COMMONWEALTH of VIRGINIA

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November 25, 2015

The Honorable Stephen H. Martin
The Honorable John C. Watkins
The Honorable Terry G. Kilgore
The Honorable Robert D. Orrock, Sr.
The Honorable John M. O'Bannon, III

Dear Senator Martin, Senator Watkins, Delegate Kilgore, Delegate Orrock and Delegate O'Bannon,

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 25, 2015 in response to this requirement.

Respectfully,

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

cc: The Honorable Nancy Rodrigues, Secretary of Administration
Sara Redding Wilson, Director, Department of Human Resource Management

OMBUDSMAN ANNUAL REPORT FISCAL YEAR 2015

Office of State and Local Health Benefits Programs

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ANNUAL REPORT ON
OMBUDSMAN ACTIVITIES & SERVICES
FISCAL YEAR 2015

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, 2014 through June 30, 2015. 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 members in using available health plan resources.

In fiscal year 2015, the Ombudsman's team handled 7,480 cases and reviewed 104 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.

Key initiatives and projects managed during this fiscal year include:

- **2014-2015 Health Benefits Plans and Programs** - the Ombudsman continued to work with other DHRM employees on various components of the health plans, including a comprehensive health and wellness management program, MyActiveHealth. In order to encourage healthy behaviors among health plan participants, the Ombudsman and OHB team members developed additional incentives for the health and wellness management program. The team also modified the process to qualify for the premium rewards program, and worked on plan year updates to ALEX, the health benefits program online counseling tool. Working with members of the OHB Policy Team, the Ombudsman assisted in the development of member communications and handbooks and the team worked on the benefit and claims resolutions for all plans.

- **Same Sex Marriage and State Health Benefits** - With the ruling to recognize same sex marriage in the Commonwealth of Virginia, employees and other participants eligible for state health benefits who became legally married were allowed to submit their request to enroll or add their spouse and other eligible dependents within sixty days of their marriage. The Office of Health Benefits provided letters to all health care eligible employees and participants with information on the required documentation and election request deadlines to assist with the enrollment process.

- **Affordable Care Act Provisions** - The Ombudsman worked with other DHRM employees on various provisions of the Affordable Care Act (ACA) during this fiscal year and continues work on future provisions. These include:
  - Mandate for reporting health care enrollment for plan members.
  - Health Benefits for "Full-time" employees as defined by the ACA.
  - Summary of Benefits and Coverage (SBC) for the available State and The Local Choice (TLC) health plans to help members compare and understand the options.
  - IRC Section 125 regulation change which now allows employees to request a waiver of their enrollment in employer-sponsored plans to enroll in a health plan offered through the Marketplace Exchange.

- **FAMIS Eligibility** –New eligibility criteria became effective on January 1, 2015, for the FAMIS, the Children's Health Insurance Program for the Commonwealth administered by the Department of Medical Assistance Services (DMAS). This change in eligibility allowed children of state employees, who met certain income criteria, to qualify for coverage under the FAMIS program. Employees could make changes to their health plan elections during the annual Open Enrollment period to enroll eligible children in FAMIS. DHRM worked with DMAS to provide information to the agencies and state employees about the new FAMIS eligibility and to include information about the DMAS qualification and enrollment process with the State's Open Enrollment materials.

- **Anthem Cyberattacks** – The Ombudsman, Privacy Officer and key DHRM staff worked closely with Anthem on several reported data breaches. The most notable was the announcement of the Anthem nationwide cyberattack in February 2015, which affected current and former Anthem members and employees. The information accessed included names, Social Security numbers, addresses, and for Anthem employees, employment information and income data. Anthem set up a website and a toll-free number to respond to member questions. DHRM provided informational updates to employees and retirees during the investigation and addressed member concerns and issues with Anthem.

- **Benefits Administrator Webinar Series -** In an effort to provide tools for Benefits Administrators to expand their knowledge about health plans and other benefits available to their employees, the Office of Health Benefits worked with the plan administrators to coordinate and implement a series of webinars. The webinars were designed to better equip the benefits administrators to communicate the unique features of the plans to current and newly-eligible participants.

