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November 20, 2018

The Honorable Frank Wagner, Senate of Virginia
The Honorable Stephen Newman, Senate of Virginia
The Honorable Roslyn R. Dance, Senate of Virginia
The Honorable Terry G. Kilgore, Virginia House of Delegates
The Honorable Robert D. Orrock, Sr., Virginia House of Delegates
The Honorable Keyanna Conner, Secretary of Administration

Subject: Report of the State Health Benefits Ombudsman

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 in response to this requirement.

Respectfully,

Emily S. Elliott

Emily S. Elliott
Director
Department of Human Resource Management

OMBUDSMAN
ANNUAL REPORT
FISCAL YEAR 2018

Office of State and Local Health Benefits Programs

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ANNUAL REPORT ON
OMBUDSMAN ACTIVITIES & SERVICES
FISCAL YEAR 2018

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, 2017 through June 30, 2018. 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 2018, the Ombudsman's team handled 9,217 issues and reviewed 152 formal appeal requests. 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:

Health Benefits Plans and Programs - working with members of the OHB Policy Team and the Communication Manager, the Ombudsman assisted in the development of

- annual member communications
- member handbooks and handbook amendments for the health plans,
- monthly EAP promotions, and
- a revised *Getting to Know Your Benefits* brochure for newly eligible state employees.

- **Affordable Care Act Provisions** - The Ombudsman worked with other DHRM employees on various provisions of the Affordable Care Act (ACA) during this fiscal year. These include

    - **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 for the 2017 tax year to approximately 150,000 state and local employees.

- **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 for the annual open enrollment period and as a newly eligible employee.

The Ombudsman worked with other DHRM employees on various components of the program for the state employee and retiree population, including the related communication materials. The additional components include:

- The comprehensive health and wellness management program, MyActiveHealth
- The premium rewards program,
- Capital Square Healthcare Clinic and
- ALEX, the health benefits program online counseling tool.

Our team continues to work with the health plan vendors to develop a communication strategy aimed at educating both the members and the provider community regarding various benefits, provisions and services available through the state health benefits program.

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 also serves as the compliance officer for the ACA Section 1557 Nondiscrimination provisions for the Office of Health Benefits.

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 2018.

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 2018, the Ombudsman's team handled 9,217 issues from employees, retirees, agency Benefits Administrators, legislators, providers, and other interested parties. These included general and member specific inquiries, complaints and requests related to benefits, communications, vendor services, policy interpretation, and system updates. Depending on the issue, the team may contact the claims administrator or the member's benefits office to obtain the details and/or information for each situation to provide a resolution for the member or a response to the question.

Although the program implemented no major changes to the plan designs for the FY 2018 plan year, there was a 16% increase in the number of contacts to our office requesting assistance, clarification and/or guidance on procedures and policies. The system platform for DHRM's personnel and benefits eligibility systems continues to be a driver for the influx of issues for the team.

The major topics, which accounted for 56% of this fiscal year's issues, were related to:

- assistance in updating the benefits eligibility system (BES) – 18%
- eligibility requirements for employees, retirees, and dependents - 17%
- qualifying midyear events (QMEs) election change requests – 11%
- healthcare claims and benefits available under the plans - 10%

