COMMONWEALTH of VIRGINIA

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November 30, 2014

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 30, 2014 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 2014

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 2014

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, 2013 through June 30, 2014. 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 2014, the Ombudsman's team handled 9,158 formal case-specific inquiries and reviewed 73 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 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. Along with developing member communications and handbooks, the team worked on the benefit and claims resolutions for all plans due to:
    - changes in claim administrators for the Preferred Provider Organization (PPO) and High Deductible Health Plan (HDHP),
    - implementation of the new Consumer Directed Health Plan (CDHP),
    - changes in the dental benefits structure,
    - implementation of an integrated health and wellness management program, and
    - implementation of a premium rewards program.

- **Value Based Insurance Design (VBID) -** The Commonwealth's self-insured PPO and CDHP plans introduced several programs that rewarded members for completing healthy activities. 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 assist with tools to encourage changes in behavior.

- **Disease Management Reporting and Coaching Pilot Program -** Volunteers in a large statewide agency participated in a pilot program designed to provide individuals with detailed information about health risks associated with heart disease, stroke and diabetes by offering advance testing to identify hidden risk factors. The program 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 provided the oversight of the pilot program with the Department of Behavioral Health and Developmental Services (DBHDS) and Health Diagnostic Laboratories, Incorporated(HDL).

- **The Local Choice (TLC) Eligibility Migration** - The Ombudsman and team continued work with the TLC program manager and the OHB systems team to incorporate the eligibility and enrollment data for the TLC groups into the Commonwealth's Benefits Eligibility System (BES).

- **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 provisions include:

    - Summary of Benefits and Coverage –The Ombudsman and team worked with the plan vendors to develop new summaries for the State and The Local Choice health plan to help members compare and understand their options.
    - Notification of the Marketplace Exchange – Coordinated the distribution of the notice which contains information about the Health Insurance Marketplace to all employees.
    - Mandate for reporting employee health care enrollment.
    - Health Benefits for "Full-time" employees as defined by the ACA.

The Ombudsman's team continued to provide services to 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 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 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 fiscal year 2014.

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.

KEY INITIATIVES

- **2013-2014 Health Benefits Program** - Over 2,000 of this year's inquiries, 23%, were related to health care claims and the benefits available under the state health benefits program.
    - *COVA HealthAware* - The program introduced a consumer-directed health plan (CDHP) which combines high-deductible health coverage with a health reimbursement arrangement (HRA). Employees covered by COVA HealthAware pay lower premiums for their health coverage and use the HRA funds to help offset the deductible. The plan provides tools to help members compare health plan services and providers in their area with the objective of creating "wise consumers" of health care benefits. Members reached out to OHB for clarification on the benefits design, particularly on issues related to the application of the deductible and HRA funds.
    - *COVA Care* – While the overall benefits for the plan changed only slightly, the claims administrators changed for the behavioral health and prescription drug benefits and the dental benefits were restructured to comply with ACA requirements. Inquiries for this plan centered around (1) authorizations and tier changes for prescriptions and (2) restorative services, previously covered in the basic health plan, moving to the optional expanded dental buy-up.
    - *COVA HDHP* - Inquiries for this plan centered around the restructure of dental benefits to include an optional expanded dental buy-up. Previously, the health plan included full dental coverage.
    - *Flexible Spending Account (FSA)* – A new vendor was contracted to administer the FSA. Member issues dealt with new account set-up, including direct deposit banking authorizations and online access, new medical payment cards and claim filing processes.
    - *MyActiveHealth* – Administration of the disease management programs for all self-insured health plans was moved from the medical vendors to ActiveHealth Management. The new health and wellness program, MyActiveHealth, provides "coaching" services for members based on specific health conditions. The programs include:
        a. Healthy Insights –aids in managing long-term health conditions,
        b. Healthy Beginnings – managing prenatal maternity cases, and
        c. Healthy Lifestyles – provides help to reach personal health goals related to nutrition, smoking, exercise, stress, and weight management.

      The vendor also has oversight for the incentive programs which are included in the plans.