- **The University of Virginia at Wise** – Although the employees and early retirees of the University of Virginia are covered by a separate health plan administered through the University, the employees of the UVA - College at Wise were a part of the state employee health plan administered by DHRM. The University of Virginia was given approval to include the employees of the University of Virginia's College at Wise in the UVA health plan. Although the College at Wise only had about 300 employees, the Office of Health Benefits provided necessary utilization and financial data, as well as input on communications, to UVA in an effort to make the transfer as seamless as possible for the employee population.

The Ombudsman's team continued to provide services to state and local government 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 the appeals procedures. The Ombudsman's team consists of two Health Benefits Specialists, five Senior Health Benefits Specialists and an Appeals Examiner, who also serves as the Privacy Officer for the Office of Health Benefits. Core groups within OHB supplement the needs of the Ombudsman's team when additional expertise is required or when there is a spike in volume. This flexibility allows the team to work efficiently and effectively, producing timely and appropriate responses to member issues.

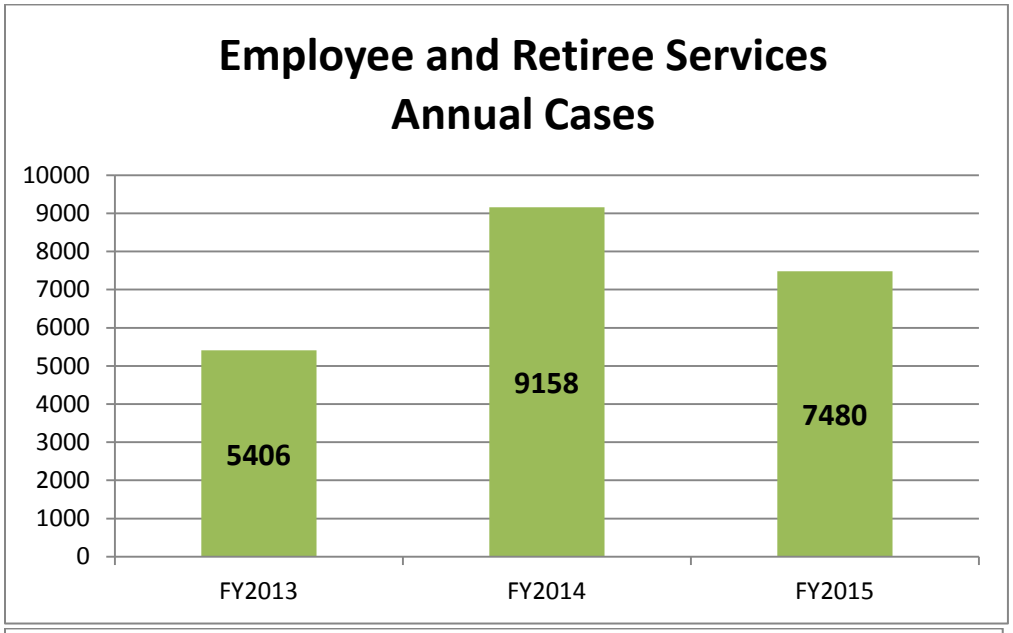
The State Health Benefits Program covered approximately 100,000 state employees and 42,000 early and Medicare-eligible retirees during this fiscal year. The Local Choice Health Benefits Program covered 322 (45 schools and 277 government) local employer groups. The employer groups provided benefits for approximately 35,000 employees and retirees of local school systems, governmental entities and political subdivisions. In total, the Ombudsman's team served over 177,000 state and local government employees, retirees, and their family members during fiscal year 2015.

