COMMONWEALTH of VIRGINIA

Sara Redding Wilson
Director

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November 29, 2017

The Honorable Frank Wagner
The Honorable Stephen Newman
The Honorable Charles Carrico, Sr.
The Honorable Terry G. Kilgore
The Honorable Robert D. Orrock, Sr.

Dear Senator Wagner, Senator Newman, Senator Carrico, 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 29, 2017 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 2017

Office of State and Local Health Benefits Programs

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ANNUAL REPORT ON
OMBUDSMAN ACTIVITIES & SERVICES
FISCAL YEAR 2017

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, 2016 through June 30, 2017. During this fiscal year, 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 members in understanding their benefits, as well as their rights, and the processes available through the program. The team also guided covered members in the utilization of available health plan resources.

In fiscal year 2017, the Ombudsman's team handled 7,923 issues and reviewed 125 formal appeals. The team continues to:

- resolve issues and solve problems in a timely manner;
- consistently analyze issues, identify emerging trends and work to correct systemic issues;
- update policies and provide meaningful communication to our customers; and
- make every effort to maximize the accessibility and effectiveness of the Health Benefits Program.

Key initiatives and projects managed during the fiscal year include:

- **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:

    - **Section 1557, Nondiscrimination in Health Programs and Activities,** prohibits discrimination in health care programs or activities on the basis of race, color, national origin, sex, age, or disability. The Department of Human Resource Management's Office of Health Benefits reviewed the provisions of ACA Section 1557 and implemented the processes to ensure compliance. This included:
        - Publishing the Commonwealth of Virginia's Health Benefits Program Nondiscrimination Notice on the DHRM web site by October 16, 2016.
        - Ensuring language accessibility taglines are included in all significant communications.
        - Working with claims administrators to ensure that all required coverage changes were effective July 1, 2017.

    - **Employer Mandate** for reporting health care enrollment for plan members. The Ombudsman and OHB team members worked with state agencies and local employer groups to update the information in our eligibility system to ensure the accuracy of the information included on the report to the IRS regarding enrollment in qualified health

coverage and the mailing of 1095 forms to approximately 150,000 state and local employees in March 2017.

- **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.

- **Health Benefits Plans and Programs** - the Ombudsman continued to work with other DHRM employees on various components of the health plans for the state employee and retiree population, including a comprehensive health and wellness management program, MyActiveHealth. The team worked to modify 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 for both the state and The Local Choice programs and the team worked on the benefit and claims resolutions for all plans. Our team continues to work with the health plan vendors to develop a communication strategy aimed at educating both the provider community and members regarding various benefits, provisions and services.

  The Ombudsman and members of her team, as requested, also assisted with the development of two new health plan options to be administered by the Department of Human Resource Management (DHRM) effective with Fiscal Years 2018 and 2019.

  - **Line of Duty Act (LODA) Health Plan -** LODA offers various benefits to public safety workers injured in the line of duty or to their surviving spouses when they are killed in the line of duty. These benefits include health benefits for them and their family at the time at which they qualified for LODA benefits. DHRM became responsible for the administration of LODA health benefits effective July 1, 2017. The Ombudsman's team assisted with updating and enrolling members in the system during the implementation phase to ensure members had access to their benefits on the effective date of the LODA Health Benefits Plans. The plans provide coverage to approximately 1,300 LODA beneficiaries and their dependents.

  - **COVA Local Option Health Plan (SB 364 Plan) -** This plan, which is being developed pursuant to the 2016 Legislation SB 364, is a health plan option for schools, local governments and other political subdivisions. It will have one risk pool and therefore one set of rates. Its benefit design will be similar to state employee health plans. The Ombudsman will continue to work closely with the OHB policy team and Director on the ongoing development of the plan design and provisions.

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.

BACKGROUND

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 Ombudsman was also appointed as the OHB Compliance Officer for the ACA Section 1557 Nondiscrimination provisions.

The State Health Benefits Program covered approximately 100,000 state employees and 45,000 early and Medicare-eligible retirees during this fiscal year. The Local Choice Health Benefits Program covered 435 local employer groups. The employer groups provided benefits for approximately 47,000 employees and retirees of local school systems, governmental entities and political subdivisions. In total, the Ombudsman's team served over 315,000 state and local government employees, retirees, and family members during fiscal year 2017.