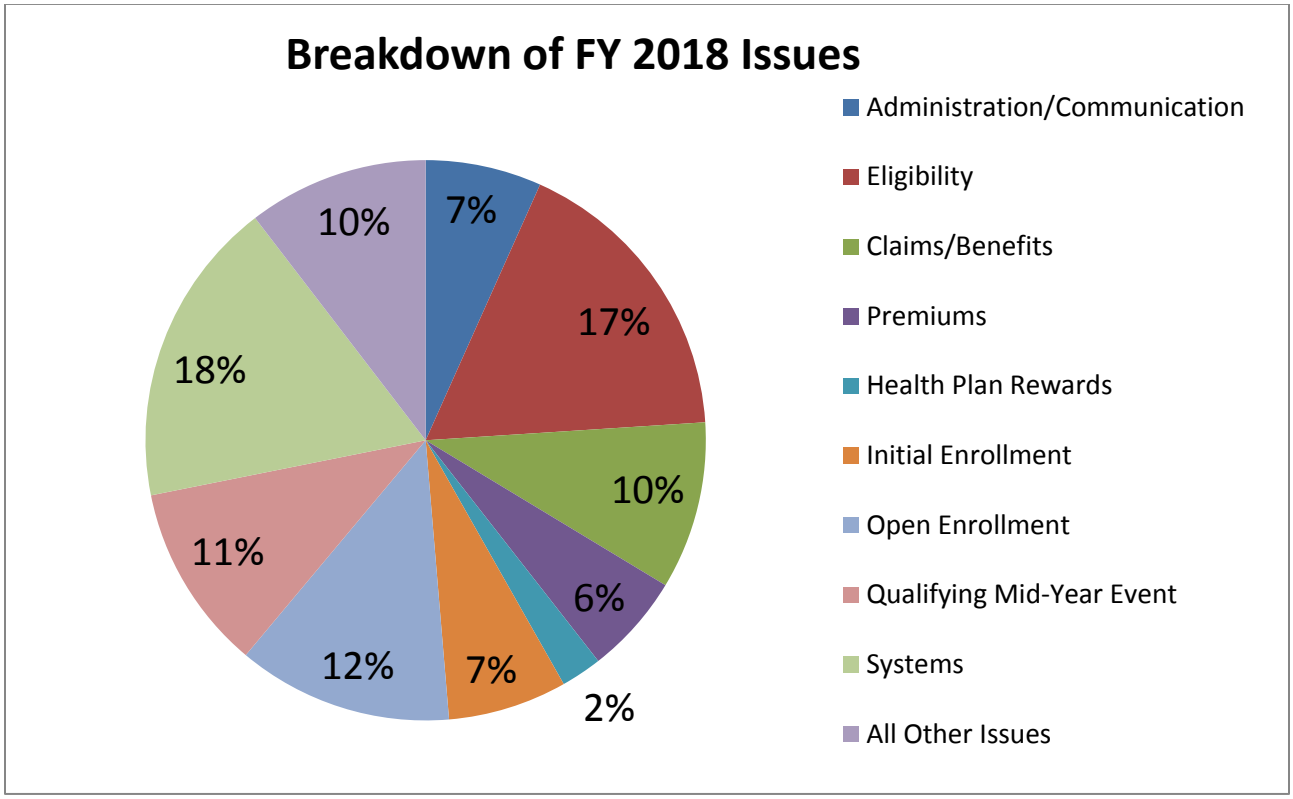
The Office of Health Benefits (OHB) received a consistent number of inquiries each quarter related to system update requests, benefits and claims, qualifying midyear events (QME), plan premiums and eligibility issues. Other topics tend to peak at specific times during the plan year. We monitor these trends and strive to prepare proactive communications and resources to assist the agencies and members. Some of these issues are:

