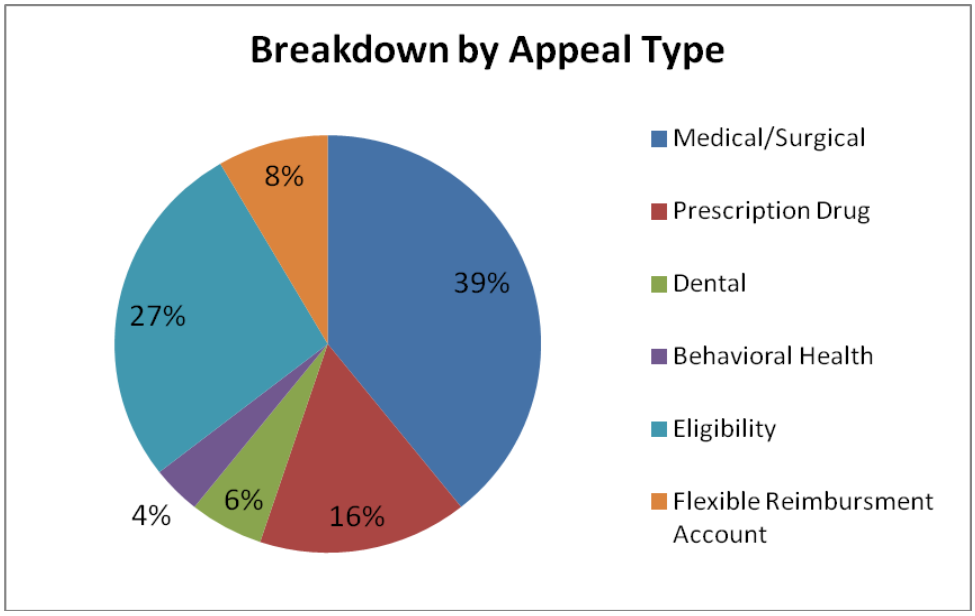
1. Plan benefit appeals which involve claim issues, and
2. Plan eligibility appeals which involve whether an individual qualifies for coverage under the program.

Each of the third party vendors responsible for administering the components of the Health Benefits Program has an internal process for benefits appeals. When an employee has exhausted the appeals with a specific vendor, they have the right to appeal any adverse decision to DHRM. When specific criteria are met, the employee has the right to appeal unresolved eligibility issues to the Director of DHRM.

Due to components of the Affordable Care Act, the appeal guidelines were revised for FY 2012 allowing members to appeal any adverse benefit determination by a plan administrator that is based on the plan's requirements for

- medical necessity and appropriateness,
- health care setting and level of care,
- effectiveness of a covered benefit, or
- services deemed to be experimental or investigational.

During the 2013 fiscal year, 107 appeals were submitted to the Director of DHRM. This compares to one hundred thirteen (113) appeals for the 2012 fiscal years and seventy-five (75) for FY2011. For FY 2013, 39% of the appeals received related to medical/surgical issues while the second largest appeal category (27%) was eligibility issues.