- **Value Based Insurance Design (VBID)** – Two of the Commonwealth's self-insured plans (COVA Care and COVA HealthAware) introduced several incentive programs that reward members for completing healthy activities. 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. Each of the components has specific eligibility criteria and compliance requirements. Questions about the VBID components administered through

MyActiveHealth accounted for 18% of this year's inquiries. The MyActiveHealth incentive components included:

A. Diabetes Management – Receive certain drugs and supplies at no cost,
B. Maternity Management – Receive a $300 copayment waiver (COVA Care) or HRA contribution (COVA HealthAware),
C. "Do-Right" Healthy Activities - Additional funding provided to the HRA for completing specific activities such as flu shots, annual physical exam, a dental exam and tracking healthy actions on the vendor's online portal,
D. Bariatric Pre-Surgery Education Program - Receive a copayment waiver (COVA Care) or HRA contribution (COVA HealthAware), and
E. Premium Rewards Program – reduction on the monthly health plan premium if the eligible member completed an online health risk assessment and a biometric screening.

OHB provided guidance to the agencies regarding these program components, worked with the vendor to facilitate worksite screening events across the state, developed communications regarding the components and worked with the members and vendors on the transition of services from the former administrators. The member compliance with the programs exceeded expectations for the first year, but as with many new programs, OHB had to provide continual explanation and/or confirmation of rules and processes to the members and benefits community to address member concerns. 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.

- **HIPAA Privacy and Security -** As a part of the administration of the Flexible Spending Accounts (FSA), the vendor produces an agency specific reimbursement account deduction variance report identifying any discrepancies between participants' expected and actual reimbursement account deductions. In July 2013, the FSA vendor sent a report identifying payroll discrepancies to individuals who are permitted to receive the report for their agency's employees; however, these individuals received the full report, not their agency specific report. The report included information for all participants enrolled in an FSA such as the employee's name, Social Security number, and plan enrollment information. The incident was reviewed in light of the HIPAA Privacy minimum necessary provision which limit how much protected health information (PHI) can be used or disclosed for a specific purpose.

  While this incident was determined not to be a "breach" of PHI as defined by the HIPAA Privacy regulations, a notification letter from the FSA administrator was sent to the affected participants. The letter, which provided an overview of the accidental disclosure, was approved by DHRM, the Office of the Attorney General, and claims administrator's legal staff, prior to distribution. The OHB HIPAA Privacy Officer, who is a member of the Ombudsman's team, obtained:

  - written assurances or certification from the human resource and payroll personnel verifying that they had permanently deleted or destroyed the correspondence containing the protected health information (PHI), and

- confirmation that the FSA vendor implemented steps to eliminate the risk of similar incidents going forward, including systematic safeguards to ensure data is sufficiently customized and restricted based on the recipient.

The Commonwealth's employee assistance program (EAP) includes a credit monitoring and identity theft service. This service was made available to all affected participants until June 30, 2016. This information was included in the notification letter. While the notification letter directed participants to the FSA vendor with questions and concerns, DHRM still received inquiries and requests for additional information from various parties regarding the incident.

- **Disease Management Reporting and Coaching Pilot Program -** Volunteers in a large statewide agency participated 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 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 provided the oversight of the pilot program with the Department of Behavioral Health and Developmental Services (DBHDS) and Health Diagnostic Laboratories, Incorporated (HDL).

  Initial Assessments for this pilot included 1,793 participants, 78% female and 22% male, with an average age of 49 years. The initial assessments provided the following observations:

  - Cardiovascular Disease (CVD) Risks - While approximately 50% of the participants showed high CVD risk with traditional cholesterol measures, over 67% of the participants showed high CVD risk with HDL advanced risk markers.
  - Diabetes Risks - Nearly 44% of participants with normal glucose levels were shown to have high risk markers for insulin resistance.
  - Overweight and Obese participants - 80% of the participants are either overweight or obese and 61% of these participants show high risk markers for both diabetes and CVD.