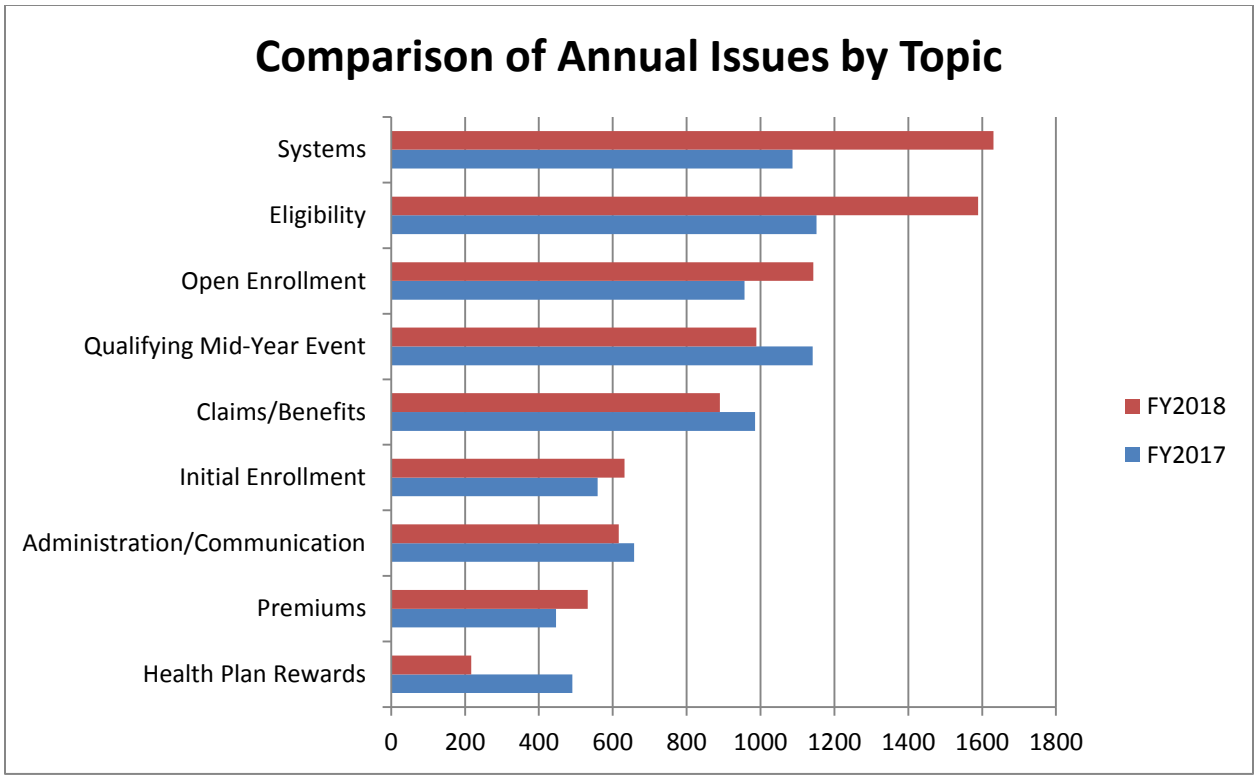
Open Enrollment - As in past years, these inquiries, which accounted for 12% of total inquiries, were received during the first and fourth quarters of the plan year. The inquiries received during the July through September period were participants trying to confirm elections or correct errors made during the 2017 Open Enrollment period, while the contacts during April through June centered on plan design and premium changes for the July 1, 2018 plan year, and clarification on the enrollment process and deadlines. The online enrollment system was not available again this year for the annual open enrollment period. OHB had an influx in the number of inquiries and complaints regarding the paper enrollment form submissions for 2018-2019 plan year elections and requests for OHB's assistance with processing Open Enrollment requests.

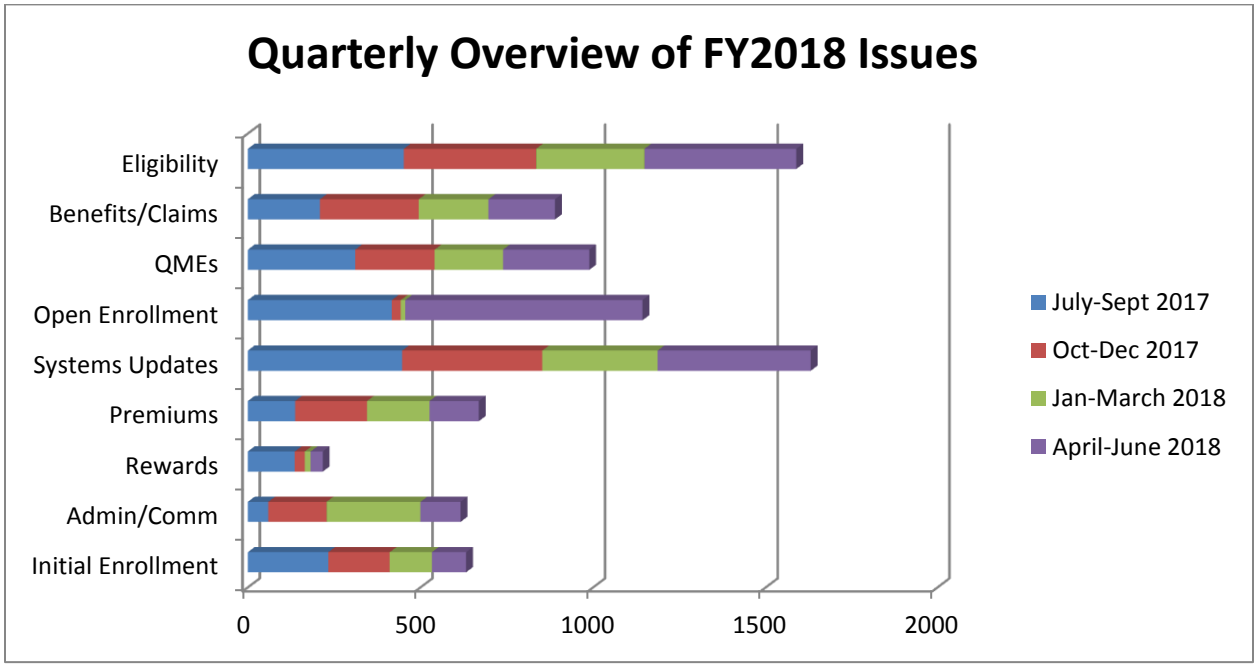
Administration and Communication - This category includes the inquiries specially related to administrative requirements such as the ACA reporting and forms, HIPAA Privacy and Extended Coverage (COBRA) notices and communications provided by our office and vendors to the agencies and/or members. These 616 inquiries accounted for 8% of this year's issues with the majority of the inquiries received during the January to March period. These included general questions about the ACA reporting procedures and specific 1095 forms questions.