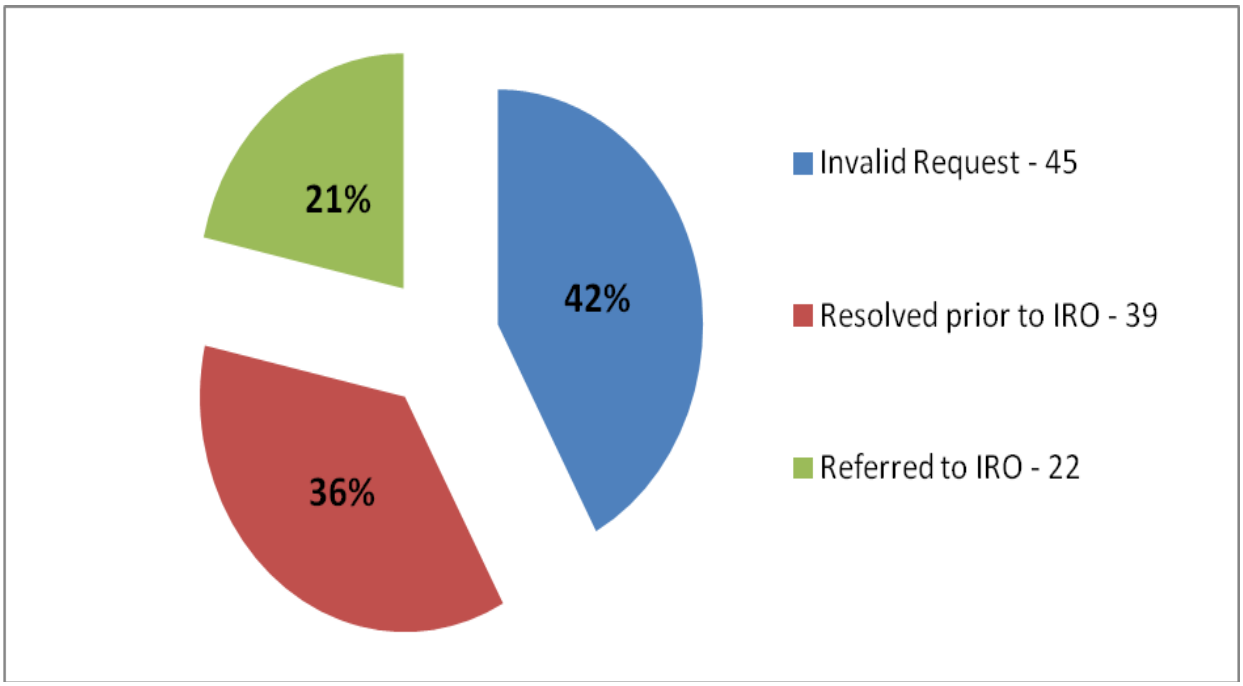


Once received by DHRM, the Ombudsman's team strives to resolve the appeal as early in the process as possible. Under the program, matters in which the sole issue is a disagreement with policy or a contractual exclusion are not appealable. Although these matters are not appealable, each case is evaluated to ensure that the program rules and benefits have been applied correctly. Forty-five (45) appeals filed were determined to be invalid or for non-appealable issues. This represents 42% of the appeals filed and in most of these cases, the member:

- had not followed the outlined appeals process and reached out to OHB before completing the internal process with the vendor, or
- made a request for an exception to a plan provision such as coverage for an excluded service or the mandatory generic prescription provision.

Each issue is evaluated to determine whether the denial was clearly in line with the provisions of the program and no substantive error was made in the initial review process. In many cases, DHRM is able to resolve the issue in the member's favor by working with the health plan vendor and/or the member. These appeals are only resolved in this phase if the resolution is in favor of the appellant. During FY 2013, thirty-nine (39) appeals or 36% were resolved by DHRM without the need for an external review.

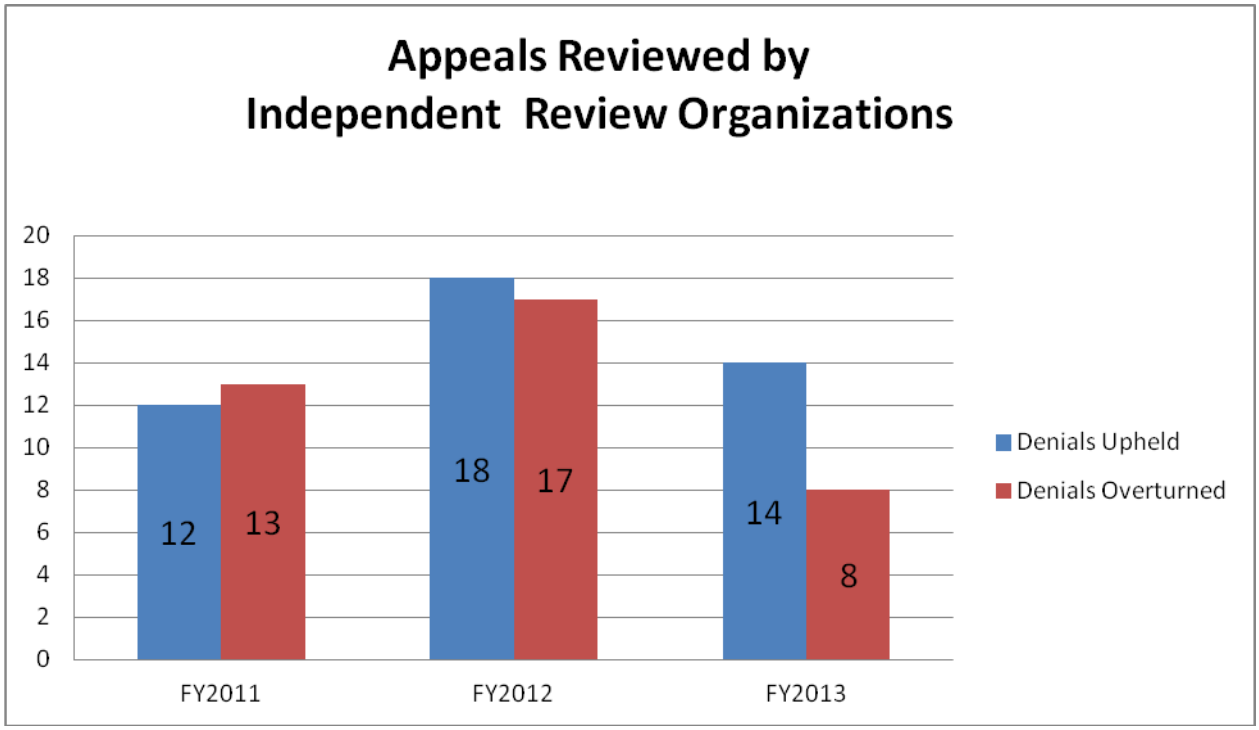
The remaining twenty-two (22) appeals (21%) were handled through the independent third party review process.