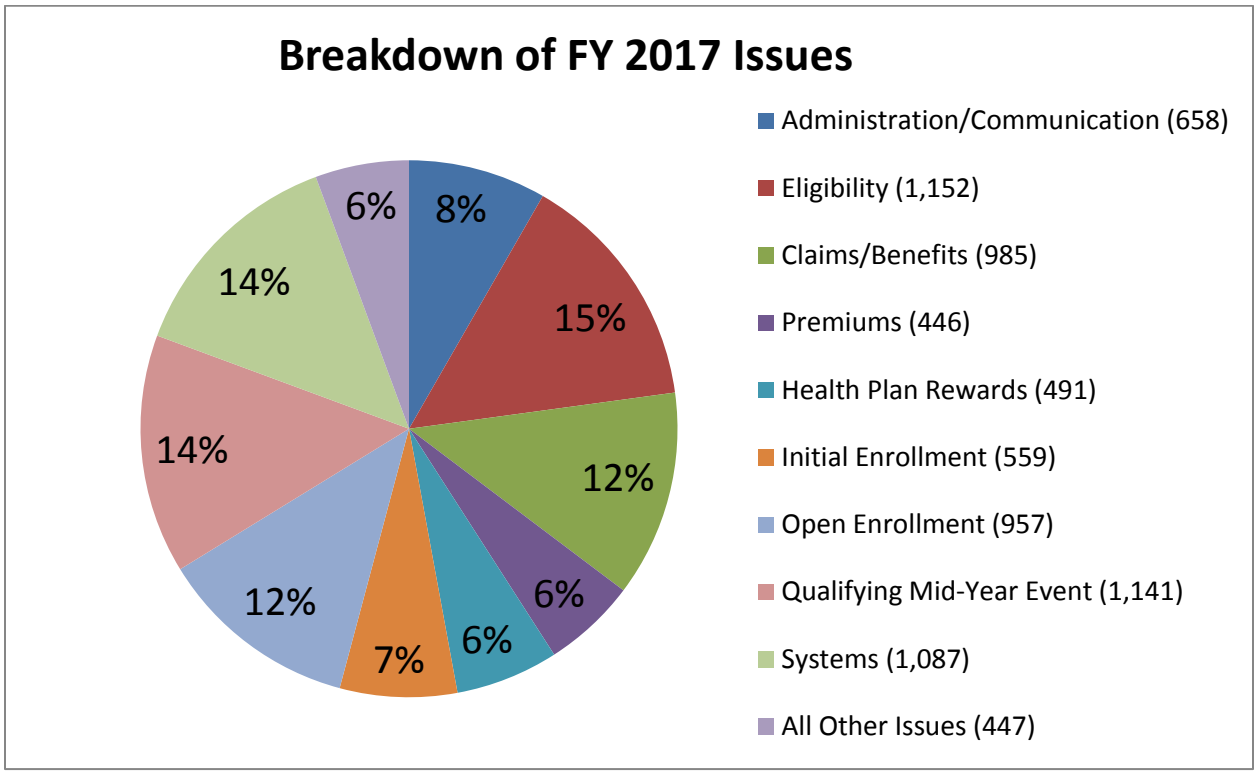
The Ombudsman's team provided services to over 600 human resource professionals during this period. The team assists for over 300 Human Resource Benefits Administrators and Managers statewide who administer health benefits within state agencies and sought assistance with program administration and policy application. Team members also serve as a resource for approximately 400 Group Benefit Administrators in The Local Choice Program.

The Ombudsman worked closely with the Office of the Attorney General for advice and legal counsel concerning appeals, compliance, and issues of equity. She also worked with the consulting services contractor who provides assistance in the design and administration of the State's health benefits programs particularly with respect to actuarial services, regulatory compliance, benefits design, and data integration.