Initial Enrollment - The program provides an opportunity for health care enrollments based on specified changes in employment status, 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. There is normally an influx in the inquiries during the first quarter of the plan year due to new faculty contracts in the higher education agencies and with the local government schools. We logged 632 inquiries regarding initial enrollments which accounted for 7% of the plan year issues.

Health Plan Rewards - Two of the Commonwealth's self-insured plans (COVA Care and COVA HealthAware) include incentive programs that reward members for completing specific activities and/or participating with our health and wellness program. 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. There is also a prenatal maternity management program with an incentive for compliant members. Inquiries related to these programs only accounted for 2% of this year's total. The questions, received primarily during the first quarter of the plan year, were related to the requirements for the premium reward program.







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.

In addition to the issues reported above, the Ombudsman, working with the Systems Team and the Communications Manager, provided assistance with 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 2017 tax year were mailed to state and local health plan participants before the March 2018 filing date.

APPEALS

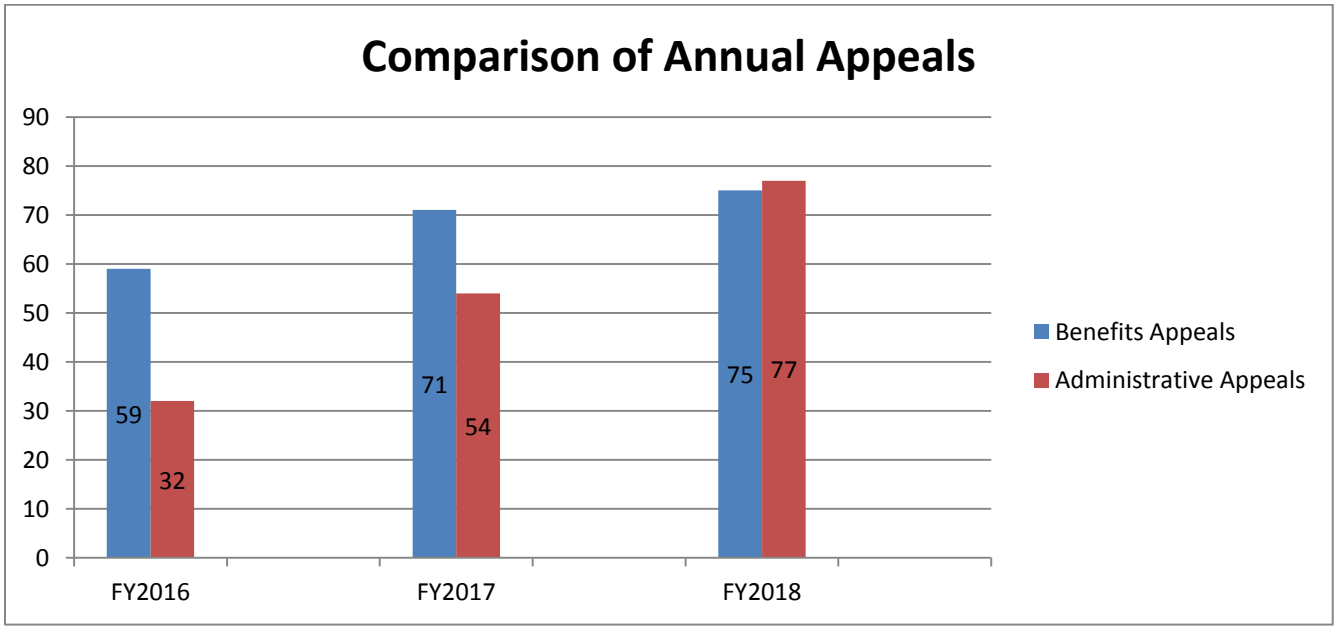
Charged with the oversight of the appeals process, the Ombudsman or an appeals examiner, served as the contact for appellants. Every effort was made to assure that all appellants received the full extent of the benefits to which they were entitled under the rules of the program.