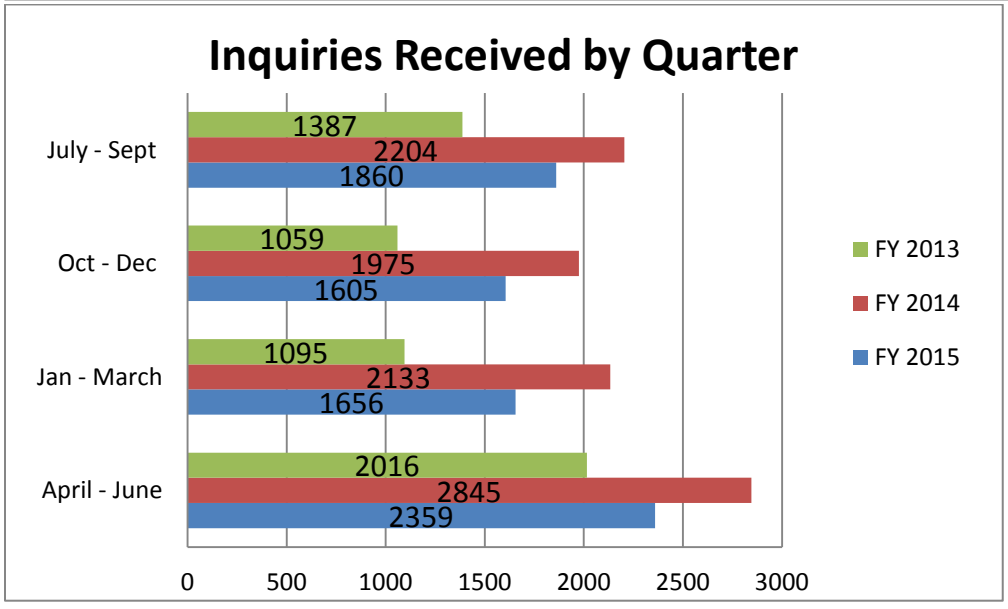
The Ombudsman's team provided services to over 600 human resource professionals during this period. The team is the resource for over 300 human resource Benefits Administrators and Managers statewide who administered health benefits within state agencies and sought assistance with program administration and policy application. Team members also served as a resource for approximately 320 Group Benefit Administrators in The Local Choice Program.

The Ombudsman worked closely with the Office of the Attorney General, which was the Ombudsman's primary resource for advice and legal counsel concerning appeals, compliance, and issues of equity.

EMPLOYEE AND RETIREE SERVICES

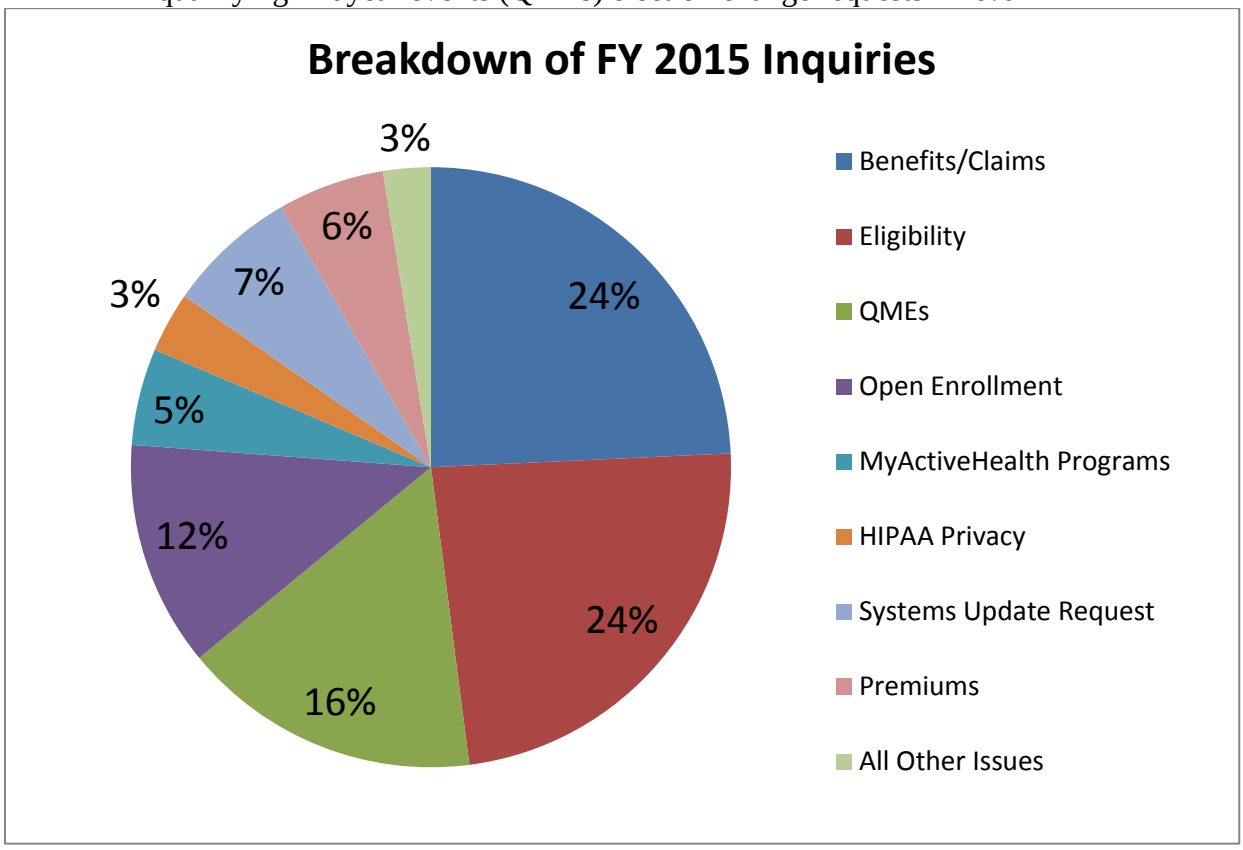
In FY 2015, the Ombudsman's team handled 7,480 cases from employees, retirees, agency Benefits Administrators, legislators, providers, and other interested parties. These contacts included general inquiries and requests for assistance related to benefits, communications, vendor services, policy interpretation, system updates and complaints. While cases increased by 69% from FY 2013 to FY 2014, reported cases decreased by 18% from FY 2014 to FY 2015. It is important to note that cases may involve multiple contacts, such as emails and telephone calls, to resolve the issues. Depending on the issue, the team may contact the plan administrator or the benefits office to work through the process and provide a resolution for the member.