EMPLOYEE AND RETIREE SERVICES

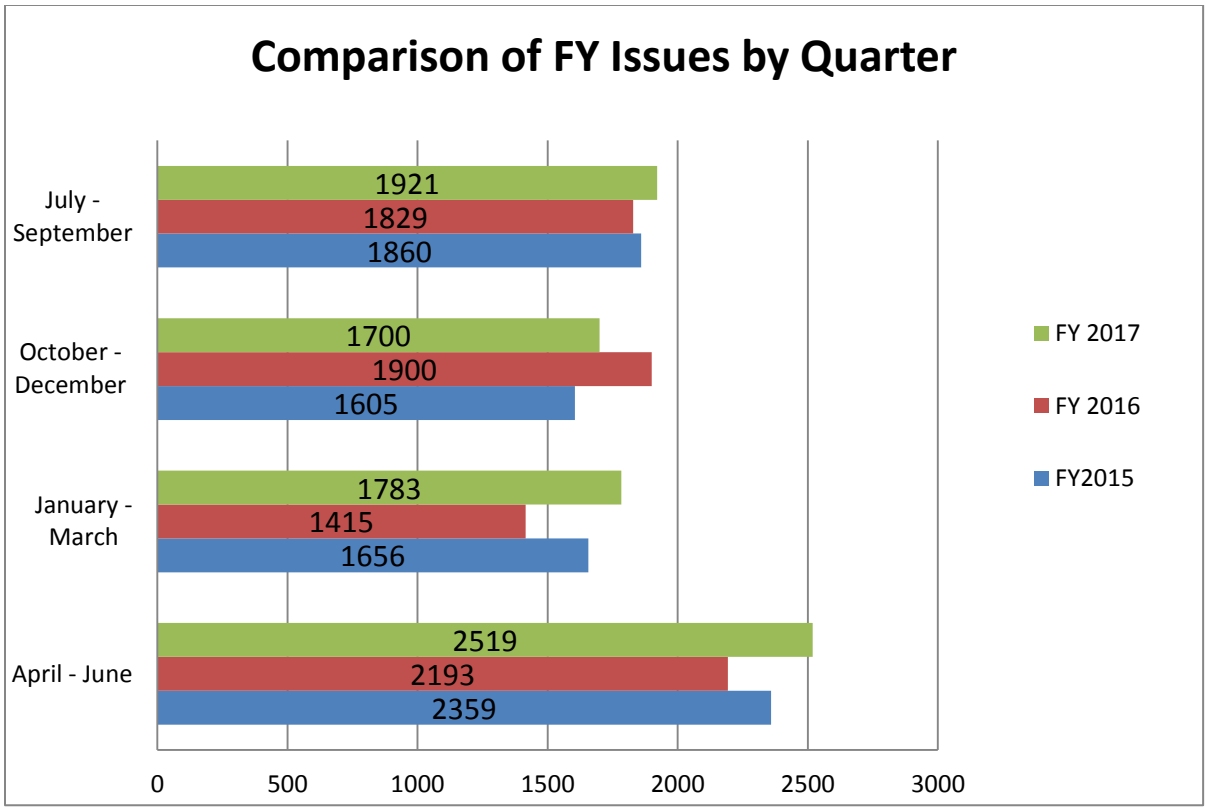
In FY 2017, the Ombudsman's team handled 7,923 issues from employees, retirees, agency Benefits Administrators, legislators, providers, and other interested parties. These included general inquiries, requests for assistance related to benefits, communications, vendor services, policy interpretation, system updates, and complaints. 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.

Although the program implemented no changes to the plan designs for the FY 2017 plan year, there was a 7.4% increase in the number of contacts requesting assistance, clarification and/or guidance on procedures and policies. The migration of DHRM's personnel and benefits eligibility systems to a new platform was the driver of the influx in the number of inquiries between January and June of this year.