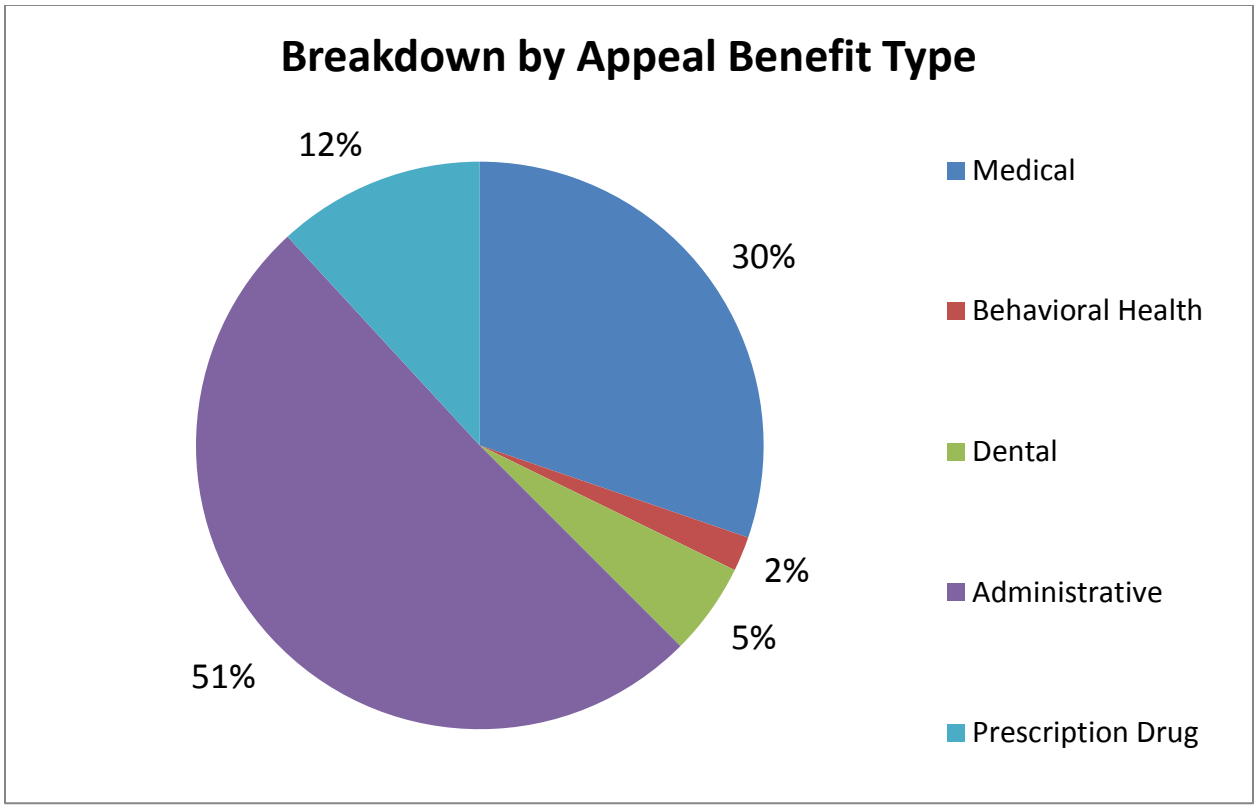
There are two classifications of appeals:

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 claim components of the Health Benefits Program has an internal process for benefits appeals. After exhausting the appeals with a specific vendor, a member has the right to appeal any adverse decision to DHRM. Members also have the right to appeal administrative denials to the Director of DHRM.