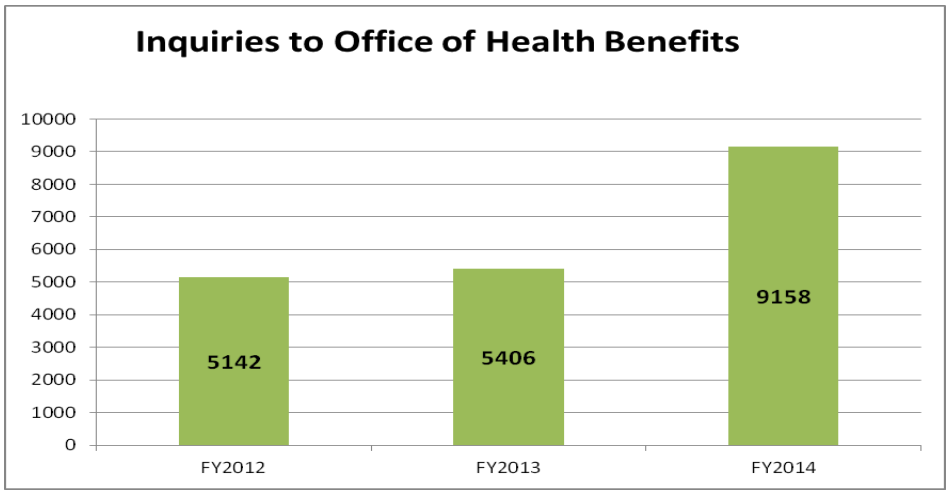
  Over 1,000 participants made follow-up appointments with HDL Clinical Health Consultants to receive coaching and guidance on lifestyle changes to effect healthy outcomes.

  The second assessments were performed in November 2013, five months after the initial contact. HDL felt the participants demonstrated a strong engagement rate and positive health outcomes. They reported:
  - 59% of the initial group continued engagement with their Clinical Health Consultant,
  - 51% shared results with their Primary Care Physician,
  - 85% were motivated to take action by lab results,
  - 48% of the overweight/obese participants lost an average of 5.7 pounds and reduced their waist size an average of 2.4 inches,
  - 14% reduced their diabetes risk factors, and
  - 6% showed improvement in lowering CVD risk factors.

There was a third assessment for the pilot which included the initial participants to evaluate the effectiveness of the HDL comprehensive testing and engagement program in reducing chronic disease risk. These assessments were completed in July of 2014. Information about the outcomes from these assessments will be included in the 2015 fiscal year report.

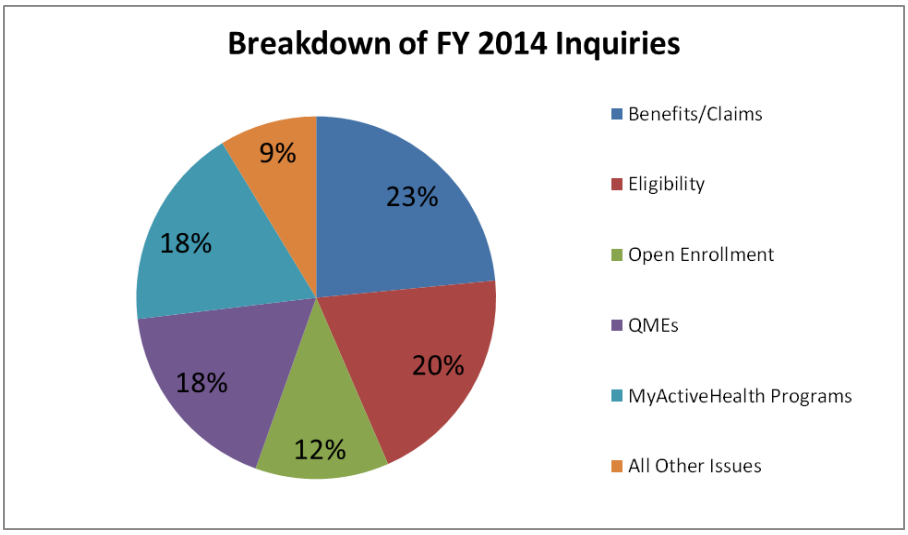
INQUIRIES

Inquiries to the Office of Health Benefits include written correspondence, e-mails, telephone calls, and in-person consultations. In FY 2014, the Ombudsman's team handled 9,158 formal case-specific inquiries from employees, retirees, agency Benefits Administrators, legislators, providers, and other interested parties. This represents a 69% increase from FY 2013 and compares to a 5% increase from FY 2012 to FY 2013.