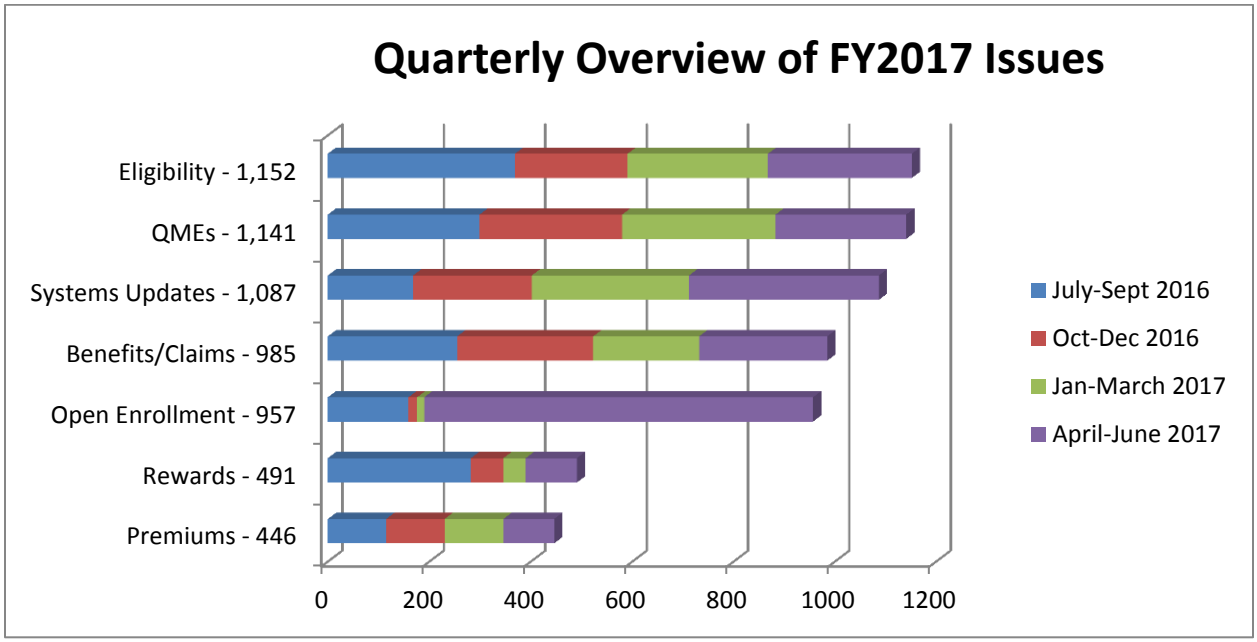


The major topics, which accounted for 55% of this fiscal year's issues, were related to:

- eligibility requirements for employees, retirees, and dependents - 15%
- qualifying midyear events (QMEs) election change requests – 14%
- assistance in updating the benefits eligibility system (BES) – 14%
- healthcare claims and benefits available under the plans - 12%



The Office of Health Benefits (OHB) received a consistent number of inquiries each quarter related to benefits and claims, qualifying midyear events (QME) and eligibility issues. Many of the eligibility and QME issues dealt with the definition of a dependent and the documentation required to support election change requests.



As in past years, the Open Enrollment inquiries, which accounted for 12% of the total inquiries, were received during the first and fourth quarters of the plan year. The inquiries received during the July through September period are participants trying to confirm or correct errors made during the 2016 Open Enrollment period, while the contacts during April through June centered on plan design and premium changes for the July 1, 2017 plan year, and clarification on the enrollment process and deadlines. This year, the online enrollment system was not available for the annual open enrollment period. OHB had an influx in the number of inquiries due to the due to the need for employees to submit paper enrollment forms for any 2017-2018 plan year elections and the need for OHB's assistance with processing the requests.

An update to the OHB Customer Relations Management system provided the Ombudsman with better data on the inquiries for two categories for the fiscal year. The first new category includes the inquiries specially related to administration issues (such as the ACA reporting and forms), and communications provided by our office and vendors to the agencies and/or members. These inquiries, grouped as Administration and Communication, accounted for 8% of this year's issues.

The program provides an opportunity for health care enrollments based on specified changes in the employment status of employees, such as the commencement or termination of employment, retirement, or transitioning to long-term disability. Under the program's provisions, the participants must submit their election within a defined period, based on the situation. Active employees have a 30-day period to make an election. There is a 31-day period for retiree group participants to make their election and there is a 60-day period for Extended Coverage (COBRA) beneficiaries. We logged 559 inquiries regarding Initial Enrollment requests which accounted for 7% of the cases.

Affordable Care Act (ACA) Section 1557, Nondiscrimination in Health Programs and Activities - Section 1557, the nondiscrimination provision of ACA, prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities. Building on many long-standing federal civil rights laws, Section 1557 extends nondiscrimination protections to individuals participating in any health program or activity. The law also requires the health plan to provide: free aids and services, such as sign language interpreters, to members with disabilities so that they can communicate effectively with the health plan; written information to members with disabilities in other formats and free language services, such as language interpreters, to members whose primary language is not English.