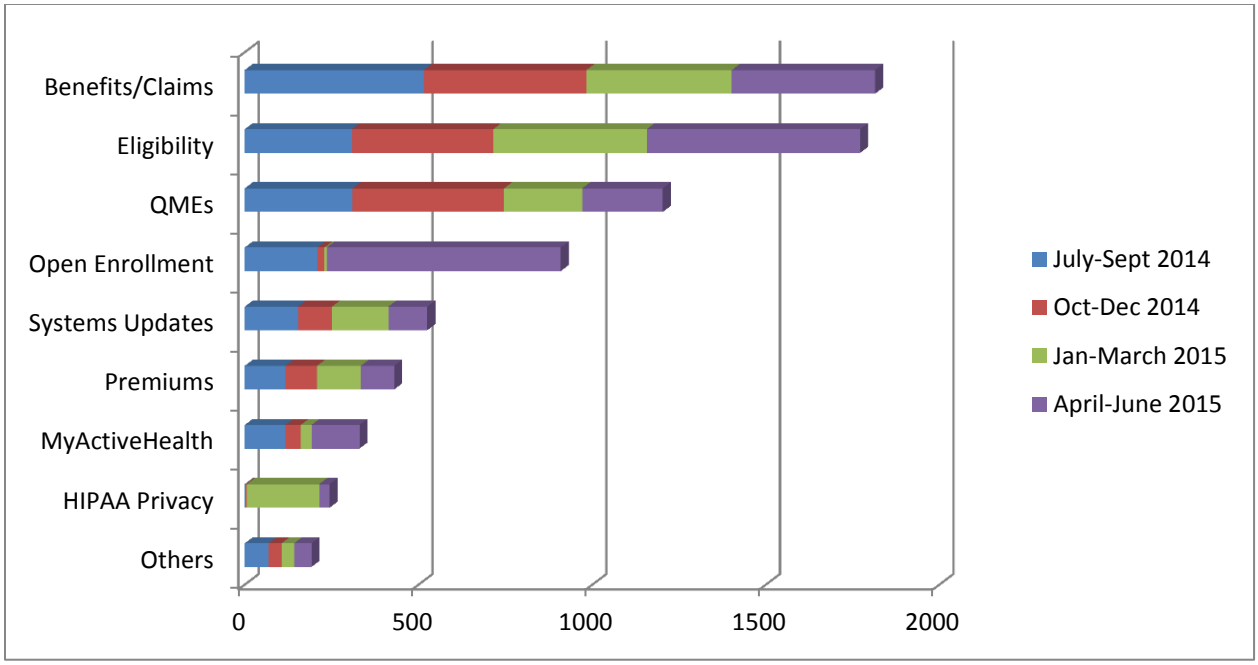




The major topics, which accounted for 64% of this fiscal year's cases, were related to:

- health care claims and benefits available under the program - 24%
- eligibility requirements for employees, retirees, and dependents - 24%
- qualifying midyear events (QMEs) election change requests – 16%





The Office of Health Benefits normally receives a consistent number of inquiries each quarter related to benefits, claims and eligibility issues. This year, we experienced a significant increase in the number of HIPAA Privacy inquiries due to the announcement of the Anthem Cyberattack. While the HIPAA Privacy inquiries only represented 3% of the year's total, they were mainly received during the third quarter of the fiscal year. As in past years, the Open Enrollment inquiries, which accounted for 12% of the inquiries, were mainly received during the first and fourth quarters of the plan year. The inquiries received during the July through September period are normally participants trying to confirm or correct errors made during the Open Enrollment process, while the contacts during April-June center on benefits and premium changes as well as clarification on how to qualify for various incentives, the communication materials, the enrollment process and deadlines.

MyActiveHealth Programs– Two of the Commonwealth's self-insured plans (COVA Care and COVA HealthAware) include incentive programs that reward members for completing healthy activities while they attempt to manage long-term health conditions. There is also a prenatal maternity management program with an incentive for compliant members. These programs were designed to encourage the utilization of plan benefits, educate the members about their personal health risks, and provide members with options to manage health conditions and/or assist with tools to encourage changes in behavior.

A. Value Based Insurance Design (VBID) Incentive Programs - The incentives for the condition-related programs have specific eligibility criteria and compliance requirements. The new incentive program components are for members with asthma, chronic obstructive pulmonary disease (COPD) and/or hypertension. When the members meet the requirements, they receive certain drugs for the treatment of the condition at no cost. The other program components include diabetes and maternity management.
B. Premium Rewards Program – This reward provides for a reduction in the monthly health plan premium if the eligible member completed an online health risk assessment and, if not already completed, a biometric screening.
C. "Do-Right" Healthy Activities - In addition to the condition related incentives, the consumer directed health plan (CDHP), COVA HealthAware, added two additional "Do-Right" activities for employees and enrolled spouses. Completion of any three of the activities will earn the eligible member additional HRA funding of $50 per activity. The plan added a routine vision exam and the completion of an online coaching module to the list of activities which already includes a flu shot, annual physical exam, a dental exam and tracking healthy actions on the vendor's online portal. All of the benefit related activities, such as the exams and the flu shot, are included in the basic in-network plan of benefits at no cost to the member.

The Ombudsman and her team worked with the vendor managers for COVA Care and COVA HealthAware to provide appropriate guidance and communication to members and vendors in the administration of these programs. The inquiries about these programs accounted for only 5% of this fiscal year's inquiries as compared to 18% of the inquiries for the 2013-2014 fiscal year. We believe that most members made the transition and became accustomed to the program requirements leading to fewer contacts and increased member satisfaction with the incentive opportunities.

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 classifications of appeals:

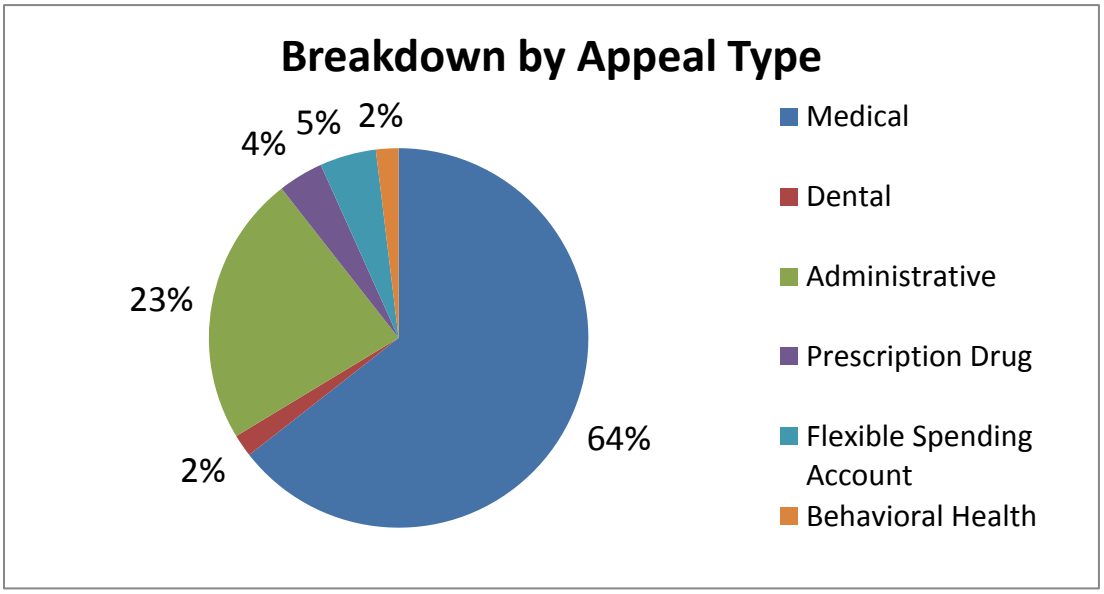
1. **Plan benefits** which involve claim and service issues, and
2. **Program administration** which involve whether an individual qualifies for coverage or a benefit under the program.

Each of the third party vendors responsible for administering the components of the Health Benefits Program has an internal process for benefits appeals. After exhausting the appeals with a specific vendor, an employee has 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.

Our appeal guidelines, which are compliant with the Affordable Care Act (ACA), allow 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 2015 fiscal year, one hundred and four (104) appeals were submitted to the Director of DHRM. This compares to seventy-three (73) appeals for the 2014 fiscal year. For FY 2015, sixty-seven, or 64%, of the appeals received were related to medical claim issues and twenty-four, or 23%, were related to program administration issues.

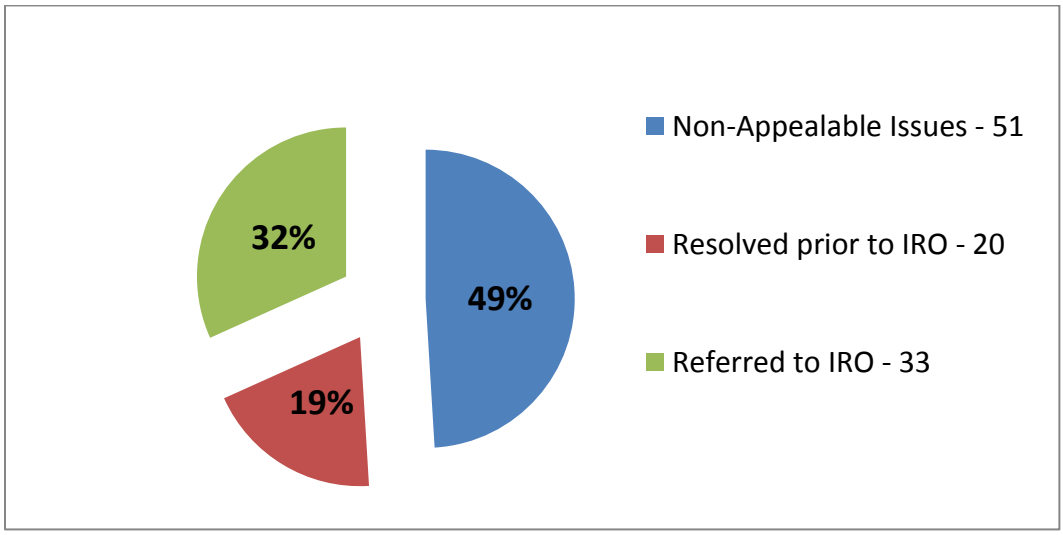


Once received by DHRM, the Ombudsman's team strives to resolve the appeal as early in the process as possible. Under the program, matters in which the sole issue is a disagreement with policy or a contractual exclusion are not appealable. Although these matters are not appealable, each case is evaluated to ensure that the program rules and benefits have been applied correctly. Fifty-one (51) appeals filed were determined to be non-appealable issues. This represents 49% of the appeals filed and in most of these cases, the member's request was in direct conflict with a program provisions or plan benefit, such as requests for:

- an exception to allow coverage for an excluded service
- an exception to the mandatory generic prescription provision
- the plan to assist with the balance billed by a non-network provider

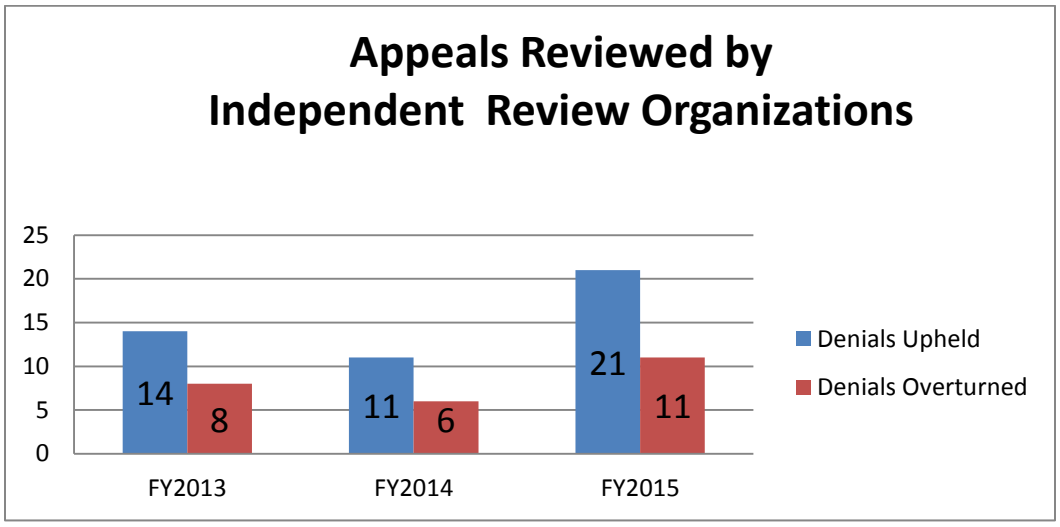
Each issue is evaluated to determine whether the denial was clearly in line with the provisions of the program and no substantive error was made in the initial review process. In many cases, DHRM is able to resolve the issue in the member's favor by working with the health plan vendor and/or the member. These appeals are only resolved in this phase if the resolution is in favor of the appellant. During FY 2015, twenty (20) appeals or 19% were resolved by DHRM without the need for an external review.

The remaining thirty-three (33) appeals (32%) 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 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. Of the 33

appeals referred to an IRO this fiscal year, 86% were submitted and handled through the standard process and three (3) were accepted as expedited appeals with a decision being rendered within 72 hours. Of the appeals reviewed by an IRO this fiscal year, only 11 or 33% of the adverse determinations were overturned or reversed and one (1) plan administrator's determination was revised and a partial benefit was approved by the IRO.



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. 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.

Administrative Process Act - 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. No APA appeals were filed in FY 2015.

Administrative Appeals - An independent review is not required for appeals involving program provisions and/or eligibility issues. When the issues involved whether an individual is eligible for coverage or a disagreement with a program provision, 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 2015 fiscal year.

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.

With the implementation of the plan changes for the 2014-2015 plan year, the Ombudsman and her team worked closely with the DHRM communications manager and each of the plan vendors to develop benefits communications on various program components, Open Enrollment, health plan member handbooks, and provided feedback on web site design and content.