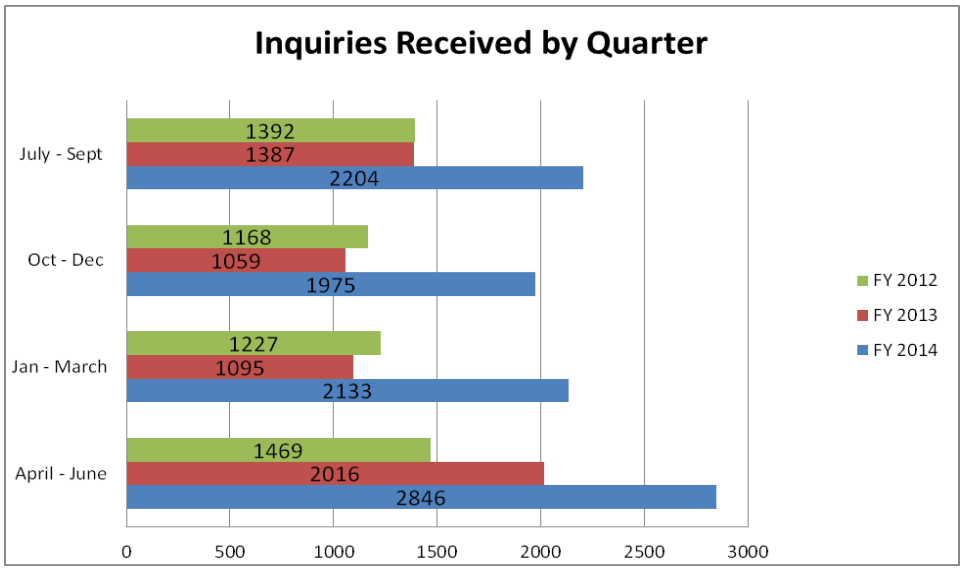


The main topics for inquiries this fiscal year were related to:

- health care claims and benefits available under the program - 23%
- eligibility requirements for employees, retirees, and dependents - 20%
- incentive and reward programs through MyActiveHealth - 18%
- qualifying midyear events (QMEs) election change requests – 18%
- Open Enrollment – 12%



There was a significant increase in the number of inquiries for each quarter of the 2013-2014 fiscal year. Last fiscal year, OHB recorded a 37% increase in the number of inquiries for the fourth quarter of the plan year. We attributed last year's increase to the implementation of the new wellness portal, premium rewards, incentive programs, and vendor changes announced before and during the 2013 May Open Enrollment.



The consistent contacts for the 2014 fiscal year appear to be related to the implementation of the various VBID components, program specific deadlines and vendor benefit system updates throughout the plan year. For example,

- During the late summer through early fall of 2013, OHB worked with ActiveHealth Management to provide guidance on the biometric screening requirement of the premium rewards program and facilitate worksite screening clinics across the state.
- In January 2014, the second phase of the premium reward program was applied to the member's premiums. OHB worked with the agencies and ActiveHealth Management to ensure all members who completed the requirements received the appropriate reward.
- The Open Enrollment period in the Spring generated questions about proposed plan and premium changes as well as clarification on how to qualify for various incentives.

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:

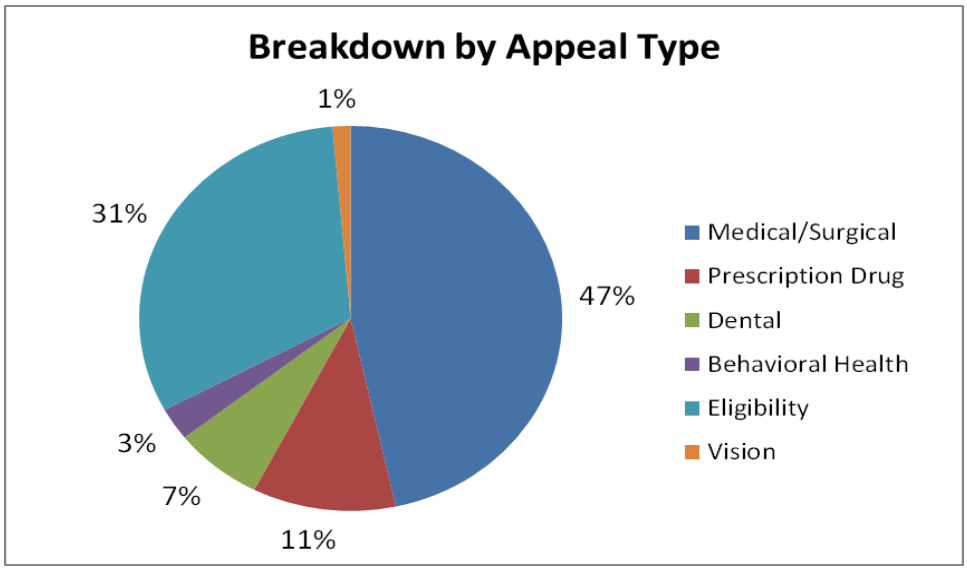
1. **Plan benefit** which involve claim issues, and
2. **Plan eligibility** which involve whether an individual qualifies for coverage or a benefit under the program.

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.

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 2014 fiscal year, 73 appeals were submitted to the Director of DHRM. This compares to one hundred thirteen (113) appeals for the 2012 fiscal year and one hundred seven (107) for FY 2013. For FY 2014, 47% of the appeals received related to medical/surgical claim issues while the second largest appeal category was eligibility issues, 31%.



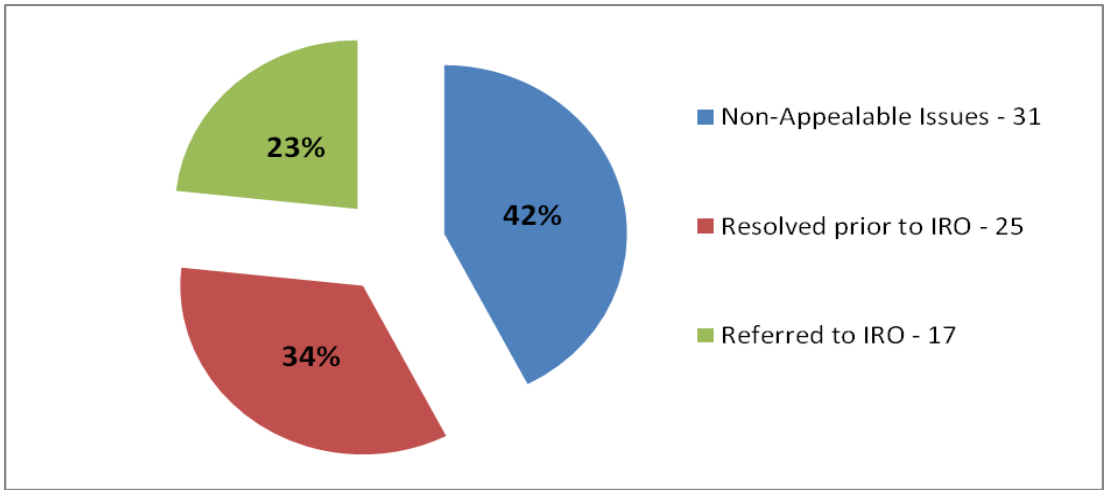
Once received by DHRM, the Ombudsman's team strives to resolve the appeal as early in the process as possible. Under the program, matters in which the sole issue is a disagreement with policy or a contractual exclusion are not appealable. Although these matters are not appealable, each case is evaluated to ensure that the program rules and benefits have been applied correctly. Thirty-one (31) appeals filed were determined to be 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 2014, twenty-five (25) appeals or 34% were resolved by DHRM without the need for an external review.