The Ombudsman was designated to serve as the Section 1557 Compliance Officer for the Office of Health Benefits. Working with the many key DHRM team members, the Ombudsman:

- established a process to access the required translation services,
- developed a grievance process for members should they feel the health plan has not provided the required services,
- developed the health plan's Nondiscrimination Notice, which is posted to the DHRM website, as required,

- implemented procedures with the plan vendors to include the language assistance information with all significant member-facing communications, and
- ensured compliance with Section 1557.

Employer Mandate Reporting - The employer mandate provision of the Affordable Care Act (ACA) requires employers, such as the Commonwealth, to offer minimum value, affordable health coverage to their full-time employees or face a penalty. To determine if the employers are offering minimum value, affordable coverage to their full-time workers, the Internal Revenue Service (IRS) requires this Employer Mandate Reporting.

DHRM, on behalf of the state agencies and local employers participating with the State and Local Health Benefits Program, compiled and reported the calendar-year information about the health insurance coverage offered to employees and their covered family members. The Ombudsman, working with the Systems Team and the Communications Manager, provided assistance in the reconciliation of the data to ensure compliance with the required reporting to the IRS on behalf of the state and local employer groups covered by the program. IRS 1095 forms for the 2016 tax year were mailed to state and local health plan participants before the March 2017 filing date.

APPEALS

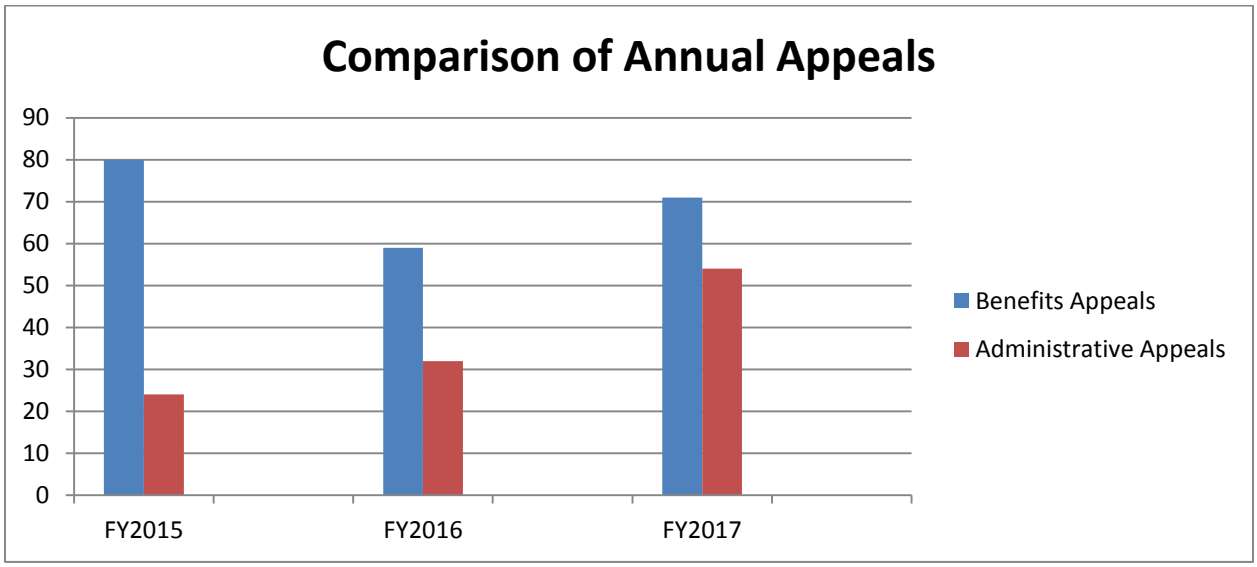
Charged with the oversight of the appeals process, the Ombudsman or an appeals examiner, served as the contact for appellants. Every effort was made to assure that all appellants received the full extent of the benefits to which they were entitled under the rules of the program.