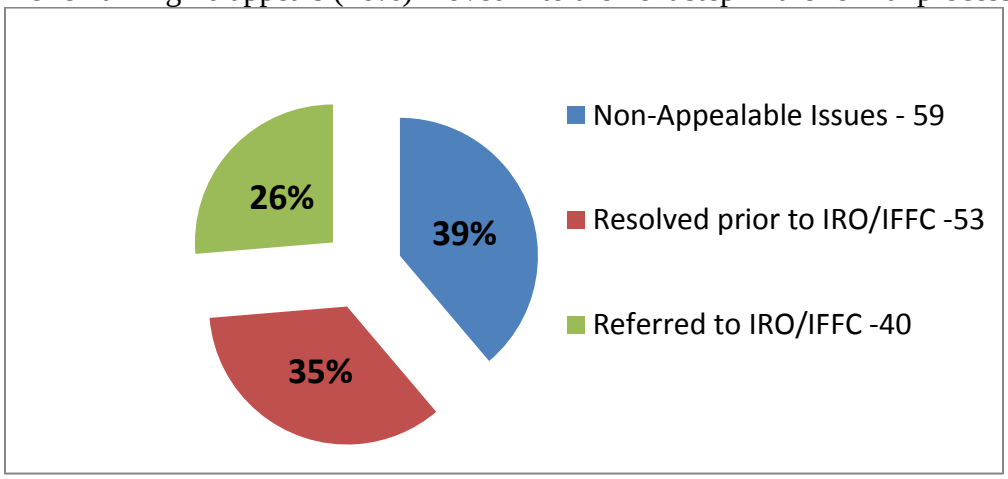
During the 2018 fiscal year, 152 appeals were submitted to DHRM. This compares to 125 appeals for the 2017 fiscal year and 91 for the 2016 fiscal year. For FY 2018, 75, or 49%, of the appeals received were related to plan benefits and 77, or 51%, were related to program administration.





Each appeal request is evaluated to ensure the denial was in line with the provisions of the program and no substantive errors were made. 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 2018, 53 appeals (35%) 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-nine appeals (39%) filed were determined to be non-appealable because the member request was in direct conflict with a program provision or plan benefit. The remaining 40 appeals (26%) moved into the next step in the formal 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) who will make a determination whether the claims administrator's 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 40 benefits appeals referred to an IRO this fiscal year, 34 (85%) were submitted and handled through the standard process and 6 (15%) were accepted as expedited appeals with a decision being rendered within 72 hours. Of the appeals reviewed by an IRO this fiscal year, only 14 (35%) of the determinations were overturned. 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.

Informal Fact Finding Consultations – Depending on the administrative appeal request, the opportunity for an informal fact finding consultation (IFFC) with the Director may be offered to the appellant. There were no IFFCs requested during the 2018 fiscal year.

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 2018 Fiscal Year.

COMMUNICATIONS

The Ombudsman is involved in the development and review of communications for Health Benefits Program publications, web site information, and vendor communications to members. The Ombudsman and her team worked closely with the DHRM Communications Manager, program managers and each of the plan vendors on the implementation of the plan changes, and the development of benefit communications on various program components. The team also worked on the literature, forms and mailing for the annual Open Enrollment period. The Ombudsman also worked on communications to the agencies to address program administration issues, many of which were identified by monitoring the trend of the inquiries to OHB.

Getting to Know Your Benefits **brochure** – During this plan year, a revised new hire brochure was posted to the DHRM web site. The brochure provides general information on the health plan options for newly eligible state employees and specific information on the rules, requirements and policies for enrolling or making changes to elections for coverage. It also highlights many of the notices associated with the health benefits program. This brochure was designed as a resource to help employees make benefit choices that are best for their family's needs. It also serves as a benefits resource for employees who choose not to enroll in coverage when they are newly eligible.

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. The Ombudsman and team, along with other members of OHB, worked with the plan vendors to update 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 with the Communications Manager on the email messages to employees regarding the onsite clinic's services. They also updated the brochures, signage and FAQs for the clinic which is located in the James Monroe Building. The Ombudsman continues to work closely with the staff of the Capitol Square Healthcare Clinic, assisting the clinic staff with eligibility and procedural issues. She and members of her team handle inquiries to OHB regarding the clinic and the services available.

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. 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 and possible health plan administrator changes, 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.