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

HIPAA Privacy - This year, we experienced an increase in the number of HIPAA Privacy inquiries due to three reported data breaches; most notable was the announcement of the Anthem Cyberattack in February 2015. Cyber attackers gained unauthorized access to the company's IT systems and obtained personal information relating to current and former members covered by Anthem Blue Cross and Blue Shield. The information accessed included names, addresses, and social security numbers. There was no evidence that medical information such as claims, test results, or diagnostic codes were targeted or obtained. Upon the discovery of the attack, Anthem contacted the FBI to begin an investigation and also retained a cybersecurity firm to evaluate their systems and identify solutions based on the evolving landscape. Anthem Blue Cross and Blue Shield individually notified current and former members whose information has been accessed. Also, credit monitoring and identity protection services was provided free of charge to all members. During the investigation, it was determined that one hundred twenty-eight thousand current and former COVA and TLC members had their social security numbers illegally accessed.

It was announced in March 2015 that Premera Blue Cross was the victim of a cyberattack. This is a different attack than the one announced in February by Anthem. Premera and Anthem are separate companies but they are both part of the Blue Cross and Blue Shield system, which includes 37 independent, locally operated companies across the U.S. This affiliation enables Blue Cross and Blue Shield customers to access care anywhere in the country through the BlueCard program. Anthem members who accessed medical care in Alaska or Washington are serviced by Premera. It was determined that 620 members or former members were affected and Premera offered all members affected by this cyber-attack free credit monitoring services.

In May 2015, CareFirst BlueCross/BlueShield announced that they had been the target of a cyberattack. It is important to note this cyberattack is not related to Anthem's recent cyberattack. CareFirst is an independent licensee of the Blue Cross and Blue Shield Association, which offers health insurance benefits through the BlueCard program to members in Maryland, the District of Columbia and portions of Northern Virginia. The information accessed as a result of the attack

was for CareFirst members only who created online accounts on www.carefirst.com prior to June 20, 2014. Anthem confirmed that no COVA or TLC members were impacted, including members who may have utilized provider services through the BlueCard program.

The Ombudsman, Privacy Officer and Communications Manager, along with the DHRM and OHB Directors and other key OHB policy team members, worked closely with Anthem to communicate information to members as quickly and thoroughly as possible. Several communications from DHRM were distributed to employees and retirees during this period to supplement and clarify the information provided by Anthem. Because we understood the anxiety of our members in the wake of data breaches, DHRM provided additional information on Tips to Prevent Identity Theft, Credit Monitoring, Fraud Alerts, and Frequently Asked Questions related to cyberattacks.

Higher Education Institution "New Hire" Presentations - As a pilot program, the DHRM Office of Health Benefits, in coordination with our health plan claims administrators, offered to provide employee presentations at state universities. The presentations on health plan benefits were directed to new faculty members hired for the fall semester. Each carrier (Anthem, Aetna, Delta and ActiveHealth) provided an overview of their plan or program benefits followed by an opportunity for the audience to ask questions. We believe this was a better method to provide substantive information to new hires so they could make an educated coverage decision.

Benefits Administrator Webinar Series - The Office of Health Benefits worked with the health plan administrators to identify webinar topics which would be of interest to employees and provide information on the benefits and features of the plans. The webinar topics for the plans are related and build upon prior webinar information. In addition, the webinars are also designed for use by the agency benefits administrators with their employees. They are posted on the DHRM web site and available for use by the agencies for employee meetings and new hire orientations. The series topics included:

COVA HealthAware:

- Consumer Driven Health Plans
- Health Reimbursement Arrangements
- COVA HealthAware Incentives
- Aetna Member Tools & Resources
- Aetna Employee Assistance Program (EAP)

COVA Care and COVA HDHP:

- COVA - Getting to Know Your EAP
- Focus on 2015 COVA Care and COVA HDHP Buy-ups and BlueCard
- Introducing LiveHealth Online
- Pharmacy Benefit
- ER Alternatives

Flexible Spending Account: Using Your Flexible Spending Account

The Ombudsman's team communicates frequently with all plan vendors to discuss coverage, eligibility and claims issues as well as various topics and concerns that directly affect our members. 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.

CONCLUSION

This fiscal year again required 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 to covered state employees, retirees and The Local Choice members. The Ombudsman's team continued to serve plan members. 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.

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