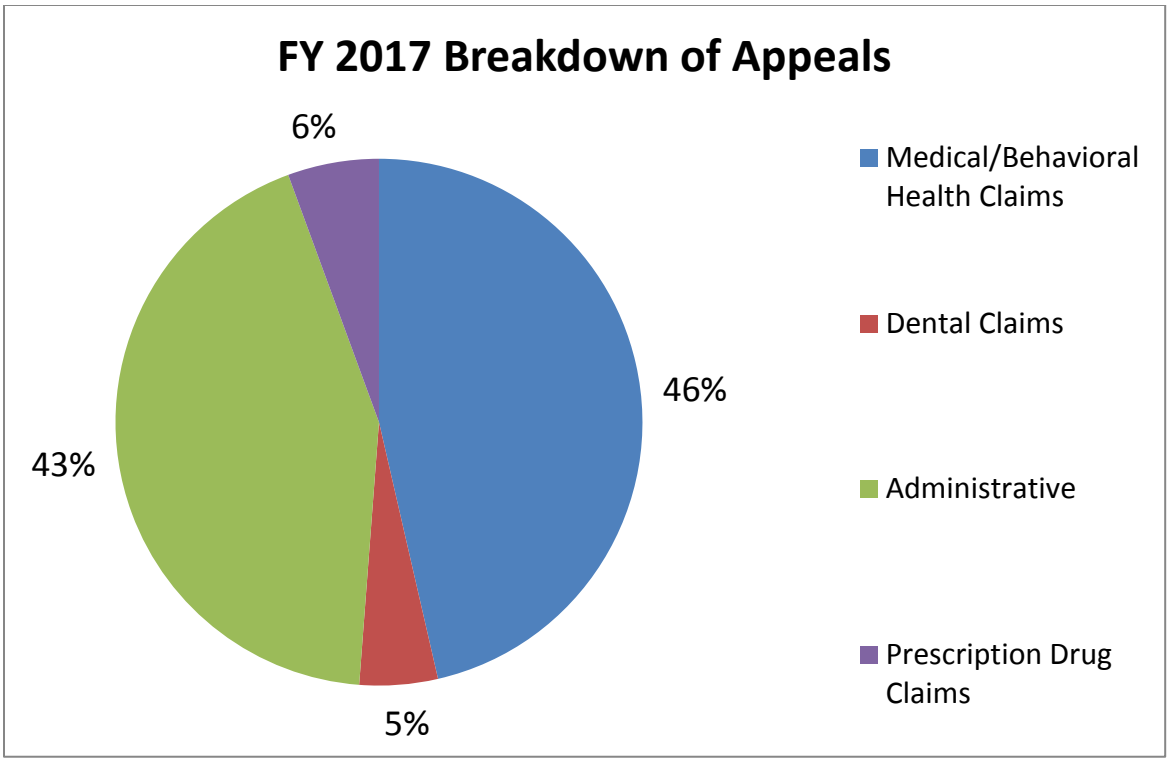
There are two classifications of appeals:

1. **Plan benefits** which involve claim and service issues, and
2. **Program administration** which involves eligibility 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. Members, also, have the right to appeal administrative denials to the Director of DHRM.

During the 2017 fiscal year, 125 appeals were submitted to the Director of DHRM. This compares to 104 appeals for the 2015 fiscal year and 91 for the 2016 fiscal year. For FY 2017, 71, or 57%, of the appeals received were related to benefits issues and 54, or 43%, were related to administration issues.