Independent Review Organizations:
An adverse determination of coverage for plan benefit appeals is reviewed by an independent review organization (IRO). In accordance with health care reform provisions, DHRM has contracts with three vendors, MAXIMUS Center for Health Dispute Resolution, Permedion, and IPRO, to conduct independent reviews. Cases are assigned to the IROs on a rotational basis. It is the responsibility of the IRO to confidentially examine the final denial by the plan administrator and determine whether the decision is objective, clinically valid, and compatible with established principles of health care. DHRM relies on the IRO to provide impartial reviews based on evidence and accepted standards of practice.

In specific circumstances, members may file an expedited appeal for adverse benefit determinations and a final decision must be rendered in a shorter, specific time period. While the program previously included provisions for expedited appeals, the expedited appeal process was a point of emphasis under the Affordable Care Act. Of the twenty-two appeals referred to an IRO this fiscal year, 86% were submitted and handled through the standard process and only three (3) were submitted as expedited appeals with decisions being rendered within 72 hours.

Of the twenty-two appeals reviewed by an IRO this fiscal year, only eight or 36% of the adverse determinations were overturned or reversed. This was the first fiscal year with multiple IROs in place. While, a definitive reason for the decrease in the number of overturned decisions was not identified, the Ombudsman and the appeals analyst review the decisions based on the nature of the appeal and the reviewer to identify any patterns.



Once the IRO has made a decision, a written notification is provided to the member, DHRM, and the plan administrator. When a medical decision is overturned, the final decision is discussed in detail with the specific plan administrator. In this way, the Ombudsman's team facilitates the evolution of the standards of care, and thus promotes continuous learning and improvement in the administration of the Health Benefits Program. While the majority of the appeals this fiscal year were due to denials of services felt to be "experimental and/or investigational" by the plan administrator, there was not a specific theme identified for the type of services being appealed.

An independent review is not required for appeals involving eligibility issues. When the issues involved whether an individual qualifies for coverage, the opportunity for an informal fact finding consultation (IFFC) with the Director is offered to the appellant. The Director and Ombudsman then collaborate with the appellant concerning the issue; reviewing any additional information that could be useful in deciding the appeal. After thorough review of all information provided, the Director makes a determination on the appeal and communicates the decision to the appellant by letter. The Director's appeal decision is final and binding. There were no IFFCs requested during the 2013 fiscal year.

In all appeals to DHRM, if the original denial is upheld, the appellant is 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. One (1) APA appeal was filed in FY 2013 but was withdrawn by the appellant before the court date.

COMMUNICATIONS

The Ombudsman is involved in the development and review of communications for all State Health Benefits Program publications, web site information, and vendor communications to members. The Ombudsman and her team constantly review communications developed by OHB, as well as by the plan's third party administrators.

This year, the Affordable Care Act required all employers to provide a standardized document that outlined benefits and the coverage provisions associated with each benefit. The Ombudsman and team, along with other members of OHB, worked with the plan vendors to develop a Summary of Benefits and Coverage (SBC) for each of the health plan options offered under the State and The Local Choice programs.

With the implementation of the plan changes for the 2013-2014 plan year, the Ombudsman and her team worked closely with the DHRM communications manager and each of the plan vendors to develop open enrollment material including a video presentation, Spotlight on Health Benefits newsletter, and an email campaign on new program components. Along with a joint communication summit for the vendors, the OHB team coordinated a preliminary open enrollment meeting hosting over 200 agency benefits administrators and managers onsite with an additional 150 attending via webinar access. OHB also expanded its open enrollment meeting schedule and facilitated 30 statewide meetings which drew a total of over 5,000 eligible members.

Furthermore, the Ombudsman's team communicates frequently with all plan vendors to discuss coverage, eligibility and claims issues. The Ombudsman works with the vendors to prepare ongoing information regarding the plan benefits and also participates in all applicable quarterly and annual vendor meetings with OHB.

CONCLUSION

The work preformed this fiscal year represents an unprecedented amount of activity for the State Health Benefits Program. In the pursuit of excellence, the Ombudsman's team focused on delivering quality service in a cost-effective manner to covered state employees, retirees and The Local Choice members. The Ombudsman's team continued to serve plan members, making a real difference in a number of ways. As always, the team continued to solicit and act on customer feedback. It thoroughly investigated inquiries and appeals, dealing with each issue fairly and consistently. The Ombudsman's team also paid particular attention to trends as they developed in order to identify and resolve systemic issues, promoting continual and lasting improvement of the State Health Benefits Program. In doing so, the Ombudsman and her team had a positive impact on OHB's vendors, both for state employees and retirees, and for the general public.

As the State's Health Benefits Program moves into the next fiscal year, the Ombudsman's team will strive to meet the highest standards in the most cost-effective way possible, and looks forward to continuing to provide needed services to members covered under the program and to the citizens of Virginia.