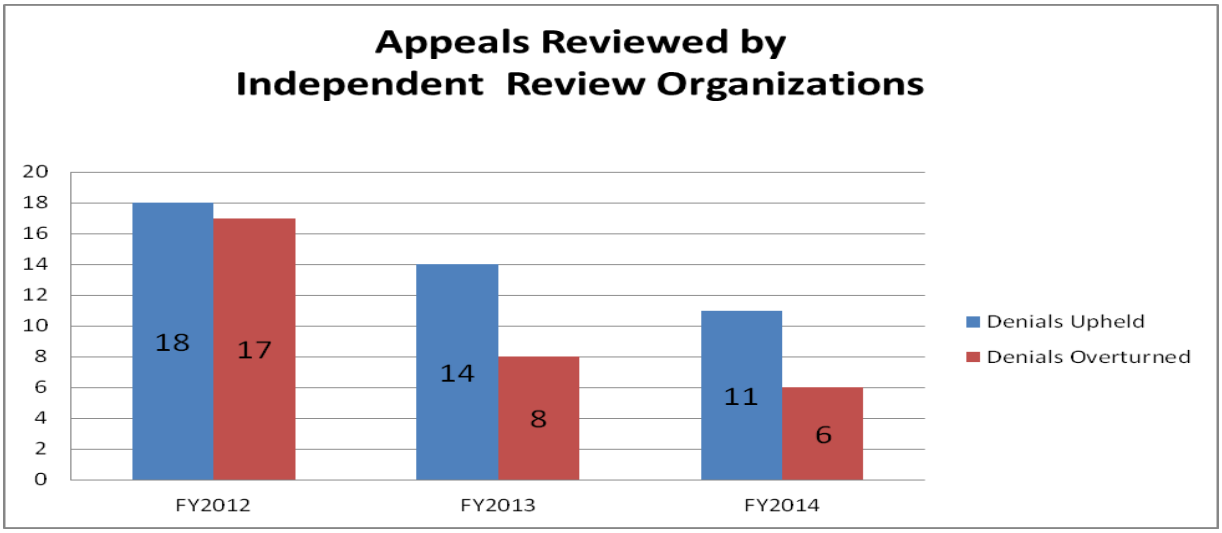
The remaining seventeen (17) appeals (23%) were handled through the independent third party review process.

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. While the program previously included provisions for expedited appeals, the expedited appeal process was a provision of the Affordable Care Act. Of the 17 appeals referred to an IRO this fiscal year, 86% were submitted and handled through the standard process and only one (1) was accepted as an expedited appeal with a decision being rendered within 72 hours.

Of the 17 appeals reviewed by an IRO this fiscal year, only six or 35% of the adverse determinations were overturned or reversed. The Ombudsman and the appeals analyst review the decisions based on the nature of the appeal and the reviewer to identify any patterns. A definitive reason for the decrease in the number of overturned decisions has not been identified.



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.

An independent review is not required for appeals involving eligibility issues. When the issues involved whether an individual is eligible 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 2014 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.

One (1) APA appeal was filed in FY 2014. The appeal, regarding an imaging request for the monitoring of cancer, was initially denied as investigational. The claim administrator's decision was reviewed and upheld by the independent review organization. An appeal was subsequently filed to the Circuit Court of Augusta County. The Ombudsman and appeal examiner worked with the Special Assistant to the Attorney General who represents DHRM in legal matters to prepare for the court case. The case was heard in November 2013 and the court's decision to uphold the determination was rendered in December 2013.

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.

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.

ACA also required employers to provide information to all employees regarding the new Marketplace and employment-based health coverage offered by the employer. The Ombudsman and OHB team members worked to distribute the Notice of "New Health Insurance Marketplace Coverage Options and Your Health Coverage" to all benefits eligible employees by the required deadline and also provided guidance to state agencies regarding distribution of the notice to non-benefit eligible employees based on the ACA requirements.

The State Health Benefits Plan meets the definition of a covered entity under HIPAA and must comply with the requirements to protect the privacy and security of health information. If a covered entity engages a business associate to carry out health care activities and functions, the covered entity must have a written contract that establishes specifically what the business associate has been engaged to do and requires the business associate to comply with the requirements to protect the privacy and security of protected health information. The Privacy Officer, along with the Ombudsman, policy team and the DHRM contracts and finance staff, worked to update the HIPAA Business Associate Agreements with the third party administrators to remain compliant with the HIPAA regulations.

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 benefits communications on various program components, Open Enrollment, health plan member handbooks, and provided feedback on web site design and content.

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

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, 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.

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 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.