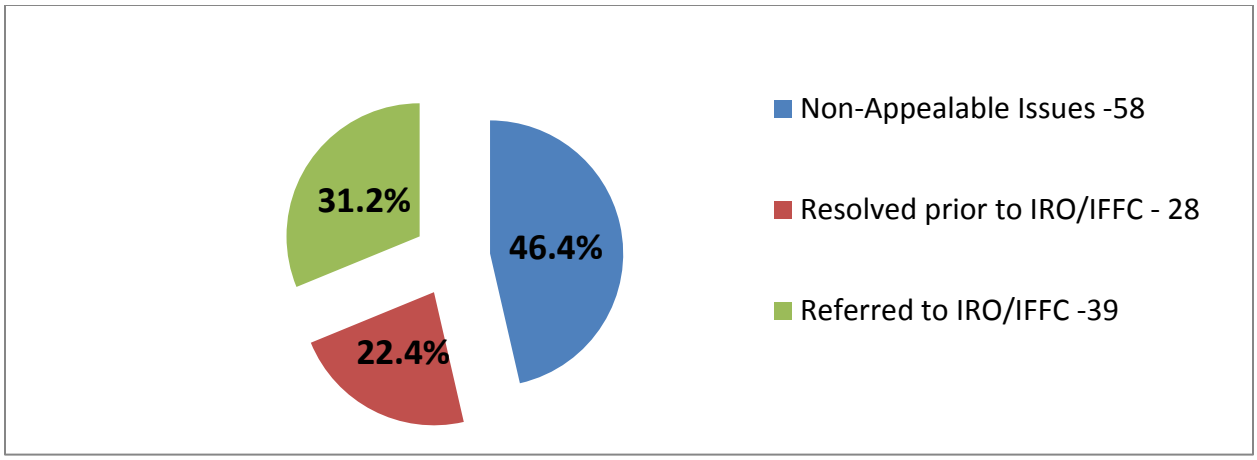


Once received by DHRM, the Ombudsman's team strives to resolve the appeal as soon as possible. Each issue is evaluated to ensure the denial was in line with the provisions of the program and no substantive error was made in the review process. In many cases, DHRM, working with the health plan administrator and/or the member, is able to resolve the issue. Appeals are only resolved in this phase if the resolution is in favor of the appellant. During FY 2017, 28 appeals (22.4%) were resolved by the Ombudsman's team without the need for an additional review.

Matters in which the sole issue is a disagreement with policy or a contractual exclusion are not appealable under the program. Each case was evaluated to ensure that the program rules and benefits were applied correctly. Fifty-eight appeals (46.6%) filed were determined to be non-appealable because the member requests were in direct conflict with a program provision or plan benefit, such as requests for:

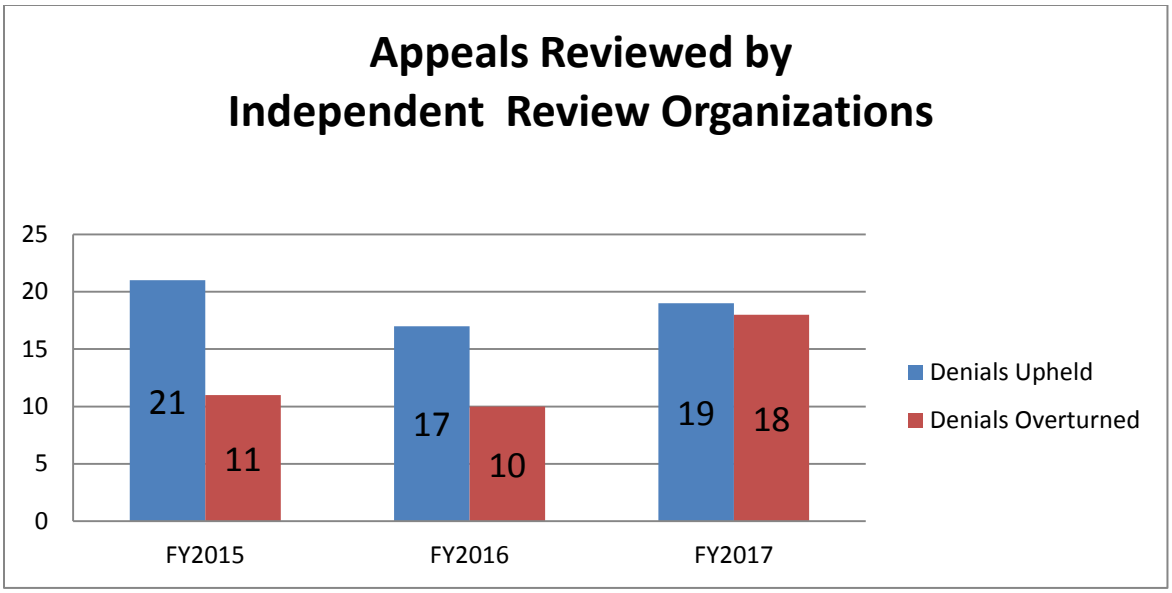
- the plan to assist with the balance billed by an out-of-network provider.
- an exception to allow coverage for an excluded service.
- an exception to the mandatory generic prescription provision.

The remaining appeals included 37 appeals (30%) which were handled through the independent third party review process and 2 appeals (1%) which were handled by the DHRM administrative review process.



Independent Review Organizations - The 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**. Adverse determination for plan benefit appeals are reviewed by an independent review organization (IRO). In accordance with health care reform provisions, DHRM has contracts with three vendors to conduct these reviews.

Appeals 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 37 appeals referred to an IRO this fiscal year, 32 (86%) were submitted and handled through the standard process and 5 (14%) were accepted as expedited appeals with a decision being rendered within 72 hours. Of the appeals reviewed by an IRO this fiscal year, 18 (46%) of the determinations were overturned or reversed, including one partial approval of the course of treatment for a member.



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. Most appeals this fiscal year were due to denials of medical services felt to be "experimental and/or investigational" by the plan administrator, there was not a specific type of service appealed.

Informal Fact Finding Consultations - An independent review is not required for administrative appeals involving program provisions and/or eligibility issues. When the issues involve 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 was offered to the appellant. There were two (2) IFFCs requested during the 2017 fiscal year. The Director, Ombudsman and Appeals Examiner 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 made a determination on the appeal and communicated the decision to the appellant by letter. The Director's appeal decision was final and binding. Both of the appeals reviewed through the IFFC process this fiscal year were approved.

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. There were no cases filed under the APA during the 2017 Fiscal Year.

COMMUNICATIONS

The Ombudsman is involved in the development and review of communications for all Health Benefits Program publications, web site information, and vendor communications to members. With the implementation of the plan changes for the 2016-2017 plan year, the Ombudsman and her team worked closely with the DHRM Communications Manager, program managers and each of the plan vendors to develop benefits communications on various program components, Open Enrollment, and provided feedback on web site design and content. The Ombudsman also worked on monthly communications to the agencies to address program administration issues, many of which were identified by monitoring the trend of the inquiries to OHB.

Summary of Benefits and Coverage -The Affordable Care Act (ACA) required all employers to provide a standardized document that outlines benefits and the coverage provisions associated with each plan. During fiscal year 2017, the Department of Health and Human Services (HHS), the Department of Labor (DOL) and the Department of the Treasury announced key enhancements to the Summary of Benefits and Coverage (SBC) template and Uniform Glossary. The improvements include an additional coverage example and language and terms to improve consumers' understanding of their health coverage. The Ombudsman and team, along with other members of OHB, worked with the plan vendors to incorporate the updates to the Summary of Benefits and Coverage (SBC) for the health plans offered under the State and The Local Choice programs.

Capitol Square Healthcare Clinic – The Ombudsman worked closely with the staff of the Capitol Square Healthcare Clinic and assisted the clinic staff with eligibility questions for employees. She and members of her team handle inquiries to OHB about the clinic. The Ombudsman worked with the DHRM Communications Manager on the monthly communication messages to employees about the clinic services. They also work on updating the brochures, signage and FAQs for the clinic.

Benefits Administrator Webinar Series – Fiscal Year 2017, the Office of Health Benefits worked with the fully-insured health plan, Kaiser Permanente, to develop a webinar on the benefits and features of the HMO plan. There was a webinar for the COVA Care and COVA HDHP plans administered by Anthem. The session was designed to increase the understanding of the Employee Assistance Program (EAP) and LiveHealth Online (LHO), in order to increase the usage of these valuable benefits. LiveHealth Online allows members to consult with board certified physician anytime by smartphone, webcam, or tablet for the cost of their normal PCP visit. In addition to the EAP services addressed in the employee's member handbook, this webinar provided a reminder that Anthem's EAP can be used as a resource to provide pertinent, professional and timely workshops for the agencies.

The Ombudsman's team communicated 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 worked with the vendors to prepare ongoing information regarding the plan benefits and also participates in all applicable monthly vendor meetings and attends the annual vendor review session.

CONCLUSION

In the pursuit of excellence, the Ombudsman's team focuses on delivering quality service to all customers. As always, the team continues to solicit and act on customer feedback. The team strives to thoroughly investigate complaints and appeals, dealing with each issue fairly and consistently. Paying attention to trends as they develop, team members endeavor to identify and resolve systemic issues and to promote continual improvement of the State and Local Health Benefits Program.

As the Health Benefits Program moves into the next fiscal year and the implementation and administration of new programs, the Ombudsman's team will strive to continue the high standards of service to customers, who include not just the members covered under the program, but the citizens of Virginia, in a cost-effective way.